An Inquiry of Early Childhood Development in a First Nation Community: Exploring how Families Experience Accessing Services

By

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DEDICATION

This work is dedicated to Msit No’kmaq, All My Relations.

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Abstract

Healthy wholistic development of Indigenous children in Canada is important to families and communities. Early Childhood Development has been identified by a First Nation community as a priority area that requires research. To gain an understanding about family's experiences when accessing services during the early years (age 0-7 years), a qualitative community based participatory study using a Two-Eyed Seeing approach and Jo-Anne Archibald's principles of Story-Work has been used to gain insight from seven parent/guardians and one Elder. Children, families, and communities are experiencing an imbalance within their physical, mental, emotional, and spiritual development due to a lack of equity in access to culturally appropriate services and supports. The knowledge gathered from the study will be useful for the community to help to inform policy and practice to improve services and support the optimal development of First Nations Children.

List of Abbreviations and Symbols Used

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ACHH	Aboriginal Children's Hurt and Healing Initiative
AHSOR	Aboriginal Head Start on Reserve
ASD	Autism Spectrum
CHN	Community Health Nurse
ECD	Early Childhood Development
EDI	Early Development Instrument
EIBI	Early Intensive Behavior Intervention
FASD	Fetal Alcohol Spectrum Disorder
GED	General Educational Development
IRS	Indian Residential School
JP	Jordan's Principle
MEW	Mi'kmaw Ethics Watch
MFCS	Mi'kmaq Family Children Services
MMIWG	Missing and Murdered Indigenous Women and Girls
N/A	Not applicable
NIHB	Non-Insured Health Benefits

NP	Nurse Practitioner
NSECDIS	Nova Scotia Early Childhood Development and Intervention Services
NSHS	Nova Scotia Hearing and Speech
RA	Research Assistant
RHS	Regional Health Survey
TRC	Truth and Reconciliation

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CHAPTER ONE: INTRODUCTION

Background

"Our Children are Our Future" is a concept that is often shared within the Mi'kmaq Nation, and possibly other First Nation, Inuit and Metis groups across Canada. It became more obvious that it truly is a shared sentiment when Greenwood (2005) quoted Shuswap First Nation Elder, Mary Thomas, who stated "children are the future" (p. 1). From coast to coast in Canada, the importance of Indigenous children's health and development is important to our communities and community members, including the next seven generations to come. The statement that "Our Children are our future" demonstrates the need in our communities to raise and help maintain healthy children who can be allowed to thrive in *all* aspects of being and development which for First Nations includes the physical, mental, emotional and spiritual development (Best Start Resource Centre, 2010).

There is evidence that First Nation children may not be meeting their optimal developmental outcomes during the early years (Critchley et al., 2007), and there are questions about how to meet our children's needs at the community level. Early years services can help fill this gap. Current systems and policies in place may not be fully supporting the developmental needs of Mi'kmaq children in Nova Scotia. Provincial models of health recognize the early years span between ages 0-6 (Province of Nova Scotia, 2019) and are a period of rapid growth and development. Indigenous frameworks of development acknowledge the age of 0-7 as a period of extreme importance (Best Start Resource Centre, 2010). Literature indicates there is a large gap in the evidence on the experiences of Indigenous families accessing services to support the early years. To

increase knowledge and understanding of the experiences parents and families have while accessing early years services, a qualitative community based study that incorporates Indigenous methodology is presented in this discussion. Using participants' stories, the study provides identification of strengths and gaps in services available to the community. With the information, the community leadership and service providers will be able to better meet the needs of the children and communities.

TRC Calls to Action

In 2015, the Truth and Reconciliation Commission (TRC) of Canada released a historic document, outlining calls to action directed at not only the Canadian Federal government, but also territories, provinces, and institutions to make amends and facilitate healing of the entire Nation from the effects of the Indian Residential School (IRS) system. Many of the calls to action have a direct or indirect impact on early child development in the community. For example, Item 3 under the child welfare heading states "We call upon all levels of government to fully implement Jordan's Principle" (p. 1), Item 5 under the same heading reads "We call upon the federal, provincial, territorial, and Indigenous governments to develop culturally appropriate parenting programs for Indigenous families" (p. 1). Item 12 under the education heading reads: "We call upon the federal, provincial, territorial, and Indigenous governments to develop culturally appropriate early childhood education programs for Indigenous families." (p. 2). The TRC calls to action should be used to guide us to healing. By addressing a number of the items in the call we can ensure that our children have the tools they need to grow, thrive, and heal.

Positioning Myself

In an Indigenous research paradigm, locating ones self as the researcher involves cultural identification, and can include identification of purpose (Kovach, 2010). I am a daughter, sister, wife, mother of three school age children, a Mi'kmaq Registered Nurse, Certified Community Health Nurse (CHN) with the Canadian Nurses Association and Chair of L'nu (Indigenous) Health at Cape Breton University. I'm also a graduate Student at Dalhousie University in the Master of Science in Nursing Program. I have lived in a First Nations community my whole life, besides time spent away at university. I was a CHN from 2011 to 2022. I've been in my new role as L'nu Health Chair at Cape Breton University's Unama'ki College since May 2022. The overarching goal of the Chair is to improve the health of Mi'kmaq people through research. I began to envision the Chair as a tree. Like a tree it has roots- the L'nu Health chair is rooted in the land, in Unama'ki and Mi'kmaki, two eyed seeing, in Mi'kmaq culture and knowledge, in language and traditions, in Elder knowledge. It's rooted in partnerships and networks with communities, organizations, government and the universities, rooted in the TRC calls to action, and decolonization. Like a tree it has branches, there is a branch of post-secondary education, a branch of integrating Mi'kmaq knowledge and language into programs and services, a branch supporting the work of others and a branch of community research. This work spans into many roots and branches of the chair work, and my positionality as L'nu Health Chair has given Mi'kmaq health and wellness new opportunities.

My family history is unique in some ways and common in others. Government policies including centralization moved some of my ancestors from neighboring

communities to my own community of Eskasoni First Nation. During World War II, my maternal grandfather enlisted into the Canadian Army, and was stationed in Holland where he met my grandmother. Although they did not share a common language, they fell in love and were married. Together, they raised a family in Eskasoni. Recently, I have started taking an interest in my Dutch heritage, and desire to learn more about the culture, traditions, and family history. My mother is the youngest of their eleven children, who went back to school to obtain General Educational Development (GED) and successfully completed two undergraduate degree programs from the former University College of Cape Breton. My late father was a proud traditional Mi'kmaw who shared with his children knowledge about culture, language and ceremony and he was an advocate and warrior for the Mi'kmaq Nation. My Parents had a great influence on my world view and shaped my initial experiences with my own Mi'kmaq culture, and the importance of education.

My Passion for nursing in a First Nation community setting started when I was in my first year of the undergraduate nursing program at St. Francis Xavier University, where I graduated from in December 2010. I can still recall the sinking feeling I had while sitting in class learning about the social determinants of health, Indigenous people's health and the disparities between Indigenous people's health and the health of other Canadians. I remember thinking about my family, my friends, community members and the conditions in my community, thinking about the poor state of housing, high rates of unemployment and social assistance, disease, death, and suicide. It was difficult as the only Indigenous student in all my undergraduate nursing courses, especially when learning about these things and the impacts. What gave me hope, and purpose throughout

much of the undergraduate journey was the fact that nurses can make a difference in First Nation communities. As a nurse I would be able to take everything I learned back to my community and make positive contributions to helping people maintain their health and well-being.

The same sentiments are the reason why I became involved in research in 2011 and became enrolled in the Master of Science in Nursing program at Dalhousie University in 2016. It has also carried me into my new role as Chair of L'nu Health. I always liked the quote I first heard from an Elder in my community, and later found out it was also shared by an Elder at the beginning of the Royal Commission for Indigenous Peoples "…we have been researched to death…maybe it's time to research ourselves back to life" (M. Castello, p. 274). This statement is a reference to years and years of western based research approaches that have been extracting knowledge and information with very little benefits at the community level where the benefits are actually needed. The call is to have communities and Indigenous scholars take the lead, to develop and create research initiatives that will contribute to the improved health and well-being of our people, empower our communities, and ensure findings are meaningful, to guarantee communities and nations benefit from the work.

Statement of the Problem

First Nation Mi'kmaq children may not be provided optimal opportunities and support that will optimize their early years development from a cultural and system perspective. Many of the health issues that Indigenous people face are a result of socio-economic disparities, environmental, political and the historical contexts that have shaped their lives (Halseth & Greenwood, 2019). There is evidence that First Nation children

may not be meeting their optimal developmental outcomes during the early years, and there is a large gap in the literature on the experiences of families accessing services to support the early years. Across the country, Indigenous children are vulnerable to not meeting their developmental outcomes as well (Critchley et al., 2007). In addition, anecdotally community leaders describe inequitable access to early years programming, such as early intervention, early childhood education opportunities, screening, and other services. Opportunities to promote healthy development during the early years are crucial as it ensures a healthy life trajectory (Nova Scotia Department of Education and Early Childhood Development, 2019). Optimizing early years development and support systems of Indigenous children who live in one First Nation community has been identified by community health leaders as a high priority area that lacks research and evidence for best practice, with growing concerns. (Personal communication S. Rudderham September 23, 2019). Support systems include formal early childhood education programs and childcare, other programming including developmental intervention services, policies and other formal and informal systems designed to support the early years.

Study Purpose

The current systems acknowledge early years span between ages 0-6 years (Province of Nova Scotia, 2019) and are a period of rapid growth and development. Indigenous frameworks of development acknowledge the age of 0-7 as a period of extreme importance, and wholistically encompasses physical, mental, emotional, and spiritual development (Best Start Resource Centre, 2010). This thesis will reflect the Indigenous perspective will refer to the early years as ages 0-7, and will encompass

wholistic development including physical, mental, emotional, and spiritual development. The rationale for this approach is to make space for Indigenous knowledge in the early years sector, and to honor our own models of health, development, and well-being. It also aligns with the decolonizing aim of the study that are reinforced in the frameworks and methodology.

Once the community-based priority was identified, choosing an Indigenous framework such as Two-eyed Seeing and using an Indigenous methodology and appropriate knowledge-gathering methods were identified as priorities. A cross sectional qualitative study utilizing a community-based approach gives the parents and community an opportunity to share their perspectives and stories to increase knowledge and understanding of the topic. Qualitative methodology is appropriate when the goals of research are to gain understanding of a social context or human experience (Tilley, 2016). It allows for the strengths and challenges experienced by parents during the early years who are seeking services, programs, or support for their children to come to light, which may lead to future programming that will improve the health of the community.

The research aimed to bring increased understanding and awareness around the topic of Early Childhood Development (ECD) in the community and answer the questions: *"what are the experiences of families accessing ECD services and programs in a First Nations community?" "What are the strengths in community services and support during the early years?" "What are the gaps in services and supports during the early years?".* The purpose of the study was to provide parents of children (0-7 years) who live in Eskasoni First Nation the opportunity to describe, using a storied approach, their own personal experiences with the current systems and services related to the early

years development of their children. A second purpose was to use this knowledge to develop recommendations that may be useful for providers to improve support to parents, children, and communities. It was anticipated that this evidence will fill an information gap and provide knowledge to decision makers to improve care with the goal being to promote and protect wholistic development among children between the ages of 0-7 years and move towards ensuring our children have everything they need in order to thrive.

Research Questions

1. What does early childhood development mean to the Mi'kmaw community? What do community Elders, parents and caregivers interpret as important priorities of healthy child development?
2. In terms of services available to the community, what are the strengths that facilitate meeting the needs of the children and community?
3. What are the major gaps in services or barriers to care?

Terminology and Population Information

For the purpose of this thesis, the terms First Nation, and Indigenous may be used interchangeably. The term Mi'kmaq refers to a specific group of First Nation people which will also be used. I may refer to the youth or children as *our* children or *our* youth. This concept of shared responsibility is embedded in how we are all part of a caring community, often referred to as *Our Eskasoni*. Mi'kmaki refers to the land of the Mi'kmaw. Unama'ki is part of Mi'kmaki and refers to Cape Breton Island where Eskasoni is one of five Mi'kmaw communities.

In 2021 Statistics Canada gathered population information about First Nations, Metis and Inuit people in Canada and found that combined, these three groups have a total population of 1.8 million with First Nation specifically represented by a population of over one million (Statistics Canada, 2023). There are 25,830 First Nation people who reside in Nova Scotia alone (Statistics Canada, 2019). The data gathered at this time was consistent with information from the past, indicating that Canada's Indigenous populations are young in age and the population is growing. From 2006 to 2016, Canada's First Nation population grew by 39.3 % (Statistics Canada, 2019). In comparison, between 2006 to 2011 and between 2011 to 2016, Canada's non-Indigenous population grew by 5.9 % and 5%, respectively. There are a number of factors that contribute to population growth including birth rate, self-identifying and changing government policies.

Chapter 1 has discussed the background, where I also was able to position myself, present the problem and purpose of the study. Chapter 2 will be an overview of relevant literature of early child development topics that include a look to the past and historical information, state of Indigenous children's health, state of Indigenous children's health research, factors that affect Indigenous children's development, impacts of child development services, significant similar studies and finally, information about the Aboriginal Head Start program and Jordan's Principle (JP). Chapter 3 presents the theoretical framework used to guide the processes and context of the research including Two-eyed Seeing and the Medicine Wheel. Chapter 4 is a detailed overview of the methodologies used including Indigenous story work, ethical considerations and procedures, participants, data collection, data analysis, sharing knowledge and my own

biases. Chapter 5 presents the findings of the study. Chapter 6 is the discussion of the findings in light of other evidence including my own reflections, and community recommendations.

CHAPTER TWO: LITERATURE REVIEW

Mi'kmaw Children Before Colonization

The lives of First Nation children have changed drastically since colonization, but some values stay the same. To gain better understanding and to build on what I had already believed, I decided to look to the far past and find out how our children developed, and to learn more about the life of a Mi'kmaw child before colonization, how it was meant to be. The information found in documents related to historical observations of Mi'kmaw early child development is limited. Going through this information I felt it was important to also keep in mind the setting and context where the data was collected, biases of the researchers and lack of cultural awareness and understanding of the time.

What has been evident in historical literature and documents are the parenting practices and cultural norms of parenting among Mi'kmaw people during the 16th and 17th centuries that influence development. Children were very well cared for. Hoffman described the childhood of Mi'kmaq children as privileged and un-traumatic (1955). Breast feeding was extended and protected. According to observations of Le Clereq, as cited by Hoffman (1955), children were breastfed until ages 4-5 years. The author also noted that children are treated with large amounts of love and affection from both parents. Mi'kmaq babies were often carried in cradle boards that the families made with various materials such as wood, leather and, furs and skins. It would also be decorated with beadwork and quills or other measures which demonstrated love and care for the infant (Hoffman, 1955). Life of a Mi'kmaq child was celebrated at various stages with feast, ceremony, and celebration among the community. Hoffman (1955) discussed several

ceremonies that were held for infants and small children including those on the occasions of their first tooth, first steps, and for males, their first successful hunting experience. The goals of developing skills and understanding of concepts for children was to ensure they could provide for themselves, their families and community.

Mi'kmaq Children in the 16th and 17th centuries were well cared for by parents, extended family members and the community (Hoffman, 1955). Importance of parents, family members and the community continue to have great impacts on child development today. The Best Start Resource Centre (2010) identified family involvement and support of parents by grandparents, community, and Elders as important to ensuring optimal child development. The love expressed in different ways towards babies and small children was a common theme in parenting and supported healthy childhood development.

Colonization

Colonization efforts had a huge impact and interrupted the lives of generation after generation of Indigenous families and children. The Indian Residential School (IRS) system removed children from their homes, robbing families the opportunity to love and care for their own children. The impacts of residential school have affected parents and parenting, which affects our children (Halseth & Greenwood, 2019). The impacts of intergenerational trauma continue to affect healthy development. Intergenerational trauma resulting from the residential school system has affected health and social outcomes in our communities (Bombay, Matheson & Anisman, 2014). Loss of language, culture, land and the IRS program continue to affect the development of children in our communities in Nova Scotia.

Measures of Development

In the province of Nova Scotia, Mi'kmaq children have access to go to school both in community-run schools (Mi'kmaw Kina'matnewey) and out of community in provincially or publicly run schools with different funding structures. The Early Development Instrument (EDI) is used among primary children in the provincial public school system to measure developmental outcomes. The EDI focuses on five areas of development which are physical health and well-being, social competence, emotional maturity, language and cognitive development and communication skills and general knowledge (Nova Scotia Department of Education and Early Childhood Development, 2019). The summary report released from the province of Nova Scotia detailing primary student outcomes across the region is a useful tool but does not discuss or evaluate early development in Indigenous communities nor does the website or document mention development in Indigenous communities, culture, or First Nation Languages.

First Nation and Indigenous Children in Canada – Health & Evidence

Indigenous children are currently the fastest growing population group in the country (Statistics Canada, 2016) and as a group has less than ideal health outcomes, especially when compared to other non-Indigenous children. In contrast with the healthy status of Canadian children, Indigenous children are vulnerable to not meeting their developmental outcomes (Critchley et al., 2007). Indigenous children have higher rates of hurt or pain and suffering in all aspects of being including mental, emotional, physical and spiritual, which can have negative effects on their optimal development in all areas (Latimer et al*.,* 2018). Among Indigenous people on a national scale, one out of eight

children have a disability which is double the rate of all the children in Canada (Rothman, 2007). These downward trends are thought to result from colonization.

Access to health data related to child development could help inform policy, practice and bring attention to issues (DiPietro & Illes, 2014). Although pain related data have been documented there are large gaps in research and evidence. Indigenous children's health data is not largely present in literature (Halseth & Greenwood, 2019). Rigorous systematic reviews of studies related to fetal alcohol spectrum disorder (FASD) involving Indigenous children exists but information regarding other areas of child development are lacking in the literature (Di Pietro & Illes, 2016; Symons, Pedruzzi, Bruce, et al., 2018). There is also little evidence and understanding about how Indigenous parents access and utilize health services to promote and protect development during the early years (Wright, Jack, Ballantyne, Gabel, Bomberry & Wahoush, 2019). The evident lack of literature related to developmental well-being of First Nation children should not be taken as the result of low rates of developmental disorders and other needs among Indigenous people, as there are many other factors that contribute to low rates of diagnosis, and evidence (Die Pietro & Illes, 2014). A review of the literature indicates although some initiatives have taken place, there is a lack of research and evidence in regard to ECD among First Nations children.

To establish a sufficient foundation for health information, continued research in Indigenous communities is needed (Critchley et al., 2007). It's important for researchers to be aware and acknowledge that although more research is needed in the area of ECD, communities must lead the way and determine their own needs. Each community has its own unique past, historical factors, culture, traditions, and norms (Niles et al., 2007).

Compiling large amounts of research for the sake of research and an evidence base in this area is not the most important goal. It is imperative that both research initiatives and policy development reflect the needs and wishes of the community (Critchley et al., 2007). Research done in this way, community lead and community owned, will allow for the findings to be more meaningful for the community and more useful to improve their health and well-being.

The Structural Determinants of Health

Greenwood (2018) identified the structural determinant of health as factors that greatly affect the health of Indigenous children in Canada. These factors include historical events such as residential schools, trauma that has been passed down from generation to generation, high rates of poverty, lack of food security, access to adequate housing and adequate health care services. There is evidence that this population has significant involvement of these factors influencing their developmental outcomes.

Poverty

Our children are at very high risk of negative impacts on their development related to high poverty rates.

> "High rates of socio-economic marginalization, including lower rates of employment, employment income and educational attainment, have resulted in many Indigenous children living in poverty, living in overcrowded or poor-quality housing, and experiencing food insecurity, which can affect their physical, cognitive, emotional and psychological development." (Halseth & Greenwood, 2019, p. 5)

Balanced nutrition is a very important part of maintaining health and achieving optimal growth and development (Halseth & Greenwood, 2019). Almost half of all First Nation households with children are food insecure (First Nations Information and Governance Centre, 2018). Out of all four Atlantic provinces which are Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland and Labrador, Nova Scotia has the highest rates of poverty among children (Frank & Saulnier, 2017). For the young Indigenous population who fall into the early years category, the rates and potential impacts of poverty are appalling. As indicated in Table 1, of the *Nova Scotia Report Card on Child and Family Poverty* document (p. 13), six out of the top 10 postal codes for the highest rates of child poverty included in the report were areas of First Nation Communities, with Eskasoni atop of the list with the highest rate of child poverty at 72.7%. The report also contains information for the youngest residents across the province. Children under six years of age, those who fall into the early years category, experience higher rates of poverty compared to all children under age 18 in all three years indicated in *Figure 8 - Child Poverty Rate for Children Under 6 Compared to All Children (AT-LIM), Nova Scotia 1989, 2000, 2015* (Frank & Saulnier 2017, p. 20). The impacts of poverty on child development in the early years indicated by these statistics can be summarized in the following excerpt from the poverty report:

> "Poverty hurts our children. It creates personal and social deficits that are felt within families and by society because it limits children's ability to grow up healthy and to develop their potential towards full participation in society" (Frank & Saulnier 2017, p. 6)

Indian Residential School System

The residential school system was put into place by the Canadian government in the 1870s, and the goal of the institutions eliminated the involvement of parents in Indigenous children's upbringing, that affected cultural, spiritual and intellectual development (Truth and Reconciliation Commission of Canada, 2019). There was one school in Nova Scotia, the Shubenacadie Indian Residential School, located between Truro and Halifax. Many children who attended these schools were forced from their homes and suffered physical, sexual, spiritual and emotional abuse at the hands of priests and nuns. Although the last school closed its doors in 1996, the effects of the system are still affecting our children today. Intergenerational trauma resulting from the residential school system has affected health and social outcomes in our communities (Bombay, Matheson & Anisman, 2014). The residential school system has affected generations of Indigenous children and continues to do so after the doors have been closed.

Adequate Health Services

Taking into consideration the numerous factors a First Nation child encounters during life which have the potential to negatively impact healthy development, it only makes sense that the number of children who are referred to the appropriate services by professionals is reflective of the population's need for developmental services. Unfortunately, this may not be the case for the Mi'kmaw children in the region. Information for developmental related referrals for the First Nation children in Mi'kmaki were not observed in the literature. There is information from Latimer et al. (2018) that shows the discrepancy in rates of diagnosed medical condition referrals, such as ear infections and pain, that impact development and contribute to unmet needs in this young

population. In the study, First Nations children's health information from several First Nation communities were compared to non-First Nations children in the same region. What the data indicates is although pain related conditions are higher among First Nation children, such as ear, throat, and oral or dental conditions, these children are less likely to have referrals to the appropriate specialists than non-First Nations children. First Nations children are also less likely to have mental health diagnoses and mental health referrals than non-First Nation children (Latimer et al., 2018). There is also the occurrence of higher rates of chronic ear infections among First Nation children that can affect development (First Nations Information and Governance Centre, 2002). The reduced number of referrals for services limits access and creates more barriers to care in a population that would benefit from support and programming.

