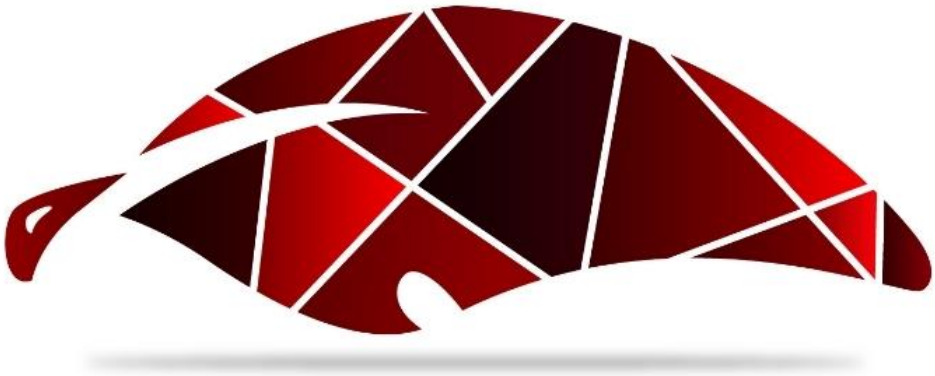


OFIFC

Ontario Federation of
Indigenous Friendship Centres

# MATERNAL AND CHILD HEALTH IN THE URBAN ABORIGINAL COMMUNITY: a position paper

**July 2015**

## INTRODUCTION

The status of urban Aboriginal maternal and child health illuminates the treatment of Canada's most vulnerable population. Raising the standing of the overall health and wellbeing of urban Aboriginal children requires the support, care and commitment of numerous stakeholders, the most important being urban Aboriginal people themselves. The prosperity of children forms the foundation of our Aboriginal cultures and their good health is necessary to our collective prosperity. Aboriginal children have the enormous capacity for learning and development, and equipping them with affirmative and culturally-appropriate knowledge, skills and resources on health can have positive replicating results over multiple generations. Healthy Aboriginal children will become healthy Aboriginal adults.

This document establishes the OFIFC's position on maternal and child health as it pertains to urban Aboriginal people regardless of status. While defining and discussing various concepts of health that are most relevant to urban Aboriginal communities, this paper will frame the OFIFC's position on wholistic and culture-based approaches on maternal and child health. This paper is intended to stimulate critical discussion and action to ensure that urban Aboriginal people are appropriately supported in overcoming obstacles to maternal and child health. Improvement in not only maternal and child health but also in the social determinants of health levels is necessary to create equitable opportunities for urban Aboriginal children, youth and adults striving to realize equitable participation in Canadian society, as both members of distinct urban Aboriginal communities and as individuals.

This paper will explore historical and traditional notions of maternal health and community child-rearing practices, including the acknowledgement of impact of colonization on Aboriginal cultural and social structure. An overview of contemporary issues will be split between maternal health and child health issues, giving consideration to social root causes of poor health outcomes. Maternal health examines health and social issues impacting the health of women, especially pregnant women, such as obesity, mental health, sexual health, family violence, access to health services, and parental roles. The child health section provides a snapshot of the current issues, including infant mortality rates, obesity, poverty, respiratory health, mental health, and sexual health. The paper moves into culture-based approaches to maternal and child health, including increasing access to health and mental health services and increasing positive outcomes of the social determinants of health. Any initiatives, strategies or stakeholders seeking to address the state of Aboriginal child health must be informed of and understand that conditions that impact and share the health status of urban Aboriginal people.

