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Understanding and Improving Aboriginal Maternal and Child Health in Canada

Conversations about Promising Practices across Canada



ABOUT THE HEALTH COUNCIL OF CANADA

Created by the 2003 *First Ministers' Accord on Health Care Renewal*, the Health Council of Canada is an independent national agency that reports on the progress of health care renewal in Canada. The Council provides a system-wide perspective on health care reform in Canada, and disseminates information on best practices and innovation across the country. The Councillors are appointed by the participating provincial and territorial governments and the Government of Canada.

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“First Ministers recognize that addressing the serious challenges that face the health of Aboriginal Canadians will require dedicated effort. To this end, the federal government is committed to enhancing its funding and working collaboratively with other governments and Aboriginal peoples to meet the objectives set out in this Accord including the priorities established in the Health Reform Fund. Governments will work together to address the gap in health status between Aboriginal and non-Aboriginal Canadians through better integration of health services.”

2003 First Ministers' Accord on Health Care Renewal

PART 1

A commentary by the Health
Council of Canada

Introduction

The problems facing Aboriginal Peoples need little introduction. The information on disparities (opposite) is a stark reminder that many First Nations, Inuit, and Métis^a people have significantly worse health and more challenging living conditions than the larger Canadian population.

This cycle must be broken. In 2010, the Health Council of Canada began a multi-year project to learn more about the crisis in Aboriginal health, with a focus on programs or initiatives that have the potential to reduce unacceptable health disparities between Aboriginal and non-Aboriginal Canadians.

In the first year of this work, we set out to learn about the health care of expectant mothers and children from the prenatal stage to age six. It's well documented that better lifelong physical, mental, and spiritual health begins in childhood; this is the place to start.¹

The Aboriginal population in Canada currently has a much younger demographic than the non-Aboriginal population,² and a higher birth rate.³ In the last few years, a number of leading organizations have urged governments to focus their attention on this vulnerable population. In January and February of 2011, the Health Council held a series of seven regional meetings across Canada to learn what is making a difference in the health of Aboriginal mothers and young children. We invited front-line workers (mostly in health care), academics, and government representatives from a mix of urban and rural, northern and southern settings, and representing First Nations, Inuit and Métis communities. Many participants had not previously met, and were eager to learn about one another's work, the issues they face, and success stories.

Aboriginal disparities at a glance

While there is diversity among First Nations, Inuit, and Métis populations, there are significant overall health and economic disparities between the Aboriginal and non-Aboriginal Canadian population:

- Aboriginal people are much more likely to live in poor health and die prematurely.
- Aboriginal people have a higher burden of chronic conditions and of infectious disease.
- Aboriginal children are more likely to die in the first year of life.
- Aboriginal people are more likely to live in poverty, which has a domino effect on other aspects of their lives. They are more likely to go hungry, to suffer from poor nutrition and obesity, and to live in overcrowded, substandard housing.
- Aboriginal people are less likely to graduate from high school, and more likely to be unemployed.⁴

One 2007 study evaluated Canada's Aboriginal Peoples using the UN's Human Development Index, which looks at factors such as education levels, income, and life expectancy. Canada consistently appears on the Top 10 of the UN's list, but according to this study, Canada's Aboriginal Peoples would rank in 32nd place.⁵

More information about health disparities can be found in *Appendix B* on page 43.

a) Section 35 of Canada's *Constitution Act*, 1982 recognizes three distinct Aboriginal Peoples in Canada: First Nations (Indian), Inuit and Métis.

A large proportion of participants were front-line workers and program managers, who provided a real-world perspective on Aboriginal health. It is one thing to read an academic evaluation of a parenting program and another to hear a group of front-line providers talk about teaching it in their community: *It's great. It's easy to use. It works. I learned a lot myself and now I use it with my own kids.*

It's important to note that we had fewer Inuit and Métis representatives than we had hoped for at the sessions; the majority of participants were from First Nations communities. In addition, there were few participants from remote northern communities, which face additional challenges such as the general availability of health care, access to affordable, nutritious food, and the need to send women away to give birth. The interests and affiliations of the participants in our sessions understandably defined the types of issues they chose to discuss and the examples of successful programs they put forward.

This phase of the Health Council's work was not intended to be an academic project; it is not a comprehensive overview of all the issues affecting the health care of First Nations, Inuit, and Métis mothers and children, or of all the promising practices that exist. Our goal was to capture on-the-ground information about what's working from people in the field. A summary of all proceedings follows in the second part of this report, and an online compendium of promising practices is available at www.healthcouncilcanada.ca.

In this commentary, we offer a window into the experiences and insights of many people who provide care to Aboriginal women and their children. What they said complemented and sometimes questioned current thinking about the best way to approach Aboriginal maternal and child health issues across Canada.

It takes a healthy village to raise a healthy child: a holistic view of health

Many participants stressed that good-quality health care for expectant mothers and young children is not just prenatal care, delivery, postnatal care and checkups; it involves looking at the woman's life as a whole. As one participant said, *We don't just talk about the fact that she's having a baby. How's she doing at home? How's her mental health? What are her relationships like?*

It has been well documented that the circumstances of a person's life and the associated physical, mental, and emotional impact play a significant role in health.¹ Canadian governments have recently started to make these connections by developing policies that focus on issues such as poverty reduction,¹ but Aboriginal communities have always believed that health requires a focus on the bigger picture. A healthy life is seen as a balance between the physical, spiritual, emotional, and mental parts of ourselves.

The typical Western medical view tends to consider health issues in isolation, rather than looking at the cultural, family, and community context. This is significantly different from the Aboriginal world view. Participants said there can be a clash of values, with Western health care providers valuing credentials, and Aboriginal people valuing the wisdom of traditional knowledge.

Participants shared examples of some primary health care centres and women's or birthing centres that integrate the two approaches, although these types of centres are not as widespread as they could or should be. Several participants noted that hospitals still have a long way to go in developing cultural sensitivity towards Aboriginal people.

“People must understand the legacy of residential schools”

When asked to share the issues facing their communities and standing in the way of better maternal and child health, participants spoke frankly and with some frustration. Most of their comments were about the life circumstances of the mothers and children they see, rather than their health issues. Poverty was at the top of the list, defined in many ways: financial, emotional, and spiritual. Participants spoke about poor living conditions, overcrowding and a lack of housing, and a lack of affordable or easily available nutritious food—factors that have cascading effects on personal health and family relationships. Domestic violence towards women and children, lack of self-esteem, addictions, and fetal alcohol spectrum disorder (FASD) came up repeatedly.

We heard less than we had expected on some topics (there was very little discussion of well-documented health care issues among Aboriginal women and children, such as diabetes, low birth weights, or breastfeeding challenges) and more on broader issues affecting Aboriginal communities as a whole. In particular, we heard about the impact of the traumatic experience of colonization—the imposition of Western values and way of life—and residential schools.

In some of the sessions, participants expressed concern that many non-Aboriginal Canadians—including those who work in health care, child welfare services, and government offices—simply don’t understand or value the Aboriginal world view, and don’t understand how the multi-generational effects of the residential school experience have had an impact on the entire culture.

Many children who were abused and shamed for their Aboriginal heritage in these schools grew into adults who had difficulty forming healthy relationships with other people, including their own partners and children. These childhood experiences have created many lives and communities of poverty, mental health issues, addictions, and domestic violence.

Part of the focus of Aboriginal healing efforts is to help people understand their own experiences in the broader context—that the pain they have suffered and may have passed on to their families is the result of these experiences. The devastating effect of residential schools has been compared to post-traumatic stress disorder (PTSD) that affects a whole culture, not just individuals.^{6,7} *You must stress this in your report, said several participants. This is still in our minds and our souls and is being passed on through the generations. The healing is still going on.*

This message is not getting through to the broader Canadian public. Non-Aboriginal Canadians may have heard about problems in Aboriginal communities, but many still don’t understand why Aboriginal issues persist, or how communities can be supported. In a major 2010 survey of urban Canadians (the Urban Aboriginal Peoples Study), nearly half of non-Aboriginal respondents had never read or heard anything about residential schools⁸—despite the federal government’s landmark public apology in 2008 and the ongoing national process of reconciliation and healing that is meant to address these effects.

Many non-Aboriginal survey respondents also said they believe that Aboriginal people have the same or better socio-economic and other opportunities as any other Canadian⁸—despite data on lower high school graduation rates, worse health, reduced life expectancies, and an epidemic of poverty that has been described by the Assembly of First Nations as “the single greatest social justice issue in Canada today.”⁹

What's working?

This simple but focused question prompted wide-ranging discussions on a broad selection of programs, strategies, organizations, and policies that are making a difference in the lives of First Nations, Inuit, and Métis women and children. A list of promising practices put forward in each region begins on page 24, and a more detailed online compendium is available at www.healthcouncilcanada.ca.

Not surprisingly, strong collaboration and integration underpin many of the promising practices. An important characteristic of these programs or strategies is the quality of relationships involved—relationships of mutual understanding, trust, and respect among different governments, among government and non-government agencies, and among Aboriginal and non-Aboriginal partners.

Participants gave many examples of good working relationships at the program level, and a number of particularly notable examples involving federal, provincial, and First Nations partnerships. Two models put forward were the Tripartite First Nations Health Plan in British Columbia, and the tripartite Memorandum of Understanding (MOU) on First Nations Health and Well-Being in Saskatchewan.

There were also two strong examples of cross-government and cross-ministry collaboration focused on a common goal: both the Canada Northwest FASD Partnership and Alberta's FASD Cross-Ministry Committee are working to prevent fetal alcohol spectrum disorder (FASD) and to provide care and support to people living with the condition.

Participants in the regional sessions said that a history of paternalistic treatment and racism, coupled with a continued lack of understanding of the challenges faced by First Nations, Inuit, and Métis people, has created a sense of wariness among many Aboriginal mothers they serve. This can be a significant barrier to good health care. Women are afraid to seek out care because of fears of racism, or of being judged for their behaviour; they're afraid of the unknown, or of looking ignorant; and they're afraid that they might reveal something which will lead to their children being removed by child welfare authorities. Approximately one in five (22%) of substantiated child welfare investigations involve children of Aboriginal heritage.¹⁰ The most common form of child mistreatment in Aboriginal communities is not physical abuse but neglect, which is linked to family poverty.¹¹

Some positive changes are starting to happen in child welfare systems across the country to address these concerns, but many of the participants at our meetings were not yet seeing improvements. At several sessions, there was significant concern about the continuing lack of coordination between child welfare and health authorities. *When children go into care, they cut us off from assisting the child—so relationships have to be established all over again, and this is very hard on the child and family.*

Participants also discussed a number of government staff educational programs and health care training programs that are helping non-Aboriginal people to become more sensitive to Aboriginal issues and traditions. One example was the Indigenous Cultural Competency On-line Training Program, delivered by the Provincial Health Services Authority of British Columbia. At several sessions there were discussions about the value of Aboriginal-specific health centres such as Ottawa's Wabano Centre for Aboriginal Health, which provides not only health care services but social, economic, and cultural initiatives.

Stumbling over the system: funding, program criteria, and other challenges

It took some time for participants to move from discussing the problems to identifying solutions that are working. There were many conversations about burnout, both from working with families and trying to navigate the system. *A lot of times people are thrown into work with the families without the proper training. Money is thrown at you, but with no policies or procedures, you're just expected to figure it out.* Mental health is a "huge" issue, several participants said, but many front-line staff aren't trained to recognize or manage mental health issues.

At every session, participants talked about funding challenges. There is a shortage of stable, multi-year funding, and this affects the ability of Aboriginal communities to provide maternal and child health services comparable to those available to other Canadians. *It's like putting together a puzzle every day with all the programs and funders, trying to piece something together.*

At several sessions, participants also mentioned that integration and coordination among programs can be hindered because they need to compete for funding. There were many comments about the need for stable, long-term funding for programs and staffing, and for more flexible program criteria that would fit a community's unique needs. *There is often a gap between programs; families get dumped when they are no longer eligible for a program, and then there is nothing for them until the child reaches the criteria for the next program—and then they have to build all new relationships.*

Participants also commented on the frustration of dealing with ongoing jurisdictional issues between multiple levels of government (and their different programs), such as federal, provincial, territorial, or municipal governments, health authorities, and band councils. Funding policies can shift with political agendas and changes in government, resulting in the loss of support for promising programs and services. Participants said that governments initiate many great programs that are responsive to the needs of Aboriginal people and incorporate all the attributes of promising practices—but then funding ends and many of the gains that have been achieved are lost. Sometimes a program will be dropped, retooled, and brought back a few years later.

