Promoting Healthy Beginnings for Indigenous Children

Research Review on Prenatal and Early Childhood Programs

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At the Children's Health Policy Centre, with gratitude we respectfully acknowledge that we live in and work on First Peoples' ancestral lands. We understand and commit to the ongoing work of reconciliation, honouring all Indigenous Peoples.

Citing this report

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Contents

Executive Summary

Early childhood experiences are recognized as crucial for the health and wellbeing of both individuals and populations. Indigenous Peoples have strong cultural knowledge and traditions to support and nurture healthy child development. Indigenous Peoples have also long resisted colonialism and are overcoming its legacies through cultural revitalization and nation rebuilding. Yet the legacies of colonialism still deeply affect Indigenous children, families and communities today.

To contribute to public conversations about Indigenous early childhood programming, we used systematic review methods and identified eight relevant reviews of prenatal, postnatal, maternal and early childhood health programs developed and implemented by and within Indigenous communities in Canada, Australia, New Zealand and the United States. All eight reviews spoke to the need to honour Indigenous voices through ensuring meaningful community leadership in choosing all aspects of the planning, development, implementation and evaluation of programs. Some reviews also focused on Canadian success stories.

Based on this review we recommend:

- Making Indigenous children a leading public policy priority for BC and for Canada.
- Committing sufficient and sustained public resources to high-quality Indigenous prenatal and child health programming — across the continua of planning, development, implementation and evaluation.
- Ensuring that all Indigenous early child health programming is led by Indigenous communities.
- Recognizing that Indigenous children deserve public investments in programs with proven benefits, with evaluations including Indigenous perspectives on child flourishing.

We are shaping the future for all children, and therefore for the population, based on the public policies we invest in today. This future starts with supporting Indigenous children, families and communities according to their needs — and celebrating their many strengths.

One expression of truth and reconciliation involves ensuring adequate resources for effective and equity-based programming, provided to all Indigenous children according to their needs.

1. Background

1.1 Importance of early development

Early childhood experiences are recognized as crucial for the health and wellbeing of both individuals and populations (Marmot et al., 2010). For individuals, early development begins in the pre-conception and prenatal periods and continues throughout the pre-school years, setting the stage for children to flourish physically, socially, emotionally and cognitively across the lifespan (Hertzman & Boyce, 2010; Hildreth et al., 2022). In turn, the health of populations depends on public policies that support *all* children by recognizing early development as a crucial time (Waddell et al., 2017). Public expenditures in early childhood can also yield positive economic returns. Evaluations of home-visiting, early childhood education, parent education and transfer (cash or in-kind benefits) programs, or combinations of these, have shown not only significant long-term child benefits across multiple domains (including mental health, learning and physical health), but also substantial averted expenditures across multiple public sectors (including healthcare, education and justice) (Cannon et al., 2017). Public investments in early childhood are also considerably more efficient than those made later in the lifespan (Heckman, 2006). Yet most public spending on health and healthcare in Canada still goes towards older adults (Canadian Institute for Health Information, 2025) — suggesting that early childhood wellbeing remains under-appreciated.

1.2 Why a report on Indigenous prenatal and early childhood programs?

In Canada and elsewhere, the healthy development of Indigenous children is crucial for young people and for the wellbeing of their communities (Greenwood & de Leeuw, 2012). Indigenous Peoples have strong cultural knowledge and traditions to support and nurture healthy child development. Indigenous children are also a particular priority given colonial harms including forced child removals to residential schools, abuses in those schools, associated rupturing of communities and losses of lands and livelihoods (Royal Commission on Aboriginal Peoples, 1996; Truth and Reconciliation Commission [TRC], 2015; Office of Independent Special Interlocuter [OISI], 2024). Systematic failures to address these issues have been coupled with ongoing exposures to racism and socioeconomic exclusion — failures and exclusions still salient today (Greenwood, 2021). Indigenous Peoples have resisted colonialism in all its facets and are overcoming its legacies through cultural revitalization and nation rebuilding, evidenced by the many legal, political, health and research remedies they have enacted (e.g., Nisga'a Nation, 1999; Supreme Court of Canada, 2014; First Nations Health Authority [FNHA], 2025; First Nations Information Governance Centre, 2026).

Indigenous leaders have also urged all Canadians to take meaningful steps towards truth and reconciliation (TRC, 2015). One expression of this involves ensuring adequate resources for effective and equity-based programming for all Indigenous children, provided according to their needs, for example, in accordance with Jordan's Principle (Blackstock, 2016). Another expression involves ensuring that all programming is culturally grounded, as determined by Indigenous communities (United Nations, 2007; Auger, 2016; Berry et al., 2025).

1.3 Goals of this research report

Given this background, we aimed to inform policymaking in British Columbia (BC) to promote health and flourishing for Indigenous populations during pregnancy and children's early years. Specifically, we conducted a scoping review of the salient literature on prenatal and early childhood programs to identify goals and crucial qualities of those that were specifically developed and implemented by and within Indigenous communities — honouring Indigenous voices.

2. Methods

For this scoping review, we searched Simon Fraser University library databases to identify literature on approaches for delivering programs with and for Indigenous families that focused on prenatal and early childhood health. Using methods adapted from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), we sought systematic, scoping or realist reviews (Page et al., 2021). For relevance to Canada, we focused our searches on high-income countries where Indigenous populations have faced similar histories of colonialism (Kenny et al., 2020). To identify additional literature, we supplemented database searches by hand-searching relevant systematic reviews. While we defined "maternal" health as referring to pregnancy and the perinatal period, we nevertheless acknowledge the important roles of other caregivers, such as fathers and other family members, who were beyond the scope of this report. As well, we required reviews to be led or co-authored by Indigenous scholars. (Two Indigenous scholars, Brandi Anne Berry and Erik Mohns, are authors on this report.) We did not use artificial intelligence tools in the analyses or writing of this report. Table 1 summarizes our search strategy and inclusion criteria.