## ONTARIO FEDERATION OF INDIGENOUS FRIENDSHIP CENTRES

Ontario has the largest Aboriginal population in Canada with 301,425 First Nations, Métis and Inuit people living there. Of the Ontario Aboriginal population, currently 84.1%

live off-reserve in urban and rural locales.[1] The migration off-reserve has been growing over the last 40 years.[2] Aboriginal people are choosing to move to and build their lives in urban areas for a variety of reasons, many of which are influenced by education, employment, housing, health, and the overall perception that city life is more stimulating.[3] The promise of increased opportunity and access is not always fulfilled. The Urban Aboriginal Task Force (UATF) found that Aboriginal newcomers were often arriving in cities with little urban experience, low levels of education and few marketable skills. They often immediately 'face major struggles of adjustment to the city including meeting such basic needs as housing, orientation to the city, transportation, lack of income and social support'.[4] Despite challenges, many Aboriginal individuals and families are succeeding in making significant social and economic contributions to the urban areas in Ontario, creating support networks, and continuing to foster a strong Aboriginal cultural identity.[5] And it is Ontario Friendship Centres who are playing a central role in supporting urban Aboriginal people in surmounting their obstacles to achieve a positive quality of life.

The primary mandate of the Ontario Federation of Indigenous Friendship Centres (OFIFC) is to advocate on issues of collective concern for its twenty-eight member Friendship Centres located in towns and cities throughout Ontario. The vision of the Aboriginal Friendship Centre movement is to improve the quality of life for Aboriginal people living in an urban environment by supporting self-determined activities which encourage equal access to and participation in Canadian Society and which respects Aboriginal cultural distinctiveness. They are dedicated to achieving greater participation of all urban Aboriginal peoples in all facets of society, inclusive of First Nation – Status/Non-Status, Métis, Inuit, and all other people who identify as Aboriginal. The Friendship Centres represent the most significant off-reserve Aboriginal service infrastructure across Ontario. This necessitates responding to the needs of thousands of Aboriginal people requiring culturally-sensitive and culturally-appropriate programs and services in urban communities.

The OFIFC administers several programs that are primarily focused on Aboriginal babies, children and youth as well as associated programs which address the health and social wellbeing of Aboriginal individuals and families. These programs are culture-based and founded on the wholistic notion of wellbeing. Children and youth programs include Aboriginal Healthy Babies Healthy Children (target group 0 to 6 year olds); Akwe:go (target group 7 to 12 year olds); Wasa-Nabin (target group 13-18 year olds); Fetal Alcohol Spectrum Disorder and Child Nutrition; Children Who Witness Violence; Children's Mental Health; and Alternative Secondary School Program (ASSP). The OFIFC administers promotion and prevention programs in the areas of health, healing,

[1] Statistics Canada. (2011). National Household Survey.
[2] OFIFC, The Ontario Métis Aboriginal Association, The Ontario Native Women's Association, OFIFC (2007). *Urban Aboriginal Task Force: Final Report*. OFIFC: Toronto. p. 17
[3] Jessica Place. (2012). *The Health of Aboriginal People Residing in Urban Areas*. Prince George, National Collaborating Centre for Aboriginal Health.p.14.
[4] UATF. (2007). p.186
[5] Ibid. p. 18

and wellness, including the Aboriginal Alcohol and Drug Program, Community Mental Health, Aboriginal Healing and Wellness, Health Outreach Workers, Kizhaay Anishnaabe Niin ("I Am A Kind Man"), Life Long Care, and Urban Aboriginal Healthy Living. Our programs have proven to be very successful in addressing people's immediate needs and increasing their capacity to fulfill long-term goals.

The OFIFC offers Aboriginal Cultural Competency Training (ACCT) to individuals, groups and organizations who wish to deepen their knowledge of and strengthen their relationships with urban Aboriginal people. The training offers participants the opportunity to build a shared understanding of contemporary priorities, allied relationships, Aboriginal wholistic healing, and the importance of infusing ongoing Aboriginal cultural competencies throughout organizational practices through meaningful engagement with the urban Aboriginal community. The goal of the ACCT training is to advance cultural safety for Aboriginal people in all areas of society to ultimately improve the outcomes across the range of social determinants of health for urban Aboriginal people.

