



Aboriginal Perspectives

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VOICES FROM THE FIELD - Aggression in Young Children from a First Nations' Perspective

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(Published online September 9, 2004)

Aboriginal perspective

These reviews of the research pertaining to aggression in young children encourage me to believe that as a society, we will gradually re-discover the knowledge necessary to create a more peaceful and less violent society for all of our citizens.¹⁻¹¹ The recognition that aggressive behaviour is learned and that it is acquired through exposure to aggressive role models during our early childhood years should come as no surprise. Similarly, family factors that have been determined to promote the development of aggressive behaviours, such as low income, low education, high family stress, single parenthood, marital discord, maternal depression and parental drug use, are but a few of the experiences that are common to disadvantaged members of our society. In the case of First Nations families, the rates of unemployment are higher than the general population. Employed Aboriginal people are over-represented in low-paying jobs and the average level of formal education attained is lowest. Almost one-third of all Aboriginal children under age 15 live with a single parent, with the proportion rising to almost one-half of the families in urban settings. More than 10% of Aboriginal children do not live with either parent and more than one-third of Aboriginal people surveyed in several studies report family violence against both partners and children. Addictive behaviours of all forms are highest among First Nations people compared to other cultural groups.¹² Overall, First Nations families experience the lowest level of health of all cultural groups in Canada.¹³ It should come as no surprise, therefore, that Aboriginal children are more likely to demonstrate higher levels of aggressive behaviours and be labelled as Oppositional Defiant Disorder (ODD) and/or Conduct Disorder (CD) in greater numbers than other cultural groups. While there are few, if any, controlled studies to verify this, clinical observation and logical deduction support this conclusion.

It is also reassuring to read that research continues to reveal that the most effective and most efficient time to intervene and prevent the development of long-term anti-social, aggressive and violent behaviours is during the first five years of life. It is also encouraging to see that research continues to support the use of multi-modal programs that attempt to reduce childhood aggression by focusing on a complex myriad of child, family, peer, neighbourhood and school factors. These models continue to be recognized as the most effective approach for reducing aggression during childhood.

Twenty years ago, I was the Clinical Director of the Merici Centre for Infant Development, an infant mental-health program that provided health-promotion services

to First Nations families with high-risk infants and toddlers in the city of Regina. Unfortunately, this program was discontinued 12 years ago, when it was unable to obtain further financial support from the provincial government. At that time, all of the above research findings were known to and promoted by the International Association of Infant Mental Health. While the research findings and common sense supported the need for this type of program, the political will did not. In addition to implementing the above research findings, this infant mental-health program had begun to identify the positive health effects associated with traditional First Nations beliefs, values and lifestyle. As Connors and Maidman¹² describe in their chapter, traditional First Nations practices of childrearing are based on a holistic world view (form of thought) that consists of values promoting minimal expression of aggression within family and community. This is what forms the foundation of present-day First Nations early childhood prevention programs, such as Aboriginal Head Start, Better Beginnings, Better Futures and a variety of parenting programs. These programs usually promote the socialization of children to express low levels of aggression and develop positive social skills by promoting traditional First Nations values and beliefs.

Connors and Maidman¹² emphasize that a full understanding of the decline in health status of Aboriginal people requires application of a holistic analysis. This includes an examination of contributing factors affecting the individual, family and community over time. By tracking the historical development of a condition, we can better determine which factors promote or detract from the state of health. In the case of aggression and violence within First Nations communities, it is evident that these behaviours have increased within families and communities as the process of acculturation has proceeded. This insight has resulted in the examination of the role that traditional First Nations beliefs and values play in the promotion of healthy lifestyle and healthy parenting practices.¹² It has also led to the development of numerous First Nations parenting manuals (e.g. Positive Indian Parenting,¹⁴ Raising the Children¹⁵).

Considering all of the above, it astounds me that only three authors of the 11 papers I reviewed identified the importance of studying cultural, social and historical factors when investigating childhood aggression. Shaw is the only author who recognized that it is vital that we evaluate the consequences of parenting styles prescribed by different cultures before making assumptions about the appropriateness of childrearing practices.⁵ Hay also states in closing that “cross-national comparisons may reveal dimensions that underlie effective prevention and intervention strategies across geographical and cultural boundaries.”⁴

I cannot emphasize enough how important it is that childhood aggression within a First Nations population be studied from a holistic perspective that includes an examination of cultural, social, political and historical factors. If we do not do this, it is unlikely that we will accomplish the outcome that Tremblay calls for in his closing remarks, when he says that we need “policies that strive to maintain peaceful environments throughout society to prevent the primitive aggressive reactions from breaking through the thin layer of civility we acquire as we grow older.” Over 20 years of clinical practice within First Nations communities suggest to me that the above goal is achievable within our First Nations

communities and that much of the knowledge that is required for achieving this lies within the traditional values and beliefs that have informed our parenting practices and relationships from times prior to contact with European cultures.

Hopefully, with continued research and effective communication of these findings, our policy-makers and politicians will re-discover and use the wisdom of our First Nations grandfathers and present-day traditional elders.

“Before he is five years of age he is already learning many things. Time has to be taken, especially when talking to a child, and the talking must be done gently. The child must be approached in a positive manner, and this goes throughout the rearing days. Harshness and punishment is avoided as much as possible. There are times, however, when a stern tone of voice has to be used, but anger is suppressed. Anger is unprofitable when teaching or correcting the child. Getting easily angered at the children is not right.”

Unidentified Elder¹⁵

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VOICES FROM THE FIELD **An Aboriginal View on Child Care**

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Aboriginal perspective

The writings of prominent early childhood researchers Belsky,¹ Howes,² Owen,³ Anherter and Lamb,⁴ McCartney⁵ and Peisner-Feinberg⁶ provide a response to the question, “What impact does child care have on young children?” As I read through the synopsis, I was continually reminded that I was reading findings and discussions that were derived from a specific way of knowing and being in the world, a way of knowing that I understand, but which is not inherently mine. I am reminded of a familiar place, a way of knowing through the words of our Elders, the words of Shuswap Elder Mary Thomas:

We have been caring for our children since time immemorial. [We have not always had the right to raise our children.] The teachings of our values, principles, and ways of being to the children and youth have ensured our existence as communities, nations, and peoples. The values of our people have ensured our existence. It is to the children that these values are passed. The children are our future and our survival. The care of these children was a shared responsibility by the family and the community.⁷

How then do the findings and discussions presented by Belsky,¹ Howes,² Owen,³ Anherter and Lamb,⁴ McCartney⁵ and Peisner-Feinberg⁶ fit with this way of knowing and being in the world? The concept of formalized child care (as it is understood by these researchers) is a foreign one to Aboriginal people and one that has found its way into our communities. I am not advocating cultural stasis, whereby we live in the traditional past and do not take advantage of current-day opportunities. I am, however, saying that we need to be critical of the impact on our children of these non-traditional structures and ways. Do Euro-colonial formalized child-care structures teach values that are born of the land and of our ways? Do they ensure the distinctiveness and survival of our peoples, or, even more importantly, can they assist our children and peoples to thrive? We must look to see whose ways of being are taught. We must be constantly vigilant against assimilation and we must determine our own destinies through our own early childhood research – asking our own questions and finding our own answers. That is not to say that we cannot learn from others, but we must have our own voice and destiny. To do any less is to run the risk of assimilation.