Table 1. Search Strategy and Inclusion Criteria

Databases	• Cumulative Index to Nursing and Allied Health Literature, Medline and PsycINFO
Search Terms	• Aboriginal, First Nation(s), Indigenous, Inuit, Métis, Melanesian, Polynesian, Torres-Strait, Māori, Native, American-Indian, Amerindian, Sami/Sámi, Saami or Sápmi; and • Early childhood, early years, prenatal, postnatal, antenatal or maternal; and • Care, service, model, intervention or prevention; and • Engage, interact, uptake, continue, access, monitor, evaluate, deliver, adapt or framework; and • Canada, Australia, Brunei Darussalam, Chile, Costa Rica, Denmark, Finland, French Polynesia, Greenland, Guam, Guyana, Israel, Japan, Kalaallit Nunaat, New Caledonia, New Zealand, North Mariana Island, Norway, Palaua, Panama, Russia, Sweden, Taiwan, United States*
Limiters	• Published in English in peer-reviewed journals from database inception through July 2025
Inclusion Criteria	• Led or co-authored by Indigenous scholars • Identified and summarized original studies or grey literature reports using systematic methods • Focused on Indigenous populations in high-income countries for comparability to Canada * • Provided actionable recommendations or guidance on design, delivery or implementation of prenatal and/or early child health programs with/for Indigenous populations

* High-income countries with Indigenous populations were identified in a systematic review using World Bank + two other databases (Kenny et al., 2020); updated searches using a similar approach identified Costa Rica, Guyana + Russia as additional qualifying countries

Our searches yielded 367 potentially relevant articles. From these we identified 127 potentially relevant abstracts. We then retrieved and assessed 71 articles. Two authors independently assessed each article. One author completed data extraction and interpretation, which a second author verified, with input from the larger team as needed. Eight reviews met inclusion criteria. Appendix 1 shows our search process.

To further identify specific examples that might pertain to BC, we then scanned the accepted reviews to identify original studies on relevant programs developed by or with Indigenous communities in Canada with quantitative or qualitative evidence of prenatal and/or child benefits. One author conducted the scans then completed data extraction and interpretation, with input from the larger team. The entire team then reviewed the findings, reached consensus on interpretations and contributed to the discussion.

3. Findings

We identified eight relevant reviews examining goals and crucial qualities of prenatal, postnatal, maternal and early childhood health programs developed and implemented by and within Indigenous communities. These reviews encompassed Indigenous populations from Canada, Australia, New Zealand (NZ) and the United States (US). All eight reviews spoke to the need for Indigenous leadership and meaningful community participation in choosing all aspects of programming — including planning, development, implementation and evaluation — as a way of ensconcing cultural awareness and safety as paramount goals, essential for success.

That said, the reviews were diverse, ranging from very general (such as covering all aspects of development from pregnancy through to early childhood) to very focused (such as examining breastfeeding only). As well, only three of eight reviews specifically noted child benefits based on program evaluations in Canadian settings (Beadman et al., 2024; McCalman et al., 2017; Smylie et al., 2016). Available effectiveness information was limited in many cases. Table 2 summarizes the included reviews. Table 3 summarizes Canadian programs with evidence of prenatal and/or child health benefits. Appendix 2 gives details on the eight included reviews.

Indigenous leadership and community self-determination are central to policy planning, as is appreciating the uniqueness of each community. There can be no "one size fits all."

Table 2. Summary of Findings from Accepted Reviews *

Author (Year)	Aims + Methods (Studies + Locations)	Main Findings (Number of Canadian Programs Noted) **
Beadman 2024	To identify ways to strengthen Indigenous cultural contexts for perinatal healthcare; systematic review (28 studies: AU, NZ + CA)	Most programs were limited regarding meeting Indigenous cultural needs; engagement with communities also limited; programs + services intended for Indigenous Peoples must involve Indigenous Peoples + communities in program planning, delivery + review; cultural safety must be determined by service users (1 CA program noted)
Harfield 2018	To identify best practices in Indigenous primary healthcare to inform services to improve child outcomes; systematic scoping review (62 studies from 7 countries; 5 from CA)	Culture, accessibility, community participation, continuous quality improvement, Indigenous workforce, flexible care, holistic/comprehensive care + self-determination were 8 crucial, inter-dependent factors that need to inform new Indigenous primary healthcare models; culture central to all (no relevant CA programs noted)
McCalman 2017	To identify + assess models + outcomes for Indigenous family-centred early childhood programs in primary care; systematic scoping review (18 studies: AU, CA, US, NZ)	Research suggests promise for family-centred Indigenous early childhood programs in primary care settings; but most studies were lower quality; new research is needed on outcomes + role of fathers + costs (2 CA programs noted)
McEvoy 2024	To identify toolkits to inform Indigenous culturally responsive, trauma-informed care in first 1000 days; scoping review (13 toolkits: AU, CA US, NZ)	Services for Aboriginal Australians + Torres Strait Islanders in the first 1000 days (perinatal to age 2 years) should be culturally responsive + trauma-informed while ensuring continuity of care + carers + being individualized, flexible, safe + welcoming (1 CA toolkit but no programs noted)
Sivertsen 2025	To identify + understand Indigenous women's perspectives on birthing experiences in non-Indigenous healthcare settings; systematic scoping review (22 studies: AU, CA, NZ, Kalaallit Nunaat/Greenland)	Over-medicalization + evacuation of Indigenous women causes cultural, geographic + social disconnection, although infant safety benefits; better cultural safety education, inclusion of cultural practices + Indigenous birth support workers can help address the problems (no relevant CA programs noted but 10 of 22 studies focused on Canadian Indigenous women's experiences)
Simpson 2020	To identify factors that help + deter postnatal engagement for Aboriginal Australians; scoping review (6 AU studies)	To improve postnatal engagement all the following are crucial + should be addressed: continuity of care, Aboriginal health workers, home visits, family involvement, Birthing on Country + cultural safety; barriers to engagement include cultural incompetence, racism, stigma associated with smoking + young maternal age; deterrents should be addressed (no relevant CA programs noted)
Smylie 2016	To identify successful Indigenous perinatal + early childhood programs in Canada; realist review (23 evaluations of 20 CA programs)	11/20 programs showed benefits; Indigenous leadership + community ownership fundamental to ensuring success; evaluations need to reflect *Indigenous* ideas of success (20 CA programs noted)
Zheng 2023	To identify ways to enhance breastfeeding rates in Aboriginal Australian + Torres Strait Islander populations; scoping narrative review (11 AU studies)	While colonization has interrupted traditional infant feeding practices, adding supports, ensuring culturally appropriate care, addressing social determinants + supporting intentions to breastfeed can help increase rates (no relevant CA programs noted)