## CHILD HEALTH IN INDIGENOUS SOCIETIES

Historically in Indigenous societies, the community was heavily invested in maternal, infant and child health as they understood that the prosperity of children was vital to cultural continuity and ongoing social wellbeing. Pregnancy and birth were celebrated community events that contributed towards a strong, interconnected Nation by strengthening relationships between extended families and the natural environment.[6] Women were surrounded by multiple generations of family at all stages of the birthing process – before, during and after – to ensure that the women and their infants received the support and care they needed. This would include the sharing of knowledge and experience of elders and older community members with the women on such topics as maternal nutrition and child care. The community cared for breastfeeding women by bringing them the best foods in order to help support breastmilk flow and increase milk production.[7] Pregnant women were still expected to continue to work and be active in the community, to a moderated degree, because it was a healthy practice that helped to prepare and strengthen women for pregnancy and birth.[8]

Children were placed at the centre of the community, to be communally nurtured, protected and cared for by the parents, extended family, and Elders. Indigenous societies recognized the importance of early childhood education, which was transmitted through cultural child-rearing practices and ceremonies, such as naming ceremonies, practical modeling, and group parenting.[9] As children grew older, there

[6] Smylie, Janet, *Strong Women Strong Nations: Aboriginal Maternal Health in British Columbia*. National Collaborating Centre for Aboriginal Health: BC. (2011). P. 1.
[7] Best Start Resource Centre (2013). *Breastfeeding for the Health and Future of Our Nation: A Guide for Aboriginal Families and Communities in Ontario*. Toronto, Ontario, Canada. P. 5
[8] Ibid.
[9] Ibid.

existed accompanying puberty rites of passage, storytelling, and teachings to explain their physical changes and evolving responsibilities and roles within the community

With the arrival of colonization in North America, traditional Aboriginal cultural and societal norms were displaced and dismantled by European patriarchal values, policies, and systems. The blunt force of colonial rule was inflicted through military, missionary, and bureaucratic government interventions and caused devastation to Aboriginal lands, beliefs, values, ceremonies, spiritual beliefs, language, education, and parenting. The health and wellbeing of Aboriginal children was substantially eroded by the kidnapping of children by residential schools, the "60s Scoop", and the Child Welfare System. It effectively broke down the traditional social support structures and values around parenting and community child-rearing, leaving parents to raise their children on their own, often in conjunction with the residual trauma from colonization, residential schools and assimilationist child welfare policies. Many children raised within those systems lost the capacity to engage in nurturing cultural and social interactions with their own children. Such interactions are the primary means of promoting self-esteem, attachment and intimacy, fostering a positive cultural identity, and developing empathy for others – all aspects that contribute to the individual's overall development of health and wellbeing.[10]

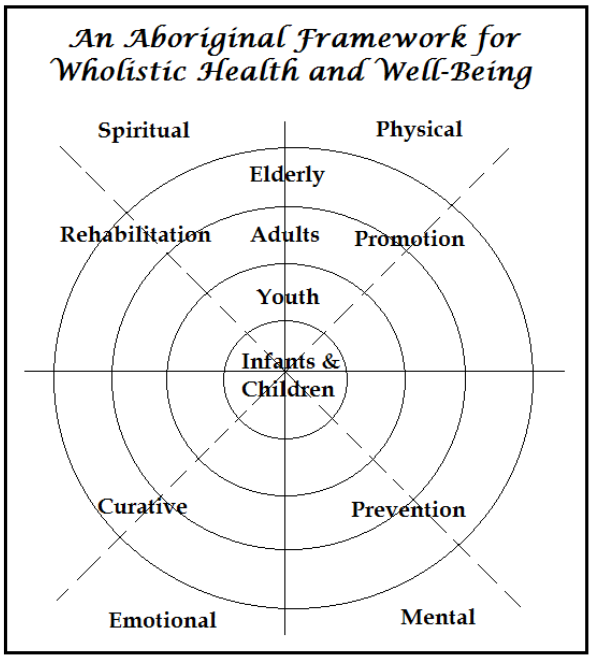
Almost every contemporary social pathology or health issue in Aboriginal communities can be directly attributed to the legacy of colonialism. The erosion of traditional lifestyles and diets of Aboriginal people has been linked to a growing epidemic in obesity and chronic disease among Aboriginal children and adults.[11] Isolation, extreme poverty, economic deprivation, lower educational achievement, poor housing and homelessness, high rates of alcoholism, substance abuse and domestic violence are all products of colonialism and create circumstances which make Aboriginal children especially vulnerable to higher rates of morbidity and mortality.