The specific work of these researchers must be set in their context (that is, works specific to the United States and its realities) and be analyzed from that critical place whereby

Aboriginal people question formalized Euro-colonial child-care structures.¹⁻⁶ To assume that these structures are neutral is wrong and can in fact be detrimental to children, families and communities.

An Elder once said to me, “Take what is good, that which you can use, and leave the rest behind.” This answers the question, “What are the implications of the research findings to my work?” There is much to be learned from these researchers that can be of use to Aboriginal peoples, but it must be the choice of Aboriginal people to use it and to use it within our contexts.

What are the main gaps between the research, practice and policy? There are few, if any, Aboriginal studies on child care. There is a need for Aboriginal people to conduct their own research. Finally, there appears to be disagreement in these authors’ works concerning the definition of quality care for young children. If we do not define quality ourselves, as Aboriginal people, we run the risk of inaccuracy. Perhaps what we need is not to define quality but rather to regard it as a process in constant evolution and fluidly reflective of the community or peoples. Diversity instead of homogeneity may be the order of the day, so that the validation and respect of all peoples may form the foundation upon which to build the care and education of children. Diversity is not tied to theories that change over time, with each being better than the last. Rather, we need to seek the essence of who we are as a people; those are the things that should be passed on and be inherent in the care and education we provide children. These values, beliefs, traditions and customs hold the distinctiveness of peoples in place. In my case, this starts with recognition and validation of Indigenous knowledge as a way of knowing and being that is distinct from others. The essence of this knowledge is built upon a respect for diversity and difference and as such offers us a path that is inclusive of all.

This diversity needs to be reflected in the ways and structures that we develop to meet the care and education needs of children and their families. Currently, there are not enough options to address this diversity. These options could be built upon community and the collective of peoples that comprise it, that is, the structure of the system, what is taught and the ways in which it is taught. Most models of child care are developed from an American or Euro-colonial perspective, including those offered here in Canada. We are thus not meeting the needs of all children and families.

I now go back to the place I started, to a place of encouraging societies to critically examine the care and education of their children, to know that we do not live in the past, to know that we have much to learn from others. As Elder Mary Thomas says, we must honour those unique values and beliefs that have been woven through time and serve as the tapestry upon which we weave the lives of our children. This will be our survival, and our future.

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VOICES FROM THE FIELD - An Aboriginal View on FAS/FAE

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(Published online June 15, 2004)

Aboriginal perspective

“In the Aboriginal community, FAS/FAE is a partner, a family and even a community issue, because we are a collective society,” says Della Maguire, Executive Director and founder of the Mi'kmaq First Nation Healing Society in Hantsport, Nova Scotia.

The Mi'kmaq First Nation Healing Society is a non-profit organization serving Aboriginal communities. Della Maguire educates and provides training and support on a number of issues, including Fetal Alcohol Syndrome (FAS).

What are the implications of the research findings in the CEECD papers for your work?

Maguire's main concerns about the CEECD papers are that:

- the research is mostly American; and
- there is a lack of Aboriginal content within this research.¹⁻⁹

When we read the CEECD papers, FAS/FAE comes across as a women's problem. “There is a need for more sensitivity and it should be stressed that FAS/FAE is not only a women's issue,” Maguire states.¹⁻⁹ The Aboriginal people look at a community holistically and therefore they talk about the partner, family and community as well. All problems are considered collectively. According to Maguire, Aboriginal communities lack this type of research information. There is a strong need to go beyond what already exists. Aboriginal people should be more involved in the research in order to make it relevant to their communities. “The CEECD papers are a good starting point.¹⁻⁹ For the time being, I need to rely on the Centre's experts and add a cultural component and a cultural sensitivity when I present them in my workshops,” adds Maguire.

Della Maguire believes that a lot of Aboriginal communities are farther ahead than non-native communities in education on FAS/FAE and moving beyond the denial stage. “We are accepting the fact that FAS is in our communities even if we are all on different levels in terms of accepting the problem,” says Maguire. Travelling across Canada has allowed her to notice these differences in each province. For instance, at one of her workshops in Ontario, she asked how many participants had attended this kind of workshop before. Out of 50 participants, only half had been to such an event in the past. Her approach in each

workshop is regularly changed and adapted to meet the needs of the participants because even though the research has been out there for a long time, people are not hearing the right message. They know the basic facts (alcohol consumption during pregnancy causes birth defects), but do not realize the extent of the impact. It is Maguire's role to further educate Aboriginal communities and provide them with advice, strategies and additional information.

She knows some of the communities have problems with alcohol, but because Aboriginal people live in a collective society, it is a challenge to get them to speak up. They fear the entire community will find out about their problem. Because of this sensitivity, Maguire has designed her workshops "according to the basic principles of respect, understanding, caring, forgiveness and hope." Different communities throughout the country keep inviting her back and each time she visits, the workshops attract bigger crowds than when she first started 10 years ago. "Now, people want to know. They want this information. They are very curious about everything and ask very good questions."

Where are the main gaps between research, practice and policy and how might they be overcome?

Maguire identifies trust as one of the main gaps in practice. It is especially noticeable when non-Aboriginal people are doing the research or coming into communities to conduct prevention or screening programs. "There is a lot of fear around the trust issue. In the past, Aboriginal communities have been scrutinized and surveyed. It will take time to rebuild that trust," adds Maguire. Timing is also important and the communities need to feel safe. Researchers, service-providers and policy-makers need to be culturally aware. FAS/FAE is still a sensitive issue and should be "community-based at a community pace."

When a non-native society looks at health, they look at the disease or the illness and its treatment, while the Aboriginal concept of health focuses on physical, emotional, mental and spiritual wellness. "It is a whole different mind-set. In a sense, this difference reflects strongly on people who try to have their children diagnosed. They do not want to be labelled, but instead want to know what could help," says Maguire.

Through her travels, Maguire has noticed that organizations are still not educated enough and do not recognize the links between what they do and FAS. Practitioners and service-providers need to be better informed and educated. Maguire has the challenge to make sure they understand these links. "FAS/FAE is a lifetime disorder, and practitioners and service-providers need to look further ahead in the future."