Several participants said they would like governments to recognize that it takes time to "grow" promising practices, and perhaps even a generation to see the evidence of success. They thought that regular data collection and evaluations, together with common goals, partnerships, and trusting relationships, would encourage governments to commit to long-term sustainable funding and support.

Participants recognized that a number of federal programs are making progress, such as the Canada Prenatal Nutrition Program, Maternal and Child Health program, and Aboriginal Head Start (see page 28), but they want to see these programs available to more Aboriginal people, more comprehensively funded, and easier to access by Aboriginal staff and communities who may lack the capacity or resources to write funding proposals. *I got less than half of the funding I applied for, which means I can't run the scope of the program I had planned. One community spent thousands of dollars on a grant writer to put together a successful proposal. I don't have that kind of money to pay someone to get the program. Can't they make funding proposals easier to understand and attain? They need to be written for communities, not in government jargon. And there should be some kind of government liaison to help—some of these small communities just don't speak the government language.*

While some front-line workers were interested in information about strategies that had worked for other programs or regions, others believed their own circumstances — particularly community, program, or government leadership — would make similar approaches difficult. Front-line workers frequently commented that their budgets didn't provide them with opportunities to attend conferences, and that the ability to meet others in the field and gain a broader perspective was the most valuable part of the Health Council regional sessions.

Culture is good medicine

Embedded in many success stories we heard was the importance of rebuilding what was stripped from Aboriginal Peoples, such as knowledge of their language and traditions, pride in their culture, and self-determination. Non-Aboriginal Canadians don't necessarily understand the importance of honouring Aboriginal practices and integrating them with modern health care or other services. One front-line provider described a common misunderstanding: *People don't see how Aboriginal needs for cultural understanding are different from the needs of the immigrant families in my program.*

Aboriginal Peoples and immigrant populations should not be compared. There is a long and painful history of efforts by past governments to deliberately eliminate Indigenous culture; one of the starkest reminders of this is the infamous statement that the intent of residential schools was to “kill the Indian in the child.”¹²

Rebuilding the cultural pride, traditions, and ownership of Aboriginal lives is not just a moral obligation. The Aboriginal Healing Foundation stated that rediscovering pride in one's culture and identity is good medicine.¹³ One landmark 2007 study concluded that communities that had taken active steps to preserve and rehabilitate their own cultures and languages had dramatically lower youth suicide rates — an important indicator of overall community health.¹⁴ One participant in a Health Council session compared the integration of mind, body and spirit to the three strands of a braid, a metaphor she uses to teach health care providers about the importance of seeing the full picture in Aboriginal health.¹⁵

Participants put forward many promising practices that integrate traditional approaches. One that was mentioned several times as an example in maternal and child health was the Six Nations Birthing Centre in Ontario. Aboriginal midwives provide a balance of traditional and contemporary midwifery services and programs, based on the philosophy that birth is serious, sacred, and carries a continued responsibility to the child. The Centre also provides midwifery training.

Participants discussed the struggle to return birthing to communities as one example of the importance of culturally sensitive care. There is currently an effort to return birthing to Aboriginal communities, particularly in the North. Pregnant Aboriginal women whose communities do not have birthing services — such as a midwife or other appropriate health professional — are sent away from their home communities, often weeks before giving birth, to another community where these services are available. They are separated from their families and support systems at this critical time, and when they return home with their babies, many smaller communities lack postnatal care services including breastfeeding support. A number of the promising practices discussed were about efforts to train Aboriginal midwives and to make birth and pre- and postnatal support more accessible in remote communities. One example of a major government initiative is Nunavut's Maternal and Newborn Health Care Strategy, which aims to return birthing to communities and to integrate modern medicine with traditional and culturally relevant practices. The Society of Obstetricians and Gynaecologists of Canada was also recognized for its work towards an Aboriginal Birthing Initiative for Canada. Further information is available at www.sogc.org/projects/birthing-strategy_e.asp.

Educating children *and* their parents

The importance of education came up repeatedly at every regional session — specifically the importance of prenatal education, support for new parents, and preschool programs for young children. Participants said that many of the new parents they see are teenagers who lack general life skills as well as knowledge about raising children and creating a home.

Participants shared anecdotal stories of the behaviour they see among young Aboriginal parents — “propping the bottle” was one example — which often stems from a lack of knowledge about child development and how to build a warm attachment to the baby. Parenting programs focus not just on skills, but on creating a loving bond. Increasingly, a number of the programs focus specifically on teaching young fathers how to be involved with their babies and be healthy role models. The importance of teaching good nutrition and life skills, such as cooking came up more than once. *The parents we see are 17, 18. Fries and fish sticks: that's what they think is a meal.*

Many parenting support programs and early childhood programs were put forward as promising or as already-recognized good practices. Some parenting support is offered at home; other programs are in primary health care centres or centres that offer a broader range of support, such as practical help to obtain housing and social benefits. Some offer specific services for pregnant women and new mothers who have drug and alcohol issues. A centre called Sheway, located in Vancouver's troubled Downtown Eastside, was held up as a model at several sessions for its work in supporting women with complex challenges. The Louise Dean Centre in Calgary, a school for pregnant and parenting teens, was also recognized for its comprehensive support for young parents.

Some words of praise for specific parenting programs and resources turned out to be informal endorsements of larger initiatives. As one example, a group of home visitors funded by the federal government's Maternal and Child Health program spoke with enthusiasm about the clear instructions and effectiveness of the parent training program they were given to use.

The early childhood intervention program Aboriginal Head Start was praised at several sessions, both for general child development and for teaching language and culture, but there was also some frustration that it wasn't more widely available. *My own granddaughter went through this program and is just flourishing. You can tell the difference in grade school between the kids who went to these programs and those who didn't. I tried to get more funding for this in our region and couldn't. If they are really trying to help us, this program should be made available to all First Nations children.*

Participants also spoke about the importance of early childhood education to set the stage for long-term success. Aboriginal people face many barriers to a good education — poverty in particular. The high school graduation rate is much lower than that of the larger Canadian population. This has a domino effect that goes beyond individual lives. Communities would like more Aboriginal maternal and child health care workers, but there is a lack of eligible candidates. Other issues are at play as well: a shortage of health care providers in rural and remote areas; a lack of training, education, and apprenticeship programs in communities; and a lack of specific programs to train Aboriginal people in particular. Participants did identify some promising programs — most commonly midwifery training programs for Aboriginal women and medical schools at some universities — but they added their caveats: *We need to support education at an earlier stage to have enough graduates for these post-secondary programs.*

Getting access to culturally sensitive care — or any health care at all

Participants had a great deal to say about this topic, starting with the barriers: There are problems with distance and transportation costs, and a shortage of trained health care workers. There are not enough midwives, not enough prenatal or postnatal care or general services (such as vision or dental care), and a lack of specialized services for children with special needs, such as physiotherapy or mental health support. There is also a lack of support to diagnose and treat fetal alcohol spectrum disorder (FASD), and a lack of consultation with Aboriginal communities when the programs are designed. These challenges are even more pronounced in northern and remote areas.

One theme that came up repeatedly was the need for improved and coordinated access to a team of health care professionals who would provide culturally sensitive care. A model discussed at several sessions was the Rocky Mountain House primary health care network. It works collaboratively with First Nations communities to develop programs and coordinate access to team-based, holistic, and culturally sensitive care, which has led to better prenatal outcomes and relationships.

Some front-line staff on First Nations reserves expressed frustration with the confusion and misunderstandings that can arise when accessing provincial resources. There were several discussions about Jordan's Principle, a child-first approach to resolving jurisdictional disputes about the care of First Nations children with complex medical needs. It was clear that jurisdictions are still at very different stages of implementing this approach.

Concluding comments

By the end of the seven regional sessions, participants had highlighted more than 100 programs, policies, organizations, and strategies that they believe are making improvements to the health of expectant Aboriginal mothers and young children.

On several occasions, participants discussed the fact that Prime Minister Stephen Harper is currently co-chair of a United Nations commission on maternal and child health in the developing world. Participants said they hoped this work would help to turn the spotlight onto Canadian issues, focusing the federal government's attention on Aboriginal mothers, their children, families, and communities. Though we did not start out with this in mind, it is fair to say that the Health Council endorses their perspective.

Two prominent messages came out of the regional sessions:

1. There is growing recognition that the living conditions and circumstances of people's lives have a tremendous impact on health, and that these factors, called the determinants of health, are complex and intertwined. Nowhere is this link between life circumstances and health more vividly apparent than in First Nations, Inuit, and Métis communities.

Participants put these broader issues on the table at the start of each regional session — factors such as poverty, addictions, family violence, self-esteem, and the underlying legacy of colonization and residential schools. They know that improving the health of the women and children they serve requires a broader approach than just the services they can offer.

There is no question that positive changes are happening in regions across the country thanks to the efforts of Aboriginal communities and leadership, providers, and governments, but these efforts are both tantalizing and frustrating to people in regions where change is moving more slowly: Why can't we have what they have? In the words of one participant, change often comes down to both "passion and leadership." This situation would be helped by improved funding, more flexible program criteria, and stronger collaboration between governments and Aboriginal leadership to support broader thinking on health and how to improve the determinants of health in Aboriginal communities.

In our December 2010 report, *Stepping It Up: Moving the Focus from Health Care in Canada to a Healthier Canada*, we learned that momentum is building across the country to take action on the determinants of health and reduce health disparities. Governments and health care leaders are beginning to recognize that they need to think differently and operate more collaboratively if they want to improve the health of Canadians; leaving the responsibility for health to one ministry, or one level of government, is not the answer. People told us these issues are being discussed with a new urgency. There is a real appetite for action. Given these factors, we believe there is a significant window of opportunity for the federal government to spearhead a new era of discussions with the provinces and territories and Aboriginal leadership about the best ways to improve Aboriginal health.

2. There are many programs and strategies that work to improve maternal and child health, but good programs often lack stable, multi-year funding, and/or don't have enough funding to meet the needs of the population they serve. Funding applications and arrangements are also too complex, limiting the opportunities for success and causing staff burnout.

These factors significantly affect the ability of Aboriginal communities to provide maternal and child health services comparable to those available to other Canadians. While many federal programs such as the Maternal and Child Health program, the Canada Prenatal Nutrition Program, and Aboriginal Head Start are making a difference, these programs are not available to all mothers and children who could benefit. There are still gaps in service in many Aboriginal communities. While positive change is happening on many fronts, progress across Aboriginal communities is very uneven. There are some highly successful communities but there are different levels of healing; a greater number of communities are still in a fragile state.

A focus on expanding programs that are clearly working to reach more mothers and children — and ensuring long-term, simplified funding arrangements — would be an effective way to improve the lives of Aboriginal children, their families, and communities. While governments are looking at the bigger picture of Aboriginal relations, we encourage them to build on existing successes in maternal and child health and ensure that front-line workers have the resources they need.

As part of this approach, evaluation of promising practices is critical. Most larger federal, provincial, and territorial programs have been evaluated, but few other promising practices have been through the process. Formal evaluations can be expensive and there is little dedicated funding for them, but a review of promising initiatives is needed in order to start an inventory of best and promising practices. Aboriginal communities and practitioners need this information to help them design effective maternal and child health programs. To support this, communities require capacity, funding, and training for evaluations.

In the government's 2008 apology to Aboriginal Peoples about residential schools, the prime minister said, "The burden of this experience has been on your shoulders for far too long. The burden is properly ours as a Government, and as a country."¹² From the Health Council's perspective, one meaningful way to turn these words into reality for Aboriginal families and communities is to provide more Aboriginal children with a better start in life.

If Canada's goal is to reduce the unacceptable health disparities between Aboriginal and non-Aboriginal Canadians, a concrete way of doing this is to expand programs that work and provide stable, multi-year funding.