* Country abbreviations: AU = Australia; CA = Canada; NZ = New Zealand; US = United States

** See Table 3 for more information on relevant Canadian programs

Table 3. Canadian Indigenous Programs Showing Evidence of Benefits *

Name + Location (Sources)	Program Description	Reported Prenatal or Child Benefits
Cited / Described in Beadman 2024 (1 program)		
Inuulitsivik, Nunavik, Quebec (Van Wagner 2007 cited in Hickey 2021) **	Indigenous midwifery education + services in remote communities aiming to prevent birthing evacuations	80% of births occurred in Nunavik 19 years after program inception compared to only 9% previously
Cited / Described in McCalman 2017 (1 program)		
Aboriginal Prenatal Wellness Program, Alberta (DiLallo 2014)	Prenatal care aiming to improve access + cultural safety + improve outcomes for Maskwacis families	Greater satisfaction with prenatal care + less prenatal substance exposure + higher breastfeeding rates
Cited / Described in Smylie 2016 (7 programs)		
Aboriginal Head Start, Canada-wide (Chalmers 2008) ***	Centre-based 4–5-day/week program including: culture + language, education + health/nutrition for children 0–6 years with parent involvement	Greater parent program satisfaction + improved physical health, knowledge + use of Indigenous languages/traditions + school readiness
Canada Prenatal Nutrition Program, Canada-wide (Andersson 2003) ***	Prenatal + nutrition + cooking classes + food coupons provided in 100 communities	Reduced prenatal substance exposure + improved breastfeeding rates + diets
Healthy Foods North, Nunavut + Northwest Territories (Bains 2013) **	Promotion of healthy eating across food stores, health clinics + community events, with community news media messaging	Improved vitamin + mineral intakes (but unchanged fat, sugar + caloric intakes)
Healthy Food Program, Nunavik, Quebec (Gagne 2013) **	Parents of children 1–4 years provided traditional Indigenous + healthy "store-bought" foods at a childcare centre	Improved intakes of vitamins, minerals, healthy fats, vegetables, fruit, grains + milk
Infant Feeding Project, Quebec (Verrall 2006)	Community messaging aimed at Cree parents to support breastfeeding + promote better nutrition, including offering cooking classes	Higher purchases of iron-enriched infant foods + more parental confidence in making infant foods
Ka'nistenhser Teiakotisnie, Quebec + Ontario (Banks 2003)	Promotion of breastfeeding for new Mohawk Kanesatake mothers with 24/7 doula-trained grandmother support	Breastfeeding initiation rates nearly tripled + 4-month duration rates doubled between 1995 and 2001
Peer Counsellor Program, Manitoba (Martens 1999)	Peer-based breastfeeding supports for new Sagkeeng First Nation mothers	Improved breastfeeding satisfaction + duration + reduced breastfeeding problems

* All programs showed evidence of Indigenous leadership/engagement; programs were excluded if only dental outcomes/benefits were reported

** Program provided to Inuit populations

*** Program provided to First Nations, Inuit and Métis populations

4. Discussion

Our review suggests that the principles of Indigenous leadership and community self-determination must be central to policy and program planning for any Indigenous community. Appreciating the uniqueness of each community is also crucial. There can be no "one size fits all." Rather, communities need to be provided with adequate resources and supports to develop, adopt or adapt their own programs, including funding to evaluate these to ensure that Indigenous children and families benefit — according to Indigenous perspectives on wellbeing and program success. Programs could be based on successful examples drawn from the literature outlined above, depending on community goals (see Table 3). Indigenous communities will decide.