Another issue that should be addressed is the use of screening tools and the way they relate to Aboriginal people. It is important to take into account the different cultural aspects, and screening tools need to be adapted accordingly in order to prevent misdiagnosis. "Researchers are not adapting the measuring scales. The tools used most of the time will not work because we have different cultural norms," says Maguire. Some physical features, such as eye slants and sometimes head size, can be part of the culture in some communities. Standardized psychological testing for Central Nervous System

(CNS) dysfunctions may also be inappropriate for Aboriginal people, especially for those who speak their own language. Maguire states that we should have “culturally appropriate” screening tools. She also has concerns about the community-based screening mentioned in the CEECD papers.¹⁻⁹ “How could this work in our communities if even our own native doctors cannot do it because of the lack of trust, confidentiality or just the difficulty of obtaining parents’ permission?” According to Maguire, Aboriginal people are not there yet.

Many Aboriginal communities have their own health clinics or health centres that provide parenting and family programs. For instance, in Nova Scotia, the Mi'kmaq Family and Children Services, a self-governing program, is responsible for the 13 Aboriginal communities in the province. This would be the equivalent of Family and Children’s Services in non-native communities. However, sometimes the services needed are only offered outside the communities, and this implies travelling, accommodation problems, language barriers, lack of support and racism. As a result of these numerous barriers, the individuals concerned do not receive the proper services.

FAS/FAE needs to be addressed on a national level because each province has its own criteria governing what can be considered a disability. “We need to look at FAS/FAE as a disability and have an agreement across the borders so the government can start developing some services around it,” Maguire says. “FAS is a lifetime disability,” she concludes.

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VOICES FROM THE FIELD - No Place Like Home: Aboriginal Midwives in Every Aboriginal Community

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(Published online June 9, 2011)

Aboriginal perspective

Home visiting programs such as Aboriginal midwifery recognize that the home environment is important in shaping early experiences. The vision of the nascent National Aboriginal Council of Midwives (NACM) is “Aboriginal midwives in every Aboriginal community”. Founded under the umbrella of the Canadian Association of Midwives, NACM brings to the Aboriginal health field a skilled, culturally safe¹ primary health care provider most appropriate to the needs of Aboriginal communities. Programs that include a trained professional who shares a positive relationship with families and that address the needs of a particular community are successful in supporting families^{2,3,4}. Aboriginal midwifery recognizes that cultural continuity of care is based in the lifecycle connection between birth, puberty, childbearing and elder-hood and is grounded in knowledge of the mind-body-spirit continuum. Competencies of midwives include women and infant care, reproductive health, and the creation of sacred, empowering spaces for aboriginal women, girls and their families.

In her Call to Action to improve Aboriginal MCH in Canada, Tough⁵ recommends attention to preconception, sexual and reproductive health in Aboriginal communities, and positions midwifery as a keystone to address these needs. NACM upholds the principle that Aboriginal Midwives are the most appropriate guides for pregnant, birthing, and postpartum women, especially in Aboriginal communities.

Discourses on Aboriginal health in the past thirty years have yielded a harvest of cultural constructs: cultural awareness, sensitivity, relevancy, appropriateness, competency, congruency, consideration and safety. Currently, there are eight Aboriginal Midwifery practice sites in Canada that exemplify the Cultural Development Model^{6,7}: Puvinituq and Inukjuak, and Salluit, Nunavik (Northern Quebec), Tsi Non:we Ionnerkeratstha Onagrahsta (Six Nations), Norway House (Manitoba), Fort Smith (NWT), Rankin Inlet, Nunavut, and Seventh Generation Midwives, Toronto. One central goal of these services is to provide family support tailored to Aboriginal practices⁸. At the Mohawk community of Akwesasne, - with the support of local health and social services - we seek to create a future in which the minds, bodies, and spirits of community members who have been devastated by disease, trauma, shame and addictions, find healing and well-being through

the power of the sharing circle. Centering Pregnancy developed by Certified Nurse Midwife Sharon Rising at Centering Healthcare Institute, expands and transforms the “medical gaze” to the democratization of knowledge where women are engaged as knowers and learners. Sitting in a group, women discuss their experiences and learn from one another, with the credentialed expert becoming the facilitator of a process of discovery and connection. Providers are developing group facilitation skills and gaining cultural knowledge necessary to positively and creatively impact the development of the mother-infant pair. Such shift-shaping in Aboriginal communities promotes processes of care that support women in developing self-agency and control of their reproductive power; not just the reproduction of children but also production of culture, knowledge and development of women’s voices.

Real Talk

Services targeted to the strengths and needs of children and their families can be addressed via home visiting programs⁸. In my experiences as a Kanienkeha:ka (Mohawk) midwife, well before the welcome wave of professionalization of midwifery swept across the Canadian provinces, home care was the gold standard of my practice. Health begins at home, at the kitchen table, using the everyday language of everyday people. Mohawk mothers’ motivation for choosing to birth at home is based in their cultural identity. The power of the birth story is that it reflects indigenous identity, keeping in mind the root word indigenous means “of the genes, arising from the ground where one’s identity is conceived.” Each birth becomes a reweaving of the essential Mohawk universe, each baby arriving within the cosmological significances of Haudenosaunee (People of the longhouse) culture. The details and patterns noted in the creative actions of gestation and birth, including dream and ceremony, enfold the story of the infant’s development, and contain narrative threads of the individual’s purpose on this earth. This explains why Kanienkeha:ka ancestral midwives would separate the amniotic sac from the placenta when it covered the newborn’s face and place it against a window to “read” the road of the child’s life. Of course, these are different actions and conversations from biomedical knowledge that provides individual risk assessment, information transmission and patient education. Mohawk culture still operates in an essentially oral framework oriented to performance. The social and cultural layer of story de-medicalizes and demystifies data and information, providing wisdom and meaning for life cycle transitions. Stories shared within kinship and peer relations influence the development of attitudes and decision-making in their reproductive lives⁹.

Human beings create language to meet the needs of social realities which are political in nature. Academic language used by “decision elites” such as the sentinel phrase “social determinants of health” require deconstruction to capture divergent attitudes by researchers, public officials and other duty bearers. Results from Robert Wood Johnson Foundation’s (RWJF) report “A New Way to Talk About the Social Determinants of Health”¹⁰ are useful in creating messaging on health disparities and avoid deepening the “discredited medical subject” position of Aboriginal women in health policy and practice described by Browne and Fiske.¹¹ The RWJF report¹⁰ encourage us in the “art of the possible”, using values driven and emotionally compelling language that resonates with the neurocognitive realities of human thought processes.