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PART 2

What we heard: A summary of regional sessions across Canada

Introduction

While there are many organizations involved in exploring the gaps in health status between Aboriginal Peoples and the larger Canadian population, the Health Council of Canada is in a unique position. Our mandate from governments at the federal, provincial, and territorial levels allows us to report to a broad Canadian audience — not only about the realities of the health status in First Nations, Inuit, and Métis communities, but also about promising practices that are improving health and well-being and addressing inequities.

The Health Council has embarked on a multi-year project to understand the issues affecting the health status of Aboriginal populations in Canada^a and to inform Canadians about issues of concern. The goals of this project are:

1. to improve Canadians' understanding of the issues that underlie disparities in health status between Aboriginal Peoples and the larger population; and
2. to identify a body of practice that could be acknowledged as “promising” for advancing the health status of Aboriginal Peoples, in the broad sense of health, wellness, and community healing.

Recognizing that Canada contributes funds to a global initiative on maternal and child health and that the prime minister plays a role as co-chair of a United Nations accountability commission, the Health Council decided this was a fitting place to begin our exploration of health status issues among one of Canada's marginalized populations.

This section of the report summarizes what the Health Council heard at seven regional sessions across Canada about Aboriginal maternal and child health. To prepare for the sessions, we were guided by meetings with national Aboriginal leaders and informed by recommendations from our May 2010 scoping report, *Addressing the Challenges to Health and Well-being Faced by Aboriginal Peoples in Canada* (available on request). This scoping document helped the Health Council understand the critical need for the sharing of Aboriginal promising practices among all stakeholders, from government to front-line community staff, as well as the importance of evaluations of these practices.

The following definition of maternal and child health offered by Nunavut Tunngavik Inc. was selected by the Health Council: *Maternal and Child Health is used inclusively to describe the range of health care needs and services required by women during their childbearing years including sexual and reproductive health, prenatal, labor and delivery care, post-partum and healthy parenting, as well as the health needs of all infants and children under the age of six.*¹

a) Throughout this document, we refer to Aboriginal Peoples in accordance with the *Constitution Act*, 1982, Part II, Section 35.2: An Aboriginal person in Canada is a member of an Indian (First Nations), Métis, or Inuit community. Indian (First Nations) includes “Status,” “Treaty,” or “Registered” Indians as well as “Non-Status” and “Non-Treaty” Indians.

In addition, it is equally important to frame any discussion about maternal and child health within the context of the determinants of health that span all Aboriginal communities,^{2,3} as well as determinants that are specifically highlighted by First Nations, Inuit, or Métis Peoples.^{4,5,6} All of the Health Council's work applies this broad framework to understand the critical health issues facing First Nations, Inuit, and Métis Peoples.

Our approach to understanding promising practices and the engagement process for the regional sessions

The Health Council commissioned Stonecircle Consulting Inc., an Aboriginal-owned consulting firm, to organize, coordinate, and facilitate regional sessions to answer the question: *If Canada wants to improve the health status of Aboriginal children as one way to reduce disparities, what promising practices around maternal and child health need to be either advanced or developed?*

The purpose of the regional sessions was to hear from front-line workers, program managers and coordinators, Aboriginal leaders, academics, health authorities, and federal, provincial, territorial, and municipal government representatives about maternal and child health realities “on the ground.” As well, we aimed to be inclusive in our sessions of on/off-reserve, urban, and status and non-status Aboriginal people.

It was not our intent to gather a complete national inventory of promising practices. Readers who work in the field will notice omissions. What we did capture at the sessions and in this document are selected front-line accounts of programs and strategies that are working to improve Aboriginal maternal and child health. The issues and initiatives that our participants chose to put forward are a reflection of their particular affiliations and experience.

Defining promising practices

The term *promising practice* can be defined many ways. For this project, we defined it as a model, approach, technique, or initiative that is based on Aboriginal experiences, that resonates with users of the practice, and results in positive changes in people's lives.⁷ A promising practice has the following attributes:

- is acknowledged to positively advance Aboriginal health status;
- is inclusive of the interests and experiences of many;
- is valued and supported by relevant stakeholders;
- may be well known and/or has a history of success;
- is adaptive, recognizing the importance of community context for successful implementation; and
- ideally is evaluated.

With this definition in mind, three questions guided the regional sessions:

- What's working and making a difference in this area?
- What programs and initiatives have you heard about elsewhere that you wish you had?
- How can the information collected about the promising practices be shared across the country in an accessible and useful manner?

Our research also identified five themes under which the practices could be grouped for purposes of discussion (recognizing that there may be elements of more than one theme in any promising practice):

1. Traditional knowledge and cultural approaches

Revitalization and incorporation of traditional knowledge, culture, or use of languages in maternal and child health programs and services; could include programs that address “wellness” as opposed to “illness” and are holistic (emotional, spiritual, physical, mental, intellectual) approaches.

2. Community-based and community-focused approaches

Programs, services, and approaches that are developed at the community level; or large-scale federal, provincial, territorial, or regional programs that are adapted at the community level.

3. Collaboration and integration

Bringing together, working together, combining funding— or other collaborative approaches between Aboriginal maternal and child health programs and services, or linking with other community programs and services (housing, employment, social services).

4. Training and human resources

Successful ways of recruiting, training, and retaining Aboriginal people who work with and support First Nations, Inuit, Métis mothers and children. This topic can also include successful ways that non-Aboriginal organizations and health practitioners are trained, recruited, or work in Aboriginal maternal and child health (cultural competency, cultural safety).

5. Policy and funding

Broad policies or funding programs at the federal, provincial, territorial, or Aboriginal government level that have improved Aboriginal maternal and child health; something that could be seen as a model or promising approach.

TABLE 1
Regional Locations

CITY	SESSION DATE	LOCAL HOST
Ottawa, ON	January 20, 2011	Wabano Centre for Aboriginal Health
Halifax, NS	January 21, 2011	Eskasoni Community Health Centre
Calgary, AB	January 28, 2011	Elbow River Healing Lodge
Winnipeg, MB	February 14, 2011	Prairie Women’s Centre of Excellence
Vancouver, BC	February 16, 2011	First Nations Health Council
Whitehorse, YK	February 18, 2011	Ta’an Kwach’an Council
Toronto, ON	February 28, 2011	Native Canadian Centre of Toronto

Seven locations across the country were chosen based on five criteria:

- accessibility for First Nations, Inuit, and Métis participants;
- accessibility to urban, rural, and remote Aboriginal populations;
- geographic regions of Canada;
- travel gateways; and
- availability of local host organizations — the Health Council engaged local Aboriginal organizations to co-host the sessions.

The regional meetings featured plenary and small group sessions focusing on critical issues in Aboriginal maternal and child health and promising practices, which were grouped under the five theme areas. While it is true that there are many serious issues that need to be addressed, the participants were also eager to speak about practices that were working. Positive change is happening on many fronts. After identifying the promising practices, participants discussed any patterns that emerged, and who had a role to play in the sustainability of the practices. Each regional session concluded with a plenary discussion about options for a resource toolkit to share information about the practices in a way that would be accessible and useful for workers at various levels in Aboriginal maternal and child health care. Participants responded with a diverse range of ideas.

This proceedings summary includes a review and analysis of the conversations that took place at all seven regional sessions. Individual proceedings reports were prepared for each of the seven sessions, and these are available on request. In response to participants' suggestions that a resource toolkit be produced from the sessions, the Health Council has prepared an online compendium that includes descriptions of the promising practices, along with contact information. It is available on the Health Council's website at www.healthcouncilcanada.ca.

The Health Council of Canada thanks all participants, local host organizations, and elders who participated in these sessions and extends gratitude to them for taking the time to share knowledge, experience, and recommendations. These sessions validated many of the Health Council's learnings from its scoping document. There is a critical need for participatory evaluation and for the sharing of promising practices among the community of practice. Indeed, we heard from participants in their evaluations that attending these sessions gave them an important across-the-country opportunity to network, discuss, and learn about promising practices in other jurisdictions and different settings.

Setting the context: critical issues affecting Aboriginal maternal and child health

While promising practices were the focus of these regional sessions, many Aboriginal people in Canada continue to live in dire circumstances and the participants described these in some detail, before discussing what was working. The summary of critical issues in this section illustrates the urgent need to ensure the development and expansion of promising practices in maternal and child health programming and service delivery. Selected demographic and health indicator information in *Appendix B* speaks further to these issues.

Key themes from the regional sessions

The participants in all sessions identified and discussed critical issues affecting Aboriginal maternal and child health in their regions. Their key points are summarized here:

Determinants of health

Health and well-being issues were seen as circumstances related to and intertwined with the determinants of health, which were identified as key factors in the lives of Aboriginal mothers and children. Poverty is extreme and participants discussed how it is experienced on many levels—emotional, monetary, and spiritual. Poor living conditions, overcrowding and lack of housing, poor-quality drinking water, and lack of food security have cascading effects on personal health and family relationships. These issues are much

worse in northern and remote regions, with a lack of affordable access to nutritious food and quality housing (no available units, overcrowding, mould) as significant problems. Aboriginal people also face many barriers to attaining a good education. This in turn blocks children from moving out of dire life circumstances, not to mention gaining access to health science careers, which limits the pool of Aboriginal people who can become health providers.

Colonialism, racism, and residential schools have had long-lasting impacts on many areas of people's lives. This has resulted in intergenerational trauma that perpetuates a wide range of health problems. For instance, individuals were separated from their communities, their families, their culture and one another. As children were taken from their homes to residential schools, parenting skills were not nurtured and family connections were severed. The fallout of this can be seen today in the form of low self-esteem, abuse, family violence, addictions, poor relationship and conflict resolution skills, high rates of single motherhood and teen pregnancy, mental health issues, lack of cultural knowledge, and a plethora of chronic health conditions.

Lack of self-care knowledge and a fear of seeking help

Linked to the effects of colonialism, racism, and residential schools, participants discussed how clients lacked knowledge about how to care for themselves and their families. This included a lack of understanding and awareness about a range of health-related issues such as mental health, birth control, family planning, and harm-reduction approaches. They said the situation was complicated by apathy or a resistance to new programs, based on the belief that nothing would help. They stressed that this was a multi-faceted problem with many complexities. There is fear of racism and being judged, combined with guilt and shame for one's circumstances. This situation results in an unwillingness to disclose information and therefore to seek help. Ultimately, there is a lack of trust in services and in the system, in particular of the child welfare authorities, where fear that their children will be apprehended prevents mothers and families from seeking help.

Parenting knowledge, skills, and support

The need for parenting knowledge, skills, and support, particularly for young parents, was a recurring theme. The example of fetal alcohol spectrum disorder (FASD)^b illustrates this complicated issue. Some parents themselves have FASD or drug and alcohol addictions, which limit their ability to manage their lives or the lives of their children. They need case management and system navigation support to help them access care and services (such as education or health) and to make life decisions. This long-term, intensive support is needed to break the intergenerational effects of colonialism, residential schools, and racism. In general participants highlighted the need for improved understanding of, and support for, child development, specifically attachment and bonding, general literacy and financial planning skills.

Lack of access to culturally relevant care

There are two sides to this issue. On one side, communities that want to provide culturally appropriate care struggle due to a lack of Aboriginal maternal and child health care workers. This is complicated by a systemic shortage of health providers, a lack of Aboriginal health human resource training programs, and a lack of training, education, and apprenticeship programs in communities. On the other side, there is (in some areas) a lack of understanding about the diversity among First Nations, Inuit, and Métis people. Non-Aboriginal health practitioners have, in some cases, shown discrimination or ignorance of Aboriginal cultures, realities, and challenges. There is not enough emphasis on the importance of cultural practices or enough acceptance or integration of traditional teachers/elders and their wisdom and experience into the health care system. This has led to health care services that are often not culturally relevant or sensitive.

Participants discussed the struggle to return birthing to communities as one illustration of this lack of cultural awareness. Pregnant Aboriginal women are routinely sent out of their home communities, often weeks before giving birth, to have their babies in unfamiliar settings, separated from their family and cultural support systems.