Another area of concern is the lack of opportunities for formal childcare and related services having negative impacts on the educational and health outcomes of First Nation children. Children who receive formal childcare may have better school readiness and educational results compared to those who did not and were instead cared for by family members or friends in a home setting. This may be a result of developmental needs being more aptly met in a formal day care setting (First Nations Information and Governance Centre, 2002). Having the structure, routine and programming available in formal childcare settings has benefits that will carry over through all stages of development and learning for First Nations children. There is evidence that there are not enough opportunities for Indigenous children to access formal childcare. Among First Nation children, about 34.7 percent require childcare while parents and guardians are working or attending school, and a majority of First Nations children who require daily

childcare are cared for by family members (First Nations Information and Governance Centre, 2002). Among the 34.7 percent of children who require daily care, only 31.3 percent receive their care in a formal setting (First Nations Information and Governance Centre, 2002).

Findings from the First Nations Information and Governance Centre's Regional Health Survey (2018) indicate that needs of First Nation communities are not being met; the main barriers to health needs were identified as poor coverage from Non-Insured Health Benefits (NIHB), lack of culturally appropriate services, and inadequate resources. First Nation children who require health care often experience barriers that prevent them from receiving the care they need. The regional health survey allowed First Nation individuals to identify their barriers when accessing care. For children, no access to service in the area was identified as the third greatest barrier to receiving care. The remaining top two greatest barriers identified were no doctor or nurse available in the area and waiting lists that are too long (Regional Health Survey, 2018, p. 22). These indicators reflect that resources and services in First Nation communities are lacking (Regional Health Survey, 2018). Colonialism has negatively affected the access First Nation people have to culturally appropriate health related services (First Nations Information and Governance Centre, 2018) which affects their health and well-being.

The Benefits of Early Childhood Services

Early Childhood Developmental services are an important part of keeping children healthy and can provide a means to help the population and individuals overcome obstacles and disparities. With access to early child developmental services, children with disadvantages may have improved outcomes, closing the gap between their

more privileged counterparts and promoting school readiness (Niles, Byers & Krueger, 2007). As a tool to offset the negative effects of inequities and trauma on healthy development, early childhood developmental services are vital (Wright et al., 2019). Early childhood developmental services and programs can potentially help to heal our nations of the effects of colonialism, the effects of the residential school legacy, loss of lands and resources (Greenwood, Leeuw & Lindsay, 2018). To promote optimal child development and address the severe disparities, developmental programming must include traditional and cultural knowledge which will foster cultural strength, sense of belonging and community (Greenwood, 2005). These extensive goals can only be achieved with culturally appropriate services that are able to meet needs of families and communities.

There is evidence in the literature that indicates incorporating culture and traditions into early childhood programs has many benefits for Indigenous families who access the programs and services. These benefits include promoting resilience and self-esteem, improving overall well-being and also may protect against mental health issues (Halseth & Greenwood, 2019). Including culture may also benefit service providers by helping achieve programming goals. Having access to cultural teachings, medicines and connections in programming may help to facilitate engagement, retention and participation with parents who access the services (Wright et al., 2019). This can help reduce the number of families who are lost to follow up, who require the services but may fall through the cracks. Extra care and consideration of cultural values and teachings needs to be incorporated into the planning of early childhood services and programs for First Nation communities. Culturally appropriate early childhood initiatives are key in

addressing the disproportionate rates of health issues that Indigenous people face (Halseth & Greenwood, 2019).

Targeted Studies

The Experience of Choosing Services

Although this study focused on the experiences of families who live in one First Nation community, there is a similar study that focused on an urban Indigenous population in Hamilton, Ontario, using qualitative methodology to explore the experiences of Indigenous mothers accessing and using early childhood developmental services for infants aged 2 and under (Wright, Jack, Ballantyne, Gabel, Bomberry & Wahoush, 2019). Researchers found that the majority of the mothers who were interviewed preferred to access Indigenous-led services for a variety of reasons including trusting relationships with workers focused on building and meeting the needs of each individual family based on unique social inequities, and inclusion of culture in programming. Cultural programming provided spiritual care for families and infants which included providing access to traditional teachings, medicines, and ceremony (Wright et al., 2019).

It should be noted that the study's authors claim that the results and strategies identified in the study can be used to provide accessible services for Indigenous families and infants (Wright et al., 2019). The authors however, also appropriately state that the limitations of the study include the population's experience may not reflect the experience of all First Nation, Metis and Inuit people.

Child Development in Mi'kma'ki

There is literature exploring early child development among the Mi'kmaw Nation in the Atlantic region. A study undertaken with the Mi'kmaw people of Prince Edward Island in Lennox Island and Abegweit First Nation through the University of Prince Edward Island focused on two determinants of health including early child development and personal health practices and coping (Critchley et al., 2007). The study included efforts to promote community trustworthiness by including a community approach through forming partnerships with leadership, development of an advisory committee and staying committed to sharing the knowledge with the community (Critchley et al., 2007). Pregnant women, parents of children aged 0-5 years and children aged 6-18 years were interviewed. Community professionals were not interviewed as part of the study, but instead served on the advisory committee that guided the process, development of questions and assisted with recruitment.

In the study parents were asked what they perceived as health and how to keep their children healthy. Parents shared that a strong self-esteem was an important part of health, and reading was identified as an important activity to promote health. As indicated in Figure 1 "Health Perceptions How Parents Try to Keep Children Healthy", the majority of parents who were interviewed (64%; n=40) felt that feeding children nutritious food was important to keep children healthy. Thirty-six percent of parents participated in physical activity with their children. Parents also identified how their surroundings and environments, as well as schedules and routines, were an important part of keeping children healthy (Critchley et al., 2007). There was no information about programs, policies and services in the data collection, but an advisory committee formed

of community members and professionals who helped to guide the research process, identified programs and supports that were in place. Information about services and programs or supports available to the community to promote health or early child development were not further explored and were not included as part of the study's findings.

Their findings lead to interventions that were guided and owned by the community, that started when the people identified their own needs in their efforts to 'build a healthy community'. Each First Nation community is different, including the Mi'kmaw of the Atlantic provinces. Each community should be given the opportunity to find their own solutions, but they can still learn from one another.

Aboriginal Head Start on Reserve

One community-based strength is the Aboriginal Head Start on Reserve (AHSOR) which is a national program aimed at children in the early years, defined in their pamphlet as age 0-6, which focuses on physical, developmental, emotional, cultural, and spiritual well-being for young community members (Health Canada, 2010). Priority areas of the AHSOR are education, culture and language, nutrition, health promotion, family and community involvement, and social support (Health Canada, 2010). The Regional Health Survey (RHS) identified that the AHSOR and similar early childhood education programs can be beneficial in strengthening language and culture amongst young children. Results from RHS phase 3 indicate that First Nations children and youth who have attended an AHSOR Program are more connected to language and culture (Regional Health Survey, 2018). The Community Health Centre provides the community with an AHSOR program that runs throughout the year targeting members of the

community aged 18 months and up. The programs available to the community are based on age, and available at different times. These programs include the Mother Goose Program (age 0-2), Literacy A Program (age 2), Literacy B Program (age 3), School Readiness Program (age 4), and a Home Base Program (special needs) (Eskasoni Health Centre, 2004). Equitable access is a pervasive issue in our communities with various band aid policies created to address them. In our community, funding and limited space is a barrier for access to the AHSOR program which affects each child's ability to access the early childhood education they are entitled to.

Jordan's Principle

Jordan's Principle (JP) is a child first initiative and the result of a fight for First Nations children's right to the services they need in a timely and equitable manner. The initiative all started with a young boy from Norway House First Nation in Manitoba named Jordan River Anderson, who was born with complicated health issues. Jordan's family never had the opportunity to take him home to his own community, because the provincial and federal governments spent his life locked into disputes over who would cover the services he needed to live. At one point, Jordan had spent two years in the hospital, waiting for the governments to decide (First Nations Child and Family Caring Society, 2019). Jordan's case is a heart-breaking example of how care for our country's Indigenous children is below standard due to funding disputes, or complete lack of funding for programs and services. First Nation children often have to wait long periods for service or have their claims completely denied, in all areas including early childhood services (First Nations Child and Family Caring Society, 2018). To ensure funding disputes between provincial and federal funding sources did not prevent another child

from having the care they need, Jordan's Principle was created. The government of Canada continued to disappoint First Nation families, children and communities in their fight to equal care and necessary services even after JP was enacted.

In 2016, the Human Rights Tribunal stepped in, and the Government of Canada had to answer for racial discrimination of over one hundred thousand First Nations children, failing to provide services and appropriate care and failure to properly uphold JP. The Human Rights Tribunal has issued legally binding statements that the Government of Canada must fulfill (First Nations Child and Family Caring Society, 2018) to ensure no First Nations child is without the care they need ever again.

> "Jordan's Principle aims to make sure First Nations children can access all public services in a way that is reflective of their distinct cultural needs, takes full account of the historical disadvantage linked to colonization, and without experiencing any service denials, delays or disruptions because they are First Nations." (First Nations Child and Family Caring Society, 2019)

When JP was first implemented, it was clear that families in our communities needed support to navigate the program. To better meet the needs that became evident, local leadership acted and The Union of Nova Scotia Mi'kmaw created a JP team to assist families in Unama'ki. In Eskasoni, the need for the program is evident in the way the department continues to grow to meet the demand of all children and families who require support. Initially, when the coordinator program was implemented in 2016/2017 the community had one Children's Service Coordinator. Today, the community's JP office has expanded to include first two and eventually several service coordinator assistants to keep up with the growing workload, and now a cultural service team.

Summary

There are many factors that have disrupted the healthy child development of our Mi'kmaq children including the structural determinants of health and many strategies put in place to overcome gaps in these determinants. ECD in Indigenous children is an area that requires more research and attention. Reducing barriers to, and encouraging, early childhood services and programs are imperative in fostering not only healthy child development but also healing of intergenerational trauma and colonialism. Including culture in early childhood initiatives and services has significant benefits for children, families and service providers.

CHAPTER 3: THEORETICAL FRAMEWORK

Two-eyed Seeing - *Etuaptmumk*

This study uses the Two-eyed Seeing approach as a guide and the Mi'kmaq Medicine Wheel as a lens to consider health, life and wellbeing for Mi'kmaq People. *Etuaptmumk* or Two-eyed Seeing is a term that was brought into the academic world by Elders Albert and the late Murdena Marshall, of Eskasoni First Nation. Two-eyed Seeing can be described as observing the world through one eye that sees the strengths and benefits of western knowledge and the other eye sees Indigenous perspectives and knowledge, and its strengths and benefits as well. Two-eyed Seeing recognizes and acknowledges that no one way or worldview is superior to the other, and both are used together to benefit everyone (Institute for Integrative Science and Health, 2019).

Elder Albert Marshall shared,

> "Two-eyed Seeing adamantly, respectfully, and passionately asks that we bring together our different ways of knowing to motivate people, Indigenous and non-Indigenous alike, to use all our understandings so we can leave the world a better place and not compromise the opportunities for our youth (in the sense of Seven Generations) through our own inaction" (Bartlett, Marshall & Marshall, 2012 p. 6).

The Two-eyed Seeing approach is not only applied to study but ingrained in the methods and methodologies, and processes of the research. For visual description of Two-eyed Seeing see Appendix A. Employing a Two-eyed Seeing approach can help us better understand the health and well-being of Indigenous people, including children, and

communities (Martin, 2012). Utilizing a Two-eyed Seeing approach and Indigenous methodologies allows the study to have a decolonizing aim in both research and early child development for communities.

For the purpose of this study the western lens focused on health and systems in place to support early child development. The Indigenous lens focused on the importance of culture in early child development and included the community's perspective and knowledge regarding early child development, which consisted of their experiences and information shared through conversations and stories. The Medicine Wheel was used as the Indigenous lens to observe child development in a traditional wholistic way.

The Medicine Wheel

Niles, Byers and Kruger (2007) describe western thinking about time as linear, past, present and future. This is also the concept of time that is dominant in the research related to early childhood interventions (Niles et. al, 2007). Indigenous perceptions about the concept of time that can be applied to child development are circular and can be explained using the Mi'kmaq Medicine Wheel (Appendix B). The Medicine Wheel is symbolic in First Nations cultures and can be used to illustrate different teachings such as the four sacred medicines, the four directions, seasons, the cycle of life and more. The teachings about the Medicine Wheel can differ among Indigenous people depending on their culture and traditions. The Best Start Resource Centre indicates how Indigenous people use the Medicine Wheel to explain the life cycle (2010). The life cycle has seven stages. The first stage, age 0-7 is referred to as the good life and are considered the most important years, and a very important time in child development (Best Start Resource Centre, 2010). There have been different views of the Medicine Wheel, for example that

it is not part of Mi'kmaq culture but there have been many things adopted into our Mi'kmaq culture from those that surround us, from language to dance and more. The *Mi'kmaq Sacred Teachings about the 7 Stages of Life with the 7 Gifts from the Creator*, by Elder Murdena Marshall uses the Medicine Wheel to teach about the life cycle and indicates the Mi'kmaq word *mijua'ji'j,* used to refer to a child, means "c*hild under 7*" (Harris et al., 2013). Marshall explained the gift from the creator during the first stage of life is Love from the creator and from one's own mother, which are both unconditional (Harris et al., 2013). Hoffman (1955) described in detail, the large amounts of love and affection shown towards Mi'kmaq children from their families during the 16th and 17th centuries.

CHAPTER 4: METHODOLOGY

As an Indigenous graduate nursing student, I was very excited to learn more about Indigenous methodologies. It resonated with my spirit and values, and I felt validated in my beliefs and even my own epistemology. It became so meaningful to have the opportunity to incorporate traditional knowledge and theories within my education journey. Even though the concept within the scope of research was new to me, it now had a name and a label and more meaning than I thought and could be applied to the work that I needed to do. It was natural to move forward with my own traditional First Nation epistemology as the guiding epistemology for this study. I was motivated when I first read what Margaret Kovach (2010) had shared, that her own Cree knowledge guided her epistemology in a tribal based study approach.

Epistemology in research refers to knowledge systems that reference within it the social relations of knowledge and its creation, and within an Indigenous methodology is the centre of the framework that guides the process, sets the context and separates itself from western approaches in qualitative research (Kovach, 2010). Epistemology refers to how we think about our reality (Wilson, 2001). Using an Indigenous methodology with my community also feels appropriate, not only because of the population and my own background, but because of the goals of the research which are for the information to be meaningful, useful, and create change if needed in the community. Using Indigenous research frameworks brings forward the possibility to use Indigenous contexts to improve both policies and practices and can help us move towards decolonization (Kovach, 2010). Presenting these worldviews and values to the readers started in the introduction

discussing the importance of children to our communities and included the First Nation framework of 'wholistic' child development during the ages of 0-7 years.

My own professional experience in the community also influenced the study approach using stories and acknowledging community stories as a source of knowledge. During patient interactions as a community health nurse, clients have often shared stories to describe illness or symptoms. Initially, in my nursing practice, I did realize the importance of making space for stories but did not realize it was not common knowledge among health providers that this information and the way it is shared is valuable in health care. In one research study, to increase understanding of how Mi'kmaq children express pain, participants were invited to share how storytelling is used by Mi'kmaq people in health care settings to express pain to professionals. One of the Elder participants shared "the more pain, the more story" (p. 135) and another participant stated, "we're story tellers..." (p. E136; Box 4). Unfortunately, people felt like they were not heard or believed when it came to sharing stories about their health in clinical settings (Latimer et al., 2014).

Elder consultation helped to ensure the study plan is appropriate. In developing my methodology, I had the honour of visiting with an Eskasoni Elder to discuss this research, and decided beforehand I would talk only a little and mostly listen. I shared the study information, aims, research questions and purpose. What he shared with me that day gave me a sense of validity that I was on the right track. There were many stories, but one of the first things he shared was a concept he translated to "speaking for those who cannot speak for themselves" (Marshall, A. personal communication, n.d). I didn't write down the Mi'kmaq word, but later I asked Barbara Sylliboy Mi'kmaw linguist/speaker

who I often go to for translations. The translation she provided me for this concept was *kelutmalswet wen,* which she described as to *intercede on their behalf.* She later gave me a translation that she believes her late sister Helen Sylliboy would have used in a similar context which was *Nuji ns~tmalsewusk* to mean *I speak for you; makes you understood* (Sylliboy, B. Personal communication. January, 2020). These words from our Elders and Knowledge Keepers gave me the feeling that I was doing good work for our community.

Story-work

Indigenous people have been using stories and oral tradition for passing information since time immemorial (Kovach, 2010). Indigenous stories often have deeper meanings; can teach important lessons and how to live a good life (Archibald, 2008; Kovach 2010). Stories are useful for gaining the perspective in another (Kovach, 2010) which was also the goal of this qualitative research. Jo-Ann Archibald termed the phrase story-work as a means of using stories for educational purposes and outlines its seven teachings or principles based on her teachings from Stó:lō and Coast Salish Elders. The principles of story work include respect, reverence, responsibility, reciprocity, holism, interrelatedness and synergy (2008). These principles were incorporated into the study and applied to the stories and information that participants share. The Principles of Storywork also created an awareness to observe the principles in play during the research process.

Holism

Holism refers to the interrelatedness of the four aspects of self - emotional, mental, spiritual and physical (Archibald, 2008). Balanced development in all aspects of being extends to and is shaped by family, community and nation (Archibald, 2008). Using the

framework of the Medicine Wheel ensures awareness of a 'wholistic' approach to the information gathering, analysis and knowledge sharing.

Respect

In an Indigenous methodology, respect is present in all stages of the research design (Kovach, 2010). Respect for community protocols has been important in this design, and respect for Indigenous knowledge, respect for the value of knowledge in our stories and respect for Mi'kmaq knowledge.

Reverence

Archibald uses the example of Ojibway storyteller Basil Johnson to explain how stories are held in reverence, and a deep respect for the words, language, stories and storytellers which stem from truth (2008). The information and stories shared in this study will be held with reverence, not only for the stories but the topic of interest. In First Nations culture, children are considered to be gifts from the creator and their special place in their families, communities and greater Nations is sacred. The responsibility to care for children is also considered sacred (Canada, 2018).

Responsibility

In Story-work the responsibility of the storyteller to others is attributed to the power that stories can have, while the person listening should listen respectfully. To share stories publicly requires careful preparation because words cannot be taken back (Archibald, 2008). I do not take the work of this research lightly and feel a deep responsibility to our children, families and communities. As the author, and researcher I take responsibility for all of this project, the responsibility of representing my community and upholding protocols as well as safeguarding against any errors or mistakes.

Reciprocity

Reciprocity can be thought of as giving back to research participants and communities (Tilley, 2016). In an Indigenous methodology, specifically story-work, reciprocity refers to being able to give back by telling the story to others, with permission (Archibald, 2008). The aims of the research are to benefit the community, and doing something that the community needed is part of giving back. With permission and once complete the information will be shared to benefit the community. Honorariums were provided and are a part of the reciprocity of the study, to show my gratitude for their help and participation.

Interrelatedness

Interrelatedness refers to the relationship between story and listener and between text and reader (Archibald, 2008). As a nurse and researcher, I have relationships with the community in a professional context. I am also a community member. As a listener I was able to bridge between the storyteller and the reader through text, as it is my responsibility to maintain the relationship with participants through ensuring the knowledge they presented is accurate, which can be accomplished with information checking during the data analysis.

Synergy

Webster's Dictionary defines synergy as "combined action or operation" (2020). Archibald describes the synergy between storyteller, listener, and story as critical as a story-work principle (2008). Together, all pieces come together with objectives to gather knowledge and increase understanding, to teach lessons and pass information. Synergy

occurred in every aspect of the study, from deepening my relationship in the community, as well as through synthesis of the knowledge shared.

These seven principles are the practical and cultural guideposts that were used in this knowledge gathering process.

Setting

This study setting takes place in the First Nation community of Eskasoni, Unama'ki. Eskasoni has a population of 4,571 (Nova Scotia, 2020) and the population is young with 34.4% of people aged 0-14 years (Statistics Canada, 2020). Eskasoni is the largest Mi'kmaw community that has its own Community Health Centre, AHSOR program, and several schools including The Eskasoni Elementary and Middle School as well as an immersion school serving grades k-4. the Essissoqnikewey Siawa'sik-l'nuey Kina'matinewo'kuo'm and the Eskasoni Allison Bernard Memorial High School. In addition, Eskasoni has a day care, JP office and the Nova Scotia Early Childhood Development and Intervention Services (NSECDIS).

Benefit to Community

This study began with the identification of an area of importance to the community which Minkler and Wallerstein (2003) documented as the first step in community-based research. The aims of community-based research include evoking social change through knowledge and action. (Minkler & Wallerstein, 2003). The purpose of this study was to gather stories from First Nation Parents and an Elder that describe their experiences supporting children through the early years, and the strengths and gaps related to optimal outcomes for ECD. The gathered knowledge has provided necessary information that can inform changes for policy and program development, to

help achieve wholistic balance and optimal outcomes in early child development for Mi'kmaq children.

Participants

The study engaged two groups of participants, 1) parents and 2) an Elder. The study was open to parents with children who did or did not have a formal diagnosis relevant to ECD and who were or were not currently accessing services. Participants had to be from the community and be a band member. One Elder participant was asked to share their perspectives on ECD as well.

Rationale for choosing the number of seven parent/guardian participants lies in the Mi'kmaw perspective of the significance of the number seven. There are seven districts in the Mi'kmaw Nation (Cape Breton University, 2020), the seven stages of the life cycle that include seven sacred teachings, or seven gifts (Harris et al., 2013) that help guide us through life, and the concept of living well for the next seven generations.

Recruitment

There were two Research Assistants (RA) who were part of the recruitment efforts. Recruitment included posters placed in public spaces and shared with the community on social media platforms, such as Facebook. Posters included information about the study, what the study entailed, and contact information of the researcher and research assistants. The Elder participant was invited to participate by the RA. This method was used because selecting participants through invitations because of their experience and background is effective (Kovach, 2010). It also seemed as the most respectful approach for an Elder. Consent was obtained virtually over the phone by the

RA once the study was fully explained and participants fully understood the study and their role. Two different consent forms were used for each group.