I leave you with a story that was told by the grand-daughter of a First Nations ancestral midwife in Quebec. The woman was raised in her Catholic grandmother's home where she studied her grandmother's knowledge of women's medicine and birthing. When the time came for her to marry and live with her husband in another First Nations community far from her grandmother's home, the woman became pregnant. She received in the mail a package from her grandmother that contained two bundles, with the following instructions: "If you want to keep the pregnancy, use the first bundle. If you don't want to keep it, use the other." The woman chose to keep her pregnancy. I asked the woman: "How did your grandma reconcile her religion with her indigenous knowledge of termination of pregnancy?" The woman answered: "My grandma used to say: When we're in the village, we're Catholic. When we're at home, we're original people." This illustrates how pre-modern Aboriginal women inhabited their ecosystem, negotiating their fertility within it, in a matrilineal context. A new generation of Aboriginal Midwives is arising from the realities of Aboriginal communities, building upon the knowledge, difference and power of our cultures.

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VOICES FROM THE FIELD - Aboriginal Service and Programs for Low-Income Families and Children

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(Published online May 4, 2005)

Aboriginal perspective

“When providing services, we consider every aspect of a person’s life. It is ineffective to deliver a service only to the child or parent(s). You need to look at the dynamics of the entire family, including parents, grandparents, children and then more broadly, at the community (in this case, the Métis/Aboriginal community),” says Ryan Calder.

The Child and Family Enhancement Plan began approximately 13 years ago with a training program that was developed to meet the needs of community members (50% of the people having a Grade 8 education or less). Once the training program was implemented, other social issues that needed attention were identified and a social department was created. Since then, the Child and Family Enhancement Plan has tried to bridge some of the gaps in rural services through the development of partnership agreements with both government and non-government organizations.

What are the implications of the research findings in the CEECD papers for your work?

Within the CEECD papers,¹⁻⁷ there are some commonalities with the services provided through the Child and Family Enhancement Plan, but there are also pieces missing. The papers fail to address the difference between reasons why the general population lives in poverty and why Aboriginal people live in poverty. The demographics of the population served by the Child and Family Enhancement Plan are 50% Métis, 25% First Nations and 25% non-Aboriginal. The Métis feel that the non-traditional environment in which they are compelled to live has an effect on their employment opportunities, community service provision and access to other programs, such as education and employment training.

Research tells us that a child in a family in which the parents are well educated has a better chance of also being well educated. However, within Aboriginal communities, there is an older generation that did not have access to education, or as children were put into residential schools. This has had a major impact on the transfer of knowledge from parent to child – a key element if children are to succeed in school.

Young adults/parents who have previously dropped out of school are now coming back to complete adult-education courses in order to increase their level of education. As they

learn, they receive support from the Aboriginal and surrounding communities, which boosts their self-esteem as parents. The children see the importance of education because their parents are involved in learning. As those parents gain more confidence in themselves, they are better prepared to be parents and members of the community.

The CEECD papers¹⁻⁷ reference home visiting as an access point. When making an intervention, it is essential to develop a trusting relationship with the family. The people do not trust social services: they remember when children were taken from their homes and placed in residential schools or foster care. The home visitor needs to be able to relate to the conditions and living environment of that home. If it is a Métis home, it works best with a Métis home visitor.

There is a big difference between rural and urban settings, a distinction not made in the CEECD papers.¹⁻⁷ There is access to public transit in urban settings, but not in small communities. If a family has to travel to access a service available only in another community and they do not have access to transportation, they are unable to utilize the service. Families living in rural areas then believe that the services are readily available only in urban centres. What do these families do? Some relocate to urban settings, which cuts them off from their family and community infrastructures. As a result, they often get lost in the urban centres. If there were a way to keep them in their community where they have their support structures and still ensure their access to needed services, there would be more success stories.

Where are the main gaps between the research, practice and policy, and how might they be overcome?

“Stove-piping of services” is an issue when dealing with other organizations. Over the last five years, this organization has been working to build new partnerships and break down barriers. However, there is no core funding and a lot of time is spent trying to develop additional funding and resources. If changes could be made to realign funding and how it is used, we would be able to provide better services.

Technology could also help facilitate rural service provision. For example, if a family in a rural community with no access to educational services were to be given access to a computer and staff to teach them how to use it, they would be able to go online for distance education. “Technology is one of the areas that we should be concentrating on,” says Calder.

When government organizations look at program development and implementation, they do not always include organizations that provide services in the discussions. Changes in government mandates for program delivery have an effect on rural programming. Yet policy-makers do not come to rural programs to see what kind of impact they would have or why. Program-providers need to have more opportunities to speak directly with governments in order to share ideas about service provision in rural areas. This lack of consultation is a serious gap in services and policy development.

Calder was once asked, “How do you know you have been successful in what you are doing?” He responded, “I haven’t been to a suicide funeral in three years. That is how I

know I've been successful. When work first began in this community, there were way too many funerals. Success like this may not be something concretely measurable, but the message is clear.”

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VOICES FROM THE FIELD - Poverty and Pregnancy in Aboriginal Communities

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(Published online June 9, 2011)

Aboriginal perspective

According to Tough,¹ while some focus on the present despair of the First Nations, others see in it a flicker of optimism and inspiration. Let us not forget that 50% of the Aboriginal population consists of young people, the youth in whom we place our hopes. That is why we must act now and help them be proud of their roots. Without overlooking the consequences of the past, it is imperative to get beyond the posture of victimization. We are a people of fighters and we will deal with adversity by confronting it.

This said, it is well established that the Aboriginal peoples of the Québec First Nations face significant health problems, and that their living conditions, in particular their economic conditions, are often inferior to those of Quebecers. Moreover, people from the Québec First Nations are likely to experience, from earliest childhood, poverty, mistreatment and placement in foster care, in proportions three to five times greater than the rest of Canadians. In view of this fact, and confirmed by, among others, a recent survey into Aboriginal health, the First Nations of Québec and Labrador Health and Social Services Commission [Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador]² is calling for absolute parity in health. Moreover, its master plan for 2007-2017 aims to rectify the disparities between the Québec First Nations and Canadians in terms of health and quality of life and to initiate a structural change in perspectives and approaches to governance in managing the health care and social services provided to members of the First Nations.

In my undergraduate and Master's programs and now in my Ph.D. in Nursing, First Nations women have always been basic to my concerns. The importance of the articles from CEECD for my research is thus understandable: they support outcomes as well as expected, and by no means negligible, interventions for communities.

These articles on poverty and preschoolers are written in a concise and accessible language by conscientious and well-informed writers.

Some of these articles I found more interesting than others. In particular, the article by Duncan and Magnuson³ which, among other things, notes that improvements in the economic condition of low-income families have a significant and positive impact on child cognitive development and academic success, but little effect on improving their psychosocial development and reducing their behavioural problems. According to these

writers, direct services and therapeutic interventions would appear to offer a more promising solution. In the Aboriginal community, the scope of the challenges to be met in order to achieve health parity entails basic changes, not only in the delivery of health care and social services, but also in the means and organization required to develop a delivery system suited to the specific characteristics of First Nations communities in general.⁴

According to the work of Harriet J. Kitzman,⁵ a number of studies show that the health and development of children from families receiving home visits are better and the environment is more positive. The data suggest that home visits are a strategy that can improve the lives of children at risk. Given these facts and the need to act on them, the actions taken in the context of a family health approach aimed at developing home care services and programs are of particular interest for Aboriginal communities. In addition, a variety of initiatives will take place for creating a network of informal caregivers in these communities.