^b Fetal Alcohol Spectrum Disorder (FASD) is a disability resulting from prenatal exposure to alcohol. It is an "umbrella term increasingly used to describe the spectrum of disabilities (and diagnoses) associated with prenatal exposure to alcohol. FASD is not itself a diagnostic term: rather, the diagnoses under the FASD umbrella include Fetal Alcohol Syndrome (FAS); partial FAS (pFAS); Alcohol-Related Neuro-developmental Disorder (ARND); and, Alcohol-Related Birth Defects (ARBD).⁸"

Health care system access, integration, and coordination

Participants described a number of factors that play a role in limiting access to health care. These factors include geography, transportation costs, a lack of integration and coordination of community programs and services, and a lack of access to culturally safe and appropriate care. There is also a shortage of primary health care providers, community midwifery, and prenatal/postnatal care. Participants noted a lack of specialized services, such as support for children with special needs, physiotherapy, health promotion, mental health and addictions services (including alcohol and smoking cessation), sexual health services, hearing and vision screening, and dental care. The situation is further complicated and more severe in northern and remote areas.

Funding

There are instances of longer-term funding agreements (e.g. five-year) between the federal government and some Aboriginal groups, allowing for stable funding of some services. Generally speaking, though, participants said that a shortage of multi-year agreements with adequate and stable funding is a persistent problem that affects the ability of Aboriginal communities to provide health care services comparable to those available

to other Canadians. There are many facets to the funding issue — funding models are complicated, disjointed, short-term, and reactive. Funding policies lack a focus on prevention and community health. They do not recognize traditional grassroots approaches as legitimate, yet it is these approaches that are often the key factor in the success of programs aimed at improving maternal and child health. Small short-term grants result in disjointed programs, piecemeal approaches, and lack of continuity — a funding approach that falls short of addressing complex problems and therefore hinders the ability to make lasting changes over time. Funding policies often shift with political agendas and changes in government, resulting in the loss of promising programs and services, sometimes before they have been evaluated or have demonstrated their effect. In the sessions, there was recognition and agreement that promising practices require time to “grow.” Governments initiate many great programs that are responsive to the needs of Aboriginal people and incorporate all the attributes of promising practices — then funding ends and many of the gains that have been achieved are minimized if not lost. Funding for First Nations is not available to Métis and some funding for Inuit is administered differently by different territories and provinces. This leads to inequity. Finally, funding programs and priorities are often driven by top-down agendas that do not reflect Aboriginal needs, when what is needed is support for programs that have been identified at the community level as beneficial.

Funding is a challenging area that is related to the governance, infrastructure, and accountability issues outlined below.

Governance, infrastructure, and accountability

Aboriginal maternal and child health concerns become mired in ongoing jurisdictional debates and processes among governments (federal, provincial, territorial, municipal, Aboriginal), health authorities, and band councils. Services and programs are often fragmented and delivered in restrictive silos. Program criteria differ across governments and may not meet a community's needs, resulting in gaps in service. Even federal programs that do address some of the gaps and are shown to be effective (e.g. Canada Prenatal Nutrition Program, Aboriginal Head Start, and Maternal and Child Health) are not offered in all Aboriginal communities. Participants described this as a piecemeal approach to funding without long-term plans, accountability infrastructures, or evaluation strategies and frameworks that are participatory and community-driven. Participants expressed frustration that this lack of coordination and integration has “set them up for failure.”

Health human resources

Recruitment and retention of front-line workers is difficult, particularly in smaller communities. The high-stress nature of these positions leads to high turnover. Smaller communities cannot afford to hire full-time permanent staff, and so must fill positions with individuals who are not properly trained or lack the required skills. No additional program funds are provided for professional development or upgrading staff skills. Community nursing staff often do not have specialized training in maternal and child health. Moreover, people without professional training or paraprofessionals are sometimes recruited to fill gaps in care; these individuals lack not only the cultural and healing training but the health care-related training that is necessary to work in complex social and cultural environments.

What participants said about the promising practices

Positive changes and innovation are taking place on many fronts in the areas of services, programs, and policies.

In this section, common features of promising practices are highlighted, along with selected examples from across Canada that show how and why they are successful. A grid with the full list of promising practices by regional session and theme is included in *Appendix A*. Descriptions and contact information can be found in an online compendium on the Health Council's website.

Common features of promising practices

Holistic approach

A holistic approach is vital to Aboriginal maternal and child health. The physical, mental, social, spiritual, and emotional components of health are inseparable. Aboriginal mothers and children cannot be considered in isolation; they are part of a larger family unit and a network of relationships in their community. The entire community — a healthy community — must be involved in connecting and supporting mothers and children, including fathers, elders, youth, aunts, uncles, grandmothers, grandfathers, friends, neighbours, and the political leadership.

Wellness, not illness

Related to a holistic approach is the need to shift from a focus on treating illnesses to creating wellness — wellness of the person, the family, and the community, which involves a shift from linear biomedical thinking to interactions and relationships. Successful practices bring people together; increase community connections; improve knowledge and access to healthy alternatives and lifestyles; incorporate traditional ceremonies, language, and knowledge; and treat birthing as a celebration, not a sickness that must be managed by health professionals. The reality is that prevention and health promotion programs are often the first to be eliminated when governments make difficult budget decisions, or they are incorporated as an afterthought after core medical services have been established.^c

Traditional knowledge and cultural practices

Traditional knowledge and cultural practices play a fundamental role in rebuilding and strengthening the Aboriginal spirit, thereby addressing health-related problems, such as chronic disease, addiction, and violence, which arise from a broken spirit, mind, and body. It is critical that traditional knowledge and cultural practices be incorporated into health care delivery and be considered a fundamental component of early intervention and education strategies for young children, as well as parenting education programs. To authentically incorporate traditional practices, it is not enough to layer a veneer of traditional knowledge over a mainstream Western medicine approach. As participants told the Health Council: *Communities need to own [their] knowledge, validate it on [their] own terms and then share it with Western approaches to health — this is the foundation.*

c) While the issue of evaluation of prevention and health promotion programs and services is a complicated one that would have an impact on decision-making to eliminate programs and services, this topic was not discussed at the sessions.

Selected examples of promising practices across Canada

Six Nations of the Grand River – Tsi Non:we Ionnakeratstha Ona:grahsta’ Maternal and Child Centre, Ontario helps Aboriginal women give birth to healthy babies and promotes the seriousness, sacredness and the continued responsibility of giving birth. The Centre provides a continuum of traditional and contemporary services and programs, including an Aboriginal Midwifery Training Program.

Inuulitsivik C.L.S.C Maternities, Nunavik region, Quebec is a model for culturally relevant, traditional knowledge-based maternal and child health. This program in the Inuit region of Nunavik (one of four Inuit regions in Canada) brings birthing and midwifery training close to home or directly into the community — respecting the Inuit belief system and building community capacity. Culture and community connectedness are embedded in the practice.

It was highlighted as a best practice in a paper prepared for the Royal Commission on Aboriginal Peoples more than 15 years ago.

Sheway, British Columbia is a partnership initiative that brings together government and the community to provide comprehensive health and social services, including outreach to a vulnerable population with highly complex needs. Holistic care is based on a determinants of health framework and is provided in a collaborative and respectful manner.

Grassroots Grandmothers Circle, Nova Scotia. The Mi’kmaki Nugumijk are L’nu grassroots grandmothers. Based on the Seven Sacred Teachings, grandmothers provide guidance and advice for parents, advocate for communities, strengthen traditions, empower families, and instill pride.

Language Nest Inuagguait Program, Nunatsiavut region, Newfoundland and Labrador is a language immersion program for babies and toddlers for the revitalization of the Inuktitut language. Based in Hopedale (in the Inuit region

of Nunatsiavut), it provides a sense of pride, and encourages language revitalization and respect for tradition and culture.

Ahp-cii-uk Aboriginal Leadership Initiative, British Columbia means “going the right way” in the Nuu-chah-nulth language and is an innovative BC-based approach to First Nations economic and social community development. Capacity building and community driven, the initiative has many projects underway including rebuilding a trail and developing a multi-use lodge, a spiritual healing centre, and an art market.

The Rocky Mountain Primary Care Network (PCN), Alberta works collaboratively with the Sunchild and O’Chiese First Nations to develop programs and coordinate access to a continuum of team-based, holistic, and culturally sensitive care, resulting in improved prenatal outcomes and relationships.

An authentic approach involves recognition and acceptance of traditional practices and knowledge, and respect for their credibility; recognition and acknowledgement of diversity among Aboriginal people; language revitalization and inclusion in early childhood development and parenting programs; ensuring that parents and children are connected to and can learn from elders and their communities; programs that are community driven and owned; training more Aboriginal health care providers; and training non-Aboriginal providers to ensure cultural competency that moves beyond awareness into implementation and ensures access to equitable care.

Cultural sensitivity and safety in care training and delivery

Cultural sensitivity is an important component of all health professional training and service delivery and should be supported by policies, guidelines, and a range of methods for delivering programs/care in a culturally safe manner. Programs and services

should be client-centred, at times client-driven, and be delivered through a participatory approach.

Coordinated access to a team of multidisciplinary front-line professionals

Some leading promising practices offer a model of care that addresses the determinants of health, and provides culturally sensitive and holistic care.

Community ownership and determination

Communities need to own their own health programs and processes. Policies and programs that “come down from on high” may lack cultural sensitivity, as well as an understanding of the realities in communities, and what will work in the context of a particular community. Governments have an obligation to provide funding, but communities must be allowed to determine how to design and deliver the programs, including evaluation and accountability mechanisms.

<p>Southwest Ontario Aboriginal Access Centre is a primary health care facility that provides holistic care by promoting Western and traditional care that supports the determinants of health. It is community based and community driven, and receives support from the federal Maternal and Child Health program.</p> <p>The Aboriginal Prenatal Wellness Program: Wetaskiwin’s Community-based Program, Alberta offers care in close proximity to several reserves. Non-Aboriginal providers understand and respect how Aboriginal people interpret and experience illness; they respect and acknowledge the socio-economic circumstances and develop a full continuum of care working in close collaboration with community leaders, resulting in improved prenatal outcomes and relationships.</p> <p>Nova Scotia: Through the provincially mandated Mi’kmaq Family and Children’s Services of Nova Scotia, a province-wide process has been established to ensure that First Nations children receive the same services available to other children in Nova Scotia in similar geographic locales.</p>	<p>The process provides a mechanism for dispute resolution in addressing children’s needs, including special medical requirements.</p> <p>Regina Qu’Appelle Health Region’s Eagle Moon Health Office (EMHO), Saskatchewan takes a holistic approach to health, understanding that complete health encompasses mental, physical, emotional, and spiritual well-being. The Eagle Moon Health Office brings First Nations and Métis community members together with health workers to collaborate and work toward meeting the holistic health needs of the population. The EMHO has been recognized as a “framework” to be considered by the Regional Health Authorities in the province.</p> <p>The Nunavut Maternal and Newborn Health Care Strategy of the Department of Health and Social Services is designed to guide the development of care options and the delivery of services in a way that integrates modern medicine with traditional and culturally relevant practices.</p>	<p>Canada Northwest Fetal Alcohol Spectrum Disorder Partnership (CNFASDP) is an alliance of seven jurisdictions (four Western provinces and three territories) that is working towards the development and promotion of an interprovincial, territorial approach to prevention, intervention, care, and support of individuals affected by FASD. It is recognized as a successful model of cross-governmental collaboration.</p> <p>Strengthening Families Maternal and Child Health Program (SF-MCH), Manitoba is a partnership co-management model and a province-wide, family-focused home visiting program for pregnant women, fathers, and families of infants and young children from 0-6 years of age. The Assembly of Manitoba Chiefs (AMC) and First Nations Inuit Health (FNIH) have agreed on a co-management structure with FNIH providing the administration and funding directly to the communities, and AMC providing the regional support to the pilot sites, with the First Nations Advisory Committee overseeing the overall implementation of the program.</p>
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Successful practices are based on Aboriginal ownership of the service and the development of local programs that address each community's distinct needs. A key component is ensuring that women play a central role in defining and participating in their care. This being said, the next three points on collaboration and integration, stable funding, and alignment of federal, provincial, territorial, and regional policies, together with communities, are integrally related to this feature.

Collaboration and integration

Maternal and child health should be a shared responsibility that is acknowledged and supported by policies and guidelines. On an informal level—and often in the absence of formal collaboration and integration mechanisms—local programs are successful because of informal relationships among providers who pool resources and support one another in a variety of ways. An important characteristic of collaboration and integration is the relationship building, mutual understanding,

and respect that develops between Aboriginal and non-Aboriginal partners.