BC has already invested in early prevention programs serving Indigenous families. Although these programs were not developed by Indigenous leaders for their communities, they offer opportunities to inform future community-led initiatives. Specifically, since 2012 BC regional health authorities have provided enhanced home-visiting programs for families experiencing socioeconomic adversity, starting prenatally and continuing until children reach age two years. The most rigorous evidence stems from a large BC randomized controlled trial (RCT) evaluation of Nurse-Family Partnership (NFP) that included 200 (27%) urban Indigenous maternal-child dyads residing across BC (Catherine et al., 2025a). This evaluation showed program benefits including reduced prenatal substance exposure, improved child mental health and language development by age two years, and reduced family exposure to intimate partner violence by 24 months postpartum (Catherine et al., 2024, 2025b). Qualitative data have also confirmed NFP's acceptability and feasibility in Indigenous communities in Australia (Massi et al., 2023). In addition to NFP, some BC regional health authorities have implemented adapted programs to better reach and serve more diverse families, including Indigenous families, with evaluations pending (Children's Health Policy Centre, 2025). A similar American Indigenous home-visiting program, Family Spirit, has also shown child benefits in RCT evaluations (Barlow et al., 2015). BC's First Nations Health Authority (FNHA) is piloting this program (FNHA, 2024). Enhanced home visiting therefore holds promise should BC Indigenous communities wish to pursue this.

Strengths of this work include our systematic methods and our requirement that Indigenous authors be represented in the studies we included. Yet we were able to examine only English-language literature and so may have excluded Indigenous-language reports. As well, while all eight included reviews had clear strengths, such as identifying that Indigenous program leadership was crucial, only three described actual programs and their outcomes — and only one gave detailed overviews on these topics (Smylie et al., 2016). By nature, any form of systematic synthesis such as this is also limited by the issue of recency in that included reviews reported on original studies, some of which were older.

Positive child outcomes must always be the paramount consideration.

Our review nonetheless highlights four significant policy opportunities.

- **It is essential to make Indigenous children a leading public policy priority for BC and for Canada**. Indigenous leaders have long called for this priority and have indicated it is long overdue (e.g., Royal Commission on Aboriginal Peoples, 1996; TRC, 2015; Blackstock, 2016; OISI, 2024).

- **Sufficient and sustained public investments must be committed to high-quality Indigenous prenatal and child health programming — across the continua of planning, development, implementation and evaluation**. To ensure equity, investments need to be directed towards programs that may be universal but nevertheless are provided at a scale and intensity that is in proportion to the unique needs of various First Nations, Inuit and Métis populations (Marmot et al., 2010; Blackstock, 2016).

- **All Indigenous prenatal and child health programming must be led by and with Indigenous communities**. As many successful models attest, this is the singular way to ensure cultural grounding and relevance (Smylie et al., 2016; FNHA, 2025). It is also the best and most ethical approach for adapting and delivering existing programs and for determining Indigenous evaluation priorities. For example, the Nunavik Inuulitsivik program had the specific community-defined goal of preventing birthing evacuations and met this goal (Beadman et al., 2024; Van Wagner et al., 2007), while the Canada-wide Aboriginal Head Start program stablished and met broader goals including improved child health and school readiness (Smylie et al., 2016; Chalmers et al., 2008).

- **Indigenous children deserve public investments in programs with demonstrated effectiveness.** There are many examples of successful or "proven" programs (Barlow et al., 2015; Smylie et al., 2016; Catherine et al., 2024, 2025a, 2025b). Indigenous communities will define effectiveness in their own terms. Yet positive child outcomes must always be the paramount consideration.

The legacies of colonialism still deeply affect Indigenous children, families and communities (TRC, 2015; OISI, 2024). Beyond the specific policy opportunities noted above, increased public resources therefore also need to be committed to assisting all Canadians to better recognize these legacies and their impact, and to addressing the resultant racism and socioeconomic inequalities that continue to cause harm. All Canadians must also recognize Indigenous Peoples' leadership in determining how to address colonial harms and promote Indigenous flourishing. We are shaping the future for all children, and therefore for the population, based on the public policies we invest in today. This future starts with supporting Indigenous children, families and communities according to their needs — and celebrating their many strengths.

We are shaping the future for all children, and therefore for the population, based on the public policies we invest in today.

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5. References

[* indicates eight included reviews; ** indicates references cited in Table 3]