One of the biggest barriers to completing the study in a timely manner was the recruitment piece. Some parents were interested but had to reschedule appointments to engage with the recruiter for the explanation and consent process. Barriers for parents included lack of time and childcare.

Knowledge-Gathering Approach

Interviews gave participants the opportunity to share their stories, perspectives, and experiences about accessing or providing services during children's early years. One-on-one conversation sessions took place over the phone. Conversation guides used in the sessions were developed in consultation with the thesis supervisor, the Community Health Director, community professional and based on my own experience and knowledge. Open-ended questions included but are not limited to "what does healthy child development mean to you?". Two separate guides were developed and used, one for each of the two separate groups: parents/guardians and Elder participants (See Appendix C and E for conversation guides).

Demographic forms were also used for data collection. The demographic form developed for parent participants provided details on age of parent, number of children in home and their ages, number of children who are accessing services and frequency and types of services. This allowed an understanding of the perspective of our families, the involvement of services in family's lives and how and when services are accessed. In keeping with the story-work principles and out of reverence and respect for Elders, our Elder participant was not required to complete demographic form. Because of the small

sample and qualitative nature of the study, the information collected was used to describe the participants and observe trends. The aspects of the Medicine Wheel are included in the demographic/health survey form and used for data collection. In each of the four quadrants of the Medicine Wheel (physical, mental, emotional, spiritual), the participants rated on a scale of 1-5 whether they believed the community services that accessed were useful in promoting development for each of the four Medicine Wheel components for their children aged 0-7 years. This was to gain perspectives of the effectiveness of community services in meeting the wholistic needs of children. See appendix D for parent demographic and health survey form.

Data Management and Storage

All electronic files related to the study are stored on a password protected drive and held in the health centre's secure storage room. This data includes 8 recorded audio files from conversation sessions, the audio's transcribed documents, NVIVO files, and Excel files used for demographic information storage and analysis. The documents are also individually password protected.

Hard copies of the demographic forms, and any notes that were taken are stored in a locked cabinet in the secure health information storage room at the community health centre as well. Any personal information of participants such as consent forms with names are stored in a separate locked cabinet in the same room, to keep the research data separate from identifying information.

Interview Guidelines

Eight 1:1 conversation sessions took place virtually over the phone. The initial plan was to have in person sessions. However, COVID-19 pandemic guidelines required a virtual approach. The over the phone conversations facilitated information sharing and storytelling at the convenience of the participants.

Potential participants were informed that their participation involved one story sharing session and possibly an information checking session if they wished to participate. The information checking took place virtually over the phone as well and one participant information was checked in person. The participants were made aware of their rights by the RA including their option to skip any question that is asked, stop the interview session or withdraw from the study at any time even if they participate and decide afterwards, with no negative consequences to themselves.

Knowledge Interpretation & Synthesis

Parent/Guardian demographic information was analyzed using descriptive statistics regarding participant age, number of children, number of family members in the home, number of children who access services.

The audio recordings of conversations/stories were transcribed verbatim. Researchers often record sessions and transcribe them word for word into written text (Lobiondo-Wood & Haber, 2009). The audio recordings and transcriptions were reviewed and listened to several times so that I could gain insight, understanding and make observations. One thing that Indigenous researchers struggle with is separating stories from storytellers, and separating parts of stories from the whole (Kovach, 2010; Archibald, 2008). To aid in this dilemma, methods guided by a Two-eyed Seeing

approach allowed the transcripts and recordings to be analyzed from both an Indigenous and Western lens.

The Indigenous lens of interpreting the data focused on *Meaning Making* (Kovach, 2010) and included using Mi'kmaq knowledge for interpretation of the stories. Making meaning was achieved by weaving awareness with interpretation. Sam (2011) stated:

> "For conducting research and co-constructing meaning with Indigenous Peoples about the early years of their people, a historical awareness, that takes into account the political, social, and ethical factors that continue to influence Indigenous Peoples lives, is thus an inevitable necessity" (p. 322)

The Medicine Wheel was used to organize the stories, concepts and experiences based on each of the physical, mental, emotional and spiritual quadrants. To help keep stories intact that will aid in the creation of meaning, a number of stories are presented in the contextualized form (Kovach, 2010).

From a Western perspective, information gathered in the conversation sessions were organized into meaningful clusters of data and themes using thematic analysis (Lobiondo-Wood & Haber, 2009). Nvivo software was used to organize the information into categories or nodes. Nvivo was also used to observe trends and identify themes within the nodes. The circumstances of the stories were interpreted as they are told and also grouped as nodes. Representative story themes were created to highlight the parents and Elder's perspectives. Health Director Sharon Rudderham is a consultant on this study, and I have engaged her to discuss and validate the story themes. I have also

engaged with an Elder for the same reason, to help ensure the work is done in a good way.

Information Checking & Sharing Knowledge

Participants having the opportunity to check and approve findings of stories is essential for true accurate representation, which is imperative to participants (Kovach, 2010). To ensure the information is accurate, and the participant's information is presented appropriately, the findings have been taken to the community participants for review with minor updates to service experiences for some and others with no revisions or changes.

A sharing session for participants and their families was held where I shared the study's findings. The Community Health Board, Health Director and community advisors are invited to the formal defense in the community. A larger community wide sharing session will be held to keep the community informed of the study's findings and results.

Ethical Plan and Considerations

Upholding ethical responsibilities within Indigenous paradigms includes fulfilling a responsibility as the role of researcher at all stages of research and being accountable to *all my relations* (Wilson, 2001). Instead of studying an area for my own benefits, and to only the ends of meeting graduation requirements, it was important for me to have guidance and follow the direction that the community needs. Seeking advice and input from the community's Health Director was part of this. It wasn't only part of the community based participatory action method, but part of Indigenous axiology (Wilson, 2001) and what I felt was an important gesture to do research that is meaningful and will benefit the community and, as I discovered, all my relations.

To understand the rationale behind the ethical procedures of the research process, its useful to consider the study's application of the Two-eyed Seeing framework. The ethical protocols of the study incorporate western ethical knowledge, standards and protocols alongside of traditional knowledge of community research ethics, standards and worldviews. Standard academic research ethical practices established by Dalhousie University will be enhanced with appropriate and respectful ethical protocols that are aligned with First Nation Community standards and world views that are intended to protect knowledge, communities and individuals.

For this study, application for ethical approval was submitted to IWK Research Ethics Board, using the required forms provided by the department. Mi'kmaw Ethics Watch (MEW) review was also granted. MEW was established in 1999 by the Mi'kmaq Grand Council (Sante' Mawio'mi), traditional governing body of the Mi'kmaq people. The goal of establishing the MEW was to ensure that research being done within the Mi'kmaq Nation was done in a respectful, culturally appropriate manner and was intended to protect communities and traditional knowledge (Metallic, n.d).

The First Nations Information and Governance Centre (FNIGC) introduced the Principles of OCAP ®, which stands for Ownership, Control, Access and Possession. The reason for using this protocol was that for too long Indigenous people were the subject of study with no input for what was done with the information. In the past, there was no access, control or sense of possession for the data that had been extracted for communities or individuals (First Nations Information and Governance Centre, 2019). Historically, research experiences of Indigenous people often left them with no rights to their knowledge once it had been extracted (Kovach, 2010). These organizations have the

goal of protecting knowledge and communities to ensure information and people are respected.

Although there are no formal documents to complete or applications to submit, the community's Health Advisory Board's approval by way of a letter of support from the Health Director was required to conduct the research within the community. Members of the board include the Health Director as well as community members, Elders, Chief and Council members and health care professionals.

At the time of the conversation the RA read over the forms with each participant. Each participant had provided verbal consent before participating in data collection. A copy of the signed consent form was provided to the participant and the researcher kept a copy for records.

Participants were informed that they can withdraw from the study at any time, they could choose to not answer any question or skip any question with no harm or repercussions. There were questions that were skipped in both the health survey and the conversation sessions. Having these opportunities helped to facilitate trust in the research process. Building trust and relationships in the community has been an ongoing as a community health nurse and during time spent in various roles in research including RA and nurse research coordinator.

Participants received a small gift for participating in the research process. Each participant received a fifty-dollar gift card from a local business and a small smudge kit with sage, a shell and prayer card.

Personal Bias

There are many of my own roles and responsibilities that influence my world view on the early child development supports and services in the community. It is important to note that as a nurse with background in research I have many pre-existing relationships with many people in the community on professional and personal levels. Based on Indigenous methodologies that include tribal paradigms, having pre-existing relationships with participants is an accepted fact in this type of research (Kovach, 2010). As a Registered Nurse in a community health department, serving the community involves professional relationships with parents, families and service providers that have been developing over the past nine years.

It is also important to note my own relationships between the concepts I have explored, which is part of the Indigenous paradigm that holds the concepts of relationships, or in relation to all of creation as an important part of knowledge and life (Wilson, 2001). In the role of community health nurse (CHN) I also played a direct role in the healthy development of the children in the community. Providing developmental screening to infants and children at the 2, 4, 6, 12, 18 month and 4-6-year immunizations is routine. We, the CHNs, also provide screening when assessments indicate necessary at any other visit or interaction with families and children. Based on assessments and/or screening results, CHNs discuss services and supports in the community and can offer to make any referrals with the parent's consent. CHNs also discuss development with parents and share with them strategies to promote development such as reading, playing and singing songs, breastfeeding support, promoting maternal mental wellness, and more. In order to avoid miscommunication or false expectations related to why I'm collecting

the stories I ensured participants understood my interaction with them as part of this study was related to my graduate school activities and not part of my previous professional role in the Health Centre. I let them know that the knowledge shared will be themed and shared with the Health Centre staff to improve community processes.

The Mothers support group is a part of the CHNs initiatives for disease prevention and health promotion in the community. At the group meetings facilitated by myself and often guest speakers mothers have health and cultural education, do crafts or activities, share a meal, and probably the greatest benefit is the mothers have time for themselves, to spend with other mothers in a supportive and safe environment. This group incorporates cultural activities that promote culture and traditions in the home such as rattle making, drum making, beadwork, moccasin making, and children's ribbon skirt making. Taking part as a facilitator and mentor in these settings has given me the opportunity to bring those teachings home to my family while bringing them into the community.

There is an early year's development working group in the community where providers gather to collaborate and discuss, plan and create strategies to protect and promote child development. As a nurse and student participating in research, I became part of this group that was on hold due to Covid. Before starting I shared with them my vision of the research project, and the group members were supportive of the task and its goals.

As a mother and community member, I have personal experiences with health professionals, service providers and the early years support systems in the community. All three of my children have attended the AHSOR program and we have had developmental services that included home and office visits with different organizations

both on and off reserve. This study is meaningful to me as a mother, as a health professional and a community member.

CHAPTER 5: FINDINGS

In this Chapter I will review the findings which include three main areas:

1) The demographic profile of parent/guardian participants and their children

2) The results of the health information survey: Access and effectiveness of the supports and services in the community

3) Parent/Guardian themes and Elder insights and wisdom related to early childhood development from the conversation sessions and overview of pre-identified priority areas.

Demographics

Parents/Guardians

In this study there was one Elder and seven parent/guardian participants reporting on their experiences with 19 children. The Elder provided insight on their experience over their lifetime with children but did not complete a demographic and health information survey. Two of the parent/guardian participants were grandmothers caring for their grandchildren. Parents and guardian participants (n=7, Table 1) shared their demographic information which was organized and analyzed with descriptive statistics using Microsoft ®Excel ®2019 MSO.

All 7 parent/guardian participants who were involved in the study identified as female, Mi'kmaq/First Nation. The average age of parent/guardian participants was 39 years, with an age range from 25-61 years.

Table 1- Parent/Guardian Age Distribution

Parent/Guardian Age	Frequency
25-35	3
35-45	2
45-55	1
60+	1

Children and Youth Demographics

The parents shared demographic information regarding their 19 children. The average age of the children was 6 years and ages ranged from 7 months to 24 years. If the outlier of age 24 is removed, the average age for participants' children was 5 years and the range changes from 7 months to 9 years. Five (n=5, 40%) of the children whose parents had participated were seven years old, which was the most frequently reported age for children.

Each participant described their families as having 2-3 children, most families (n=5, 71%) having three children. Sixteen (84%) of the children were age 7 and under. Only three children were eight years and up. Three of the families who had participated had three children all age 7 and under. Every parent/guardian participant had at least one child who was age 7 or under in their family.

Health Information Survey Findings

Access to Services

Families were asked to share information about accessing certain services that support their child's wholistic development. The health information survey was adapted by the Aboriginal Children's Hurt and Healing (ACHH) Initiative from the Regional Health Survey (2017) and used with permission. The survey captured information about services such as *Family Doctor, Nurse Practitioner, Walk-in Clinic, Emergency Room, Nurse, Dental Professional, Mental Health, Traditional healer, Developmental Service* and *Formal Childcare.* Dental Professional included Oral Surgeon, Dental Hygienist, and Dentist. Parents shared whether their children accessed these services at three time points: in the past 6 months, past year, and in the past 5 years. Parents also had the option

to share if they have not accessed a service, or if the service was not needed in the past six months. Not applicable (N/A) was also an option for parents to select.

Most Frequently Accessed Services

The two services most frequently accessed by participant's children in the past 6 months were *Family Doctor* (n=12, 63%) and *Dental Professional* (n=12, 63%). *Nurse Practitioner* and *Developmental Service* were the second most frequently accessed service in the past 6 months (n=5, 26%). There have, occasionally, been full time Nurse Practitioners (NPs) at the health centre however, currently, there are no NPs in the community. *Nurse* was the most frequently accessed service in the past year (n=4, 21%) and third most frequently accessed service in the past 6 months (n=4, 21%). The strength of services in community lies with the services and professionals' available at the community health centre.

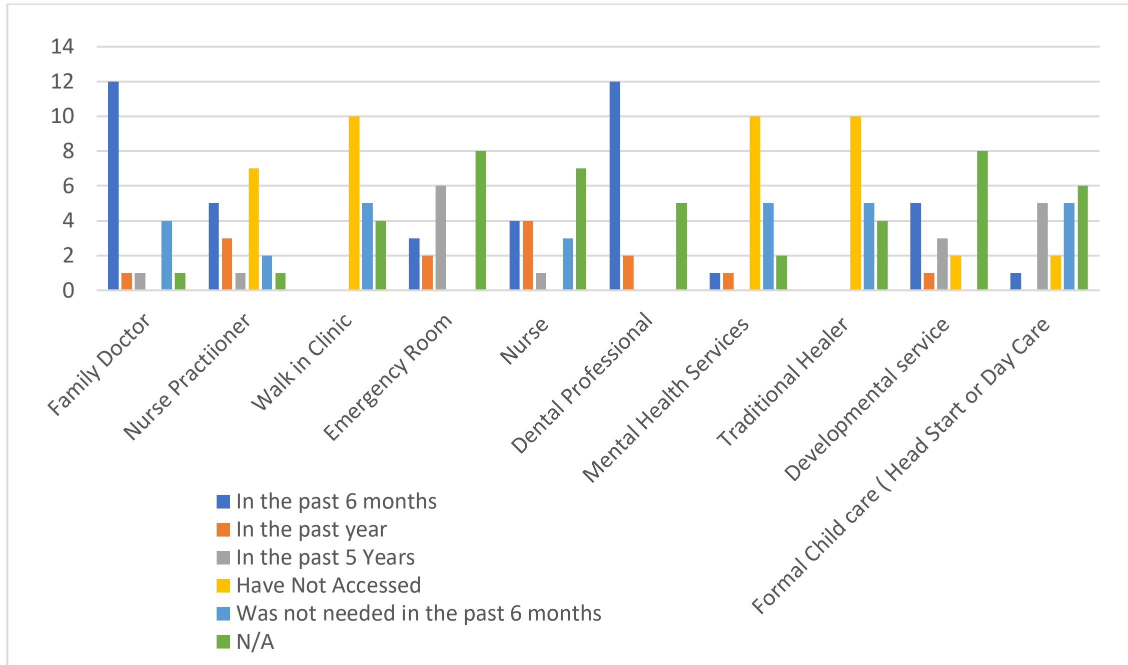
Least Accessed Services

The least accessed services were walk-in clinics, mental health services, and traditional healers. All three services were *not accessed* (n=10, 52%) at higher rates than other services not accessed. *Mental health services* were accessed by only one of the children/youth in the past year and by only one of the children/youth in the past six months. A traditional healer was **not** indicated as accessed at any time by any of the 19 children/youth whose parents were surveyed.

The second most frequent service that was *not accessed* was NPs (n=7, 36%). The rate of children and youth accessing formal childcare is low. Two (n=2, 10.5 %) children had accessed formal childcare such as Head Start or daycare in the past six months. Five (n=5, %26) children had accessed formal childcare in the past five years.

Only (n=1, 5.25 %) of participant's children had access to formal childcare in the past six months and roughly a quarter (n=5, 26%) of children had access over the past five years.

Figure 1- Frequency of Services Accessed



Parent report (n=7) of children's frequency of accessing services (n=19 children)

Rating Services through a Wholistic Lens

Parent/Guardians were asked to use the medicine wheel and rate, using a scale of 1-5, the effectiveness of all community services that they have accessed in their ability to meet the needs of their children related to their *physical*, *mental*, *emotional* and *spiritual* health and development. Participants were asked to score services that were low on effectiveness as a one, three was neutral and a five indicated the services were perceived highly effective. See Table 2 for ratings.

The parents/guardian's feedback and ratings of the services and programs that support *Mental* health and development ranged from 1-5. The mode was three (neutral, n=3, 42%) the average rating was 3.4 and was the lowest rated out of the four quadrants.

One parent wanted to include the middle school and Mi'kmaq family children services are both at a 1.

The ratings for *Emotional* developmental supports and programs/services ranged from 3-5, with a mode of 3 (n=4, 57%) and an average rating of 3.5. Parents/guardians most favorably rated the supports for *Physica*l health development in the community with an average of 4.7 and a range of 3-5 with only one parent/guardian out of seven who didn't rate it a 5.

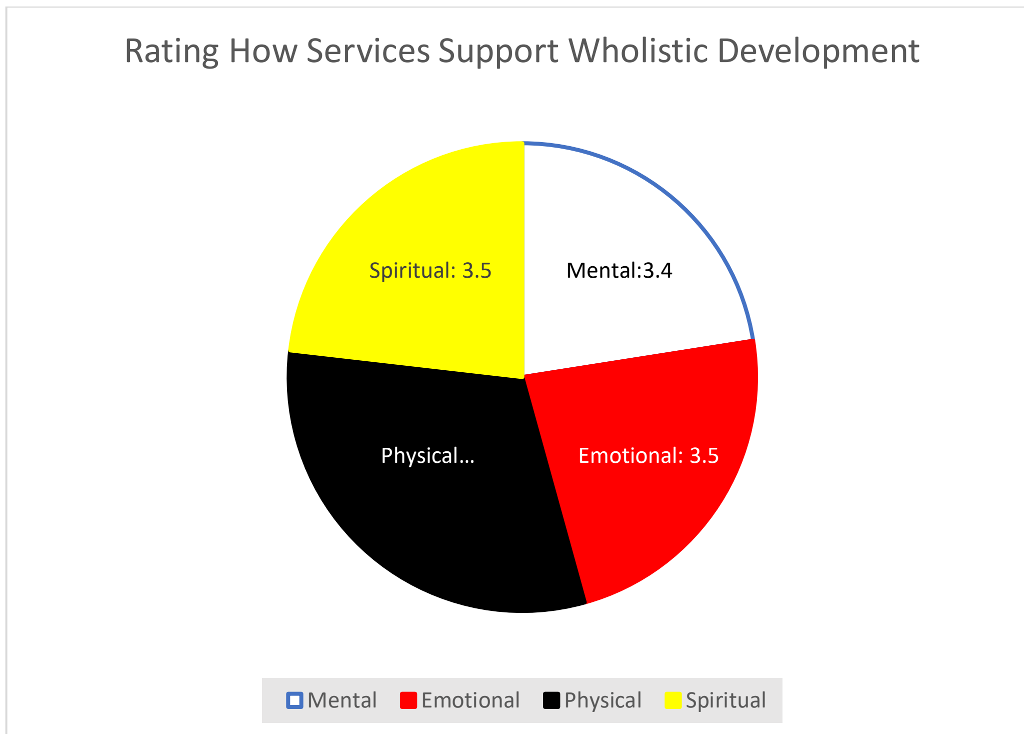
The average rating for services in their ability to support *Spiritual* health was 3.5. The range of ratings for spiritual health was 2-5, with a mode of 4, (n=4, 57%). One participant had difficulty with the question, and was unable to provide a numerical value only stating that they were not sure about how services in the community are meeting the spiritual needs for children aged 0-7 years. Another participant said that it wasn't applicable. The participants had no difficulty in rating the physical, social/emotional or mental quadrants. For the purposes of calculating the mean value of spiritual health, both participants who were unsure or said n/a were assigned neutral values of 3.

Table 2- Rating Community Services Ability to Support Each Quadrant of Development

Participant	Mental	Emotional	Physical	Spiritual
P001	5	3	5	Not sure
P002	3	3	5	5
P003	1	4	5	2
P004	3	3	5	4
P005	5	5	5	N/A
P006	3	3	5	4
P007	4	4	3	4

Scale of 1-5 with 1 being low on effectiveness and 5 being highly effective

Figure 2- Services Support for Wholistic Development



Participant rating of community services ability to support wholistic development

The average scores of the spiritual, mental, emotional, and physical values were used to create a pie chart, using the Medicine Wheel colors to represent the four quadrants (See Figure 3). The resulting image created with the data is not a visually balanced Medicine Wheel. Using the means of mental (3.4), emotional (3.5), spiritual (3.5) and physical (4.7) to calculate the over-all average rating of services in their ability to support wholistic health, the resulting average is 3.77. There is no precedent for analyzing information this way but the opportunity to create a novel way to use Indigenous knowledge and ways of knowing with the Medicine Wheel creates a new way forward for evaluating community perspectives.

Parents were asked if they prefer to access services: i) in their community, ii) in their home or iii) outside of the community. *In the community* (n=4, 57%) and *in the home* (n=4, 57%) were favored answers; one parent/guardian checked both boxes. The option *outside of the community* was not chosen by any parent/guardian participant.