On a formal level, programs are successful because diverse people come together and form partnerships among levels of government and government departments, together with community-level organizations, First Nations, Inuit, and Métis governments and organizations, health care providers, and others are key. When this happens, there is positive change.

Alignment of federal, provincial, territorial, and regional governments, together with Aboriginal leadership and communities

When practices work well, it is because they are not constrained by jurisdiction; they are sustainable with secure funding and are community-owned and driven. All levels of government work towards common goals and in partnership with communities.

Selected examples of promising practices across Canada

Seventh Generation Midwives, Ontario is an urban collective of Aboriginal midwives in Toronto, working directly with clients and a range of partners including hospitals, universities, research centres, and community health organizations. Services assist pregnant women and recent mothers with holistic and culturally sensitive maternity care from conception to six weeks post delivery. Everyone involved benefits: clients and their families, the community, medical students, hospital staff, and providers.

Healthy Beginnings, Supportive Communities: A Strong Future Métis Maternal and Child Health DVD developed by the Métis Centre at the National Aboriginal Health Organization, is based on extensive consultations with Métis parents, elders, midwives, and other maternal care providers. Themes discussed

in the DVD include cultural continuity, birthing options, historical birthing practices, breastfeeding, self-care for pregnant women, and the role of community in raising children.

Sioux Lookout Meno Ya Win Health Centre, Ontario is a fully accredited acute care and extended care facility. Governed by Aboriginal and non-Aboriginal people, it is an example of how federal, provincial, and Aboriginal health authorities can come together to provide a full range of hospital and community outreach services.

Memorandum of Understanding (MOU) on First Nations Health and Well-Being in Saskatchewan. The Federation of Saskatchewan Indian Nations (FSIN) Tripartite MOU is an agreement between the federal and provincial governments and FSIN to improve the delivery of health services by reducing duplication, closing gaps, and improving the coordination and efficacy of the health care system. The agreement includes a 10-year health and wellness plan and represents an opportunity to improve health.

First Nations Health Council, British Columbia. A Tripartite Aboriginal Maternal and Child Health Committee, which includes representatives from First Nations, Inuit and Métis communities and the federal and provincial health systems, was established in 2008 to lead the implementation of maternal and child health actions. Key priorities include a Safe Sleep Initiative for Aboriginal communities; early childhood screening programs for newborn hearing, vision, and dental care, offered in schools and on reserve; and an Aboriginal doula initiative, which involves providing non-medical and non-midwifery services (physical and emotional) to women, leading up to and during labour and delivery.

New Brunswick Community Health Centres are a network of centres focused on outcome and evidence-based practice. They were praised for this outcome or goal-oriented focus (rather than being task focused), which is seen as being very important for supporting a population-health promotion approach and a community-driven model.

Stable funding

Long-term, multi-year, stable, and adequate levels of funding support successful, sustainable Aboriginal maternal and child health programming.

Evidence and accountability

Outcome-focused programs need to be based on knowledge of what works (i.e. desired outcomes), which comes in part from participatory evaluation. Results of evaluations can be used to respond to accountability requirements of funders, but also as a tool for the community to strengthen and adapt their programs based on evidence.

Participants said there needs to be a commitment to support emerging promising practices. Governments initiate many programs that are designed to be responsive to the needs of Aboriginal people and incorporate all the attributes of promising practices—then funding ends and many of the gains that have been achieved are minimized if not lost. Recognition and agreement is needed that it takes time to “grow” promising

practices and perhaps even a generation to see the evidence of success. Regular data collection and evaluations, together with common goals, partnerships, and trusting relationships should go a long way towards encouraging governments to commit to long-term sustainable funding and support.

Supportive education and training

Successful initiatives ensure that Aboriginal children have access to educational systems and an opportunity to thrive in them, beginning with early childhood education and continuing throughout the cycle with social, emotional, and economic support. Other characteristics of successful initiatives include amendments to training processes that are respectful of and incorporate traditional knowledge and practices, the delivery of training in accessible ways, and acknowledgement of the life experiences of students.

The Mi'kmaq (Aboriginal) Health Policy Framework, Nova Scotia, currently in development, was funded by the Aboriginal Health Transition Fund (AHTF) until March 31, 2011. It is an initiative to improve access to provincial, publicly funded health care programs and services for all Aboriginal people in Nova Scotia as insured residents, while respecting the special constitutional relationship between the province and Aboriginal people in the context of a complex, inter-related federal/provincial/First Nations health system.

Louise Dean Centre, Alberta is a partnership between the Calgary Board of Education, Catholic Family Services, and Alberta Health Services. As a community-based intervention and prevention program for pregnant and parenting youth, the focus is on a comprehensive social, health, and educational program. Based on a determinants of health model and the provision of holistic care, it is recognized as a good example of collaboration among organizations and governments working towards a common goal.

National Collaborating Centre for Aboriginal Health supports the advancement of Aboriginal public health goals and reduction of inequities with groundbreaking research and knowledge development and translation.

Early Development Instrument (EDI), Manitoba is a tool for measuring school readiness at the kindergarten level. It helps communities identify strengths and target needs so they can better plan programming. It is well recognized internationally and used in Australia with Indigenous populations. It currently does not involve all First Nations communities but is seen as an important tool.

Métis Centre Health Literature and Statistical Databases, the Métis Centre at the National Aboriginal Health Organization (NAHO) developed two databases in 2009. The first database, developed in collaboration with Statistics Canada, contains hundreds of statistical tables and graphs generated from the 2006 Aboriginal Peoples Survey. It is user-friendly and searchable by keyword. The second database is a searchable catalogue of peer-reviewed and grey literature on Métis health published over the last 30 years.

Northwest Territories Aurora College (Yellowknife) Nursing Program is part of a community-based college system in the NWT that is providing culturally relevant training and educational opportunities for Aboriginal students in rural and remote communities.

Behavioural Health Aide Training Program, Nunatsiavut region, Newfoundland and Labrador is a training program for Labrador Innu and Inuit communities to provide standardized skill development in the area of FASD. The program is culturally relevant to both the Innu (a First Nations group) and the people of the Nunatsiavut Inuit region. It is an ongoing collaborative effort among multiple partners including the Labrador-Grenfell Regional Health Authority, the Mushuau Innu First Nation, the Sheshatshiu Innu First Nation, the Labrador School Board District and the Nunatsiavut Department of Health.

What participants said about who has a role to play

Participants stressed that there must be shared responsibility. Governments have an important role to play by providing long-term/multi-year sustainable funding, governance, and accountability frameworks, but the initiatives themselves need to be community-owned and driven. Governments are not responsible for fixing the system alone.

Who is responsible for health care for Aboriginal peoples?

Health Canada provides the following breakdown of responsibilities:

“The federal government provides health promotion programs and public health services on First Nations reserves and in identified Inuit communities. In remote and isolated areas, where

provincially or territorially insured services are not readily available, the Government of Canada provides on-reserve primary and emergency care services.

Non-Insured Health Benefits are also provided to approximately 749,000 eligible First Nations and Inuit people. Coverage includes a specified range of medical goods and services (such as prescription drugs, vision care, dental services, medical supplies and equipment, and medical transportation) when these benefits are not provided through private or provincial/territorial health insurance plans.

Best practices in federal programming

Federal programming for Aboriginal maternal and child health falls largely under the First Nations and Inuit Health Branch (FNIHB) and the Public Health Agency of Canada (PHAC). Three well-established, evidence-based federal programs were mentioned at the Health Council's regional sessions as having a strong, positive impact on the lives of Aboriginal women and children in their communities. These programs are outlined separately because they are well-established best practices.

The Canada Prenatal Nutrition Program (CPNP)

The Canada Prenatal and Nutrition Program, a broad-based funding program that is locally implemented and community-based, is delivered through the Public Health Agency of Canada (PHAC).

For more than ten years, CPNP has helped communities to promote public health and provide support to improve the health and well-being of pregnant women, new mothers and babies facing challenging life circumstances.

The goal is to improve maternal and infant nutritional health. Program clients include pregnant First Nations and Inuit women, mothers of infants, and infants up to 12 months of age who live on reserve or in Inuit communities, particularly those identified as high risk. It also includes First Nations and Inuit women of childbearing age on reserve and in Inuit communities.

There are currently 330 CPNP sites serving close to 50,000 women in over 2,000 communities across Canada each year. In addition, a separate stream of the program administered through Health Canada serves Inuit and First Nation women living on reserve.

CPNP fills a distinct gap in communities. Almost all sites (98 percent) report that they provide a unique service in their community. Many of the other

available prenatal services do not meet the needs of the CPNP target population.⁹

Aboriginal Head Start

There are two types of Aboriginal Head Start programs in Canada, which started in the 1990s: Aboriginal Head Start On Reserve (AHSOR) for First Nations children on reserve, and Aboriginal Head Start in Urban and Northern Communities (AHSUNC) for First Nations, Inuit, and Métis children living in urban and northern communities.

Whether on or off reserve, Aboriginal Head Start programs aim to provide Aboriginal children with a positive sense of themselves and a desire for learning. These early intervention programs support the spiritual, emotional, intellectual and physical development of Aboriginal children, while also supporting their parents and guardians as their primary teachers. They address general health concerns in vulnerable populations and work to benefit the health, well-being, and social development of Aboriginal children.

Provincial governments provide universal insured health services to all citizens, including all Aboriginal people. First Nations and Inuit access health services provided by the provincial or territorial government (notably physician or hospital care), like any other resident.

In the Territories, the federal government has mostly devolved health services to the territorial governments, with the exception of some health promotion and disease prevention programs among First Nations and Inuit.”¹⁰

Participants emphasized the following points:

- Ideally, federal, provincial, and territorial governments have a role in policy development, leveraging initiatives with funding, partnerships, knowledge dissemination, and education. Together they support community development and capacity building, ensure cultural competence, and align goals across the different levels of government(s).

- The role of service providers involves networking, collaboration, project management, resource development, needs assessment, partnerships, service delivery, training, data collection, and ensuring cultural competence.
- The role of communities is to advocate, to be a voice for the community, lobby (governments etc.), support families’ relationship building, show leadership, provide role models/mentors for families, interface traditional ways with mainstream modern systems, and to be an active and equal player in the development of programs and services.

Aboriginal Head Start programming is centered around six components: education, health promotion, culture and language, nutrition, social support, and parental/family involvement.

Aboriginal Head Start On Reserve is part of four community-based programs (Maternal and Child Health, Canada Prenatal Nutrition Program-First Nations and Inuit Component, and the Fetal Alcohol Spectrum Disorder Program) aimed at improving the health status of First Nations and Inuit individuals, families and communities. The Cluster Evaluation Report, which includes the AHSOR program, was completed in 2009-10.¹¹

The Aboriginal Head Start in Urban and Northern Communities Program is a community-based program delivered by the Public Health Agency of Canada. Over the past 15 years it has demonstrated that locally controlled

and designed early intervention strategies can improve the health of Aboriginal children by supporting their physical, personal and social development.¹²

Maternal and Child Health (MCH)
Maternal and Child Health (MCH) is a national program that is delivered through partnerships and builds on other community programs. It is a proactive, preventative and strategic approach to promoting the good health and development of on-reserve pregnant First Nations women and families with infants and young children. The program aims to reach all pregnant women and new parents, with long-term support for those families who require additional services.^{13,14}

A key element of the program is home visiting by nurses and family visitors (experienced mothers in the community), who provide information, support, and linkages to other services; integrating culture into care is a key aspect of the program.¹⁵

Program objectives include increasing First Nations training opportunities for MCH service providers, increasing participation of on-reserve community members in planning and developing services, increasing coordination of services for on-reserve clients, and developing and/or using existing evaluation tools to measure progress using evidence-based models and approaches.¹⁵

For the past ten years the provinces and territories have been strengthening their maternal and child health programming because it has such a positive effect on the lives of pregnant women, and families with infants and young children.¹⁴

Summary points

The Health Council asked the question: *If Canada wants to improve the health status of Aboriginal children as one way to reduce health disparities, what promising practices around maternal and child health need to be either advanced or developed?*

Through the regional sessions, we heard that Aboriginal maternal and child health programming is crucial in addressing health disparities, reducing inequities, and improving health outcomes for First Nations, Inuit, and Métis communities and individuals. Moreover, there are common elements that characterize service models, programs, policies, and other initiatives as “promising.” In one way or another, the practices outlined by participants are having a positive impact. To go back to the Health Council’s definition for this project, these practices are:^d

- acknowledged to positively advance Aboriginal health status;
- inclusive of the interests and experiences of many;
- valued and supported by relevant stakeholders;
- well known and/or have a history of success;
- adaptive, recognizing the importance of community context for successful implementation; and
- ideally they are evaluated.