Furthermore, the suggestions of Tama Leventhal⁶ are also of interest, especially as they relate to policy decisions. In fact, policy decision makers should pay greater attention to needs for service, which far exceed their availability or offer. Many actions can be taken but substantial investments are necessary to make services more accessible. From an Aboriginal viewpoint, in comparison with the rest of the Canadian population, a person from a Québec First Nations community is four times more likely to experience the inaccessibility and lack of health care and social services. Fortunately, the 2007-2017 Master Plan⁴ has two strategic goals:

- 1) Progressively remedy the disparities that separate First Nations from the rest of the Canadian population in terms of collective health and welfare;
- 2) Initiate a structural change in governance perspectives and approaches for the delivery of health care and social services to First Nations.

However, significant gaps exist between research, practice, and policies. How are they to be overcome?

According to Duncan and Magnuson,³ earlier studies tended to focus on determining the possible effects of poverty on the behavioural problems of young children. These writers have pointed to an interesting avenue of research in examining the links between low family income and other psychosocial impacts on children. In fact, the emergence of problems such as infant mortality, teenage pregnancy, abortion, the rate of non-breastfeeding, foetal alcohol syndrome, (FAS), HIV-AIDS and sexually transmitted infections (STIs) among the First Nations could establish a link between low family incomes and other psychosocial impacts.¹

These research results are similar to those noted in the Aboriginal communities of the Québec First Nations.⁴ As a result, this reinforces the approaches taken by the FNQLHSSC Master Plan concerning maternal and infant health care, since the objectives, among other things, include introducing pre-natal and post-natal services in all Aboriginal communities, developing services and programs for home health care and, finally, initiating the effective promotion and support of breastfeeding, prevention of

teenage pregnancies, support for teenage parents and prevention of various syndromes and diseases.

What are the implications of these objectives for the development of policies and services?

As mentioned above, the 2007-2017 Master Plan has developed objectives substantially along the same lines as the recommendations listed by Tough.¹ Tough advocates pre-natal health improvement in an effort to improving the pre- and post-natal health of mother and child, efforts to reduce the use of harmful substances, transmission of human immunodeficiency virus (HIV) and sexually transmitted infections (STIs), improving knowledge of the biology of reproductive and sexual health in order to reduce the number of unplanned and teenage pregnancies and improve the planning of births and nutrition. Tough¹ criticizes the obvious lack of substantive scientific data and recognizes its impact on programs but finds that this is no justification for inaction. In fact, the scarcity of reliable data and specific information on First Nations' budgets and programs is detrimental to the credibility of accountability that is reciprocal and respectful of commitments; it fails to define the communities' satisfaction and real needs, to anticipate trends and emerging problems or to account for all the effects and impacts of programs, in terms of failures and successes, in First Nations communities.²

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VOICES FROM THE FIELD - The First Nations and Inuit Perspective on Nutrition

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(Published online December 15, 2004)

Aboriginal perspective

In the past, First Nations and Inuit obtained all of their food from the land and water around them. Traditional food was central to the culture and the way of life. As long as there was enough to eat, traditional food gave everyone all the nutrition they needed to stay strong and healthy. Most people now eat a mix of traditional and store-bought food. For some First Nations and Inuit groups, this shift to more commercial foods has happened very quickly. Reasons for this change in dietary patterns include, but are not limited to, relocation into settlements, decreased access to land, less time and energy and fewer skills for harvesting due to employment, depletion of game, concern for environmental contaminants, and costs of or restrictions on hunting.

At the same time, the geographic isolation of many First Nations and Inuit communities is such that nutritious store-bought foods, especially perishable items, are expensive and sometimes difficult or impossible to obtain. The Government of Canada, through the Food Mail program, subsidizes the cost of transporting nutritious foods to remote, isolated communities, but even with such a subsidy, market foods are often much more expensive than they would be in southern urban centres. In some communities, virtually all after-shelter social assistance income is required to purchase the basic amount of food required to feed a family. Families are forced to make tough decisions between purchasing food for their family and buying other essentials.

The decrease in traditional food use, food insecurity, the lack of knowledge and skills in selecting and preparing a nutritionally adequate diet of store-bought foods or combining traditional and store-bought foods have had major consequences for the nutritional well-being of many First Nations and Inuit. Many groups experience significantly higher levels of nutrition-related health problems than other Canadians. For example, the rate of diabetes in the adult population is three to five times higher,¹ rates of iron deficiency anemia among infants is higher,² and rates of overweight and obesity are at least twice as high.^{1,3} There is evidence of poor intakes of key nutrients required for good health, including iron, calcium and folate.⁴

Improved nutritional health would improve quality of life, prevent a wide range of health problems and reduce health-care, economic and social costs. As concluded in the CEECD research papers,⁵⁻¹³ nutritional health promotion targeted to First Nations and Inuit must be part of an integrated, holistic approach and grounded in the broad social, economic and environmental determinants of health. Such an approach also requires a human and financial resource capacity, especially at the community level, that does not currently exist. Nonetheless, there are a number of national initiatives supported by the Government of Canada that address important aspects of nutritional health, including those with a particular focus on pregnancy and early childhood, such as the Canada Prenatal Nutrition Program. This particular program adopts what is close to a true life-cycle approach, with women of childbearing age, pregnant women and infants all included in the target population. As highlighted in the CEECD papers,⁵⁻¹³ a life-cycle approach with interventions at all life stages is most effective in improving the nutrition of women and children.

In the CEECD research papers,⁵⁻¹³ emphasis is placed on the importance of a multidisciplinary approach with experts in the field of reproductive health, nutrition and child development working together. This is currently difficult to achieve for First Nations and Inuit, given the limited access to health professionals and the need to coordinate services between the federal and provincial health-care systems.

In describing the impact of poor nutrition during pregnancy, the CEECD papers⁵⁻¹³ emphasize low birth weight as an outcome. The reduction of low birth weight rates is the goal of prevention programs, especially for nutritionally vulnerable populations. However, prevalence of low birth weight among First Nations, and among most Inuit, is on par or lower than rates reported in the general population.¹ Further, the majority of these low birth weights can be linked to prematurity. As discussed in the CEECD papers,⁵⁻¹³ prematurity is multi-factorial, and prevention programs need to focus on reducing stressors before and during pregnancy to improve pregnancy outcome. This is very relevant, as First Nations and Inuit women are often living in stressful situations due to such factors as lack of employment, isolation and poor housing.