Conversation Session Findings

Themes, Insights and Wisdom

There was some overlap across parent/guardian themes and Elder wisdom/insights but for the most part the two groups are kept separate in this chapter. There were eight Parent/Guardian themes, with seven sub themes related to experiences, eight subthemes related to participant recommendations and four Elder Insights and Wisdom, and these included:

Parent/Guardian Themes

Theme 1: Access to Services is Key to Optimizing Healthy Development

Theme 2: Services Missing the Mark: Culture & Language

- **2: 1:** Lack of inclusion of Mi'kmaq Culture in programs and services
- **2: 2:** Lack of equity in screening, testing and assessments for fluent Mi'kmaq Speaking children and youth

Theme 3: School Readiness Related to Early Education and Childcare

- **3: 1:** Gaps in Access to Early Education and Opportunities to Develop School Readiness**.**
- **3: 2:** Positive Impacts of Early childcare and education related to school readiness

Theme 4: Special considerations for Special Groups

4: 1: Lack of programs for neurodivergent children and youth

4: 2: Intersection of parent/Guardian and Elder/Grandmother wisdom and experiences

4: 3: Lack of safety in health care system for children and youth with special needs and their families.

Theme 5: Medicine Wheel Insights: Effect of Early Childhood Developmental Supports and Services on Child, Parent & Community Well-Being

Theme 6: What works: Exemplars of Cultural Development - Essissoqinikewey Siawa'sik-l'nuey Kina'matnewo'kuo'm (ESK)

Theme 7: Mi'kmaq perspectives of Early Child Development

Theme 8: Visioning a Better Future: Parents recommendations to support wholistic health including eight subthemes related to recommendations:

8:1: Supporting Social/Emotional and Spiritual health

8:2: Supporting Physical Health and Development of Children, Families and the Community

8:3: Supporting Mental Health and Development During the Early Years

8:4: Creating More Spaces and Services in the Community

8:5: Increase Indigenous Staff in the Early Years and Developmental Services

8:6: Recommendations for Families and Children who have special needs

8:7: Involving Intergenerational Family in Health Education

Elder Insights and Wisdoms

Insight and Wisdom 1: Gardening Elder Knowledge/Wisdom Perspectives of Early Childhood Development

E1: 1: Early childhood development & the life cycle

E1: 2: Important role of family & family dynamics

Insight and Wisdom 2: Supporting all Children and Youth and Their Unique Physical, Mental, Social and Emotional Needs.

Insight and Wisdom 3: Language Matters: Mi'kmaq Language and Child Development

Insight and Wisdom 4: Mi'kmaw Language Building

E4: 1: Nurturing spiritual development through intergenerational relationship building and language

E4:2: Mi'kmaw language development and its relationship with Mijua'jijk & the life cycle.

Community Priorities:

Covid 19

Jordan's Principle

Mi'kmaq Family Children Services

Theme 1: Access to Services is Key to Optimizing Healthy Development

As I listened to audio and read the transcripts of the participants describing their experiences seeking support/treatment I started to envision a map of service and eventually took marker to paper to draw out what I was hearing and then re-created that initial sketch with a digital image (Figure 4). I saw the map starting out with referral

sources which were: the school, kindergarten registration & screening, self-referral, and community health centre provider or nurse. The second layer/level I envisioned in the map is the actual services families had accessed in the community including youth mental health, Early Intensive Behavior Intervention (EIBI), Jordan's Principle (JP), Day Care, Hearing and Speech, Nova Scotia Early Childhood Development and Intervention Services (NSECDIS), Assessment appointments seeking diagnosis (ADD/ADHD/Autism) and Mi'kmaq Family and Children Services. The third phase in the map is the three outcomes of the referrals that parents/guardians identified which included 1) denied/not approved, 2) approved/accessed or 3) parents/guardians were still waiting.

Having the referral experience mapped out allowed me to observe some trends. Having a child/youth receive the right referrals and approvals is a key step and can lead to more services. For example, on line 07 in dark blue **(07)**, a self-referral to JP that was approved led to the participant's child receiving new referrals and services to hearing and speech services and assessment appointments as indicated by branching lines on the approved/accessed line. This parent gave me permission to share that they work in the system, and they acknowledge that they have a different perspective and experience than most. The same occurrence of an approval branching off into more services can be observed in the light blue line 02 (02) when a child/youth's parent expressed concerns during a routine immunization appointment which prompted a routine developmental assessment by the Community Health Nurse. From there, the parents received the referral to NSECDIS which was approved and accessed. Because that referral was approved and

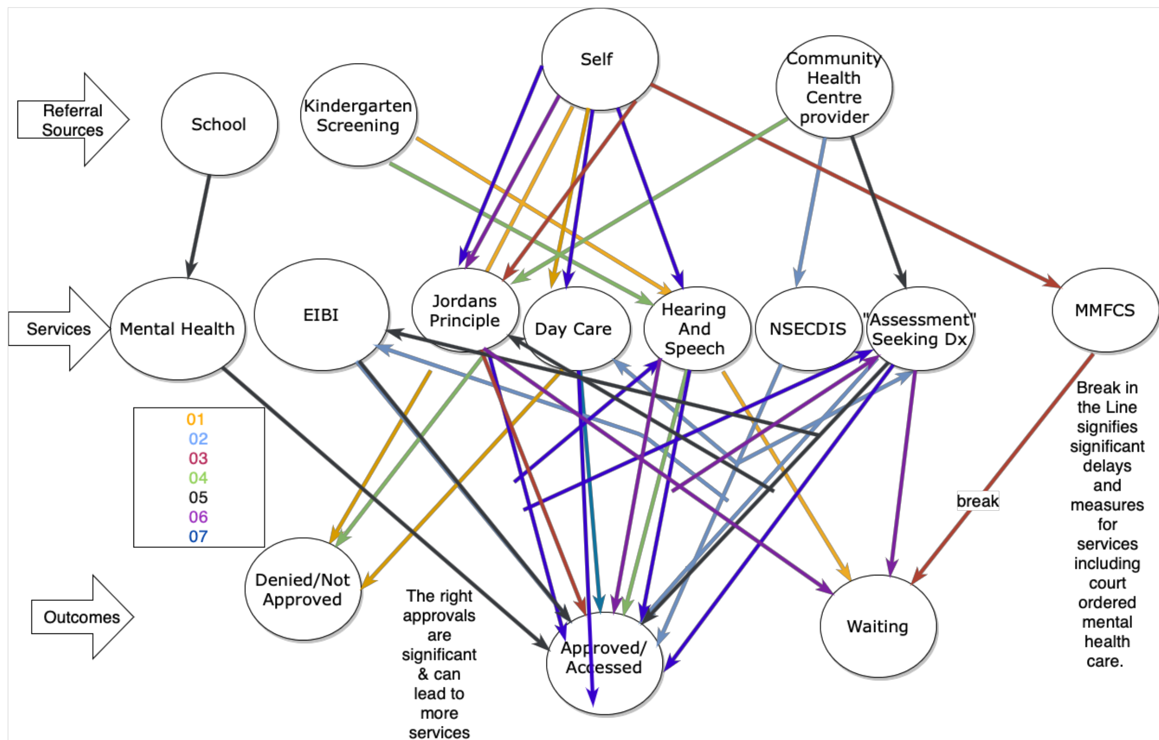
accessed, the family gained support and access to other programs and services observed in branches and resulting approvals from those branches.

The concept of more access resulting from approvals was reinforced in the transcripts. Parents shared their experiences of getting more service when they receive a diagnosis. One participant (P002) noted:

> *… you wait a few months and then you get booked and then you do your test and once you do your test, more services opens up for you once your child gets a proper diagnosis. Like they will get the EDI program, they like just more help ah. like right now they suspect child 3 might be autistic too ah. So um, we're just waiting for September to open up more programs for her when she gets the proper diagnoses.*

It’s important that families receive the timely services and support they are requesting. Not only does it provide that one instance of support, but it also often provides opportunities for expanded services and support the child needs. In contrast, when referrals are not made or denied and services are not accessed, it prevents that positive cascade of services. No child should be denied the services their families are requesting. The map appears to display successful referrals and services accessed. What the map doesn’t show is the fight, struggle and hardship families endure while seeking services. There were many instances of people waiting for program approvals and services, and families ‘begging’ for support.

Figure 3: Service Access Map



Parent/Guardian identified referrals, services and outcomes.

Theme 2: Services Missing the Mark: Culture & Language

2:1 1: Lack of inclusion of Mi'kmaq culture in programs and services

Considering the importance of culture and the protective factors it offers when included in programming, programs and services in the community were perceived as *not* including culture in their programs. Parents/guardians were specifically asked about community programming including *culture* for the 0-7 age range, participants did not respond favourably.

> *J: do you know if any of these programs include Mi'kmaq culture into their programs?*
>
> *P001: No, none.*

When culture was identified as present in programs for children aged 0-7 it is in the form of a Mi'kmaq speaking provider.

J: ...do the programs in the community including culture?

*P002: Not the one we are currently in it's a English one because unless it's with **, she speaks Mi'kmaq to them but majority of the programs that are for the children are in English because they're not community based programs there more like outside source program that comes into the community.*

J: Um, and do these programs include Mi'kmaq culture?

*P005: No. Well, I know ** she does. Like she incorporates that with Child 2, like in the past with their sessions. With child 1 it wasn't um. Like it would be amazing if we did have someone that is Mi'kmaq in the EIBI like staff. That would be, that would be good!*

One program that includes culture was identified, however this program is not open for children aged 0-7 and not able to directly impact the early childhood development for children and youth in the community.

*P007: For children or over all? Um, it would be there is an after-school um, land-based program even ** and ** do that. So, they are teaching kids how to harvest medicine and they also teach them um like fishing and hunting, stuff like that.*

J: What age is that for?

P007: For 10 and up.

It is exciting to hear about these programs available in the community for ages 10 and up but we need more services and programs in the community that include culture for parents, children and families aged 0-7.

2:2 Lack of equity in screening, testing and assessments for fluent Mi'kmaq speaking children and youth

P004: "L'nuisijik Nijink aq Ni'n" – My children and I speak Mi'kmaq

We are very fortunate to have children and families who speak the Mi'kmaq language. Our communities have fluent speaking children and youth whose first language is Mi'kmaq. Mi'kmaq language is in danger and all efforts must be made to protect and promote the language but also to protect the speakers as well, especially children.

P004: Paqsik Lnusijik and mu aklasiewisijik, they don't speak English. And it is very rare, because our language is dying, but there are some kids that are out there that are still like that because their parents do speak it to them. My kids being one.

The study has provided insight into an important matter that requires immediate action. Our Mi'kmaq Families are experiencing inequitable access to culturally safe screening and assessment services during the early years. Fluent Mi'kmaq speaking children and families experience language barriers, lack of accommodation, and in some cases no translation services and unjust treatment. Our precious children who are fluent Mi'kmaq speakers are falling through the cracks. Examples shared include speech and language screening/tests and psychoeducational assessments. The children who are fluent speaking are having difficulties with tests/assessments available only in English. One parent had an experience during a psychoeducational assessment:

*P004: Because when I went to see Dr. ** with child 3 he told child 3 "pick it up and put it over there." And child 3 looked at him like "what?" And I knew as a mom because I'm child 3's support person and his number one, I knew he knew that in Mi'kmaq.*

Parents will do whatever they can to advocate for their children. Parents are trying to support their children while accessing services not available in Mi'kmaq but barriers including oppressive policies and no translators continue to cause gaps and inequitable testing. The same parent (P004) commented:

Child 2 understands more Mi'kmaq than English and he failed on the English side of something, some test he was taking. But he passed when I translated it in Mi'kmaq. But because speech, the hearing and speech woman wasn't fluent she said it won't, it won't, um, they wouldn't accept it. So, I find that they need to do those screenings for everything they need to have either a linguistic on call, or they need to accept it in most ways pretty much, that some kids are going to excel with Mi'kmaq language than they are with English in those kind of test fields.

*P004: And when I told Dr. ** I said, can I say it to him in Mi'kmaq those exact words you are saying? And he said, "yeah but I won't be able to accept it on my report." and I'm like "why? And he goes "because I don't understand it, I don't know if that is really what you are saying." And I'm like "excuse me?" And he's like you can try, so when I said it. I said child 3, "Kinen aq ikate'n ala." And he picked it up and he put it over there. And I told him, 'The exact words you said in English, I said in Mi'kmaq. And he did it. And he did the task you wanted to do.' But because it wasn't accepted, which I don't know why! But he, he brushed it off like he just, he said "no". He couldn't.*

As we move forward in truth, reconciliation and language revitalization the experiences of fluent Mi'kmaq speaking children and families in health care cannot remain the same. We have to move forward to address these gaps and accommodations

must be provided on a systems level that does not put extra costs or pressure on communities and their resources.

Theme 3: School Readiness Related to Early Education and Childcare

3:1: Gaps in access to early education and opportunities to develop school readiness

The main theme heard from parents related to the node 'school readiness' was the relationship of culturally appropriate early education and childcare opportunities and its impact on social/emotional health and development on school readiness. The majority of feedback was children in the community are **not** prepared for school by the time they start:

J: "do you think children are prepared for school by the time they start?

P001: no no"

Parents felt that kids are lacking opportunities to develop social skills during the early years that directly impacts their social/emotional health. It continues to affect them as they grow, and the impacts are most apparent when begin attending kindergarten:

J: Ok. And question number 8 do you think children are prepared for school by the time they start.

P003: No

J: in terms of language, social development, what do you see that makes you say no?

P003: Um, a lot of kids are, um.. how do you…they don't have social skills. Like, yes they will have birthday parties and kids will come over but that's it, parents don't go visiting or play time with one another, or play dates you know what I mean?

P003: and as a result, when a kid goes to school, they are extremely scared. They are scared of new faces.

Another aspect of school readiness was the importance of having the services and supports in place to ensure the children have everything they need to be successful in school.

P006: Um, helping them in whatever areas that they need help um. Um help with right. Um like my Grandson, has um a speech impairment ah. Um, he had a hard time like he, he really had a hard time first few years. From 1-4. We immediately didn't understand him. We struggled to understand what he was saying. We knew certain words that he was saying. But it was really hard with the covid. Covid like nobody coming, nobody coming um over anymore. And there was like um, a halt. Like you know, they didn't come, go over anywhere. And we just had to wait, wait it out. That was hard. Now he is like, we can understand most of what he says now. His words are coming out. And I'm really, really hopeful that Um, it's just going to get better. And once he is assessed like you know like. I am really hoping that he gets to have the um, speech therapist. Soon. J: Yeah I was just going to ask did he ever see anybody P: Because he really needs one for school

J: Do you think children are prepared for school by the time they start?

P006: Um yeah I think so. Sometimes, sometimes yeah if they really did assessment like before. Before they started school ah.

For this family, not having services in place when the family noticed a speech language condition may have contributed to the child repeating a grade.

P006: Um yeah, and he was having a lot of hard time at school. He was um, like we couldn't understand what he was saying. He repeated grade Kindergarten. They

thought it was a good idea to keep him back another year. So, he um, it has been um, a long wait. You know.

Although families haven't had access to early childcare services they feel it is a very important pilar in early childhood development and school readiness.

J: …how would you vision optimal child development for children in our community?

P001: ah like it would be nice to have like better, better services for children interactions with other children instead of just throwing all the kids into kindergarten expecting to you know, know what to do or know how to react to that that's my biggest concern because my son starts kindergarten this year and I don't know how he's going to react to it because right now he can't really talk and I'm not quite sure what could help or what I'm gonna get yet or what to expect.

The limited access and opportunities to early childhood programs such as day care and head start impacts not only language development but other aspects of wholistic health of children. One participant (P001) shared the impacts on her child's social/emotional and physical health.

Um OK yeah like say like my like my 3-year-old son doesn't hasn't, hasn't really been playing with any other children so like that's like made an impact on even his social and physical like he doesn't know how to react when he sees other kids, because he hasn't got like um access to head start or stuff like that so.

The participant shared what has made access difficult, which include program policies.

P001: it was easier with child number one because we, we lived in a different community where they welcomed any child at that age as compared to in [community], it's only working parents or if you're going to school.

J: for the daycare or the head start?

P001: the daycare, yeah, oh for like, oh OK for like the other communities yeah I used to live in [another Unama'ki community], I lived there like majority of my life, but um, yeah my daughter I raised my daughter there until she started kindergarten but she had access to daycare and um, it was like she was completely welcome even though I was on welfare and I wasn't a student at the time and that helped with her and now she's, she's very outgoing compared to my son at this age because my son hasn't, wasn't access to that.

P001: yeah or even if like he were to go to like a head start program even I don't even think there's one this year in [community] to be honest.

J: no, I haven't seen anything posted for any programs

P001: Nope it's like a bump in our road this year.

Some of the barriers to early childhood education and childcare identified by families included policies of the day care (prioritizing working parents, those who are going to school, etc.), lack of consistent programming with the Head Start and no other options available in the community.

3:2: Positive impacts of early childcare and education related to school readiness

Families who did have access to day care and head start had a very different outlook and experience related to school readiness compared to children whose parents did not have access to day care and head start services. Parents of children who did attend day care felt that kids are ready for school, and they directly credit the service for the progress that they have seen.

J: question #8. Do you think children are prepared for school by the time they start?

P002: Yes, they really are. Head start, day care. Day care does a phenomenal job, because they helped my baby son. Mmhmm Umm head start helps them with that too.

For the children who do have access to day care it opens up doors for assessments, and other services such as speech therapy. It also provides a quality learning environment and developmental progression. Parents see a positive impact for their children. Another parent/guardian reinforced this message:

P007: child 2, I like that he is in day care. He is able to socialize with people, with kids his age. And provide him with all the, I feel like extra attention and teachings that I wouldn't be able to do while I'm at work or if I got a babysitter. It wouldn't be the same, I feel like he is benefitting from the day care a lot. He is talking more; he gets speech therapy there. And I always, I always go to them for advice like if he were to need additional assessments or if I had any concerns.

The same parent summarized the reality very well.

P007: The children that have the opportunity to go to day care, and head start. I think they are ready to attend kindergarten. But that's not, not everybody gets that opportunity right, when they are that age. Because the programs have limited seats, and not everyone gets to access those programs.

Every single child should have the opportunity to early childhood education and childcare programs. Every child matters, and like my own kids like to say, every parent matters too. Communities need support to obtain the capacity to deliver these essential early childhood services to all children regardless of parent income and education.

Theme 4: Special Considerations for Special Groups

4:1: Lack of programs for neurodivergent children and youth

There is a gap of programs in the community available for all children, but especially for children with special needs. Special Needs was the term was used by parents and families in conversation sessions Parents shared that there are few programs available for children with autism or other special needs. Several parents and guardians shared their perspectives:

P002: "… that's it's like there's no other services for autistic ..there's no programs put them into play like there's no there's barely any sports there's just like only certain sports you know what I mean?"

All children deserve access to services for their mental, emotional, physical and spiritual wellbeing and development. In some families, not all of their children have access to services that are safe to them. It creates challenges for families, described as hard:

P005: … we are going to hopefully um find more, more programs for our son because I know um, ...I find like um, there, there isn't very much things. There isn't very much things for kids with Special needs. So that is hard for us. Like we are, there's a lot of stuff available for one of our children but not the other. So, I called and ask are you going to have any more services or programs for kids with special needs? Usually, they don't really reply.

Parents/guardians acknowledge the overall lack of afterschool activities and support programs. Specifically for children with autism, the only service identified was a hockey program.

P007: Because there is not much, especially autistic children. There isn't much, there isn't any programs in [community] for these children. Other than like, the hockey program that they have every Saturday. But there is no support programs or like any after school activities, there is nothing. Unless you go out to, out of community.

Not only is there a lack of services, but there is a huge gap in health providers and programs with trained staff. This causes discomfort for families and negatively affects mental health of parents due to fear and mistrust in community programs. Lack of training for staff related to autism and other special needs poses a safety hazard for children who run away.

P002: yeah it's like everything is like when you ask like is it for special needs too? They'll be like no but you can bring your child and I don't want to bring my baby if there's no one there that's not trained to handle a child like they won't understand like my child is a flight risk and if they're used to being with children who are not special needs they're not going to pick up on my child running you know what I mean.

Staff that are trained will be better equipped to meet the needs of children with autism and other special needs. Being able to identify and address sensory issues was also identified by community members as an important part of training for staff to be able to accommodate their children.

P002: or if my child sees something or they won't understand sensory issues like if my child didn't want to play with the painting and they're forcing him they stress him out, and he flips out and then like that kind of stuff makes me nervous because I know not too many programs have people that will be able to handle children, they'll understand that this child has sensory issues maybe when we're doing play group you

guys can do this and other kids that have other issues or wanna do this will do this with us.

4:2: Intersection of parent/Guardian and Elder/Grandmother wisdom and experiences – Reflection: Kitnamatijik Kisiku'k - Elders are having a hard time

Grandparents who care for their grandchildren are struggling and require timely and intensive support. Two (n=2) participants who were recruited as guardians care for their grandchildren. One of the grandmothers who participated in the study identified as an Elder and their perspectives are included in the parent/guardian findings. The Elder parent participant shared her experience waiting for a fence for her yard from JP for her grandson.

"J:…what has it been like for you, trying to get the supports you need for your grandchildren?

P006: Oh, it's been hard for me. It's been hard. As an Elder, I am 61. And I remember you know chasing my...trying to chase my grandson you know, down my driveway. And um, he was hyper when he was younger like. He was hyper… Gee he would run away. And I had a hard time with my knee, and at the time I needed cortisone, I couldn't even um walk down too fast on the um, stairs. And I had a hard time chasing him around. With, like limping at the same time on that one knee. So, I had a hard time, I had a hard time anyways. I know a lot of people have a lot of support with Fence and all that, but it was bad timing for me ah. And um, its its still! Right now, I feel like it's still bad timing because the waiting system is not good. Right now, I mean, it's not. It's not good. So, we haven't been able to get any, we haven't been able

to get any support. In the area. Like other people are getting. Because he still needs to be assessed. Finish being assessed ah."

After speaking with the Elder parent/guardian participant and hearing their stories I decided, while on my way to deliver a smudge kit to them, to include in the discussion or recommendations special considerations needed to support the wellness and development of children in the care of the grandparents. It is of utmost importance to provide these special families with wrap around services that are timely and meet the unique needs of the dynamic family unit because caring for children with special needs can be difficult for Elders and grandparents due to their health.

When I arrived to deliver the kit, the participant came outside to speak with me and asked me to please include in her perspective the fact that grandmothers who care for their grandchildren need more help and support. I let her know that I heard this message from her in our conversation, she validated that information for me. The Elder guardian participant also validated my ability to apply the meaning making methods to the stories that were shared.