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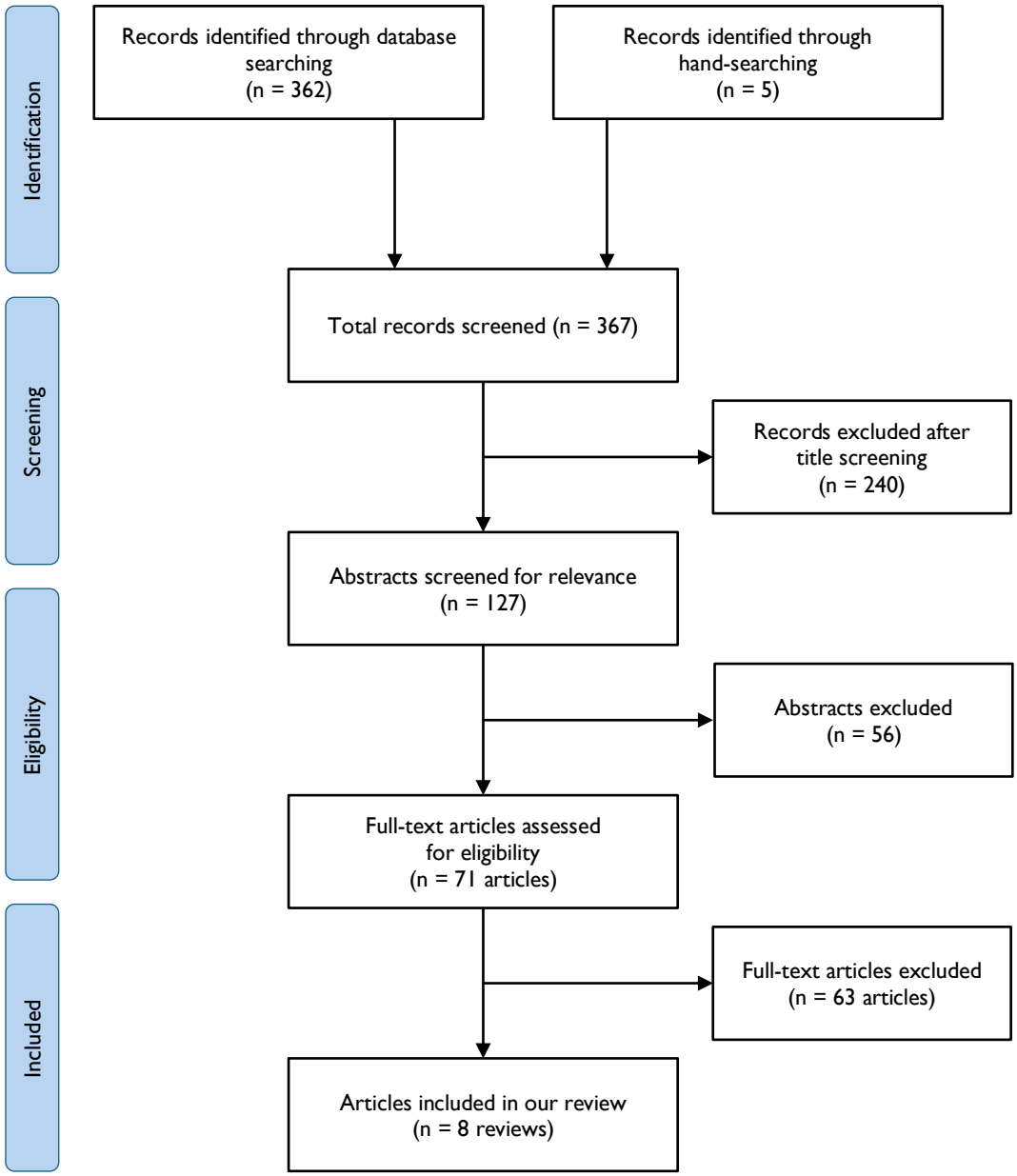
Appendix 1: Search Process for Identifying Systematic Reviews*



* Adapted from Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021)

Appendix 2: Detailed Descriptions of the Eight Included Reviews

1. Beadman KA, Sherwood J, Gray P, McAloon J (2024) *	
Goal	To identify ways to strengthen cultural contexts for perinatal healthcare for Aboriginal Australian + Torres Straight Islanders
Methods	*Study design:* systematic review; followed PRISMA guidelines
	Search strategy: used academic databases to identify peer-reviewed English- or Aboriginal-language articles published 2000–2023
	Inclusion criteria: 1) documented engagement with Aboriginal women + children prenatal to age 5 years regarding perinatal programs/services; + 2) described models or services developed or delivered by communities that have substantively contributed to new knowledge; + 3) described models developed in Australia
	Quality assessment: used Effective Public Health Practice Project for quantitative studies + Critical Appraisal Skills Programme for qualitative; studies deemed strong, moderate or weak
Main Findings/ Themes	*Sample:* 28 studies from AU only (27/28) + AU+ NZ + CA (1/28) **
	Sample sizes/number of participants: not reported
	Study types: quantitative 10/28; qualitative 17/28; mixed methods 1/28
	Study quality: quantitative 5 strong, 5 moderate, 1 weak; qualitative 13 strong, 4 moderate
	Main findings/themes • Community participation: initial program assessment in 10/28 studies; program development 2/28; program approval 6/28; program administration 2/28; for program review 13/28 • Cultural appropriateness of program content: – 22/28 studies reported birthing supports from Aboriginal health workers, grandmothers, other female family members or Aboriginal researchers; 14/28 reported community-driven supports including Aboriginal health services, grandmothers or families – 4/28 studies reported including cultural concepts/traditions within programs; 5/28 noted these as significant to programming; 19/28 did not report on integration of cultural concepts/traditions • Models of care: 23/28 studies reported on continuity of care; 14/28 described harm reduction being offered within models of care; 3/28 reported offering social-emotionally responsive care; 3/28 considered trauma-informed care in context of harm reduction while 3/28 considered it in context of social-emotionally responsive care
Authors' Conclusions	• Most programs were limited regarding meeting cultural needs of Aboriginal Australians + Torres Straight Islanders; engagement with communities also limited • Programs + services intended for Aboriginal Australians + Torres Straight Islanders must involve Aboriginal Australians + Torres Straight Islanders in program planning, delivery + review • Cultural safety must be determined by service users
Canadian Programs * **	• Inuulitsivik Midwifery Service + Education Program, Quebec (see Van Wagner 2007 cited in Hickey 2021)

* Beadman, Sherwood + Gray are Aboriginal Australians

** Country abbreviations: AU = Australia; CA = Canada; NZ = New Zealand; US = United States

*** Canadian programs had to show both evidence of child benefit + Indigenous engagement (see Table 3)

Appendix 2: Detailed Review Descriptions (continued)