In contrast, rates of high birth weight are elevated among this population. In 1999, 22% of First Nations births were classified as high birth weight, which is almost double the rate for the general Canadian population.¹ High birth weight is higher in overweight mothers, as is the prevalence of gestational diabetes.¹⁴

In an environment of increasing obesity, it is particularly important to protect First Nations and Inuit women against gestational diabetes, especially given the strong link to the development of diabetes later in life. To develop effective prevention programs, the individual and collective factors influencing maternal weight gain in the First Nations and Inuit population need to be identified. Socio-cultural factors, including perceptions of overweight and high birth weight babies, and environmental factors, such as access to opportunities to engage in physical activity and healthy eating, need to be considered.

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VOICES FROM THE FIELD **Aboriginal Children and Obesity**

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Aboriginal perspective

Why is obesity in Aboriginal children such a concern?

There are more obese and overweight Aboriginal children in Canada today than ever before. Although obesity is a major health concern for all Canadians, the situation is more problematic for Aboriginal populations because we have both lower levels of good health and overall lower socio-economic status than other Canadians. We face more barriers to accessing health services due to a multitude of systemic factors, including living in remote communities, having problems with health insurance across jurisdictions, having a sense of mistrust of Western/medical institutions, and lack of availability of health services in our languages.

Aboriginal children in Canada are increasingly developing Type 2 diabetes, and related complications, at a younger age. This type of diabetes used to be seen only in adults. The decrease in age of onset and the prevalence of Type 2 diabetes are consistently linked with issues of overweight or obesity in children.¹

Childhood obesity is especially a concern for Aboriginal children because we have both the youngest population and the fastest growing birth rate in Canada. We also tend to be spread far and wide across the country. Health services are often a treaty right for Aboriginal people, yet in remote locations these services can be difficult to coordinate and expensive. If our children continue to be affected by obesity and its complications, we are going to see a major financial burden on Canada's health care system.

How do the research findings in the papers from the Centre of Excellence for Early Childhood Development (CEECD) influence my work?

Let's Be Healthy Together: Preventing Childhood Obesity in Ontario's Aboriginal Communities is a project of Health Nexus, a non-profit organization that promotes health and well-being and develops tools and programs for service providers and the public in Ontario. First Nations, Inuit, and Métis people have worked together to design the culturally appropriate toolkit and training package that help parents and communities prevent childhood obesity in Aboriginal children between the ages of zero and six.

The papers on childhood obesity from the Centre of Excellence for Early Childhood Development²⁻⁷ validate the approach taken by Health Nexus to develop its culturally

appropriate toolkit on preventing obesity in young Aboriginal children. The findings are as follows:

The importance of a holistic approach

First Nations, Inuit, and Métis people in Canada generally view health as holistic. We consider health to include the well-being of our mind, body, emotions, and spirit. We will stay healthy and well if all of those elements are kept in balance.

When Health Nexus started to develop the *Let's Be Healthy Together project*, we had received funding to focus on obesity prevention for Aboriginal children between the ages of two and six. We decided to take a holistic approach, developing tools to help encourage entire families and communities to change their lives and become healthier. Findings of the Centre's papers²⁻⁷ support this approach in two ways.

First, signs of obesity and overweight issues can be evident during the prenatal period. Overweight and smoking women are more likely to deliver babies who might eventually develop obesity.⁷ Further, exclusive breastfeeding and the delayed introduction of solid foods for young babies are key to helping prevent obesity amongst young children, so they should be supported and promoted within all populations.^{2,3,7}

Second, while many argue that parents are perhaps the most important factors in preventing obesity among young children, the Centre's papers share the finding that all levels of society must work together.²⁻⁷ Governments, charities, schools, and communities all need to support strategies and programs for preventing obesity.^{4,6}

Obesity is not genetic

Researchers who examine childhood obesity generally find that it is not usually a matter of genetics. In some cases genes do play a role, but obesity is most often the result of an imbalance between the energy that comes in and the energy that goes out.^{3,6} For example, obese children may be eating too many high-calorie foods or large portions along with spending too much time in front of the television. For everyone across the globe, rising rates of obesity reflect changing lifestyle over the past 20 years.

The Aboriginal people working on the *Let's Be Healthy project* are well aware of the fact that our people are not facing obesity as a crisis because of our genes. Throughout history, we have been a land-based people. Our health issues stem from the move away from our traditional, active lifestyle. As a people, we now face deep-rooted and complex issues of poverty, geographical isolation, food insecurity, unequal access to education, and others that place our health at risk.

Obesity does not just affect a child's body

While obesity does have a number of serious impacts on a child's body, the impact is not only physical. This finding affirms the Aboriginal approach to health which considers all parts of a person's well-being. The CEECD papers show that children who become obese suffer in many areas, including their social and mental health.³⁻⁵

Obesity is difficult to treat

The papers²⁻⁷ demonstrate that obesity is always difficult to treat. There is no magic solution, no pill or quick fix to obesity.^{2,6}

“Nobody is born obese,” writes Dr. Martin Wabitsch in his paper *Preventing Obesity in Young Children*.⁶ This statement emphasizes the importance and efficacy of focusing on obesity prevention during the early years. In fact, most researchers argue that prevention needs to start with parents, even before a baby is born.

Gaps among research, practice, and policy

The papers of the CEECD²⁻⁷ make a clear case that preventing childhood obesity needs to start early. The information is all relevant and applicable to Indigenous populations, but those working with Aboriginal people should also recognize the multitude of gaps that still exist in research, policy, and practice in relation to our populations. In Canada, we lack:

- *health statistics on First Nations, Métis, and Inuit populations*; specifically, where they live, their health status, and the health services they are accessing. This lack of health statistics results in chronic underfunding for our health programs.

Two common reasons for poor statistics include the transient nature of housing amongst Aboriginal people, as well as in the common unwillingness to identify as an Aboriginal person. Underreporting of Aboriginal identity across Canada contributes to problematic and chronic under-funding for delivering prevention-related activities and programs.

- *involvement of the voluntary sector among the on-reserve First Nations population along with a lack of access to holistic, family friendly healing programs.*

In his paper, Dr. Wabitsch explains that parents play an important role in whether children become overweight or obese.⁶ The CEECD papers also explain that parents need to provide good role modelling when it comes to nutrition and physical activity.²⁻⁷ But for several generations, Aboriginal people were removed from their families and communities. They were put into schools where they received little support or parental guidance. This is also true for the multitude of Aboriginal people adopted out into non-Aboriginal families during the “sixties scoop,” and for the many children who continue to be raised in non-Aboriginal foster families today. This deep-rooted and ongoing trauma is the reason many of us did not have parental, or even familial, role models of healthy eating or physical activity. Many of us have “lost” our traditional ways and no longer know how to do physical activities that would have been common for us—such as building a fire, making our own garden, hunting for game, or gathering wild plants and berries.