4:3: Lack of safety in health care system for children and youth with special needs and their families

All Indigenous people have less safety when accessing services outside of the community health system. There are many examples that have had media attention such as Joyce Echaquan (CBC, 2021) and Brian Sinclair (CBC, 2017) and many more that have not even been reported. Families whose children have special needs face particularly dangerous and scary situations when accessing services outside of the community. At the end of one parent/guardian session I asked if there was anything else she would like to

share before we end our conversation. The parent shared her experience that she had with her son who is on the autism spectrum.

P005: Um, just our incident at the Cape Breton Regional Hospital, they were like rectified and like, that um. Even the Manager of um, Ultrasound Department at Diagnostic Imaging he personally called me, and he was, he was apologetic and um, like I tried to tell him how this like it really... like…

I asked the parent for more information and clarification regarding what she was referring to. The participant clearly recalled the date, time and what happened at their son's ultrasound and bloodwork appointment in December 2021. She described the event as 'traumatizing'. Her answer would affect both of us emotionally and spiritually:

P005: He, like in the ultrasound room he was just like hitting the counter hard, and he was really upset and, and there was more people coming in. Then he started to get really scared, and he was grabbing on to me. And where, to them it looks like he is trying to fight me. But he is just, he wanted me to pick him up like a baby like that's how scared he was, and I kept telling them when we were upstairs, I said I don't feel right taking him downstairs, I think he is too nervous, he is really scared. And I said can you guys give him midazolam? And they were like oh no he should be fine. And I kept begging them. I said, just give him enough and then I said I don't care if I'm up here all day until he is done being sleepy, I don't mind, I don't mind at all. And they were like well let's just try it and see how it goes. And so, we went down, and then that is when he, he was super agitated, and then they, they did a code white on us. And then, and then I was like …one of the security guards like he wanted like, he said, 'well we need to restrain him' and everything, and I was like you are not touching my

son, he is not even violent he is scared like can't you guys tell the difference? You know. And where he is non-verbal, everything. There was so many nurses, like so many like the security guards. And they were just making the situation worse. So finally, I'm just telling them, just leave us alone, just give us a minute, just let us, just let us be."

Code white refers to the code called in the hospital setting referring to a violent patient. The situation was traumatizing for the client, and she worried about his response to health care in the future. Thankfully, just like in community, supportive staff make all the difference for clients.

The parent went on to say:

*P005: So, at this point he hasn't eaten anything in sixteen hours, no food or drink. And where he is like diabetic, like that might of triggered all of this. So, the nurse gave him glucagon and then like, he was, he was ok after a few minutes, and they gave him apple juice. Like normally I water it down, but they gave him straight up apple juice. That helped a lot too. All he needed was food… So, but one security guard, he...his older brother was autistic, so he knew how to de-escalate everything like how he talked to ***, how he rubbed his back and calmed him right down. And he kind of told the other guy, like 'just leave, if you are not going to be helpful just go somewhere I am fine!'.*

In the end, the parent shared that the IWK Children's Hospital stepped in to file a formal complaint on behalf of the family and has outlined in the child's care that they are to receive no more care at the local hospital due to concerns.

J: And how did you do it?

P005: I.. I..well… IWK got our report. And they are the ones who went forward with it.

J: Oh Good, they advocated for you guys?

P005: yup, they did. Because they seen the report and they know him so well there. So, for them it was like woah you know like, this isn't him. This.. this isn't right. So, they, they did that and then like within, in a matter of days like I got that phone call from the manager, and he gave me his number and he said anything you need for us to make his next scans, or anything he needs done, like better just let us know. But by that point its already too late. Like um, anything, like any appointments or anything um test they have to do, we have to go IWK now. Like even for blood work, X-rays, anything, they…

J: He won't go to the regional?

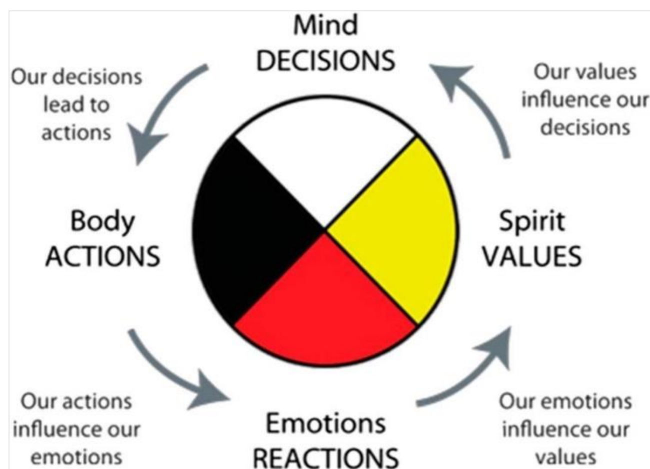
P005: It's not that they won't go, it's the Doctors at the IWK, they don't want him there. Even, even if it's just for blood work. Even if we need an X-ray you know. He had surgery on his leg in February, so we had to go all that way! Just for an X ray. But there, they just knew like how traumatizing it was for him and how they feel like he doesn't get the best care here. And it's just so easy for them to just say like, "Patient was too difficult, won't do the exam" or whatever ah. So, like that's now he, like we have to go so far."

This parent reported that the local children's hospital has made this decision on behalf of their patients to receive the best of care. It reduces the accessibility of services for the family, but it will help to ensure they receive care in a safe environment, despite having to travel four hours to receive it.

Theme 5: Medicine Wheel Insights: Effect of Early Childhood Developmental Supports and Services on Child, Parent & Community Well-Being

The Medicine Wheel framework was used in the qualitative analysis and healthy survey data analysis to categorize themes. Qualitative information was analyzed through the lens of the medicine wheel through drawing and writing along with NVIVO. My past experiences using the Medicine Wheel in research and data analysis proved very helpful, as well as the mentorship and guidance of co-authors, "JS" who is an Indigenous scholar and LM, ally and advocate (Latimer et. al, 2018).

Figure 4- Medicine Wheel Used to Guide Analysis



Latimer et al., 2018

I used the same medicine wheel framework for this analysis, and I used the methodology framework to help me confirm I was coding appropriately. The medicine wheel began as a singular circle representing the child, that included the four parts of self: mental, emotional, spiritual, and physical.

The physical themes include nutrition, physical safety, hygiene, access to home and community services and programs, medicines, abilities, limitations, play, access to play spaces, formal play groups, access to safe spaces, playgrounds, outdoor play, play

and outdoor learning. Some of the structured programs that promote physical activities that were accessed by parents included dance, swimming, gymnastics, tee ball, and pageants. The main theme related to these physical activities is that more programs are needed in the community. Programs fill up quickly and many are left at a disadvantage.

The mental health themes coded in the medicine wheel framework were parental support, school support, school readiness, and choices. The social/emotional themes were early learning and social exposure and coded here also was school readiness, language and culture. Spiritual themes were language, culture, and sharing generational knowledge and teachings, nurturing personal interests.

After working on the Medicine Wheel, I realized there was a second layer; there was a parent/family experience that was related to and affected by the children's experience. Once I had a step back it was easy to see that parents have a disproportional amount of emotional and mental health themes related to early childhood development. Parents shared how their emotions were impacted by what they had experienced while attempting to access services:

P001: "I felt really sad for my daughter being declined. Like, I felt like…I was reaching out for help, and I couldn't even get it."

The themes in the emotional aspects of the parent Medicine Wheel analysis included fear due to lack of safety, waiting for services, denial of services, anxiety, sadness, the stress related to suspecting diagnosis or having a concern with their child's development, fear and nervousness related to lack of training for community workers related to special needs, frequent staff and program changes, and denial of diagnosis. One parent described taking time off work for their mental health. Gaps in services and

programs have a direct impact on the mental and emotional health of parents. When parents and families have appropriate and timely access to early childhood services that support the wholistic needs of the child we may see an improvement in parent and guardian mental and emotional health.

A third *community* layer emerged through the Medicine Wheel analysis as well. Families' experiences with services impacted the health and wellbeing of their community. One parent shared their experiences of being "traumatized" in the non-community health system and stated, "I cried all the way home". The community members who were directly impacted by the traumatizing experience included "aunt", "uncle", "my partner", "my supervisor", "my Dad".

An interconnectedness between the Medicine Wheel layers of the child, family and community was very evident and I realized that my findings were not siloed into child, family and community. Child and family health affects community health and vice versa. It brings me back to the concept of Msit No'kmaq, All my relations. We're all connected in the community and that concept of interconnectedness as a principle of story-work helped guide this process and analysis.

Theme 6: What works: Exemplars of Cultural Development

- Essissoqinikewey Siawa'sik-l'nuey Kina'matnewo'kuo'm (ESK)

One parent shared her experience with the Mi'kmaq Immersion school, Essissoqinikewey Siawa'sik-l'nuey Kina'matnewo'kuo'm (ESK). The parent identified the school as one of the programs that give children aged 3-4 years and up the opportunity to learn about their culture. The ESK school identified as a huge strength in

the programming offered that includes a culture rich education in the Mi'kmaq Language. One participant (P007) commented:

> *…and then um, I know at the immersion school, they teach them drumming, they teach them singing in Mi'kmaq and they teach the Mi'kmaq language. They do smudging there, those teachings. The culture teacher teaches how to cook like moose meat and then they get to try it. So, their traditional foods are introduced to them. Um, what else is there? Mi'kmaq dancing like the Kojua, or they will have somebody come in and do the fancy Mi'kmaq dancing. Um, they always have pow wows and the give the kids the opportunity to wear their regalia's.*

Children who attend the school have a unique education experience, one that is fully immersed in Mi'kmaq language and culture.

Theme 7: Mi'kmaq Perspectives of Early Child Development

Parents and guardians shared their perspectives on what Mi'kmaq children need to develop and what child development means to our communities and Mi'kmaw Nation. The underlying themes align with Medicine Wheel teachings of the life cycle. Parents felt our children need love and nourishment from their families and communities and many parents mentioned their children need support (from family, community, professionals) in whatever area they require to thrive in all areas of being. *Mijua'jij* was a Mi'kmaq word that was shared to describe a child and their potential for development.

Mi'kmaw words related to early childhood development

I asked parents/guardians to share any words related to early childhood development. Participants had difficulty answering the question; Some people skipped

the question, others would ask to come back to it, and some parents couldn't think of any words. Table 3 provides the words that some parents/guardians were able to share.

Table 3-Mi'kmaq Words Related to Child Development – Parent/Guardian

No'kmaq	My relations
Msit No'kmaq	All my relations* English given
NuNu	Milk/bottle
A'	Yes
A! A!	Don't
Sespenimat	Can't sit still
Mijuajij	Children (specifically their growth and development)
Nutaq Mawi apoqinamuttitew *especially when they are babies	We need someone who helps the most
Pa'pa	Sleep
Pu'ti	Bottle

Organic Mi'kmaq Words

Besides the words shared in Table 3 when people asked about language related to early childhood development some words were more organically shared and came up in conversation. P005 shared words related to denial of a diagnosis or issues that came up when asking about school readiness.

P005: Yes, yup. And like um, I feel like a lot of parents are like me. Where they say like oh mu tatikek like you know. Kenutamasitow na! like they are, I find there is a lot of denial in their sense too. So, if, we make it more Ok to talk about it, of our like children who have struggles, um, I think they would benefit. Like um, like what I said about me you know finally accepting like Ok we need to get someone in, and we need to get him like checked out and stuff like that.

Table 4- Mi'kmaw Words Related to Uncertainty Regarding Child Development

oh, mu tatikek -	There is nothing wrong with them
Kenutamasitow na!	They will teach themselves or They will learn how on their own

Theme 8: Envisioning a Better Future: Parents Recommendations to Support Wholistic Health

Participants had the opportunity not only to share their experiences and stories, but also to envision optimal child development in their community. Parents were asked about what programs, services or supports they would like to see. Some parents shared their ideal environment for children when asked what do Mi'kmaq children need to support growth and development.

8:1: Supporting Social Emotional & Spiritual Development

Parents identified in their own recommendations the need for opportunities for children to gather with members of the community from all ages. When parents were asked about what they would like to see to support the optimal development for children in the community they responded:

> *P007: ...a bigger headstart or day care. For the clients, kids that are like between 2 and 4.*

Promoting social and emotional development through programming was identified as a strategy to help children be ready for school. A bigger head start, or day care centre would allow for more children to have access to the service. One parent shared what they would like to see to support social development improve school readiness:

P001: ah like it would be nice to have like better, better services for children's interactions with other children instead of just throwing all the kids into kindergarten expecting to you know, know what to do or know how to react.

One of the grandmothers shared how social/emotional development can be nurtured in group play settings outside of institutions but could perhaps be applied to a support group or parent and child group gathering.

P003: like I just said, they could have play dates, go to playgrounds regularly or even go for a walk and meet up with people you know. Just to be able to see that there's more than your, the people in your house in this world.

Participants felt it was especially important for gatherings to include culture and language which would also nurture the spiritual health and development for children in the community. Including Elders in the gatherings was also identified as important for the purpose of intergenerational knowledge sharing.

P006: Oh. It was nice when we used to have these gatherings. Like kids... well they used to have gatherings like. Kids like getting together like you know. Doing stuff um, activities you know. and um, I think it would be nice if, we had something like that. And that had a lot to do with like um Mi'kmaq, like Mi'kmaq words like encouraging them like in the activities ah.

J: Ok. and what does child development, excuse me what does child development mean to our community and for the Mi'kmaq nation?

P005: Um I would like to see, more like, I don't know like more gatherings or like something like that. Like more, more things to do with children. Like say, with Elders and like to teach them and....pass on their knowledge to them.

One of the grandmother parent/guardian participants shared their perspectives on the importance of connecting parents with culture and language so it can be shared with their children. parents are the first teachers and need to have the teachings to support their families. Other activities that could promote spiritual health and development were identified as important for all members of the community,

P006: teach the parents like how to access training, teaching them like speak Mi'kmaq ah… Mi'kmaq activities like singing or anything like in Mi'kmaq, words in Mi'kmaq, and anything that they might spark their memory they have with Mi'kmaq. Like Mi'kmaq words and the culture of it. Yeah. I think it would be good for them. It would be good.

8:2 Supporting Physical Health and Development of Children, Families, and the Community

One of the grandmother parent/guardian participants shared their experiences with programs and services to support physical health. The common theme was that these programs fill up quickly and children do not have an equal opportunity to physical programs that promote physical health and development. One grandmother participant wanted to see the programs include adults so the children and families will benefit.

P003: … they have a brand-new gym, and they have 2 gymnasiums in [the community]. How come they are not utilizing that with the community, how come they

*don't have a community schedule? Not just for our kids but also for our adults. Our adults need to be physically fit and know how to do these things in order to keep, get the kids involved. If the parent is going to be sitting at home lazy, they are going to teach the child to be sitting at home lazy… I would like to see having access to gymnastics. ... But the thing with ** dance is they need to expand. They don't just need one class here, one class there. They need to make like instead of one class they need 2 classes because they leave out a lot of kids… They say they are going to make a recreation centre, what is this, what is this recreation centre going to be, just a gym? A building that houses a gym, and that's it? We need more than just a gym.*

Among the programs to support physical health, most were identified to be available outside of the community, the least preferred location of services for community members.

P003: We don't have tee ball here, a lot of our…yes we have ball teams. But we lack coaching ah, we lack people who want to come out and teach these kids. So, we are stuck with going to town. Tuju ah, I would like to see ex-after school extracurricular activities come back for our kids. They've got nothing… And we need gymnastics in [community]. There are a lot of gymnastics, a lot of natives taking their kids to gymnastics in town.

P002: I say swim programs would be beneficial to everybody here because they wouldn't have to travel out of the community because maybe we need a community pool, you know.

8:3 Supporting Mental Health and Development During the Early Years

Early Intervention was established as an important factor for supporting the mental health and development of children, especially ensuring supports are in place before they start school.

P006: …if they really did assessment like before. Before they started school ah. It would have been a better idea to have them assessed like before school started. Should be encouraged more ah.

Another common thread among the supports needed to support mental well-being and development is that they are available outside of the community, and participants prefer to access those services in the community.

J: Are you aware of any programs or initiatives that you see in and around Unama'ki that are not available in [community]?

P007: Um, I would say tutoring programs. Tutoring services... And I would like a Mi'kmaq Immersion tutoring program… So, any service really that could be in community would be the best.

Another aspect of mental health development support for school was identified in the strategies used with students, to accommodate their neurodiverse learning styles and strengths. Lack of accommodations, adaptations and support can affect the mental health and development of children, and families. This lack was flipped to be included with recommendations - adapt to the students.

J:.. what do Mi'kmaq children need to achieve optimal growth and development? So optimal growth can mean different things for each kid. like every kid is different, and their needs are different but it's about meeting kids where they are at.

P005 Yeah, I know for sure child 2 struggles in school so much. like the school part of him, like it, it's so difficulty because like, it makes him feel like he doesn't like school, or he, he doesn't feel like...he doesn't feel smart. Like that's what he'll tell me he'll say, "I always have a hard time" and I'm like, well you just learn differently. I try to tell him that, where he is, he is ADHD and I find they didn't really adapt to him."

Just as the lack of support and adaptations for children can negatively affect their wholistic health, positive experiences with education through adaptations to learn in their own way can have positive effects on their social/emotional and mental development. The same child who was facing challenges at school had a much more positive experience when adaptations were made:

P005: Oh, um tutoring for child 2, at the Montessori school. Like the, I wish I could take him there like every day for school. Um, he did amazing over there and she was so patient with him **…***Um, like I pity him because it's like he, he really, his scared to get it wrong like on the first try, when they do stuff. So, with her, it never felt like that, Like he always like you know would make sure to think, and like she got him even like, um ways to cope when he wants to fidget or if he can't sit down. Like she will modify what they are doing and then she'll, he'll be comfortable and where it doesn't even feel like his learning, like you know it doesn't feel like he's doing work, he's having fun. Yup.*

Unfortunately, this parent felt they would not be able to access the school full time due to the cost.

8:4:Creating More Spaces and Services in the Community

Increasing capacity of community programs, services and supports was identified by the parent/guardian participants as a means to support wholistic development for children in the community. Having providers come into the community or the home would be the preferred service delivery method, in the health survey receiving services outside of the community was not preferred by any of the parent/guardian participants.

P007: I just wish um, the service providers that we do have were able to come into community and provide those services in community instead of us leaving. That would be best… What I would like to see as a community is to have a building, really focusing on the youth. And that building have lots of resources and have service providers provide services in that building. So that no one has to leave the community to get these services, it's just right there at our back yard.

J: so, question number four how would you vision optimal child development for your children or for our community?
P005: um I would like to see like more services in [community]. I know we have hearing and speech, and we've got um like the I think we have an early childhood development person. We do right? … and like, like more, more community-based um things where like the children would feel more comfortable instead of going to like a new place, or like different surroundings where in [community], everything would be familiar with them.

8:5: Increased Indigenous Staff in the Early Years and Developmental Services

The parent/guardian perspectives include the importance of Indigenous providers for the early years, specifically Mi'kmaq providers.

P005: "Like it would be amazing if we did have someone that is Mi'kmaq in the EIBI like staff. That would be, that would be good!"

One of the benefits of having Mi'kmaw providers is that they include the language during interactions with families which is an important factor, and often the only way culture is included in the programs. Often our community members prefer to have care from an Indigenous provider, for our Elders and fluent speakers the most important reason is access to services in their own language.

P004: And I know people, that are Elders that will deny a nurse because mu lnuisijik (they don't speak the language). They want someone lnuisijk, (who does speak the language) same aq (and) health care like home care aq kowey (and whatnot) they need people like that.

J: so, its barrier for services when there are no services for language translators?

P004: Yeah we need more of that, when it come to- especially with the developmental tests and stuff. Like some psychologists say "oh.. they don't get it!" And I'm like "maybe they just don't understand you."

Two of the participants were pursuing education to fill the gaps in Indigenous providers. One parent shared after recording, that she was pursuing an Early Childhood Education Certification to benefit her children and community and gave me permission to share. The main reason she went for the training was to meet the needs of her own children. Another parent participant shared their reason for entering the nursing profession.

P004: "And I'm in nursing now. And the reason why I'm in nursing is because we need more people in the hospitals and in the communities that speak Mi'kmaq."

Indigenous providers are so important for Indigenous communities and its members. Access to culturally appropriate care and services, language, understanding and more are some of the strengths of an Indigenous provider. Efforts to create culturally appropriate education opportunities for all areas of early years professionals is needed for First Nation and Indigenous people.

8:6 Recommendations for Families and Children who Have Special Needs

Families with special needs are yearning for community, support, programs, and inclusion. The challenges of even accepting that there may be support needed is something that causes parents emotional/mental stress. One parent shares how a child can benefit if parents can talk about their experiences:

> *P005: So, if, we make it more Ok to talk about it, of our like children who have struggles, um, I think they would benefit. Like um, like what I said about me you know finally accepting like Ok we need to get someone in, and we need to get him like checked out…*

Among those with special needs, families would like to see an all-inclusive approach, not just for a specific diagnosis such as autism.

> *P002: "…by having more programs available for parents of children who are special needs not just autistic like to have more programs available like dance."*

Parents experienced challenges with childcare that they felt was part of their children's needs and demands. This exacerbates the mental and emotional imbalances parents experience because they cannot easily get childcare to meet their own and their family's needs.

P002: it would be really cool if there was a program for babysitting that involved helping babysitters understand stuff like for autistic children ... I sometimes wish there was like weekend... Like a place where you can take your kids and leave them there a couple hours. You know what I mean? Yup besides day care, like somewhere to like, like what they have in town like fun play and all that …that uh play palace?

The same parent had a simple request for the community services and providers for her child that she identified has special needs.

P005: "just have them included like that's all I want. That's all I want. Yup like more inclusion."

8:7 Involving Intergenerational Family in Health Education

Grandparents were identified as a source of support during the early years, and among participants two primary care givers were grandmothers. The Elder was the first to note that there are education needs of grandparents as well. The Elder Participant felt that parents can get the wrong information "old wives' tales" instead of the best up to date information to support optimal child development. One parent did share their experience regarding support from their grandmother, and a generation gap.