We also heard from participants that these practices are not without challenges. While the federal government, provinces, territories, regional health authorities, Aboriginal leaders, community partners and others have made great strides in developing promising practices, participants’ overriding message was that the “landscape on which the promising practices are occurring is fractured,” for essentially three reasons:

1. While many federal programs are paving the way for success, the perception on the ground is that there is no comprehensive, long-term, coordinated and concerted approach to service delivery, which is needed to fill gaps remaining in many First Nations and Inuit communities or to address gaps faced by Métis people. Programs such as Maternal and Child Health, the Canada Prenatal Nutrition Program, and Aboriginal Head Start result in improved outcomes for mothers, infants, and young children and are incorporating many of the common features of promising practices. Yet not all Aboriginal people share in the advantages offered by these programs.
2. Participants said that the level of complexity involved in the various funding arrangements severely limited opportunities for success—specifically the lack of alignment among governments’ goals, the multiple rounds of grants and administrative requirements, and the lack of coordination among government programs for streamlined approaches and reporting. Moreover, participants indicated that front-line providers are “burning out” in the process of trying to make the programs work amidst this complexity. Participants emphasized the need for governments to commit to expanding programs that are working—based on participatory evaluation—with a long-term, coordinated, outcomes-focused approach to service delivery.

The importance of evaluation, specifically participatory evaluation, was emphasized. Without a sustainable plan and dedicated funding for evaluations, the gains achieved from many great initiatives are lost on so many levels: not only does the community for which the program was designed lose out, but there are missed opportunities in terms of helping other communities in need. Participants validated what experts have been saying for years: we need a solid base of evidence with which Aboriginal communities and practitioners can move forward their healing

d) There is a large and growing body of practice that could be acknowledged as “promising” for moving Aboriginal health status forward, and there are many more examples across Canada that were not part of this discussion.

efforts.¹⁶ While most larger federal, provincial/territorial programs such as those funded by the Public Health Agency of Canada (PHAC) and Health Canada are evaluated, few other promising practices have been formally evaluated.¹⁶ Evaluations are costly, requiring not only dedicated funding but expertise as well.

3. Finally, participants say “the model is inside out.” Traditional knowledge and community-based approaches need to be the foundation of Aboriginal health care. Culturally relevant approaches should be driven by and owned by the communities themselves. Yet the current norm is the development of a medical model based on Western notions of illness and medicine, often imposed “from the top down.” For Aboriginal communities, successful practices are based on Aboriginal ownership of services and the development of local programs to meet their needs.

In the final plenary session, participants were asked about a resource toolkit to share information about the promising practices in a way that would be accessible and useful to workers at various levels in Aboriginal maternal and child health care. Participants provided a range of ideas. In response, the Health Council has prepared an online compendium that includes descriptions of the promising practices, along with contact information. It is available on the Health Council’s website, www.healthcouncilcanada.ca

Communities ready to participate in health research

Research to define and understand promising practices is a key component of the Institute of Aboriginal Peoples’ Health (IAPH) strategic plan and one of the two main planks of the CIHR-IAPH (Canadian Institutes of Health Research) Roadmap Signature Initiative “Pathways to Health Equity for Aboriginal Peoples.” The other plank, which is closely related, is the translation and scaling up of the knowledge of promising practices in order to achieve the goal of closing the gap in Aboriginal health.^{17,18} Moreover, Aboriginal maternal and child health is a major area of interest being raised in most First Nations, Inuit, and Métis dialogues, including the IAPH Four-Directions Summits carried out last year.¹⁸ A main message of these dialogues was that communities are ready to participate in health research and knowledge translation, provided that the goals are action-oriented, and that community knowledge is respected in the process, with the same principles applied to evaluation.^{18,19} This finding resonates with what the Health Council heard in the regional sessions.

Appendix A

A listing of promising practices by session

Participants at seven regional sessions discussed programs or initiatives that they were aware of (in their own communities or elsewhere) that are making a difference in Aboriginal maternal and child health. Listed in the tables below are the titles of the promising practices that were put forward by participants at each regional session.

CALGARY SESSION

THEME	TITLE
Traditional Knowledge and Cultural Approaches	Northwest Territories Food Guide, the Northwest Territories *
	CHEP Good Food, Saskatchewan *
Community-Based/Community-Focused Approaches	Ingamo Hall Friendship Centre Inuvik, the Northwest Territories
	Fort Qu'Appelle Women's Centre, Saskatchewan
	Start Thinking About Reducing Secondhand Smoke (STARSS), Yukon *
	Boyle Street Co-op, Edmonton, Alberta *
	Aboriginal Best Beginnings Book — Alberta Health Services, Alberta *
	Centering Pregnancy (Group Prenatal Care Model), Alberta *
	Improving Perinatal Outcomes in First Nations Communities within David Thompson Health Region: Findings & Recommendations (2008), Alberta
Training and Human Resources	Friendship Centre — University of Calgary Women's Resource Centre, Alberta *
	Health Workforce Action Plan — Aboriginal Health Workforce Strategy, Alberta
	Undergraduate Medical Education — Indigenous Health Initiatives Program, University of Alberta *
	Faculty of Medicine, University of Calgary, Alberta *
	Northern Ontario School of Medicine, Ontario *
	Northern and Remote Family Practice Training Program, University of Manitoba, Manitoba *
	Strategies for Teaching Obstetrics to Rural & Urban Caregivers (STORC), Alberta; Northwest Territories *
	Best Beginnings — Alberta Health Services Calgary Zone, Alberta
	Bow Valley Practical Nurse Program, Alberta
Collaboration and Integration	Eagle Moon Health Office (EMHO), Saskatchewan *
	Honouring Life — Aboriginal Youth and Communities Empowerment Strategy (AYCES) — Alberta Health Services, Alberta *
	Alberta Health Services *

* A description and contact information is available in the online compendium on the Health Council's website. Please visit www.healthcouncilcanada.ca

CALGARY SESSION *continued*

THEME	TITLE
<p>Collaboration and Integration <i>continued</i></p>	Midwifery — Alberta Health Services *
	Netcare (formerly called Wellnet), Alberta Health and Wellness, Alberta *
	Northern Alberta Teddy Bear Fair/Health Screening Event *
	Louise Dean Centre, Calgary, Alberta *
	Elbow River Healing Lodge — Prenatal Education, Alberta *
	Primary Care Networks (PCN), Alberta *
	The Rocky Mountain House/First Nations/Primary Care Network Partnership — Sunchild/O’Chiese First Nations, Alberta *
	Alberta FASD Cross-Ministry Committee, Alberta *
	Canada Northwest Fetal Alcohol Spectrum Disorder Partnership (CNFASDP) *
	Families First Edmonton — Families Matter Partnership Initiative, Alberta *
	One World Child Development Center (CUPS), Calgary, Alberta *
	Aboriginal Head Start, Federal *
	UN Committee for Maternal/Child Health (the Partnership for Maternal and Child Health)
	Calgary United Way, Alberta
	Aboriginal Prenatal Wellness program (APWP): Wetaskiwin’s Community-based Program, Alberta *
<p>Policy and Funding</p>	Memorandum of Understanding on First Nations Health and Well-being in Saskatchewan — Federation of Saskatchewan Indian Nations (FSIN) Tripartite MOU (2008), Saskatchewan *
	Best Practices in Aboriginal Health Programming Project Final Report (2008), Alberta
	Canada Prenatal Nutrition Program (CPNP), Federal *
	Urban Aboriginal Strategy — Calgary Urban Aboriginal Initiative (CUAI), Alberta *

* A description and contact information is available in the online compendium on the Health Council’s website. Please visit www.healthcouncilcanada.ca

HALIFAX SESSION

THEME	TITLE
Traditional Knowledge and Cultural Approaches	Child Help Initiative Program (CHIP), Nova Scotia
	Language Nest Inuagualuit Program, Nunatsiavut *
	Prenatal Class Partnerships, Nova Scotia *
	Moss Bag Making, Nova Scotia
	Baby & Me, Maternal and Child Health Program (Mijua'ji') Aqq Ni'n, Nova Scotia
	Seven Sacred Teachings, Nova Scotia
	Grassroots Grandmothers Circle, Nova Scotia *
	Eskasoni Early Intervention and Prenatal Clinic, Nova Scotia
	Healthy You: Healthy Me, Nunatsiavut *
Community-Based/Community-Focused Approaches	Boot Camp for New Dads, Nova Scotia
	New Brunswick Community Health Centres *
	Breastfeeding Support Group, Nova Scotia
	Eskasoni Community Health Centre, Nova Scotia
Training and Human Resources	Growing Great Kids Inc. International, Nova Scotia *
	E'pit Nuji Ilmuet Prenatal Program, Nova Scotia *
	Behavioural Health Aide Training Program, Nunatsiavut *
Collaboration and Integration	Unama'ki Maternal and Child Health Program, Nova Scotia *
Policy and Funding	Mi'kmaq (Aboriginal) Health Policy Framework, Nova Scotia *
	Inuit Early Childhood Education, Development Strategy *
	Mi'kmaq Family and Children's Services, Nova Scotia — Province-wide dispute resolutions process
	New Brunswick Community Health Centres, New Brunswick *

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OTTAWA SESSION

THEME	TITLE
<p>Traditional Knowledge and Cultural Approaches</p>	Six Nations of the Grand River, Tsi Non:we Ionnakeratstha Ona:grahsta' Maternal and Child Centre, Ontario *
	Enaahtig Healing Lodge, Ontario *
	Nunavik Midwifery and Community Health Team Program (FASD) Nunavik, Quebec
	National Inuit Early Childhood Education Gathering *
	Aboriginal Head Start, Federal *
	Healthy Beginnings, Supportive Communities: A Strong Future Métis maternal and child health DVD, Métis Centre at National Aboriginal Health Organization *
	Grandmother's Guide Facilitator's Manual, Ontario
	ISPAYIN Métis Youth Express Yourself, Métis Centre at National Aboriginal Health Organization *
<p>Community-Based/Community-Focused Approaches</p>	Inuit Midwifery Interviews, Pauktuutit *
	Pregnancy Calendar, Pauktuutit *
	Children's Oral Health Initiative, National *
	Pauktuutit Resource kit (DVD/Manual) *
	Peguis Aboriginal Head Start On Reserve (AHSOR), Manitoba
	Action Schools BC, British Columbia *
	Fort Smith Health and Social Services Centre (NWT) — Midwifery Program *
<p>Training and Human Resources</p>	BC Nursing Training, Aboriginal Nurses Association of Canada
	Miziwe Biik Employment and Training, Ontario *
	Ontario Ministry of Health and Long-Term Care, "Grow your own Nurse Practitioner" program, Ontario
	Inuulitsivik C.L.S.C. Maternities, Nunavik, Quebec *
	Aboriginal Diabetes Initiative (ADI) Capacity Building – Community Diabetes Prevention Worker Training, National *
	Kahnawake Health Careers, Quebec
	Nursing Extern Mentoring Program, Quebec
	Cultural Competence and Safety in Nursing Education *

* A description and contact information is available in the online compendium on the Health Council's website. Please visit www.healthcouncilcanada.ca