2. Harfield, Davy, McArthur, Munn, Brown, Brown (2018) *	
Goal	To identify best practices in Indigenous primary healthcare to inform new service models to improve child outcomes
Methods	*Study design:* systematic scoping review; followed Briggs Institute guidelines
	Search strategy: used academic databases + hand searches to identify peer-reviewed + other/grey English-language articles published 1978–2015
	Inclusion criteria: 1) described primary care services that were socially appropriate, universally accessible, scientific + provided by suitably trained multidisciplinary teams for primarily Indigenous populations; + 2) described program characteristics including values, principles + components implemented within Indigenous services
	Quality assessment: not reported
Main Findings/ Themes	*Sample:* 62 studies from AU (32/62), US (18/62), CA (5/62) + NZ (4/62); 3 from middle-lower-income countries (Mexico, Papua New Guinea + Peru) **
	Sample sizes/number of participants: not reported
	Study types: not reported
	Study quality: not reported
	Main findings/themes • Perinatal + infant health: main focus in 9/62 studies • 8 characteristics identified as central to Indigenous models – *Culture:* embedded + crucial to all models – *Accessibility:* 24/62 studies defined as services being affordable, available + acceptable – *Community participation:* 16/62 studies emphasized Indigenous governance; 12/62 emphasized strong community relationships – *Continuous quality improvement:* importance of evaluation noted in 8/62 studies – *Indigenous workforce:* importance noted in 18/62 studies – *Flexible approaches to care:* identified in 19/62 studies including tailoring programs to local communities; 23/62 studies also noted importance of integrating all related services – *Holistic care*: 31/62 studies identified importance of meeting physical, social, emotional + spiritual needs across promotion, prevention + primary + secondary/tertiary treatment programs + across all life stages; 18/62 studies emphasized promotion + prevention; 18/62 studies noted importance of traditional health practices; 16/62 studies addressed social determinants; 16/62 studies documented need for harm reduction –*Self-determination:* community leadership + ownership emphasized in 16/62 studies
Authors' Conclusions	Culture, accessibility, community participation, continuous quality improvement, Indigenous workforce, flexible care, holistic/comprehensive care + self-determination were 8 crucial, inter-dependent factors that need to inform new Indigenous primary healthcare models; culture central to all
Canadian Programs	No relevant programs noted

* Harfield, Brown + Brown are Aboriginal Australians

** Country abbreviations: AU = Australia; CA = Canada; NZ = New Zealand; US = United States

Appendix 2: Detailed Review Descriptions (continued)

3. McCalman, Heyeres, Campbell, Bainbridge, Chamberlain, Strobel, Ruben (2017) *	
Goal	To identify + assess models + outcomes for Indigenous family-centred early childhood programs in primary care
Methods	*Study design:* systematic scoping review; followed PRISMA guidelines
	Search strategy: used academic + Indigenous research databases to identify peer-reviewed + other/grey English-language articles published 2000–2015
	Inclusion criteria: 1) participants were Indigenous children conception to age 5 years; + 2) study described or evaluated comprehensive family-centred care models that included several parenting criteria; + 3) intervention achieved > 50% on validated family-centredness scale; + 4) intervention led by a primary healthcare service
	Quality assessment: used Effective Public Health Practice Project for quantitative studies + Critical Appraisal Skills Programme for qualitative; studies deemed strong, moderate or weak
Main Findings/ Themes	*Sample:* 18 studies from AU (11/18), CA (3/18), US (3/18) + NZ (1/18) **
	Sample sizes/number of participants: sample sizes ranged from 12–7730; total N not reported
	Study types: quantitative 7/18; qualitative 7/18; mixed methods 1/18; program descriptions 2/18; protocol for longitudinal study 1/18
	Study quality: 1 study rated as strong (randomized controlled trial of US Family Spirit program); 7/18 moderate; 7/18 moderate-to-weak; remainder could not be assessed
	Main findings/themes • Crucial elements of family-centred early childhood interventions within primary care: – Identifying crucial strategies: supporting family/parenting "behaviours" + self-care; increasing parental knowledge + skills; linking families with clinical services; building the Indigenous workforce; promoting cultural connections; addressing social determinants – Enabling family-centred interventions: competent + compassionate delivery; flexible access including offering home-based services + transportation; continuity of care + integration across settings; culturally-supportive + respectful care • Outcomes: 15/18 studies reported on child, parent or community indicators; 7/15 reported better child nutrition including breastfeeding; 4/15 reported better child mental health; 5/15 reported reduced child injuries + illnesses; 6/15 reported better parental mental health; 8/15 reported better parental knowledge + skills; enhanced community revitalization + reduced health disparities were added benefits; 1/18 considered costs
Authors' Conclusions	Research suggests promise for family-centred Indigenous early childhood programs in primary care settings; but most studies were lower quality; new research is needed on outcomes + role of fathers + costs
Canadian Programs * **	• Aboriginal Prenatal Wellness Program, Alberta (Di Lallo 2014)

* Campbell, Bainbridge + Chamberlain are Aboriginal Australians
** Country abbreviations: AU = Australia; CA = Canada; NZ = New Zealand; US = United States
*** Canadian programs had to show both evidence of child benefit + Indigenous engagement (see Table 3)

Appendix 2: Detailed Review Descriptions (continued)

