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 Magnuson[3] 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 Leventhal[6] 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 Plan[4] 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. Tough[1] 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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To cite this document:

Duchesneau L. Voices from the field – Poverty and pregnancy in aboriginal communities. In: Tremblay RE, Boivin M, Peters RDeV, eds. *Encyclopedia on Early Childhood Development* [online]. Montreal, Quebec: Centre of Excellence for Early Childhood Development; 2011:1-4. Available at: http://www.child-encyclopedia.com/documents/DuchesneauANGps1.pdf. Accessed [insert date].

This article is funded by the Centre of Excellence for Early Childhood Development (CEECD), the Strategic Knowledge Cluster on ECD (SKC-ECD) and the Alberta Centre for Child, Family and Community Research.