*P005: Yes I just thought of that, and I think Nutaq Mawi apoqinamuttitew especially when they are babies, like when I think about it with my grammie and how she was with ** it was so like, it was interesting because like where she was like super old school and you know, it was interesting to see like that, generation gap I guess. And how she's, she still did her old ways and old things that she would do but it was always good.*

Involvement of grandparents in childrearing is a strength for families and communities. Ensuring including grandparents in prenatal education and early childhood education in both the development of materials and delivery could bridge the gap between old ways and new best practices. The community could lead their own creation and development using two-eyed seeing to integrate grandmother knowledge and best practices into service delivery.

Elder Insight/Wisdom 1: Gardening Elder Knowledge/Wisdom Perspectives of Early Childhood Development

E1.1: Early childhood development and the lifecycle

The Elder, who is a retired teacher, responded quite differently than parents/guardians when asked about early childhood development:

Julie: "And I want to know what do you think the term healthy child development means.

…E: Well, probably, it starts prenatal…"

The Elder participant was the only participant who had mentioned prenatal care as part of early childhood development, noting prenatal education and preparing for the pregnancy journey as important.

E: well probably it starts prenatal. I would say for the parents and the mothers to be. Like I would say that .uh, Prevent. And I think even before that. You know they should have some kind of if like you are planning on getting pregnant or something they should have some kind of um prenatal stuff or all that stuff what parents are supposed to know. You know like uh, cause we don't really know where autism comes from or all this stuff coming up. So, I, I feel that maybe we have some kind of uh, early thing for them to um or

get, get it up date. Or update whatever we have, update to hear because there are lots of pills and drugs and alcohol and before the baby is born, And I would say there should be more information on it.

The Elder perspective also included a significant focus on what parents need in terms of support to nurture and support their children. Prevention of issues came up for the Elder and she had strategies identified to overcome. This included prenatal education starting in high school including information on what to expect for mother and child and drug/alcohol effects. The Elder also recognized the importance of wholistic supports for mothers that encompasses social, emotional, spiritual and physical health.

E1.2: Important role of family and family dynamics

The Elder shared that wholistic development starts at home with the family.

> *E: they all need that! They need all those things mental, spiritual, and emotional and all that stuff I think every child needs that. And every parent should, be able to um, should get that. And they should be lot more support from um, like grandparents and parents, you know.*

The Elder also focused on the importance of co-parenting though stories about her grandchild. They noted the importance of the relationship between all parents/guardians including grandparents and Godparents to be able to raise the child in a healthy way.

Elder Insight/Wisdom 2: Practice for all Children and Youth and Their Unique Physical, mental, Social and Emotional Needs

The Elder recognized the importance of support staff in the schools for all children, regardless of ability or disability, and shared strategies for the staff to handle the unique needs of children.

E001: We could have more trainings … and I like the idea of when they had teachers' assistance helping a kid like Teacher aid or teacher assistance helping a child, when they go to school kindergarten and pre-school and all that stuff… each kid, each teacher aid should have …a guide you know. What to do…what's the problem with the kid because every kid is different you know. Every kid, they are not they don't all have autism, they don't all have learning disabilities, they don't all have those same things. But they should be able to know that … this is what he has to learn, this is what he likes and dis-likes, and this is what going to trigger, triggers him to you know have a meltdown you know. They should … have more training .. for those assistants. And they should have more … male assistants, not just the female assistants, that was a good one time it really worked really good.

The Elder participant had an overlap with parents when it came to strategies for supporting the unique needs of children through staff training, specifically in the school system. They also recognized the need for policy and practice implementation.

Elder Wisdom/Insight 3: Language Matters: Mi'kmaq Language and Child Development

The Elder shared the importance of starting to expose children to the Mi'kmaq Language early, and if the same concept for language is applied to their view of early childhood development it starts prenatally. Mothers require access to Mi'kmaq materials, mentorship and support to expose the growing baby prenatally. Examples include nursery rhymes and lullaby songs.

The Elder shared words related to child development, words she felt important for the parent and child to know and use. They focused on what they described as easy words and commands, as well as praise.

Table 5- Elder Provided Mi'kmaq Words Related to Child Development

Mi'kmaq	English
Musamatu	Don't touch it
Moqo	No
Na	Take it
Ta'	Hand it over
Nunu *	Feeding time
Pa'pa *	Sleep
Kewisin	Are you hungry?
Samqwan	Water
Kesalul	I love you
Pe	Listen
Yi-Ya*	Injury, pain
Keluk tela'tiken **	Good Job **

*Described as a Universal Word

**English word Given

Some of the commands were related to safety, easy words or "universal words" related to child needs such as eating, sleeping, pain/injury. The praise words were affirming and important for Mi'kmaw language development, as the Elder mentioned, to instill pride.

Elder Wisdom/Insight 4: Mi'kmaw Language Building

E4.1: Nurturing spiritual development through intergenerational relationship building and language

The Elder shared the importance of Elders in language development and shared strategies that promote safety, trust and relationships including praise:

E001: Or um, a especially Elders. And you have to learn to, the language goes with the Elders. They you know you gotta make sure the Elders know to speak to the kid in Mi'kmaq softly and don't force the language on them. I know a lot of kids don't know Mi'kmaq you have to introduce it easy, make it fun and praise them. Because praise works, a lot, works wonders! Haha

The Elder shared 3 specific strategies which can be implemented by anyone who works with children who does not know the Mi'kmaq Language; 1) Introduce it easy, 2) Make it fun and 3) Use praise.

The Elder envisioned bringing together Kisiku aq Mijua'jij (Elders and children under grade 2/3) to support wholistic health.

E001: … we should have like, they should have a, also well I would think would help would have an Elder in the school and come in once a while and just talk to the kid, get to know the kid. Elders, sit down this is what an Elder does. This is what he or she does you know. I would say but I don't you know. That's all I could say. Yup.

Bringing together Elders to share knowledge with children would create nurturing relationships, and support language and spiritual/social emotional development.

E4.2: Mi'kmaw language development and its relationship with Mijuajijk & the lifecycle

The Elder, a retired educator, demonstrated language development is most important for children aged 0-7.

E001: They are able to learn the language the fastest in the early years. It's kind of hard to teach them after when they are grade 2 or 3, when they are in grade 2 or 3. You can't teach them then. But if they can teach them early ages, even simple little

words… commands and exposed to language that it's fun, that we are part of the Mi'kmaw Nation we are part of this. Get them to understand. And I guess it would be, I would love to see them all speaking Mi'kmaq. But that's in the future I guess.

Children are roughly seven years old during grades 2-3 in the community run school. Kindergarten begins each September for the children who are three and turning four by December 31st or who are already four years old. In primary, children are roughly four and five. By the time the children reach grade one they are five and six. *Children in grades two and three are roughly six-seven and seven-eight, respectively.*

The children and youth of the participants have had limited opportunities to have access to services that include Mi'kmaq language, and opportunities for language development, exposure and especially in the early years before starting kindergarten.

Community Priorities

The community had requested certain questions be included in the study including i) The impacts of the Covid-19 pandemic on early childhood and ii) Jordan's Principle. I have also included a perspective on Mi'kmaq Family and Children's Services in this section. While not specifically asked about it is relevant for all communities.

Impacts of the Covid-19 Pandemic on Early Childhood

The pandemic affected families and children in a variety of ways which ultimately impacted their wholistic development. The most apparent impact of Covid was on the social emotional health of children and youth aged 0-7.

P006: But it was really hard with the Covid. Covid like nobody coming, nobody coming um over anymore. And there was like um, a halt. Like you know, they didn't come, go over anywhere. And we just had to wait, wait it out. That was hard.

The services families received were of course directly affected. For some it caused services to stop, be "cut off" or become virtual. P003 shared that they had to re-apply for services with JP which caused significant delays and more waiting for services with re-application.

P003: We were totally cut off JP. We weren't able to go to gymnastics or Tee ball.

The changes to virtual or over the phone were hard on some children and families. Abrupt service halts and moving from in-person to virtual or over the phone appointments was an unwelcome disruption during the initial pandemic response for one of the parents.

*P002: Yeah because child 3 was seeing ** but then we had to stop because she wasn't allowed to go in the houses. So, we did a lot of over the phone calls, and he loves his ** time with her. His time with her is his time. He's really a separate person he doesn't like change so that threw off everything.*

For one family however, it worked out well.

P007: That is also outside the community, but it is a private speech therapist. And like we were able to see her virtually, so we don't really have to go see her in person. And then um, I really like that he likes that too. He enjoys um, talking to her every week.

Families have different needs and preferences when it comes to services and programs being available virtually. Offering a hybrid model of service delivery when possible and including a virtual option when possible could lower missed appointments and further delays. The long-term impacts of Covid on early childhood are yet to be uncovered.

Elders Perspective of Jordan's Principle

The Elder participant acknowledged the good work of JP and the positive impact it has made on the lives of parents and families. They shared that JP helps parents and kids and supports parents, so they are not alone in their struggles.

E001: Well one thing we have now that we didn't have is that Jordan Principle thing. I think that's really helping the parents and the kids…I feel that the parents doesn't feel that they are alone with this kid. They are not working all just for that kid alone all by themselves, there is lots of help.

Parent/Guardian Experiences with Jordan's Principle

It was nice to see the parent experience reflected the same idea and parents are no longer alone in the fight for services for their children.

P005: Um, but in between like whatever we do need um, I just let our worker know um, and she like, she'll argue with head office like she'll fight for us. So, like, its, it's great to have someone um, who has your back and who knows your struggles and you know…they are amazing. I would be lost without them.

Parents shared stories about accessing services from JP which is mapped out in the Service Access Map (Figure 3). Five referrals were made to JP, two were approved, two were rejected and one was waiting for results of the referral at the time of the interview. Within the stories there were different experiences with the JP program and staff. Some parents felt very supported others, after being denied services, felt horrible. One grandmother had difficulty with staff at JP related to following up and submitting paperwork. Another parent said they would be lost without the staff who strongly advocate for their children.

The biggest theme, and one that causes concern with JP's services, is the waiting. It takes time to have assessments, referrals and services but this can negatively affect children especially when services are denied. The waiting has an impact on the child's development and the parent's mental health and well-being.

Mi'kmaq Family and Children Services

Two families consisted of grandparents raising their grandchildren. Among those two, one had shared their experience with Mi'kmaq Family and Children's Services, the Mi'kmaq child welfare system. There is no website or social media page for this program regarding information on what they do. The grandmother was not sure of what services and support the agency provides to support child development.

P003: Like I mentioned earlier, the only services that I have utilized while I've had these kids are um, well Mi'kmaq family, helped us uh, well they didn't really help us they just, I don't know they didn't really provide any services they just come over and see the kids,

When the grandmother had identified needs for her grandson there was significant challenges to obtain services from this program.

*P003: like I said I tried to get MMF as well to provide us with mental health services for ** the 7-year-old. I asked for a year, almost 2 years.*

P003: Yeah, so I have been begging and begging - This kid needs help, this kid needs help - ... So, I have been asking them for help. And all they would do is "Yes, ok we will get on it, So and So will call. Ok!" And I never got anything.. I asked uh Mi'kmaq Family this several times they still denied him I said he needs mental health! ...So, my

lawyer pushed it, and we finally got a court order to have him get help. That's how, that's how far I had to go. I had to pursue court for a court order.

What Mi'kmaq Children Need in Order to Reach Their Optimal Development

I want to leave the last part of this chapter for what parents, guardians and Elders feel are important priorities for Mi'kmaq children to reach their optimal development.

Love

P002: They need love from both parents and nourishment…they need love and nourishment from both parents and their community.

E001: they all need that! They need all those things mental, spiritual, and emotional and all that stuff I think every child needs that. And every parent should, be able to um, should get that. And they should be lot more support from um, like grandparents and parents, you know. If your um, if your um if you need to help your kid and what is going to happen you know all that stuff. I don't think they need, mostly support. We need to support them and make sure that they are on the right track. And kind of, guide them and help them get through those, emotional stuff that, that the baby that the kid will need.

Summary

Participants included one Elder and seven parent/guardian participants with an average age of 39 years who commented on their experience with 19 children (average age of 6 years). The least accessed services included walk-in clinics, mental health services, and traditional healers. Formal childcare was also not frequently accessed. There were patterns within the access to service information, for example, it was difficult to get referrals but for families who were able to access services and programs for their children, they were more likely to get wholistic and comprehensive care indicating that

once in the system they were referred on for other services. While they did indicate services had some Mi'kmaw culture there were concerns that there was not enough.
Of the eight parent and guardian themes and eight subthemes, there was some overlap but primarily what emerged was consistent with health access information; that access to culturally appropriate and safe programs and services is key. In the current services being accessed there is a lack of cultural content that reflects Mi'kmaw worldview and a lack of equity in services such as offering screening in the language of Mi'kmaw, the child's first and formal language.

There is little access in the community to early childhood education and early learning services and spaces. For those services that were accessed there was a positive impact noted in terms of school readiness such as social/emotional development, and communication. Participants also identified the importance of special consideration for children who require even more services due to having neurodivergent needs. Consistent themes and insight across the two groups identified the integral need for taking a culturally safe and wholistic approach and Elders and grandmothers identified the unique relationship between spiritual and social development. At the core of all of the knowledge gathered was the central essence of the Mi'kmaw language being recognized as important for early child development, programs and service delivery. Community based recommendations or community led solutions offer key insights into what communities perceive as needed to meet the needs of their children and families.

CHAPTER 6: DISCUSSION

In this chapter I will discuss the interpretation of the knowledge in light of community evidence and published information. I will also provide information about the strengths and limitations of the study and discuss how I consider Jo-Ann Archibald's principles of story-work were reflected. I include the dimensions of trustworthiness that were considered during the knowledge interpretation and synthesis. The chapter includes research and community implications as well as other innovative initiatives that are occurring that may assist the community in implementing specific projects that reflect the recommendations. Finally, I include my own personal reflections about the study and some considerations such as covid and the discovery of the unmarked graves that may influence the study outcomes.

There has been a long-standing gap in First Nation community-based research related to early childhood and early childcare experiences which are important for policy and program decisions (FNIGC, 2018). This research contributes to filling that knowledge gap through a community-led, community-owned research partnership.

In this study parents who live in a First Nation community shared their own experiences with current systems and services related to the early years development of their children and offered recommendations that may be useful for communities and policy makers to improve supports and programming for parents, children, and communities.

The research aimed to answer three questions:

1. What does early childhood development mean to the Mi'kmaw community? What do community Elders, parents and caregivers interpret as important priorities of healthy child development?

2. In terms of services available to the community, what are the strengths that facilitate meeting the needs of the children and community?
3. What are the major gaps in services or barriers to care?

Key Findings

Early childhood development (ECD) is very important for our First Nation communities on an individual, family, and community level. Early childhood development refers to the physical, mental, emotional, and spiritual well-being of children and youth. Elder knowledge teaches us that healthy ECD starts prenatally and education for parents and families should start well before conception. Supporting a new mother is important for healthy child development. Healthy child development includes families that are healthy and have healthy relationships and access to Community, Language and Culture. Love is the most important thing for a Mi'kmaq child development. Parents, guardians and communities want their children to receive wholistic supports to achieve optimal development in their communities.

There are significant inequities in services and programs that impacts the wholistic health of children, parents and community including: lack of inclusive and equitable Mi'kmaw language policies and practices for First Nation families who access screening services, inequitable access to early childcare and early education opportunities, and lack of culture in programs to support the early years. The biggest contributor to school readiness is the capacity in early childcare and education programs (daycare and Head Start) available in the community. First Nation families experience a lack of safety outside of their communities and prefer to have services in community.

Families need support and tools in order to give their children everything they need in order to thrive.

During information checking I found the most common thread was additional concerns from parents, services that were approved no longer accessible especially with JP due to their policies.

Demographic and Health Survey Key Findings

All parent/guardian participants identified as *female, Mi'kmaq* and or/*First Nation* who had an average age of 39 and families consisting of 2-3 children. I noticed the small family size of two-three children for each parent/guardian participant and how that differs from what I know about First Nation families. Indigenous families are usually larger, have extended family members and are young (Halseth & Greenwood, 2019). Census data from 2006 found Indigenous children who were under the age of 6 were more likely to live in larger families of four or more children. The families who participated were from smaller families and that may be due to the capacity of parent/guardians with two-three children which allows them to be involved in a study that requires time commitments compared to the capacity of parent/guardians with four or more children. It also may indicate how important the topic is to them.

The children's demographic information indicates that the recruitment efforts were successful in recruiting families with children aged 0-7 years. Eighty-four percent (n=16, 84%) of the participant's children were age 7 and under and the mode for children's age was 7. Most of the children involved in the study fit into the "early years" definition used in this study and all families had at least one child aged 7 years or under in their family.

Two of the guardian participants involved in the study were grandmothers. It's not uncommon for children in the community to live with extended family members including grandparents. National statistics from, Statistics Canada (2021) indicates First Nations children aged 14 and younger live with at least one grandparent at a higher rate than non-Indigenous children. Across the country, 14.2% of Indigenous children live with at least one grandparent in the household, compared to only 8.9% of non-Indigenous children (2021). The important role of Grandparents in a First Nation family is raising the younger generation with sharing culture, values, tradition, and knowledge.

Using the Medicine Wheel to integrate knowledge from the demographic and health survey alongside of the conversation themes creates an opportunity to identify what supports are necessary in the community. The health survey results indicate all parent/guardian participants prefer to have services that support the wholistic development in their home or in the community. None of the parent/guardian participants prefer to access services outside of the community yet many services that parent/guardian participants identify accessing were outside of the community.

Physical - some of the activities that fit into the Medicine Wheel under physical health and development available only outside of the community include physical activity and programming such as, tee ball, pageants, gymnastics, and swimming. People often feel they have no choice but to leave the community because the small number of programs available in the community often fill up quickly.

Mental - the services that support wholistic mental health and development are not available in the community include tutoring, occupational therapy for handwriting, and psychoeducational assessments.

Emotional - services that support emotional/social development that are more readily available outside of the community were inclusive of Mi'kmaq community-based early childhood education/daycare programming and private speech therapy.

Spiritual - services that support spiritual health and development were not clearly available inside or outside of the community. Programs that support spiritual health could include aspects of culture, language, and nurturing the identity within the child and family. Families report that services in the community meant to support the early years are not including culture. It's also important to note that Non-Insured Health Benefits (NIHB) does not cover a Traditional Healer, which was the only service not accessed at any time.

Using the Medicine Wheel Medicine Wheel as a framework, we can see where and what programs and services are supporting the wholistic development of children aged 0-7 that are needed in the community within the physical, mental, social and spiritual domains of early childhood development.

As a community member and CHN it was notable for me to observe the difference in access rates between *Family Doctor* and *Nurse*. The model of care at the Health Centre, at almost all times, includes triage by a nurse before seeing a family doctor. I would expect the data in the rates of access to *Family Doctor* and *Nurse* to reflect that model of services, but it may not have been the same way the community participants perceive accessing nurses and family doctors.

Nurse Practitioner services have sporadically been available in the community, and participant data regarding access to services tell a story. *Nurse Practitioner* is both the second most frequently accessed service, and the second least most frequently

accessed service. It seems that demand was high for these services while it was available, but not easily accessible otherwise. There is currently no NP in the community.

There is a disconnect between the health survey and what participants share in the conversations regarding the services to support early childhood. The health survey services most frequently accessed in the past six months were family doctor, dental professional, nurse practitioner or developmental service, however these were mostly absent from experiences parents and guardians described in the qualitative data. Parents and guardians perceive the services that support early childhood as the services mentioned in Figure 2, youth mental health, hearing and speech, JP, appointments seeking assessment/diagnosis, NSECDIS and EIBI. These seem all very intervention based and are accessed to support the urgent needs of the family. Most of the referrals were self-referrals.

Conversation Theme Findings

Parent Sessions

In identifying gaps in services or barriers to care, one common thread between a number of themes was an overall *lack of* - lack of timely access in community and inclusion of Mi'kmaq culture, lack of equity in screening and tests, lack of programs for neurodivergent children and lack of safety in healthcare system. There were also gaps in access to early education and opportunities to be school ready. The current systems are not meeting the needs of children and families.

Gaps in access to early education and opportunities to be school ready

Parents shared their experiences with how lack of access to early education and childcare has impacted the wholistic health and development of children in the community, especially related to social/emotional and mental development and its impact on school readiness. Considering this I reflect both on the EDI criteria used to assess developmental outcomes and school readiness across the province and the Medicine Wheel. The five areas of development assessed in the EDI are: physical health and well-being, social competence, emotional maturity, language and cognitive development and communication skills and general knowledge (2014/2015). I imagine the overlap of these areas with the themes from this study within the Medicine Wheel quadrants of mental, social/emotional, spiritual, and physical development.

In the 2014/1015 report, EDI data compared Aboriginal children and non-Aboriginal children in each of the five domains. Aboriginal children scored lower than non-Aboriginal children in all five categories. It makes one wonder if they are in fact not meeting the expectations for the western developed instrument, or if the measure reflects Mi'kmaw ways of knowing, would the children score differently? The same document compares the EDI outcomes for children who attended preschool and children who did not attend preschool. The children who did attend preschool scored higher in each of the five domains compared to children who did not attend pre-school. Community participants did not believe the children were ready for school but there are many factors to consider with the provincial reported EDI data.

The current infrastructures, systems and programs in place do not meet the needs of our children and youth. Limited space, staff, and seats available in Head Start and

daycare create an environment in the community that is not meeting the developmental needs of our children, parents, and families. The current systems in place are not capable to deliver equitable early childcare services to the community. Children are not ready for school by the time they start and their access to daycare or head start plays a significant role in school readiness, especially on social/emotional and mental health and well-being. The rate of children in the community accessing early childhood education and childcare from the daycare or AHSOR is low. Only 5.25 % (n=1) of participant's children had access to formal childcare in the past six months, and roughly a quarter (n=5, 26%) of children had access over the past five years. These rates are low compared to the average rate for First Nations children. Key findings from *Understanding Childcare in First Nation Communities* (First Nations Information and Governance Centre, 2018) indicate up to 28.9% of First Nations children aged 0-4 years access some type of childcare, and of those children 67.1% were in formal settings such as day care. National data of First Nation children aged 0-4 accessing formal childcare is over double the rate compared to the participant children involved in this study in the past 6 months. In this study respondents identify a direct relationship between child's attendance at daycare and AHSOR and being ready for school.

Lack of equity in screening and tests

If translators are not available services are not equitable, and parents cannot advocate or translate for their children, the system is failing our kids and failing to address the TRC calls to action (Truth and Reconciliation Commission of Canada, 2015), UNDRIP (United Nations General Assembly, 2007), and the MMIW Calls to Justice from the Final Report of the National Inquiry (2019). Mi'kmaq language is protected

under the Nova Scotia Legislature Bill-148 "Mi'kmaw Language Act" (Nova Scotia, 2022) and speakers should be protected in the health care system.