OTTAWA SESSION *continued*

THEME	TITLE
Training and Human Resources <i>continued</i>	National School of Dental Therapy (NSDT), National *
	Aboriginal Diabetes Initiative Capacity Building—Community Diabetes Prevention Worker Training Program, Canada *
	The Nunavik Child Care Centre Nutrition Project, Nunavut *
	Inuit Early Childhood Development (ECD) Strategy, Nunatsiavut, Nunavik, Nunavut & Inuvialuit *
	Ahp-cii-uk Aboriginal Leadership Initiative, British Columbia *
Collaboration and Integration	Aboriginal Healing and Wellness Strategy, Ontario *
	Wabano Centre for Aboriginal Health, Ontario *
	Hudson Coast Prenatal Committee, Inuulitsivik *
	International Meeting on Indigenous Child Health, Canadian Pediatric Society *
	Rosie the Robot—Virtual Access, Labrador-Grenfell Regional Health Authority
	Eskasoni School-Based Health Centre, Nova Scotia
	Aboriginal Cultural Helper, Alberta
	Cree Health Advocate, Manitoba *
	Kahnawake Shakotiia'takehnhas Community Services, Quebec
	Northern Alberta Teddy Bear Fair/Health Screening event *
	Strengthening Families Maternal and Child Health Manitoba—a partnership co-management model, Manitoba *
	First Nations and Inuit Mental Wellness Team (MWT) pilot projects *
Métis Centre Health Literature and Statistical Databases *	
Policy and Funding	Cultural Competence and Cultural Safety in Nursing Education, Aboriginal Nurses Association of Canada, Canadian Nurses Association & Canadian Association of Schools of Nursing *
	Nunavut Midwifery Program
	Aboriginal Health Transition Fund, Nunavik

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TORONTO SESSION

THEME	TITLE
Traditional Knowledge and Cultural Approaches	Inuulitsivik C.L.S.C. Maternities, Nunavik, Quebec *
	Modified Healthy Babies, Healthy Children for Aboriginal Communities, Ontario *
	Sheway, British Columbia *
Community-Based/Community-Focused Approaches	Primary Health Care for Aboriginal Populations — Aboriginal Health Access Centres (AHACs), Ontario *
	Peetabeck Academy School Nutrition Program, Fort Albany First Nation, Ontario
	Primary Health Care for Aboriginal Populations — Aboriginal Community Health Centres, Ontario *
	Primary Health Care for Aboriginal Populations — Aboriginal Family Health Teams (FHT), Ontario *
	SOAHAC — Southwest Ontario Aboriginal Health Access Centre *
Training and Human Resources	Six Nations of the Grand River — Tsi Non:we Ionnakeratstha Ona:grahsta' Maternal and Child Centre, Ontario *
	Northern Ontario School of Medicine (NOSM), Ontario *
Collaboration and Integration	Simcoe County Children's Aid Society, Ontario
	Four Directions Medical Supply, Ontario *
	Seventh Generation Midwives, Ontario *
	Aboriginal Hospitals Ontario — Weeneebayko Area Health Authority, Ontario *
	Aboriginal Hospitals Ontario — Meno Ya Win Health Centre (Sioux Lookout Hospital), Ontario *
Policy and Funding	Ministry of Child and Youth — Maternal and Child Nutrition Program/Fetal Alcohol Spectrum Disorder, Ontario
	Maternal and Child Health (MCH) program, Federal *
	Ministry of Child and Youth, Ontario
	Aboriginal Healing and Wellness Strategy, Ontario *

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VANCOUVER SESSION

THEME	TITLE
Traditional Knowledge and Cultural Approaches	Grandmother's Project, British Columbia
	Ahp-cii-uk Aboriginal Leadership Initiative, British Columbia *
	Weaving Families Together, British Columbia *
Community-Based/Community-Focused Approaches	Responsive Intersectoral Children's Health, Education and Research (RICHER) Initiative, British Columbia *
	Inner-City Response Team, British Columbia *
	Toddler Fair, British Columbia *
	Communities That Care, British Columbia *
	Sheway, British Columbia *
	Centering Pregnancy — (Group Prenatal Care Model), Alberta *
	Healthy Children Healthy Futures, United States *
	"Hook and Hub": University of Victoria Documentation of First Nations Operated Multiservice Hubs, British Columbia *
Atira Women's Resource Society, British Columbia *	
Training and Human Resources	Nuu-chah-nulth Tribal Council (NTC) Quu'asa Program — Counseling Diploma, British Columbia
	National Collaborating Centre for Aboriginal Health *
	Speech Language Pathology Assistant Training, FASD Project, British Columbia
	Aboriginal Youth Internship Program, British Columbia *
	BC Aboriginal Doula Training, British Columbia *
	Licensed Practical Nurse Training, British Columbia *
	University of Victoria First Nations Partnership Programs, British Columbia *
Indigenous Cultural Competency On-Line Training, British Columbia *	

* A description and contact information is available in the online compendium on the Health Council's website. Please visit www.healthcouncilcanada.ca

VANCOUVER SESSION *continued*

THEME	TITLE
<p>Collaboration and Integration</p>	<p>First Nations Health Council, Child Health BC & Vancouver Island Discharge Planning Program for Aboriginal Children with Complex Health Needs, British Columbia</p>
	<p>Community Dental Prevention — Maternal and Child Health, British Columbia *</p>
	<p>Nuuchanulth Tribal Council — Culturally Safe Nursing Care, British Columbia</p>
	<p>North Island Midwifery Demonstration Project, British Columbia *</p>
<p>Policy and Funding</p>	<p>Early Childhood Development Reinvestment Initiative, British Columbia *</p>
	<p>First Nations Health Council: The Transformative Change Accord, First Nations Health Plan and the Tripartite First Nations Health Plan British Columbia, British Columbia *</p>
	<p>Haida Nation Designated Aboriginal Child and Family Services Agency, British Columbia *</p>

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WHITEHORSE SESSION

THEME	TITLE
Traditional Knowledge and Cultural Approaches	Dolly Parton Literacy Imagination Library, Yukon *
	Culture Camps — Vuntut Gwitchin First Nation, Old Crow, Yukon
	Lunch at School, Old Crow, Yukon
	Skookum Jim Friendship Centre Traditional Parenting Program, Yukon *
	First Nations Health Programs, Yukon Hospital Corporation, Traditional Diet Program, Yukon *
	Husg gus teye in Teslin, Yukon
	Champagne and Aishihik First Nations Bi-cultural program (Primary School), Yukon *
Community-Based/Community-Focused Approaches	Aboriginal Head Start, Federal *
	Canada Prenatal Nutrition Program (CPNP), Federal *
Training and Human Resources	Fetal Alcohol Spectrum Disorder Yukon (FASDY) Training Program, Yukon
	Students at Health Centres/First Nation Health Careers — Yukon Summer Career Placement Program *
	Teen Parent Centre, Yukon *
	Early Childhood Education Program Training for Daycare Workers, Yukon *
	Early Childhood Development, Yukon College, Yukon
	Yukon Government Cultural/Land Claims Training, Yukon Public Service Commission, Yukon
	Aboriginal Human Health Resource Initiative (AHHRI), Federal
Collaboration and Integration	Ross River Health Centre Collaboration with Non-Insured Health Benefits (NIHB), Yukon
	Child and Family Services Act (Yukon Government) and Relationship with First Nations, Yukon
	The Nunavik Childcare Centre Nutrition Program *
Policy and Funding	Ta'an Kwach'an Council — Self-Governing First Nation, Yukon

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WINNIPEG SESSION

THEME	TITLE
Traditional Knowledge and Cultural Approaches	Cambridge Bay Wellness Centre, Nunavut *
	Native Women's Transition Centre, Manitoba *
	Opaskweyak Cree Nation Midwifery Integration Pilot Project, Manitoba
	Let's Be Healthy Together, Ontario *
	The Sacred Path: Building Healthier Children, Parents, and Communities, Ontario, Alberta, Manitoba *
	Reclaiming Our Voices: A Gathering for Women Affected by Alcohol, Drugs and Pregnancy, Manitoba
	Aboriginal Health Programs (AHP), Manitoba
	Healthy Smile Healthy Child Project, Manitoba *
	Primary Health Care for Aboriginal Populations — Ontario Aboriginal Health Access Centres *
Community-Based/Community-Focused Approaches	Canada Prenatal Nutrition Program (CPNP), Federal *
	Maternal and Child Health (MCH) program, Saskatchewan *
	Sheway, British Columbia *
Training and Human Resources	Six Nations of the Grand River-Tsi Non:we Ionnakeratstha Ona:grahsta' Maternal and Child Centre, Ontario *
	Aurora College (Yellowknife), Nursing Program, the Northwest Territories *
	Northern and Remote Family Practice Training Program, University of Manitoba *
	Nunavut Midwifery Education Program and Maternity Care Worker, Nunavut Arctic College
	Nunavik Community Midwifery Education Program
	National Aboriginal Council of Midwives (NACM) *
	Native Nurses Entry Program (NNEP) Lakehead University, Ontario *

* A description and contact information is available in the online compendium on the Health Council's website. Please visit www.healthcouncilcanada.ca

WINNIPEG SESSION *continued*

THEME	TITLE
Collaboration and Integration	Strengthening Families Maternal and Child Health Program (SF-MCH) — a partnership co-management model, Manitoba *
	Southern Ontario Aboriginal Diabetes Initiative (SOADI)
	Villa Rosa, Manitoba *
	Canada Northwest FASD Partnership *
	Healthy Child Manitoba, Manitoba *
	Parent-Child Coalitions — Healthy Child Manitoba, Manitoba
	Grass Roots Mentoring FASD Prevention Program, Burntwood Regional Health — Thompson Service Delivery Area — Manitoba's FASD Strategy *
	Women's Health Clinic, Manitoba *
	Community Health Clinics & Access Centres, Manitoba
	Triple P: The Positive Parenting Program — Norway House, Manitoba *
	Breastfeeding in Manitoba: Provincial Strategy and Framework *
	Early Development Instrument (EDI) *
Policy and Funding	National Birthing Initiative, Society of Obstetricians and Gynecologists of Canada *
	Nunavut Maternal and Newborn Health Care Strategy 2009–2014, Nunavut *
	Manitoba Midwifery Act, Manitoba
	Aboriginal Hospitals Ontario — Meno Ya Win Health Centre — Sioux Lookout Hospital, Ontario *
	Early Development Instrument (EDI), Manitoba *
	MotherFirst Maternal Mental Health Strategy: Building Capacity in Saskatchewan, Saskatchewan *
	Prairie Women's Centre of Excellence, Winnipeg, Manitoba *
	Pauktuutit Resource Kit (DVD/Manual) *

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Appendix B

Demographics^e and health indicators of Aboriginal maternal and child health

Four critical points are highlighted in this section, which provide further context on the state of Aboriginal maternal and child health in Canada.

The first critical point is that as a whole, the Aboriginal population in Canada is younger than the non-Aboriginal population, as illustrated in Table 1.

The pattern is the same when looking at the Aboriginal population under 14 years of age, as illustrated in Figure 1.

Also important is that between 1996 and 2006, the overall Aboriginal population grew by 45%, compared with 8% for the non-Aboriginal population. The birth rate among the overall Aboriginal population continues to be much greater than for the general Canadian population:

Aboriginal women have on average 2.6 children over their lifetime while the average for women as a whole in Canada is 1.5.

A second critical point relates to the quality of information that is available. The Health Council reported in 2005 that due to the varied ways that information was collected or not collected, an accurate assessment of the health status of Aboriginal Peoples remained beyond reach at the time. Shortfalls in Aboriginal child health assessment and health system performance measurement represent a missed opportunity to address the health status inequities experienced by Aboriginal children in Canada, compared to the rest of Canadian children. Addressing these and encouraging First Nations, Inuit and Métis organizations to partner in the health information process could lead to overall better health information to address and prevent unnecessary child illness and death.²⁰ Nevertheless, it is widely acknowledged that there is a long way to go.^{16,20} Information on health disparities between Aboriginal and non-Aboriginal populations is necessary in order to develop public health programs to reduce these disparities.²¹ If the problems are unclear, then they cannot be adequately addressed.²⁰ Reliable and comprehensive data are required for better evidence in decision-making.²⁰

TABLE 1
Proportion of Aboriginal and non-Aboriginal population aged five years and under

	5 AND UNDER	TOTAL POPULATION	% TOTAL = 0.5 YEARS
First Nations	71,720	698,025	10.27
Inuit	5,875	50,480	11.64
Métis	29,030	389,785	7.45
Total Aboriginal	108,895	1,172,790	9.29
Non-Aboriginal	1,581,500	30,068,240	5.26

Source: Statistics Canada, 2008:2006 Census

e) According to Statistics Canada (2008) in the 2006 Census, just under 1.2 million persons in Canada report Aboriginal identity:

- approximately 60% (698,025) identified as ‘North American Indian’ (the term used in the Census to identify persons of First Nations Ancestry)
 - 81% of the First Nations population is considered ‘Status Indian’
 - 564,870 people identified as First Nations with status or treaty (on/off-reserve)
 - 133,155 people identified as First Nations without status or treaty (on/off-reserve)
 - approximately half of the First Nations population (51% or 284,794) live off-reserve and 76% of those living off-reserve live in urban areas
- 33% identified as Métis (389,785)
 - The majority of Métis live in urban areas (69%)
- 4% identified as Inuit (50,485)
 - A growing number of Inuit (22%) live outside of Inuit Nunaat (which comprises the four Inuit regions: Nunatsiavut, Nunavik, Nunavut and Inuvialuit)
- 3% identified with more than one Aboriginal group and/or self-reported as ‘registered Indians’ or members of First Nations bands but didn’t identify as Aboriginal.