4. McEvoy, Henry, Karkavandi, Donnelly, Lyon, Strobel, Sundbery, McLachlan, Forster, Santos, Sherriff, Marriot, Chamberlain (2024) *	
Goal	To identify practical toolkits to inform Indigenous culturally responsive, trauma-informed continuity of care in first 1000 days (perinatal to age 2 years)
Methods	*Study design:* scoping review; followed Briggs Institute + PRISMA guidelines
	Search strategy: used academic databases + hand searches to identify peer-reviewed + other/grey English-language articles published from database inception to 2024
	Inclusion criteria: 1) practical toolkits focused on care prenatal to age 2 years; + 2) models included culturally responsive care or trauma-informed care or continuity of care
	Quality assessment: toolkits graded out of 8 points based on 3 main concepts (culturally responsive or trauma-informed or continuity of care); studies had to achieve 6/8 points
Main Findings/ Themes	*Sample:* 13 toolkits from AU (7/13), US (2/13), CA (1/13) + NZ (1/13); 2 United Kingdom toolkits did not involve Indigenous populations **
	Sample sizes/number of participants: not reported / not applicable
	Study types: not reported / not applicable
	Study quality: all models/toolkits had scores 6/8 or greater on at least one of 3 main concepts, according to inclusion criteria; 1/13 scored 8/8 on all 3 concepts (Birthing on Country); none covered the full 1000-day spectrum of care (perinatal to age 2 years); 2/13 showed evidence of effectiveness (none were Canadian)
	Main findings/themes • Principles: 9/13 toolkits noted continuity of care; 7/13 noted collaboration, e.g., across agencies; 3/13 noted sharing of power, encouraging Indigenous leadership + being culturally responsive; 8/13 noted woman- or family-centred care; 5/13 noted holistic care • Model components: 13/13 toolkits named individualized care as crucial; 10/13 named effective multidisciplinary teamwork; 10/13 named flexible, safe + welcoming care; 9/13 named continuity of both carers + care over first 1000 days
Authors' Conclusions	Services for Aboriginal Australians + Torres Strait Islanders in the first 1000 days (perinatal to age 2 years) should be culturally responsive + trauma-informed while ensuring continuity of *care* + *carers* + being individualized, flexible, safe + welcoming
Canadian Programs ***	• Practitioner resources, CA (National Council of Indigenous Midwives / National Aboriginal Council of Midwives (2014, 2019, 2021); evaluation not reported/applicable

* Henry, Marriot, Sherriff + Chamberlain are Aboriginal Australians
** Country abbreviations: AU = Australia; CA = Canada; NZ = New Zealand; US = United States
*** Canadian programs had to show both evidence of child benefit + Indigenous engagement (see Table 3)

Appendix 2: Detailed Review Descriptions (continued)

5. Sivertsen, Johnson, Mehus, Ness, Smith, McGill (2025) *	
Goal	To identify + understand Indigenous women's perspectives on birthing experience in non-Indigenous healthcare settings
Methods	*Study design:* systematic scoping review; followed PRISMA guidelines
	Search strategy: used academic databases + hand searches to identify peer-reviewed + other/grey English-language articles published from database inception to 2024
	Inclusion criteria: 1) focused on women's perspectives on birthing Indigenous babies in "mainstream" health facilities; + 2) studies conducted in Australia, Canada, Kalaallit Nunaat (Greenland), NZ, US or Sápmi (cultural region traditionally inhabited by the Sámi People, now known as Finland, Norway, Sweden + Russia's Kola Peninsula); + 3) presented results of qualitative or mixed methods studies of women's dissatisfaction with "mainstream" services
	Quality assessment: authors completed structured reviews of design strength, relevance to Indigenous women + reliability for each study
Main Findings/ Themes	*Sample:* 22 studies from AU (11/22), CA (9/22), NZ (1/22) + Kalaallit Nunaat/Greenland (1/22) **
	Sample sizes/number of participants: sample sizes ranged from 4–344; total N = 1578 (including women, Elders, fathers, family members + health providers)
	Study types: qualitative (17/22); mixed methods (5/22)
	Study quality: not reported
	Main findings/themes • Preference for community-based care + negative impact of evacuations: 22/22 studies noted importance of birthing in or near home communities due to isolation, lack of supports + concerns about caring for children left behind; care in non-Indigenous hospitals also associated with cultural insensitivity + violating norms • Importance of culturally appropriate supports: 7/22 studies identified families, partners, cultural advisors, Indigenous health workers/midwives as crucial to wellbeing • Benefits of continuity of care: 3/22 studies reported fragmented care being particularly harmful if care was also culturally unsafe, but continuity of care was beneficial in general, particularly if good communication + personalization of care • Need for cultural understanding: 7/22 studies noted experiences of racism + disrespect + lack of empathy in non-Indigenous maternity facilities, leading to loneliness + isolation • Need for education for healthcare providers: 11/22 studies emphasized importance of meaningful cultural safety education for all providing Indigenous maternity care
Authors' Conclusions	Over-medicalization + evacuation of Indigenous women causes cultural, geographic + social disconnection, although infant safety benefits; better cultural safety education, inclusion of cultural practices + Indigenous birth support workers can help address the problems
Canadian Programs	No specific programs noted but 10 of 22 studies focused on Canadian Indigenous women's experiences

* Sivertsen is Sámi + Johnson is Aboriginal Australian

** Country abbreviations: AU = Australia; CA = Canada; NZ = New Zealand; US = United States

Appendix 2: Detailed Review Descriptions (continued)