In other knowledge mobilization research in the community related to ear health and access to timely care in our community, we know that our children have higher rates of ear infections but are not getting referrals (Latimer et all, 2018). Since the implementation of the tertiary-level Ear, Nose and Throat clinic in the community, we know children are now being seen in a timely way, with Mikmaw nurses assisting with the care and translating for families. While we have not done the formal analysis there has been a notable increase in the number of children requiring necessary surgeries and treatment to correct chronic ear infections and improve health which will likely have an impact on readiness for school. This is one direct example of how accessibility, service and culture all come together to improve early childhood development.

Strengths of Community Services and Programs

The strengths of services and programs to meet the needs of the community are Mi'kmaq providers themselves who incorporate language and culture into the programs and services they deliver. We need to create capacity in communities to ensure we have more Indigenous providers in all roles in health care and services. Our communities are capable to lead the way towards their self-determination in ECD, education and programming providing the necessary infrastructure and sustainable funding for program objectives.

Infusing Elder Insight and Wisdom into Early Years Programming

Innovative opportunities to share language, culture, and best health practices

I couldn't help but smile when I first read the newly published Baby Smiles Weskewikwa'sit Mijua'jij *(*2021*),* a book provided to new First Nations parents in Nova Scotia. This book is the work of the Tui'kn partnership. My smile was for two reasons; Firstly, because of my involvement in the development of the book through our collaborations with the ACHH Initiative and the Tui'kn Partnership. Secondly, because the very first page of content starts off "Mna'w je me'weskwijinuiwanek nkij welo'tkp~nn wipitl wjit nekm aw wjit ni'n meaning" which translates to *"even before I was born, momma took good care of her teeth for her and for me"* (2021). That same answer was shared by the Elder regarding early childhood development; that healthy growth and development for a child starts prenatally. Considering the importance of prenatal care and education from an Elder's perspective, it's surprising to see the disconnect between what parents perceive as priority (support for children, family, intervention services) and what Elder's see as important (prenatal care and education, support for new mothers, prevention, parent education, family dynamics).

The Elder validated the Medicine Wheel life cycle and the importance of Mi'kmaq language development during the early years. Elders say language can be learned at school, especially alongside of Elders but also informally at home with parents, grandparents, extended family members and other kinship ties. We need the same level of intensity of support for communities to have the tools they need to revitalize their language as we do in the immersion schools.

Study Strengths & Limitations

A big strength of the study is that it is community driven and addressing the needs of the community. Using Mi'kmaw epistemology as the methodology contributes to decolonizing my education, the research, and the early years sector. Being able to engage with community health leaders and knowledge users to guide me such as Sharon Rudderham, and Community Elders, along with my nurse colleagues, has meant the study represents what is important to community members, health leaders and parents and guardians. This knowledge is unique in comparison to the way Indigenous research often takes place with non-Indigenous people deciding what to research and using western ways. Indigenous knowledge and beliefs such as age of children to include in the sample and ensuring both pre-and post-engagement with community knowledge holders and Elders, created a rich experience both for me as a learner but also contributing to the findings and this discussion. This is a definite strength.

Some limitations include that there can be major variations in experiences between individual community members, but also between communities and nations. While these findings may be useful for other communities it's important to recognize that each community has their own unique strengths and needs.

The five-point Likert scale used for the Medicine Wheel rating of services and supports may have been a limiting factor. Due to the small scale, it was easy for participants to choose the neutral position. Having a larger scale of 1-7 could have resulted in a more diverse range of answers. It was also an opportunity to incorporate the theme of 7 into data collection. Using the Likert scale and Medicine Wheel can also be

considered a strength because it allowed for a new way to conceptualize and understand healthcare in the community.

An additional limitation was that the health survey could have been more specific about services. For example, including more community specific programs and other categories such as JP, Nova Scotia Hearing and Speech, EIBI, and more.

Community Implications

Thoughtful implementation of these recommendations in the community and province will have a meaningful impact. It will take recognition of the importance of meeting the needs of families during the early years, funding, resources, coordination, and community involvement.

Establishing Trustworthiness

Lincoln and Guba (1985) outline criteria that assists with evaluating the rigor of qualitative research in the concept of trustworthiness. Trustworthiness consists of four dimensions: credibility, transferability, dependability, and confirmability. Credibility is the confidence in the truth of the findings. Credibility was established in this research by pre-engagement with health leaders, community members and Elders and then staying in touch during the study for guidance and then again post knowledge collection. I also went back to the participants and reviewed the themes for accuracy. In addition, I was able to triangulate the information using different Indigenous ways of knowing such as the Medicine Wheel and conversation sessions. Transferability is showing the findings may have applicability in other contexts-while this isn't generalizability, I took a great deal of time to listen and using thick description, wrote about what I heard from participants.

This contributes to transferability and ways for others to recognizes similar experiences may apply to them.

The third criteria of dependability is showing that the results are consistent and could be repeated is demonstrated by doing an inquiry audit, by asking others do you recognize the themes, and would they be applicable in your practice? The evidence in the literature suggests the themes have been identified previously plus when I talk to colleagues and in my own practice the feedback is supportive.

The final criteria of confirmability, the degree the findings are shaped by the participants and not the researcher or my own bias, motivations, and interest. This was something I thought carefully about because of my own positionality. To ensure each participant's views were accurately captured and included, I gave an overview of the themes I heard/learned from them, and asked if it was accurate and represented what they experienced and shared. Then I would present more broad findings and ask if it was accurate and represented community experience. Each participant validated the findings.

Recommendations for Further Research

Further research on the topic of early childhood development in First Nation communities must be community-led, community owned and uphold community standards. It must also focus on strengths-based approaches and implementing best practices to support the wholistic health of communities and their members.

Recommendations for Practice & Community

The community requested that the researcher provide a list of recommendations to improve services in the community. Below is a detailed list, and summary of recommendations.

Communities' self-determination and self-governance over health and wellness can improve outcomes for First Nations communities and its members. To ensure interventions to support ECD in First Nation communities are successful the programs need to be planned, designed, and controlled by First Nation communities to reflect their lived experiences and unique traditions and values (Halseth & Greenwood, 2019).

Revitalize, Promote and Protect Indigenous Midwifery in Mi'kmaki – Elder Wisdom and Insights allowed a different perspective of early childhood development compared to the other participants. Elder knowledge tells us the early years start prenatally, and even before conception. The elder perspective included a focus on prenatal and post-natal care and education for the family and especially the mother.

Establishing a Centre of Excellence for Mi'kmaq Early Years- Participants recognize the need for a larger childcare centre to accommodate the large population of children aged 0-7. In addition to childcare and education, parent/guardian participants would like to see more early years services in the community, ideally under one roof. A Centre of Excellence for Mi'kmaq Early Years would build a bridge over the huge gap parent/guardians have identified by providing space reflective of the population, and space for services.

Prioritize and provide additional supports for Grandmothers/Grandparents caring for their grandchildren.

Grandmothers and Grandparents who care for their grandchildren have significant challenges that impact the wholistic health of the child, family and community. These families need timely wrap around supports to meet their needs.

Cultural Revitalization in New and Existing Programs - Existing and new programs require evaluation to determine if culture and language are adequately included to meet the needs of the population. Engaging with community leaders, knowledge holders and language experts for review and revitalization of program materials could allow for more cultural integration into programs. The protective factors of culture in the lives of Indigenous and First Nations children are becoming evident in the literature. National data indicates that among First Nations youth a stronger sense of community belonging reduced the psychological distress from cyberbullying. Among the youth surveyed, those who participated more frequently in traditional practices and events also had lower psychological distress. (Paul, McQuaid, Hopkins, et al., 2022).

Creating Access to Traditional Healers and Traditional Healing Practices- Traditional healer was the service not accessed at any time, by all 19 children participants. There is no specified role for anyone in the community for traditional healer. NIHB does not cover this service, only travel to a traditional healer if needed. Creating access to traditional healers and healing practices could bridge this gap and provide a wholistic healing environment in the community.

Creating Community Mi'kmaq Language Nests for the Early Years – Mi'kmaq Language was identified as a priority of early child development and well-being. *Language Nests* can be a strategy created for each community, by each community, that promotes and supports early language exposure in a community setting. Borrowed by Canada'as Indigenous people from the Māori of New Zealand, and distinctly different from a day care or head start program, Language nests are language immersion programs for children from birth to five years (First Peoples Cultural Council, 2014). Lessons

learned from other language nests could be helpful in designing *Mi'kmaq Language Nests for the Early Years (*Chambers & Saddleman, 2020; McIvor, 2006).

Decolonizing Learning - Utilizing the First Nations Holistic Lifelong Learning Model from The Canadian Council of Learning (2007) in community wellbeing and education. The First Nations Holistic Lifelong Learning model is a framework for measuring lifelong learning and is already impacting how the progress of first nations learners is evaluated (FNIGC, 2016).

Department & Staff to Focus on Early Years Programs and Services Specifically for Children and Families with Neurodivergent, ADD/ADHD, ASD and other Special Needs - Currently, there are no specific programs available in the community, that are community led to support the needs of families with children who are on the autism spectrum, or who have a diagnosis of ADD/ADHD or other special needs. Strategic planning for an early year's program must be community led. Staff training for all community employees who serve the community.

Nova Scotia Hearing and Speech Language Project - An example of action. Through existing partnerships and networks, I have been collaborating with Nova Scotia Hearing and Speech on different community projects and strategies to improve health service delivery and outcomes. One of those initiatives will address systemic injustice and inequitable access to services. In Nova Scotia, there is Assistive Communication Technology available in French, English and Arabic. Our goal is to see this technology available in Mi'kmaq for our Mi'kmaq speaking households who require such tech support for their communication needs. We are also beginning to explore what equitable

testing and other services looks like. Like all parts of research, this has been done in consultation with our First Nation communities.

Francis' Principle - Together with the family, I propose the development and implementation of Francis' Principle. This principle is named after Francis Googoo whose mother gave verbal permission to include this in the discussion, and recommendations because of his traumatizing experience with the healthcare system. Francis' Principle would see a team of youth and child mental health responders who address calls and codes in all hospitals under Nova Scotia Health and the IWK. The responders would address issues related to children and families who need additional supports, rather than calling "code white". Our communities report increasing rates of children on the Autism spectrum, special needs or even a Mi'kmaq or Indigenous child who has been previously traumatized by the system. These occurrences will continue to happen, where code white is called on children, until we have better systems in place. Francis' Principle would ensure families are supported, heard and children and youth are protected while navigating the health care system.

Mi'kmaq Family and Children Services Awareness campaign - The participant who was involved with Mi'kmaq Family and Children Services had no awareness of the programs or services available under the agency. As a member of a First Nations community, service provider, and former foster parent it is difficult to understand what services are offered through Mi'kmaq Family and Children Services. There is a disproportionate number of Indigenous children in care, whether with kinship homes or foster placements. I went searching online for information regarding services and programs offered by Mi'kmaq family. I checked google, and social media pages and there was no website or

page. Guardians under Mi'kmaq family were also unaware of what programs were available. Mi'kmaq Family serve the entire Mi'kmaq community of the province and all communities would benefit from knowing what services are provided by MMF. An awareness /media campaign and share information on their services and programs especially among the current care providers who have children in their care. A media campaign and more services

Reflecting on the Principles of Story-Work

Holism

Using the framework of the Medicine Wheel ensured awareness of a 'wholistic' approach to the information gathering, analysis and knowledge sharing. The Medicine Wheel and holism also proved helpful in seeing where the strengths and the gaps lie for parents, family, and community.

Respect

In an Indigenous methodology, respect is present in all stages of the research design (Kovach, 2010). Respect for community protocols has been important in this design and it has been a journey. It's important that First Nation communities take back their self-determination, autonomy, and power in terms of the relationships and partnerships with research. The Community had a newly developed research agreement, that I was not required to use but was happy to do so. Initially I had received a draft copy of the new Community Research Agreement that was to be completed and sent back to the community, and to the IWK REB. The research agreement was included in my protocol as part of the community requirements and would be uploaded when completed. I remember anxiously adding some language I felt was missing such as including the

term *student* where my name was to be signed. Once I had the form filled out to the best of my abilities, it was to be signed by someone at the institution, Dalhousie University. I reached out to my supervisor, the document was sent to Research Services, and there were delays. I went to see my Health Director to give her an update and I recall bringing paper and pen to record our meeting notes. I had one note "Just do the research".

The University, this department, felt the research agreement was not document for the task, considering I am a graduate studies student. The Dalhousie Research Services, my supervisor and the legal department of the band collaborated and created a new research agreement to reflect the dynamics in a research relationship between university, student, and First Nations community. Moving forward, this will be available for others to use and conduct research in a good way, following university standards and respecting community protocols. It was a huge learning curve for the university and started important conversations and increased their knowledge about the principles of OCAP ®, data sovereignty, and community standards. The data stayed in my community and my community has sovereignty over this knowledge.

Responsibility

In Story-work the responsibility of the storyteller to others is credited to the power that stories can have, while the person listening should listen respectfully (Archibald, 2008). As a researcher, I felt that I had much more responsibilities on top of the power of the stories. The work itself was important. This research is not only for me, so I feel responsible to the community to complete it and in a timely manner, despite the many delays. I had been offered the opportunity to do a direct entry into the PhD Nursing program at Dalhousie. My background and 10+ years of experience in research and

current work were providing me with new opportunities. I met with my supervisor and with the Director of graduate nursing studies to discuss the possibilities. However, making a switch would mean putting the research on hold for up to two years while completing the course work and comprehensive exams required for the PhD program. I decided it was important to continue with this study and my master's program.

Reciprocity & giving back

Reciprocity can be thought of as giving back to research participants and communities (Tilley, 2016). In an Indigenous methodology, specifically story-work, reciprocity refers to being able to give back by telling the story to others, with permission (Archibald, 2008). The families and parent/guardians have been so grateful for their stories being told, grateful that their recommendations are being heard, like Elder Albert said, giving a voice to the community. Giving back in this way, through research as service, is the best thing I could give back to the research participants.

I always had the intention to gift the study participants a smudge bowl and sage. I stopped by the crisis centre in our Mental Health Department and talked with one of the workers about what I was doing (research for school) and what I wanted to give to each participant. With no hesitation, she was happy to give me 11 bowls that were wrapped in plastic wrap, and contained cedar, sage, sweet grass, tobacco, a prayer card and matches. I wanted to give back to the Crisis Centre for their contribution to my project, and to the gift of wellness that they offer everyone. I asked if they needed anything for their food pantry program, which they didn't. "Just take it", the worker told me. I felt like I couldn't just accept something, especially something so meaningful without contributing something back to the centre. Then she said I could buy a case of water. The water is

used by the staff members, who rotationally staff the centre which runs 24 hours a day, 365 days a year. Water is life, and I was happy to provide the staff with two cases of bottled water. Reflecting on this I realized, it was the responsibility to reciprocate, and respect for the gift of the medicine that guided my drive to give back. Joann Archibald's (2008) principles of Story-work were at play during this exchange and interaction. The smudge bowl ended up playing another important role in this study that will be shared later.

Interrelatedness

Interrelatedness refers to the relationship between story and listener and between text and reader (Archibald, 2008). Keeping that inter-relatedness in mind was important especially during the writing process. Interrelatedness came through as a teaching in the medicine wheel analysis of services and the three layers- child, family and community. You can't separate one from the other because all three are connected and affect one another. It was reinforced in the transcripts also and Mi'kmq words related to child development – Msit No'kma'q.

Synergy

Synergy occurred in every aspect of the study, from deepening my relationship in The community, as well as through synthesis of the knowledge shared. The stories also worked together, creating a clear picture of early childhood development services and experiences for children in the community. Improving synergy of services, programs, governments is what is needed to see positive changes in the experiences of accessing early childhood services. I observed synergy in the data collection and consent process: The IWK REB advised that I not recruit participants or collect consents. I was happy to reach out to some of the RAs I have worked with in the past who steered me in the

direction of my first RA. She stayed with me for a short time before having to resign prior to us starting any consent or data collection while we waited for more ethics approvals. The day she handed in her resignation, I informed my supervisor that by the end of the day I would have a new and wonderful RA by myside. I was right. The second RA to join me was a nursing student and mother. As the recruitment and data collection slowly progressed my supervisor suggested a second RA to help move things along. Again, I was extremely lucky with who joined our team: a nurse and colleague. Together, their efforts were tremendous, and I am very grateful for the work that they have done. I hope that by them joining this journey, I helped to spark an interest in research and knowledge translation for them both.

Reverence

Archibald (2008) describes reverence in story work as a deep respect for the words, language, stories, and storytellers which stem from truth. There have been lots of challenges along the way to my education and some days are harder than others. One particular day in December 2021 I felt very confident in a decision I made to quit the MScN program. I was leaving my office and planning to text my supervisor, log into the university website and withdraw from the program when I knocked my smudge bowl off of my desk. The smudge bowl broke and I felt it was a message that I got loud and clear, to keep going. I couldn't quit. As I was wrapping up final drafts of these chapters in July 2023 I had a different thought, one I never had before and that was "I'm not even going to graduate". I felt like again, there was no point, and I was done. The same instant I had the thought, I knocked a smudge bowl off my desk and it broke. Again! I could almost cry because I felt like I had no choice at this point, I had to keep going. My two oldest

children came into the room, and they noticed the broken smudge bowl. It upset them to see it broken in two pieces and they wanted to know what happened. I told them about how I was feeling and about what happened. My 8-year-old son told me “It’s your ancestors Mom, they are telling you not to quit”. I shared this story with an Elder, and they agreed with my son.

December 2021 - Broken smudge bowl

July 2023 - Broken smudge bowl

Personal Reflections

I began the journey of formally verifying my sons ADHD diagnosis in 2017 when he was two, going on three, years of age. I started the process to have supports in place before he would begin school the following year. My son finally received his diagnosis in Summer 2022, after he had completed the second grade and was seven going on eight. Between 2017 and 2022 we had a lot of challenging moments and many beautiful

moments. I can only imagine that our experience could have been more positive had we received a diagnosis sooner. My positionality as a Registered Nurse certainly influenced our outcomes in many ways. One thing I always heard from providers during the early days of advocating for my son was “You are doing great!”. We heard it so often; it became a slap in the face. It undermined the difficult days and nights, the challenges and made me feel like they thought we were less in need of services, because we were apparently “Doing great” but it did not feel that way to us. Even after his diagnosis, services and supports are slow. Having gone through this with my son and family while doing this study gave me unique insight into this challenge for families. It was both hard to experience yet motivating.

The Recovering of Residential School Children Found In Unmarked Graves – Missing And Murdered Residential School Children

My thesis has acknowledged that the structural determinants of health, including the Residential School System (RSS) has had lasting impacts on healthy child development for Indigenous children today. Studying child development during the discoveries of missing and murdered children at residential school grounds across the nation strengthens the importance of this work for me, considering the relationship between intergenerational trauma and the current effects on child development. The rest of the nation and the entire world is becoming aware of the horrific conditions an estimated 150,00 children were exposed to while they attended these institutions. My continued thoughts and prayers are with all Residential school and Indian Day school survivors, their families, and communities and for all the children who never returned home.

I have felt overwhelmed. Not only by the growing number of children being found, hopefully all will be one day brought home, but by the uncovering of research that was carried out at the Shubenacadie IRS that included involvement by my own education institution. Furious is an understatement to describe how I felt after I had read findings shared on social media. The post included a **trigger warning** but I was still not prepared for what many of my family members would learn from a simple social media post; My late Paternal grandfather and two of his siblings were not only residential school survivors, but also survivors of medical experiments that Dalhousie University was involved with, during their time at the Shubenacadie IRS (Gates, 1938). That was how myself, and many of my family members found out that our grandfather had attended the IRS. Just like that, I was a second-generation descendant of a residential school survivor. It was, and continues to be, a lot to process. It takes me back to philosophy class, and questions like not only *what do we know*?, but *how do we know what we know?* Indigenous people, and non-Indigenous settlers will be introduced to more uncovered knowledge and truth. What we do with the information, and how we move forward will be a true determining factor in healing and reconciliation. Be kind, open your mind and your heart. Love your children and give Indigenous communities what they need in terms of support, services, programs, and the right to self-determination.

Covid-19

The impact of COVID-19 has had on the study has many layers. All over the world, everyone has been impacted by the Covid-19 pandemic. Nurses in particular were greatly impacted. I attempted to find some literature related to how Covid affected nurses, and graduate nursing students. Reviewing the literature caused a lot of discomfort and

distress for me, which affected my mental health. I decided for my well-being not to continue reading about it. I lived a nurse's version of it, that's enough for now.

I presented my thesis proposal a day before Covid was declared a global pandemic. During the initial weeks of the pandemic, I completed a statistics course that had been shifted to online learning and followed up with all recommendations and requirements of my committee after the proposal presentation. At this time, I was also a CHN at a First Nations Health Centre. Community Health is like an extension of public health. Along with my nursing colleagues, we were front line, "essential", and going to work while everyone else was ordered to stay home. My community had a variety of strategies in place including an eight-week-long mandatory "lock down". The outside world had no idea what we were experiencing in my community.

Many things have been modified since Covid, from the way we shop, interact, and travel, to the way we learn. While Covid had caused world-wide disruption over the past years, it has contributed to delays with the progression of my study. I have had to adjust the study approach to include virtual or over the phone recruiting, consents, and data collection. I have also included Covid into the study, and amended the questions to ensure the families have the opportunity to share how the pandemic has impacted any services that support healthy child development.

Prior to Covid, stay at home orders and imposed curfews I had many strategies and supports in place to support my education. These included protected time at work, family support and even my own special tool of noise cancelling headphones for working at home alongside my family of five. I'm pretty sure the peak of the Covid lockdown ended my protected time for education; for nurses it was all hands-on deck. At times, my

support system of our families was outside of our *bubble*. I had also noticed the impacts of the pandemic on myself, and my children. My youngest had regressed and the three kids needed me more. I put the headphones away to be more present for my children. In winter 2022/2023 I felt extremely ready to bring the headphones back and get this work done.

Conclusion

Access to timely, culturally appropriate community-based programs and services that Mi'kmaq know will increase a child's early development and readiness for school will create a stronger pathway for our children, families and strengthen our communities. This evidence will fill a gap in information and provide knowledge to decision makers to improve care with the goal being to promote and protect wholistic development among children between the ages of 0-7 years and move towards ensuring our children have everything they need in order to thrive.