Many service providers want to educate and support Aboriginal parents in providing healthier meals and more physical activity for their children, but it is difficult for parents to take good care of their children when they still have not received the therapeutic care they need. It is possible that some voluntary sector organizations could help to provide these programs. However, Dr. Blackstock shows that the

voluntary sector does not operate in reserve communities because of inequitable government funding.⁸ More charities need to be able to operate on-reserve to help provide healing services to families.

- *community-based and community-driven solutions* developed and run by and for Aboriginal people.

Many of our current health care programs and services have not been designed by Aboriginal people. This needs to change.

One popular Canadian program for Aboriginal children is Head Start. It helps Aboriginal children get ready for school while providing education in a culturally appropriate environment. Head Start has six areas of focus in its mandate—one of them is nutrition. Another area is culture, but there is no clear link made between nutrition, physical activity, and culture. Any person with a strong tie to Indigenous culture will attest that physical activity, food, and culture are inextricably linked. This link needs to be played out in daily activities for Indigenous pre-school children.

Aboriginal people are generally served by a mish-mash of (sometimes poorly coordinated) programs funded by multiple levels of government. Aboriginal people can help figure out ways of providing more efficient and seamless services in their communities, as long as their voices are welcome at the table.

How can we overcome these gaps?

“Our people have the answers,” is something that Mohawk teacher Diane Longboat said to me when I interviewed her for our *Let’s Be Healthy* project. Her quote is echoed by many other Aboriginal people who have told Health Nexus, “We know what we need to be healthy.”

The solutions to obesity in Aboriginal children need to be designed, controlled, and led by Aboriginal people themselves. Too often, government policy people come into our communities to implement a quick fix. They try to design programs or provide funding to programs in a way that they see as fitting their (sometimes narrow) view of health.

When government leaders think about supporting healthy Aboriginal children, they need to look at the bigger picture. Aboriginal children need Aboriginal health care providers. Funding for post-secondary education needs to increase. For a Status Indian or Inuit, it is a treaty right to attend post-secondary education. However, most Band councils and funding bodies have to turn away applicants because they do not receive adequate support from the federal government. When Aboriginal people have equal access to post-secondary education, our communities will gain access to skilled Aboriginal people who will know how to provide health care to their clients.

To date, no comprehensive, community-based research has been conducted on obesity prevention among Aboriginal children on a national scale. The *Let’s Be Healthy Together project* is one of the first holistic toolkit and training initiatives that aims to use culture as one way to help children be healthy.

**

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VOICES FROM THE FIELD - First Nations Children in Care

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(Published online September 30, 2005)

Aboriginal perspective

Introduction

There are approximately three times as many First Nations children in the child-welfare system today as there were at the height of residential school operations in the 1940s.¹ The Canadian Incident Study on Child Abuse and Neglect (CIS),² coupled with research on service access, provides the first indication as to why First Nations children are so drastically over-represented in the child welfare system today.^{3,4} These studies indicate that poverty, poor housing and substance misuse are the critical factors accounting for the over-representation of Aboriginal children in care, pointing to the need for interdisciplinary research and responses that address these structural risk factors.

Subject

A report prepared for the Law Commission in Canada indicates that the annual cost of child maltreatment in Canada is over \$15 billion.⁵ Investments in early childhood are likely to be helpful in addressing this problem, but a more comprehensive range of targeted prevention services is critically needed for all children from birth to 18 years, with a specific focus on poverty reduction, safe housing and substance misuse treatment.

Challenges with interdisciplinary approaches to child maltreatment

1. Despite an almost universal acknowledgement that we need to stop assessing the needs of children piecemeal or one age at a time, there continues to be very limited interdisciplinary research between early childhood and child welfare constituencies. The CEECD papers⁶⁻¹⁵ attempt to address this gap, but it is apparent that there is a critical need for further work.
2. First Nations children are too often excluded from national studies on child well-being. For example, First Nations children were not included in the National Longitudinal Study on Children and Youth. This means that there is a very limited pool of research on First Nations children, including the interrelationship between structural and historical factors on child well-being.
3. Consistent with recommendations made by the United Nations Committee on the Rights of the Child,¹⁶ there is a critical need for disaggregated data within ECD and child welfare studies that explore distinct experiences of Aboriginal children within, and between, the major cultural groups (Inuit, First Nations and Métis).¹⁷

Research Context

Despite the over-representation of Aboriginal children in care, the CIS was the first study to specifically include First Nations children and to undertake secondary analysis of the data pertaining to Aboriginal children.

The CIS study engages social workers to describe the situation of clients referred to the child welfare system over a three-month period. Three First Nations child and family service agencies participated in CIS, with the remaining data coming from provincial child welfare authorities. Data were collected describing the reason for referral to the child welfare authority, child and family functioning and case disposition. Aboriginal children represented 614 of the 3,159 children included in the CIS. First Nations children (status and non-status) composed 64% of the Aboriginal children in the sample, with children from birth to seven years representing 52% of Aboriginal children in the sample.

Secondary analysis of CIS data indicated that Aboriginal children were slightly less likely than non-Aboriginal children to be reported to child welfare for physical or sexual abuse. However, Aboriginal children were twice as likely to be reported for neglect.¹⁸ There is arguably an assumption that when social workers assess a family as being neglectful, the caregiver has the ability to influence the risk factors leading to the neglect. CIS findings indicate that this does not necessarily hold true. When researchers controlled for poverty, substance misuse and neglect, there was no over-representation of Aboriginal children in the child welfare system.³

Research aimed at determining the degree to which First Nations children receive equitable child welfare services adds context to the CIS findings. A national review of federal government funding for child welfare services found that First Nations child and family service agencies receive an average of 22% less per child for child welfare services than their provincial equivalents.¹⁹ A research project conducted by the First Nations Child and Family Caring Society of Canada revealed that First Nations children and families on reserves receive negligible support from the voluntary sector that delivers a myriad of quality of life and risk prevention services with an aggregate annual value of \$90 billion.^{1,4} Taken together, these two research reports suggest that First Nations children and families on reserve have less access to quality of life and preventive services support than other children. The dearth of voluntary sector services (food banks, low-income housing coalitions, recreation and arts programs, domestic abuse and child at risk services) is particularly important, given the CIS findings that suggest that the key to keeping children out of care is addressing poverty, substance misuse and housing — areas typically considered beyond the traditional scope of child welfare services.

Overall, research results affirm the recommendation made by Shangreux²⁰ that investment in prevention services for children at risk of or who are experiencing maltreatment is likely to reduce the number of Aboriginal children in care as long as the services focus specifically on poverty reduction, substance misuse and housing adequacy. There are no data to indicate the degree to which children served by early childhood educators are simultaneously served by child welfare authorities, but anecdotal reports indicate that this happens frequently. In order to ensure that families at risk of child

maltreatment are able to benefit from the best of what ECD and child welfare have to offer, there is a critical need for further research exploring how these two professions could better coordinate services and optimize outcomes for children and their families — particularly for those at risk of child maltreatment.