6. Simpson, Wepa, Bria (2020) *	
Goal	To identify factors that help + deter postnatal engagement for Aboriginal Australians
Methods	*Study design:* scoping review; followed Briggs Institute guidelines
	Search strategy: used academic databases + hand searches to identify peer-reviewed + other/grey English-language articles published 2009–2019
	Inclusion criteria: 1) included women birthing an Aboriginal baby + receiving postnatal care in Australia; + 2) discussed factors that encourage or deter engagement in postnatal care
	Quality assessment: not reported
Main Findings/ Themes	*Sample:* 6 studies, all from Australia as per inclusion criteria
	Sample sizes/number of participants: sample sizes ranged from 7–1024; total N = 2265
	Study types: quantitative (2/6); qualitative (1/6); mixed methods (3/6)
	Study quality: not reported
	Main findings/themes • Factors encouraging postnatal engagement: continuity of care; Birthing on Country model of care; services being accessible, e.g., home visits or transportation available; use of Aboriginal birthing programs + health workers; provision of culturally safe care, e.g., by Elders; support from family • Factors deterring postnatal engagement: being excluded from care planning; location of services not responsive to rural + remote communities; relocation to centralized care services far from home, causing fear if sent away alone + anxiety about care for children remaining at home; being younger due to stigma associated with teen pregnancy; shame associated with smoking; racism + disrespect towards Aboriginal Peoples
Authors' Conclusions	To improve postnatal engagement all the following are crucial + should be addressed: continuity of care, Aboriginal health workers, home visits, family involvement, Birthing on Country + cultural safety; barriers to engagement include cultural incompetence + racism + stigma associated with smoking + young maternal age; deterrents should be addressed
Canadian Programs	No relevant programs noted

* Wepa is Māori

Appendix 2: Detailed Review Descriptions (continued)

7. Smylie, Kirst, McShane, Firestone, Wolfe, O-Campo (2016) *	
Goal	To identify successful Indigenous prenatal + early childhood programs in Canada
Methods	*Study design:* realist review
	Search strategy: used academic databases + hand searches + informant interviews to identify peer-reviewed + other/grey English-language articles including program reports published through until 2015
	Inclusion criteria: included evaluation of prenatal or child health programs or maternal health promotion programs in Indigenous populations in Canada
	Quality assessment: used customized appraisal tool to assess: 1) Indigenous community relevance of method + measures; + 2) rigour of quantitative or qualitative methods; + 3) strength of evidence according to current quantitative/qualitative standards
Main Findings/ Themes	*Sample:* 23 evaluations, all from Canada, describing 20 programs
	Sample sizes/number of participants: numbers reported for some studies; total N not reported
	Study types: quantitative (19/23), qualitative (1/23), mixed methods (3/23)
	Study quality: not reported
	Main findings/themes • Positive outcomes: 11/20 programs had positive benefits including: prenatal nutrition + prenatal substance use; birth outcomes; access to care; breastfeeding; child dental health; nutrition; child development; exposure to Indigenous languages + traditions • Community investment: programs fostering community investment + ownership + active participation led to better outcomes
Author's Conclusions	11/20 programs showed benefits; Indigenous leadership + community ownership are fundamental to ensuring success for prenatal + early childhood programs; evaluations need to reflect *Indigenous* ideas of success
Canadian Programs **	• Aboriginal Head Start (Health Canada 2003, Ball 2005, Chalmers 2008) • Canada Prenatal Nutrition Program (Andersson 2003) • Healthy Foods North, Nunavik + Northwest Territories (Bains 2013) • Healthy Food Program, Nunavik, Quebec (Gagne 2013) • Infant Feeding Project (Verrall 2006) • Ka'nistenhser Teiakotisnie, Quebec + Ontario (Banks 2003) • Peer Counsellor Program, Manitoba (Martens 1999)

* Smylie is Métis + Wolfe is First Nations

** Canadian programs had to show both evidence of child benefit + Indigenous engagement (see Table 3)

Appendix 2: Detailed Review Descriptions (continued)

8. Zheng, Atchan, Hartz, Davis, Kurz (2023) *	
Goal	To identify ways to enhance breastfeeding rates in Aboriginal Australian + Torres Strait Islander populations
Methods	*Study design:* scoping narrative review; followed Briggs Institute guidelines
	Search strategy: used academic + grey literature databased to identify peer-reviewed + other/grey English-language articles published from 2010–2020
	Inclusion criteria: 1) participants were Aboriginal Australian or Torres Strait Islander mothers or mothers of Aboriginal Australian or Torres Strait Islander children; + 2) study/report assessed breastfeeding initiation or duration or breastfeeding programs/supports (derived from search strategy supplemental information)
	Quality assessment: not reported
Main Findings/ Themes	*Sample:* 11 studies (9 journal articles, 1 book, 1 conference summary), all from Australia
	Sample sizes/number of participants: sample sizes ranged from 8–3932; total N = 7321
	Study types: quantitative 5/11, qualitative 3/11, mixed methods 1/11
	Study quality: not reported
	Main findings/themes • Sources of support: 4/11 studies reported community support + knowledge as crucial, particularly inclusion of partners or family members in postnatal education; participants preferred Indigenous health workers who also understood systemic barriers such as overcrowded housing + interrupted intergenerational transmission of breastfeeding • Culturally-appropriate care: 5/11 studies emphasized importance of culture + culturally safe care in supporting breastfeeding • Social determinants: 4/11 studies noted determinants such as maternal age, education + geographic isolation as influences; older maternal age + higher education encouraged breastfeeding; rates also higher in rural + remote communities compared to cities • Intention to breastfeed: 3/11 studies reported that intention was positively associated with initiation
Authors' Conclusions	While colonization has interrupted traditional infant feeding practices, adding supports, ensuring culturally appropriate care, addressing social determinants + supporting intentions to breastfeed can help increase rates
Canadian Programs	No relevant programs noted

* Hartz is Aboriginal Australian