Strategies to support early childhood development in First Nation Communities must be wholistic, encompass Indigenous world views and begin prenetally. Parents and families experience challenges when accessing services to support the early years that include lack of programs, challenging policies, lack of equity for Mi'kmaq speaking children and families. These challenges impact school readiness, testing and assessment outcomes as well as diagnoises and in turn the services and supports that often result from successful diagnosis. Community voiced recommendations can help bridge the gap in services and programs, and contribute to improve the outcomes for Mi'kmaq children, communities and Nation.

My goal was to meet the academic requirements to graduate and to do something that would benefit the community. Involving community in the process of leading the research, giving our community that space has brought us here. The Elder participant and all parent/guardians were pleased to hear updates about the work at check in calls for ensuring their information was captured appropriately and at the information sharing session. Their feedback was positive, and validated I did capture their experiences and themes were reflective and appropriate. Parents/guardians had supportive comments, and expressed their gratitude for the work, and their trust in me. Their comments made me feel I have accomplished my goal.

Msit No'kmaq.

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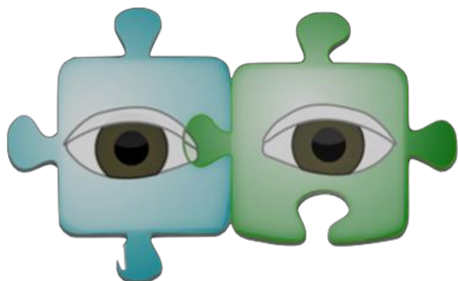
APPENDIX A: Two Eyed Seeing



Two Eyed Seeing

Institution for Integrative Science and Health (2019).

APPENDIX B: The Medicine Wheel

The Medicine Wheel

Institute for Integrative Science and Health (2020).

APPENDIX C: Parent Conversation Guide
(Mi'kmaq Version)

Kwe', teluisi Julie aq eym kiskuk mɨta pem-lukwatm research wjit program-m Dalhousie University. Ketu kjijitu koqoey Child Development wjit ki'l aq koqoey experiencem-mek ta'n tujiw kelutmu'tɨp apoqnmasuti wjit knijan weja'tekemk weskijinuitek mi'soqo L'uiknek(7) tetuje'kek.

Aq mu ketu siaw-i'mu'n wjit msɨt ula session pasɨk kinua'tui, kisi naqa'ttesnu ta'n pasik. Aq kisi piamteskɨtesnu question menuekenal.

Poqtamka'tinej (if it's between only you and another person; if more than one, then say Poqtamkita'nej). Tmk, kisi kinua'lsitesk aq tlimitesk wjit ki'l aq knijan kisna knijink.

Kis-kitmn information wjit la study aq pasɨk ketu pipanimulan questionsl klaman kisi poqji ankite'ttesnu ta'n teli accessowa'tasik developmental services-l me' apsikilkek knijan.

<u>Sample questions</u>

1. *Tal-meanowik Healthy Child Development wjit ki'l? (koqoey l'nu'k mijua'ji'jk nuta'jik wjit nikwen?)*
   (Tal-meanowik Child Development wjit wutanminu? Aq msɨt L'nu'k?)

2. *Mikwite'tmn ta'n tujiw mesnmu'tɨp apoqnmasuti kisna ta'n pas telamu'kl service-l wjit Child Development wjit knijan apsikilkek, weja'tekemk weskijinuitek kisna L'uiknek tetuje'kek? Koqoey mesnmu'tɨp aq talteksɨpnl? (koqoey istue'k ta'n tujiw tetuje'kek 0-3 kisna 3-7.) Wiaqa'tasik Koqoey L'nuey programs-mual?*

3. *Koqoey kisi ankite'tmn L'nue'l klusuaqnn ta'n wesku'tk Early Child Development?*

4. *Tal-nmituk ki'l maw-klu'lk Child Development wjit knijan/Knijink, kisna wjit wutanminu?*

5. *Kejitu'nl pilue'l programl ta'n etekl Unama'kik ta'n mu nemitu'nl tett? Probe: Kisi tlimitesnen ta'n koqoe'l? (Tal-kis nutma'sɨp? Wla'siktɨtal tett?)*

6. *Koqoey ki'l aq kikmaq wejitaioq ta'n tujiw mesnmoqsɨp kisna mu mesnmuoqsɨp apoqnmasuti wjit Early Child Development nkutey nike', ta'n koqoey etek wjit apoqnmasuti, kisna ta'n koqoey mu etenuk apoqnmasuti wjit Child Development.*

7. *Ki's ki'l aq kikmaq wejekeyoq koqoey wejiaq Jordan's Principle? Aq amuj, talamu'ksɨp apoqnmasuti mesnmu'sɨp kisna kelutmu'sɨp? Koqoey wejiaqsɨpnek?*

8. *Telte'tmn ki'l mijua'ji'jk kiskajo'ltijik wjit l'ta'new Kina'matno'kuomk ne'wt poqtamkita'jik? (nkutey Tli'sutiktuk, Social aq EDI)?*

9. *Kis aknuttesk ta'n telitpia'tioq wjit Early Childhood development kisna apoqnmasuti, weja'tekemk ta'n tujiw poqjiaqek wla Covid-19 Ksnukwaqn?*

10. *Etek me' koqoey ta'n ketu aknutmn kisna tlimiek?*

Tlewistu'titesnen ap me' pilue'k wskijinu'k aq kisiku'k.

Ne'wt kisi mawo'tuekl msɨt a'tukwaqnn ta'n nutaiekl, mawo'ttesnen msɨt tujiw apaja'tultesnen aq kinua'tultesnen.

*Wela'liek. Paqsitpi wela'liek aknutmuiek aq e'wmn ki'l time-m. Aq ketu apankɨtulek *$50*

Translated by Alwyn Jeddore

APPENDIX C: Parent Conversation Guide

Hi my name is Julie and I am here today because I am doing research required for my program at Dalhousie University. I am interested to know about what healthy child development means to you and your experience with accessing developmental services and support for your children during the ages 0-7.

If you don't feel like staying for the whole session just let me know, you can stop at any time. We can also skip any question if you would like.

Let's get started- First on the paper can you give me some information about yourself and your child or children.

You have read the information about the study topic and I have just a few questions to get us started thinking about accessing developmental services during the early years.

Sample Questions

1)What does the term healthy child development mean to you ? Probe:

What do Mi'kmaq children need to achieve optimal growth and development?

What does child development mean to our community? And for the Mi'kmaw Nation?

2) Do you remember accessing any supports or services for healthy child development for your children age 0-7? What where they, what was it like? (are there differences by age group is 0-3, 3-7.) Probe: do these programs include Mi'kmaq culture into their programs?

3) Can you think of any Mi'kmaq words that are related to or describe early child development?

4) How would you vision optimal child development for your child(ren), or for our community?

5)Are you aware of programs or initiatives you see in and around Unama'ki that are not available here?

Probe: Can you share information on what they are ?(How did you find out about these programs? Would they work here? Why or why not?)

6) What has your family experienced when accessing services to support early child development For example, supports in place, or even not in place to support child development?

7) Have you or your family accessed services from jordans principle?If so, What types of support did you seek/receive? What was the outcome?

8)) Do you think children are prepared for School by the time they start? (In terms of language, social and other EDI`?

9) Can you share how the Covid-19 Pandemic has impacted you and your family's experiences with any Early Childhood services or support?

10) Is there anything else you would like to share?

We will be talking to a few other parents and an Elder.

Once we collect everyone's ideas we will put it all together and then bring it back to share with you.

Wela'lin. Thank you very much for taking the time to share your ideas. To thank you we are giving you a $10 "thank you"

*$10 dollar thank you was amended to $50

Version 2

APPENDIX D: Demographic Survey

Parent Group

Code Number ________

Section 1: Demographics

1. Age____

2. How many children do you have? ________________________________

3. What are their ages? ____

   4. *Your Gender:*

__ Female

__ Male
__ X (don't identify exclusively as
male/female)
__ Non-binary gender, queer, Two-Spirit
___ Prefer not to disclose
I identify as ____________

5. How you identify? Mi'kmaq___ Non Mik'maq____ First Nation_____

Section 2: General Health

1) Complete the table below regarding when your children age 0-7 last accessed specific health care and other services.

	In the past 6 months	In the past year	In the past 5 years	Have not accessed	Was not needed in the past 6 months
Family Doctor					
Nurse Practitioner					
Walk-In Clinic					
Emergency Room					
Nurse					
Dental Professional*					
Mental Health Services*					
Traditional Healer					
Developmental Service					
Formal Child Care (Head Start or Day Care) # of weeks					

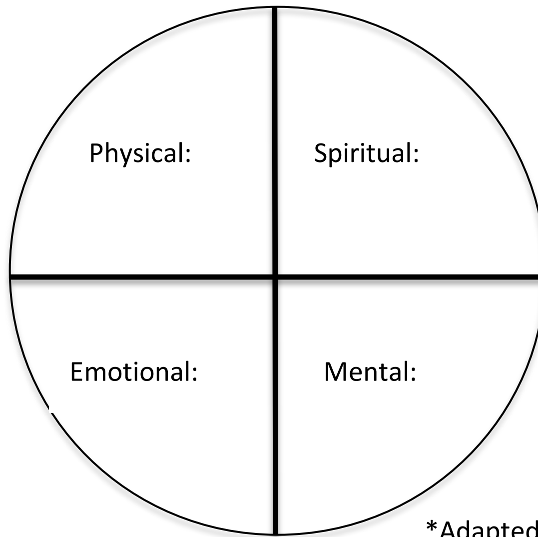
*Adapted from the RHS, 2017

2)Are your children currently accessing services? Yes___ No___

3) If so, what type of service or programs?

____

4.Please rate on a scale of 1-5, how the services available to children in the community help to meet their developmental needs. 1 is low, 3 is neutral and 5 is high.



*Adapted from the RHS, 2017

5) How do you prefer to access developmental services?

In The Community ____

Outside of the Community ____

In My Home____

6). Do you have any other comments about child development you'd like to share?____
____
____
____

Adapted from ACHH Demographic form with Permission

APPENDIX E: Elder Conversation Guide

Hi my name is Julie and I am here today because I am doing research required for my program at Dalhousie University. I am interested to know about how our families experience accessing developmental services and support for children during the ages 0-7.

If you don't feel like going through for the whole session just let me know, you can stop at any time.

Let's get started

I Have gone over the information about the study topic and I have just a few questions to get us started thinking about accessing developmental services during the early years.

Sample Questions

1) What does the term healthy child development mean?

2)Optimal growth and development can look different for each child and their own abilities, but all kids including those with special needs can be supported to meet their best outcomes in physical, mental, emotional, and spiritual wellbeing. What do Mi'kmaq children need to achieve optimal growth and development or to achieve their best outcomes?

3) Can you think of any Mi'kmaq words that are related to or describe early child development?

4) How would you vision optimal child development for your child(ren), or for our community?

5) Can you tell me about the programs and services offered in our community that promote, protect and support healthy childhood development?

6) What can you tell me about the Jordan's principle program? What supports do they offer?

7) Is there anything else you would like to share?

Once we collect everyone's ideas we will put it all together and then bring it back to share with you.

Thank you very much for taking the time to share your ideas. To thank you we are giving you a $50 "thank you"

Version 2

December 2020

APPENDIX F: Research Consent Form Parents

Title of Research Project: An Inquiry of Early Childhood Development in a First Nation Community. From Stories to Understanding; Exploring Families Experiences of Accessing Services for Children age 0-7.

Co Principle Investigator
Julie Francis, MScN student, Dalhousie University
Julie.Francis.rn@Gmail.com
902-578-8703

Principle Investigator:
Dr. Margot Latimer, Professor Dalhousie University
Indigenous Health Chair in Nursing (2020)
mlatimer@dal.ca
902-949-2391

Introduction
My name is Julie Francis, I am from Eskasoni First Nation and I am a Master of Science in nursing student at Dalhousie University. I am working with the community to understand the experiences that families and children have while accessing developmental services during the early years (ages 0-7).

Why are we doing this study?
This study is part of my program requirements. I wanted to choose a topic that would benefit the community. We are doing this study because we want to know what our community members experience when they access early childhood developmental services for their children. We want to learn about the strengths and the gaps, to better serve the community and support our children and families.

It is important that you understand the purpose of the study, how it may affect you, the risks and benefits of taking part and what you will be asked to do if you choose to participate. Taking part is entirely your choice. If you have any questions that this form does not answer, please contact me, the Principal Investigator Julie Francis, And I can give you more information and answer your questions. I can be reached at 902-578-8703

What does this research involve?
One on one interviews will take place with 10 parents and one Elder from the community. You will be asked to provide your thoughts and perceptions on child development, the experience of accessing services, and your stories.

This research is part of the requirements for my program, and will include :

1. Conversation sessions – One 30-60 minute conversation to explore your family's experiences accessing developmental services during the early years.
2. Demographic forms – Over the phone, we will complete a demographic and healthy survey form that asks for some of your info such as age, gender, number of children and their ages, the frequency that you access some services, and how you feel about the services.

Taking part in this study will help us to learn how to better understand what resources are in place that support First Nation community members to access care for their children and youth in these areas.

What will you be asked to do?

Part 1: Conversation Session
-Take part in a 1-hour conversation session at time that is convenient, and it will be audio-recorded
Part 2: Demographic and health survey

-Provide your child or children's age, some information about yourself, and how often you have accessed services for your children.

Are there good things and bad things about the study?

A good thing about the study is that the community professionals and policy makers will have information to guide their decisions and meet the needs of the community because of the things you share in the study – but we cannot be sure that will happen. There are no bad things about the study except that you might feel uncomfortable talking to the investigator about your experience. You are not required to share anything that you feel uncomfortable about sharing.

Who will know about what I did in the study?

We will respect your privacy. The only persons who will know what you did in the study is The principle investigator (Julie Francis), and possibly the research assistant. If there are any translations needed, the research assistants will be providing translations, they may also transcribe some of the audio recordings and may become aware of what you have said. There will be a large online information sharing session for all participants; at this time other participants may become aware that you were a part of this study. You are

not required to attend - the session it is optional. If you choose not to attend but still would like to learn about the results a written copy of the results can be delivered to you.

No information about who you are will be given to anyone or be published without your permission, unless required by law.

You will be given an ID number which will be used on all study items to make sure your name is not connected to any data, stories or information. The information we get from this study will be stored in a secure, locked location. Only members of the research team will have access to the data. After the study is over the data will be kept for 5 years then destroyed as required by the Mi'kmaq Ethics Watch and IWK Health Centre policies. Published study results will not reveal your identity.

I will give you a copy of this research consent form.

Can I decide if I want to be in the study?

It is totally up to you if you want to be in the study. Nobody will be angry or upset if you do not want to be in the study. The care you, your children or family receives at the health centre or from any other provider will not change whether you participate or not. Even if you say you want to be in the study now but change your mind later, that's okay – just let me know that you do not want to be in the study anymore. You also are not required to answer all the questions, you are free to choose what you share and can choose to skip a question if you like.

Reimbursement

Participation in this study will not result in any expenses to you. As a 'thank you' for participating you will
receive a $10 honorarium and small gift.

No way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing the health care you are entitled to receive. If you have any questions at any time during or after the study about research in general you may contact the Research Office of the IWK Health Centre at (902) 478-5096, Monday to Friday between 8:00 a.m. and 4:00 p.m.

Consent for Study Participant

By signing this form, I agree that:

1) You have explained this study to me. You have answered all my questions.
2) You have explained the possible harms and benefits (if any) of this study.

3) I know what I could do instead of taking part in this study. I understand that I can refuse to take part in the study. I can also withdraw from the study at any time. My decision to take part in the study will not affect my health care at the Eskasoni Health Centre or any other program or service in the community.
4) I am free now, and in the future, to ask questions about the study.
5) I understand that no information about me will be given to anyone or be published without first asking my permission.
6) I have read and understood p.g1 to 3 of this consent form.

Would like to receive a copy of the study results? Please check the Yes box below and include your name and email address.

Yes _____ No _____

Name: ______________________ Email: __________________________

Please indicate if you are willing to be contacted for further research in this area.

Yes _____ No _____

Person Giving Consent
I agree to participate in the study. My consent has been given freely.

Printed Name of Participant	Signature	Date

To the best of my knowledge, the information that I have provided to this participant fairly represents the project. I am committed to conducting this study in compliance with all agreed upon ethical standards.

Name (Print)	Signature	Date
Role in study (Research Coordinator/Research Assistant)		

If you have any questions about this study, please call Julie Francis 902-578-8703. If you have any questions about your rights as a research subject, please call the IWK Health Centre Research Ethics Coordinator at (902)470-8520.

Adapted from ACHH Consent form with permission

Version 5

November 2021

APPENDIX G: Research Consent Form Elder Participant

Title of Research Project: An Inquiry of Early Childhood Development in a First Nation Community. From Stories to Understanding; Exploring Families Experiences of Accessing Services for Children age 0-7.

Investigator
Julie Francis, MScN student, Dalhousie University
Julie.Francis.RN@Gmail.com
902-578-8703

Supervising Investigator:
Dr. Margot Latimer, Professor Dalhousie University
Indigenous Health Chair in Nursing (2020)
mlatimer@dal.ca
902-949-2391

Introduction
My name is Julie Francis, I am from Eskasoni First Nation and I am a Master of Science in nursing student at Dalhousie University. I am working with the community to understand the experiences that families and children have while accessing developmental services during the early years (ages 0-7).

Why are we doing this study?
This study is part of my program requirements; I wanted to do something that could help the community. We are doing this study because we want to know what parents describe as their experience to have access to early childhood developmental services for their children. We want to learn about the strengths and the gaps, to better serve the community and support our children and families.

It is important that you understand the purpose of the study, how it may affect you, the risks and benefits of taking part and what you will be asked to do if you choose to participate. Taking part is entirely your choice. If you have any questions that this form does not answer, please contact me, the Principal Investigator Julie Francis, and I can give you more information and answer your questions. I can be reached at 902-578-8703

What does this research involve?
One on one interviews will take place with 10 parents and one Elder from the community. You will be asked to provide your thoughts and perceptions on child development, the experience of accessing services, and your stories.

This research is part of the requirements for my program, and will include
1. Conversation Sessions
2. **Parent** Demographic and Health Surveys

Taking part in this study will help us to learn how to better understand what resources are in place that support First Nation community members to access care for their children and youth in these areas.

What will you be asked to do?
If you choose to take part in this aspect of the study, you will be asked to:

> -Take part in a 30-60 conversation session at time that is convenient for you, and it will be audio-recorded, if you are comfortable with recording.

You do not need to complete a parent demographic and health survey. This will be for parent participants only.

Are there good things and bad things about the study?

A good thing about the study is that the community professionals and policy makers will have information to guide their decisions and meet the needs of the community because of the things you share in the study – but we cannot be sure that will happen. There are no bad things about the study except that you might feel uncomfortable talking to the investigator about your experience. You are not required to share anything that you feel uncomfortable about sharing.

Who will know about what I did in the study?

We will respect your privacy and confidentiality. The only persons who will know what you did in the study are the principle investigator (Julie Francis), and potentially the research assistant. If there are any translations needed, the research assistant will be providing translations, may also transcribe some of the audio recordings and may become aware of what you have said. There will be a large online information sharing session for all participants that is optional for all study participants to attend; at this time other participants may become aware that you were a part of this study. If you would rather have a copy of the results written, I could share the results with you that way.

No information about who you are will be given to anyone or be published without your permission, unless required by law.

You will be given an ID number which will be used on all study items to make sure your name is not connected to any data, stories or information. The information we get from this study will be stored in a secure, locked location at the Eskasoni Health Centre. Only members of the research team will have access to the data. After the study is over the data will be kept for 5 years then destroyed as required by the Mi'kmaq Ethics Watch and IWK Health Centre policies. Published study results will not reveal your identity.

I will give you a copy of this research consent form.

Can I decide if I want to be in the study?
It is totally up to you if you want to be in the study. Nobody will be angry or upset if you do not want to be in the study. The care you and your family receive at the health centre or from any other provider will not change whether you participate or not. Even if you say you want to be in the study now but change your mind later, that's okay – just let me know that you do not want to be in the study anymore. You also are not required to answer all the questions, you are free to choose what you share.

Reimbursement

Participation in this study will not result in any expenses to you. As a 'thank you' for participating you will receive a $50 honorarium and small gift.

No way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing the health care you are entitled to receive. If you have any questions at any time during or after the study about research in general you may contact the Research Office of the IWK Health Centre at (902) 478-5096, Monday to Friday between 8:00 a.m. and 4:00 p.m.

Consent for Study Participant
By signing this form, I agree that:

1) You have explained this study to me. You have answered all my questions.
2) You have explained the possible harms and benefits (if any) of this study.
3) I know what I could do instead of taking part in this study. I understand that I can refuse to take part in the study. I can also withdraw from the study at any time. My decision to take part in the study will not affect my health care at the Eskasoni Health Centre or any other program or service in the community.
4) I am free now, and in the future, to ask questions about the study.
5) I understand that no information about me will be given to anyone or be published without first asking my permission.
6) I have read and understood p.g 1 to 3 of this consent form.

Would like to receive a copy of the study results? Please check the Yes box below and include your name and email address.

Yes _____ No _____

Name: ______________________ Email: __________________________

Please indicate if you are willing to be contacted for further research in this area.

Yes _____ No _____

Person Giving Consent
I agree to participate in the study. My consent has been given freely.

Printed Name of Participant	Signature	Date

Person Collecting Consent
To the best of my knowledge, the information that I have provided to this participant fairly represents the project. I am committed to conducting this study in compliance with all agreed upon ethical standards.

Name (Print)	Signature	Date
Role in study (Research Coordinator/Research Assistant)		

If you have any questions about this study, please call Julie Francis 902-578-8703

If you have any questions about your rights as a research subject, please call the IWK Health Centre Research Ethics Coordinator at (902)470-8520
Modified from ACHH/IWK with permission

Version 4
June 2021

APPENDIX H: Parent Recruitment Poster

Appendix H: Parent Recruitment Poster

Volunteers for research opportunity needed,
PARENTS we would like to hear from you!

Parents who access services to support development for their children age 0-7

The purpose of the study is to gain an understanding of how our community perceives child development, and to explore the experiences that families have while accessing services for their children ages 0-7 years.

- Flexible Scheduling.
- One 30-60 minute interview, audio recorded (Can be over the phone)
- Private & confidential.

For More information, questions or concerns please contact :

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