However, it’s likely that these numbers underestimate the actual Aboriginal population for a number of reasons including non-participation in the census by a number of First Nations living on-reserve and possibly other Aboriginal groups and individuals opting not to self identify as Aboriginal to government workers.²⁰

Currently, there is no accurate picture of the health status of Canada's Aboriginal children. Two critical data gaps are:

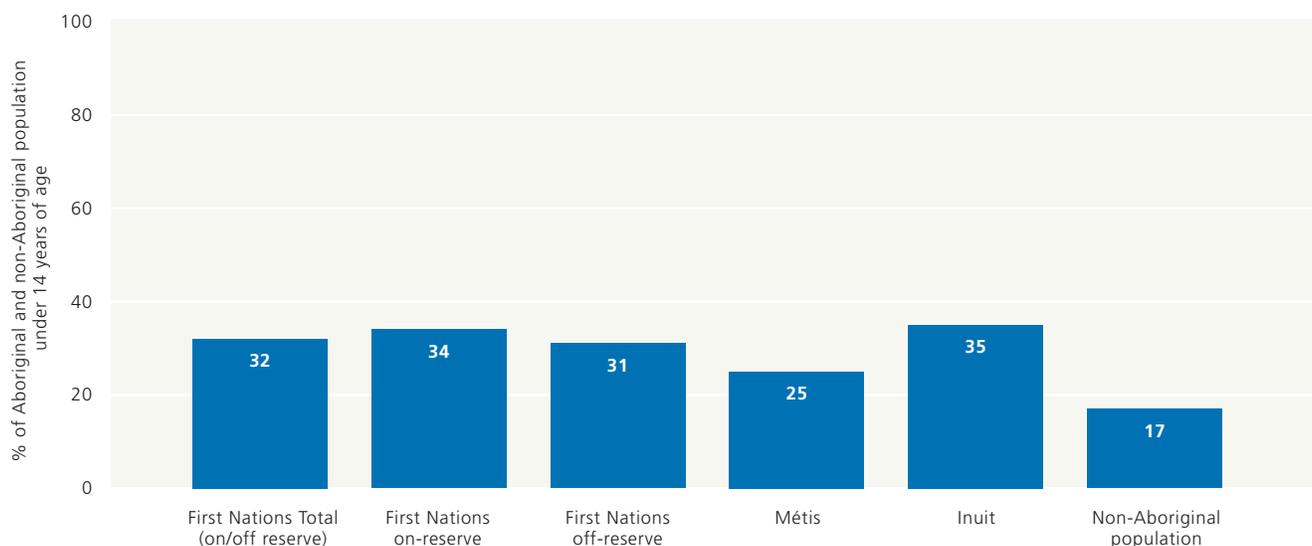
1. A lack of standardized First Nations, Inuit, and Métis identifiers in vital registration, health care utilization, and surveillance databases. For instance, when looking at Canada in comparison to Australia, New Zealand, and the United States, Canada is the only country without systems in place for Indigenous self-identity in most hospital, surveillance and vital registration systems (i.e. birth and death registration).²⁰
2. A lack of organized linkages of First Nations, Inuit, and Métis health data to First Nations, Inuit, and Métis health policies, programs, and services.²⁰

According to researchers Smylie and Adomako (2009), "...shortfalls in Aboriginal child health assessment and health system performance measurement represent a missed opportunity to address the health status inequities experienced by Aboriginal children in Canada, compared to the rest of Canadian children."²⁰

A third critical point relates to health status; a few facts will serve to highlight the urgency of conditions. Based on health status information that is available, there are severe inequities in health status and health determinants between Aboriginal and non-Aboriginal Canadians. The following snapshots illustrate the serious state of Aboriginal maternal and child health in Canada:

- Compared with non-Aboriginal Canadians, more Aboriginal mothers are single and are adolescents. The number of First Nations children born to teenagers has remained high since 1986, at about 100 births per 1,000 women — a rate seven times higher than for other Canadian teenagers.¹⁵
- Compared with the rest of Canada and other rural and northern areas of the country, the Inuit-inhabited areas had substantially higher rates of pre-term birth, stillbirth, and infant death.²¹
 - According to Payne (2010), "Pre-term birth rates are so high among Canada's Inuit that pregnant women are usually flown out well in advance of their due dates."²²

FIGURE 1
Proportion of Aboriginal and non-Aboriginal population under 14 years of age



Source: Statistics Canada, 2008:2006 Census

The following information is from Smylie and Adomako (2009)²⁰, unless otherwise indicated:

- The infant mortality rate among the Inuit is four times higher than for the general Canadian population.
- Infant mortality among First Nations people with status is almost twice the rate of the general Canadian population (no mortality rates for non-status First Nations available).
- For First Nations with status in British Columbia and Inuit in Nunavik, Sudden Infant Death Syndrome rates are three to 12 times higher than non-First Nations and non-Inuit rates, respectively.
- Among First Nations, Inuit, and Métis, low birth-weight rates are higher than among the general Canadian population.
- For First Nations and Métis, there is a higher incidence of high birth weight babies than for Canadians in general.
- There is a disproportionate burden of respiratory tract infection among First Nations living on reserve and Inuit children (with no data for First Nations without status, Métis, or urban Aboriginal children available). Inadequate housing, poor ventilation, and crowding contribute to the elevated rates.
- First Nations, Inuit, and Métis children face striking disparities in the social determinants of health including family income, parental employment, food security, and housing compared to non-Aboriginal children:
 - Rates of food insecurity for First Nations populations living on reserve vary from 21% to 83%.
 - 30% of Inuit children have experienced hunger as a result of their family having run out of food or money to buy food.
 - A healthy food basket to feed a family of four for a week costs between \$350 and \$450 in Inuit Nunaat,^f compared to \$200 in the south.
 - A 2007/08 Nunavut Inuit Child Health Survey indicates that nearly 70% of Inuit preschoolers resided in households rated as food-insecure.²³
- In general, rates for high school graduation are somewhat lower for Aboriginal populations as compared to the non-Aboriginal population. This is particularly the case for Inuit living inside Inuit Nunaat where there is a considerably lower rate of high school completion.
- Rates of obesity for First Nations children living on reserve (there is only data available for this population) are over four times higher than for the general Canadian population. Obesity has been linked to the determinants of health, in particular family income, parental education, and physical activity.
 - Among First Nations adults the rates of diabetes continue to grow, with elevated rates also being reported among subpopulations of First Nations youth.
 - From the first prospective national surveillance study in Canada to report the incidence of type 2 diabetes in children, a key finding is that the incidence is increasing. Obesity is the single most important risk factor for type 2 diabetes. Canadian Aboriginal children <18 years have the highest incidence of type 2 diabetes and the majority of these are from Manitoba, explaining the 20-fold higher incidence rate of type 2 diabetes in the province.²⁴
- Fetal alcohol spectrum disorder (FASD) is a complicated area, with much controversy around the diagnosis for Aboriginal communities. At present, there are no population-based estimates for First Nations, Inuit, or Métis children in Canada.
- In terms of disabilities, the rate of activity limitations for First Nations children living off reserve was higher than for other Canadian children (no rate for First Nations children living on reserve).
- According to the Public Health Agency of Canada, the rate of substantiation^g was four times higher in Aboriginal child maltreatment investigations than in those involving non-Aboriginal children (49.69 per 1,000 versus 11.85 per 1,000).²⁵

f) Inuit Nunaat comprises all four Inuit regions: Nunatsiavut, Nunavik, Nunavut, and Inuvialuit.

g) Level of Identification and Substantiation: There are four key steps in the case identification process: detection, reporting, investigation, and substantiation. Detection is the first stage. Little is known about the relationship between detected and undetected cases. Reporting suspected child maltreatment is required by law in all provinces and territories in Canada. Reporting mandates apply at a minimum to professionals working with children, and in many jurisdictions apply to the general public as well. The CIS-2008 does not document unreported cases. Investigated cases are subject to various screening practices, which vary across sites. The CIS-2008 did not track screened-out cases, nor did it track new incidents of maltreatment on already opened cases. Substantiation distinguishes cases where maltreatment is confirmed following an investigation and cases where maltreatment is not confirmed (unfounded). The CIS-2008 uses a three tiered classification system, in which a suspected level provides an important clinical distinction for cases where maltreatment is suspected to have occurred by the worker, but cannot be substantiated.²⁵

Additionally, Aboriginal children in Canada are over-represented in the foster care system, with 22% of substantiated cases (an estimated 18,510 cases) involving children of Aboriginal heritage. Of these, 15% were among First Nations status, 3% were among First Nations non-status, 2% were Métis, 1% were Inuit, and 1% with other Aboriginal heritage.²⁵

Finally, some information about birthing in northern communities illustrates additional context around the issues facing Aboriginal mothers, their families and communities.

- It is extremely costly to transport women from their homes in the North to southern communities to give birth. In 2009, the government of Nunavut spent \$60 million on plane tickets and emergency medevacs to fly pregnant women out (and in some cases their escorts), or specialists in, which is almost one-fifth of the government's total health and social services budget and five times the amount it spent on public health.²²
- \$12,000 is the estimated cost savings every time midwives assist with a birth in northern Quebec.²²
- Women who live on the northeast and east coast of Labrador are required to leave their homes at about 37 weeks gestation to travel to Happy Valley-Goose Bay to give birth at the Labrador Health Centre.^{26,27}

The case has been made that the status of maternal and child health in Canada as a whole is falling. The Society of Obstetricians and Gynaecologists of Canada states that, "there are warning signs that the quality and scope of maternity care in Canada is diminishing."²⁸ For example, data released by the OECD in June 2006 (based on 2002 data) indicated that Canada's ranking had slipped to 21st with regard to the prevalence of infant mortality (we were in sixth in 1990). Canada also slipped to 14th in perinatal mortality rates from a previous rank of 12th, and to 11th position in maternal morbidity rates (we were second).²⁸ It has also been argued

that the socio-economic determinants of health play a large role in Canada's deteriorating ranking. In contrast to the Canadian situation, other wealthy nations are achieving better child health outcomes by reducing the prevalence of socio-economic disadvantages.²⁹ While the situation for Canada as a whole is of concern, the status of maternal and child health and socio-economic disadvantage for Aboriginal people is urgent.

From an international perspective, studies show there are striking similarities in health disparities for Indigenous children across the four countries of Canada, Australia, New Zealand, and the United States.²⁰ For example, there are:

- infant mortality rates 1.7 to 4 times higher than those of non-Indigenous infants;
- higher rates of Sudden Infant Death Syndrome;
- higher rates of child injury, accidental death, and suicide;
- higher rates of ear infections;
- a disproportionate burden of respiratory tract illness and mortality;
- a disproportionate burden of dental caries; and
- increased exposure to environmental contaminants, including tobacco smoke.

Underlying these health status commonalities are common themes across the countries that are related to the determinants of health:

- poor-quality data on Indigenous child health;
- colonization as an underlying determinant;
- poverty and substandard, overcrowded housing conditions; and
- lack of access to the same quality health care and social resources, as well as economic opportunities, compared to non-Indigenous populations.

As stated by Smylie and Adomako (2009), "Given the diverse genetic heritage of these widely dispersed Indigenous groups, we must conclude that similar exclusionary social policies active in all four countries are at the root of these profound and unjust differences in child health." Significant efforts and resources have been devoted in all four countries and there have been improvements. However, even in the face of improvements, Indigenous children continue to fare worse than their non-Indigenous counterparts....²⁰

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