What are the gaps and how can we address them?

As noted, there is a general dearth of disaggregated data that describes the experiences of Aboriginal children and young people in Canada. This is surprising, given their persistent over-representation for poor population health outcomes and other risks, including child welfare placement. The Canadian Incident Study on Child Abuse and Neglect² provided important insights into why so many Aboriginal children are in care, but there is a critical need for further research in the following areas:

- 1) The interrelationships between the structural risk factors of poverty, poor housing and substance misuse and neglect;
- 2) The relationship between inequitable service access and child maltreatment;
- 3) Interdisciplinary research that informs coordinated policy and service responses between child welfare, ECD and other child-related professions;
- 4) A longitudinal study describing the well-being of Aboriginal children and youth, including children in care;
- 5) Studies that explore the experience of Aboriginal children and families throughout the child welfare system.

The syntheses of the Centre of Excellence for Early Childhood Development⁶⁻¹⁵ provide a foundation upon which child welfare and early childhood researchers could work with Aboriginal communities to respond to these critical questions. Increased mechanisms for interdisciplinary relationship-building, information-sharing and collaboration between ECD and child welfare researchers, policy-makers and practitioners are also recommended.

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VOICES FROM THE FIELD - Aboriginal Women and Tobacco

**Deborah Schwartz, Executive Director
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Aboriginal perspective

“As an Aboriginal, I think it is extremely important to weave cultural identity and cultural content into programs,” says Deborah Schwartz, Executive Director, Aboriginal Health, B.C. Ministry of Health Services in Victoria, British Columbia.

Schwartz, a private Aboriginal Health Consultant for many years, has served on many Steering Committees, facilitated a number of women’s programs and worked for women’s centres and non-profit organizations. She developed a smoking cessation program for all women called *Catching Our Breath*, based on which she wrote a self-help book and developed a facilitator guide so practitioners could run their own support groups for Aboriginal women who smoke. She currently manages the Aboriginal Tobacco Strategy for British Columbia.

What are the implications of the research findings in the CEECD papers for your work?

Schwartz finds the CEECD syntheses and commentaries on tobacco and pregnancy quite relevant and informative.¹⁻⁹ She states that smoking is still the norm in Aboriginal communities. Aboriginal people tend to be poor, they have fewer options and smoking is viewed as one of their few pleasures. As is the case for most women who smoke, Aboriginal women’s smoking behaviour is inextricably linked with all of their other life experiences and needs to be viewed within that context. For instance, when Schwartz ran a program for single Aboriginal mothers, they talked about smoking and how cigarettes are used as a coping mechanism very early in their youth. For these women, smoking is a way to take care of themselves, a way to take a break, escape, and deal with anger or emotional issues. However, just as smoking is linked to the stress of life, it can also be linked to positive experiences. The associations connected with smoking are often seen as positive, allowing them to connect and bond with their peers. Smoking cessation programs for Aboriginal women focus on a consciousness-raising process, on the role smoking plays in these women’s life and on self-care (how a woman can take care of herself without cigarettes). Self-care is a very important developmental process for a lot of women; they learn to meet their needs directly rather than through addiction.

Tobacco cessation programs also focus on the health consequences of smoking, the kinds of treatments that are available, the importance of expressing emotion, stress and anger management, and the importance of good sleep, good nutrition and exercise. For

Aboriginal women, breaking free of this addiction requires a holistic approach. It is essential to include the woman's family in the programs and not take an individualistic approach to quitting. Being pregnant and having the ability to create a child is very revered in Aboriginal culture, even in the most troubled communities. Those traditions still run deep, even when women have been disconnected from the teachings around traditional parenting skills and what it is to be a parent and how you ought to behave as one. It is important to help women understand that they have power and they can make a difference by taking care of themselves. Schwartz believes the information provided by the CEECD authors¹⁻⁹ should be communicated to Aboriginal women, who are quite eager to know the impact of smoking on their unborn or young children. It matters to them that they are modelling an addictive behaviour for their children, but there must be a balance in the way this issue is addressed. Women should not be blamed or shamed; instead, they should know that if they cannot quit, reducing the amount they smoke or making their home smoke-free will make quite a difference.

There are not many data available on the most effective ways to help Aboriginal women quit smoking, but it is essential to weave sessions about cultural usage of tobacco into tobacco cessation programs. Schwartz thinks this should be a core component of any kind of programming and any public health education on tobacco. In many Aboriginal cultures, tobacco is a sacred plant and a medicine that was used in sacred ways before contact with Western European culture. Traditional tobacco re-education teaches women how to integrate the traditional use of tobacco into their contemporary lives. They enjoy having that kind of meditative or spiritual place honoured in their day-to-day lives. Tobacco had a place before contact with Europeans, and reconnecting with its traditional place is one way out of the addictive use of tobacco. Many tobacco cessation programs also include traditional culture: women learn to weave a cedar basket, can salmon, prepare traditional food, bead or carve. Many of them attend the sessions because they want to learn those skills, and while they are learning, they actively participate in reflective conversations around tobacco and the reasons they smoke, why they quit, why quitting did not work. This practical knowledge, an informal way to exchange information, builds women's confidence in their abilities. On a practical level, this type of program gives them something to do with their hands because when they quit, most smokers don't know what to do with their hands.

When the B.C. Aboriginal tobacco strategy was evaluated, it was noticed that about one-third of Aboriginal women were seeking nicotine patches. The mainstream providers need to offer more than just clinical options to Aboriginal people. Even though these clinical interventions are important, they should be part of a more holistic approach that would include other tools. Schwartz believes that Aboriginal communities need a more holistic approach – one that would be better integrated in the communities and would allow them to be more connected to the community's development.

Where are the main gaps between research, practice and policy and how might they be overcome?

A policy deficiency that has huge practical implications for running a culturally sensitive program in the community is the lack of funds to supply the food and craft materials

needed for the programs. Most funders do not have a category for that because they do not understand the concept of having a feast and do not recognize the alternative methods of engaging Aboriginal people to participate. There is a lack of cultural sensitivity. Sometimes, in order to get funding, you have to prove that you are building your program on evidence-based data. However, how can one innovate if only what is already done in the mainstream community gets repeated? Policy-makers need to be open-minded and allow a space to implement what is known to be useful in Aboriginal communities by using the research in a way that is more receptive and acceptable. Schwartz feels that there should be more dialogues between practitioners and researchers and that there is a need to create more opportunities for Aboriginal people to have these kinds of discussions. As a practitioner, Schwartz loves connecting with researchers. That kind of exchange is always very valuable. Schwartz can act as a knowledge translator and present the information contained in the CEECD papers¹⁻⁹ in a way that feels more real to Aboriginal women attending tobacco cessation programs. Local artists and young people should also be involved in bridging the gap between research findings and their application in Aboriginal communities.

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