## MATERNAL & CHILD HEALTH IN URBAN ABORIGINAL COMMUNITIES

The Ontario Aboriginal population is steadily growing at a rate that outpaces the non-Aboriginal population. This trend is being attributed to both improved life expectancies amongst Aboriginal peoples and higher fertility rates.[12] Not unexpectedly, Aboriginal people in Ontario have a much younger age profile than the non-Aboriginal population. Over 40% of the total Aboriginal population in Ontario is comprised of children and youth aged 25 and under.[13] In combination with the fact that over 84% of Aboriginal people live off-reserve, it can be concluded that there is a significant number of urban Aboriginal children in Ontario who have distinct health, social and cultural needs.

[10] Smylie. (2011).
[11] National Aboriginal Health Organization (2012). *Aboriginal Children and Obesity: Fact Sheet*. NAHO: Ottawa. P. 3
[12] Statistics Canada. (2011). National Household Survey.
[13] Statistics Canada. (2011). National Household Survey.

When discussing health in this paper, the OFIFC is referring to the "Aboriginal Framework for Wholistic Health and Wellbeing" as outlined in the *Aboriginal Health Policy for Ontario*. Aboriginal worldviews of health incorporate the three interrelated concepts of the life cycle, wholistic health and the continuum of care.[14] The life cycle relates to the passage of life stages – from infancy and childhood, youth, adulthood and senior years. Wholistic health incorporates the physical, mental, emotional, and spiritual needs of the individual, family and community. The continuum of care encapsulates health promotion, prevention, treatment and curative programs and services, and rehabilitation. People will have different and evolving needs over their lifetime, which must be addressed through appropriate health policies and programs. This approach forms a multi-dimensional matrix for Aboriginal health to ensure that the whole of the individual is addressed and all individuals are included.




In examining health issues in the urban Aboriginal population, it is important to understand the role and impact of social determinants of health on health outcomes. The social determinants of health are the circumstances and environments as well as structures, systems and institutions that influence the development and maintenance of health along a continuum from excellent to poor.[15] They are socio-economic, political conditions influencing the health vulnerabilities and capacities, and health behaviours and management of individuals, communities and peoples. Aboriginal individuals and communities that live with the inequalities of the social determinants of health experience a greater burden of negative health outcomes while also experiencing greater limitations in their access to resources that would improve the situation.

## MATERNAL HEALTH ISSUES

Maternal health care issues and cultural needs differ significantly for urban Aboriginal people in contrast to the non-Aboriginal population. When discussing maternal health related to Aboriginal children, it is heavily associated and interconnected with the health

[14] Ministry of Health, Chiefs of Ontario, Ontario Federation of Indigenous Friendship Centres. (1994). *New Directions: Aboriginal Health Policy for Ontario*. Toronto: Ministry of Health. P. 5

[15] Reading, Charlotte, Wien, Fred. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health*. BC: National Collaborating Centre for Aboriginal Health. p. I

of the mother and the social determinants of health surrounding the family and community.[16]

Aboriginal Women's Health

Maternal health issues begin with an examination of the health and wellbeing of mother. The mother is the determining factor in many short and long-term health outcomes for Aboriginal children, so promoting optimal wholistic health for Aboriginal women will empower and enable them to provide the best care for their children. As will be further explored in this paper, it is crucial to consider the experiences and needs of Aboriginal women, recognizing that they are more likely to experience negative social conditions of poverty, racism and violence that influence and shape the health status of the mother and their families.

The high rates of obesity and overweight among Aboriginal women is a serious concern because it increases health risks during pregnancy and in healthy child development. The prevalence rate for obesity and overweight is higher for Aboriginal people when compared to non-Aboriginal people;[17] and within the Aboriginal population, women are more likely than men to be obese.[18] Being obese or overweight is especially problematic for pregnant urban Aboriginal women because it increases the risk of pre-eclampsia, pregnancy-induced hypertension, and large babies, which in turn raises the chances for induced labour, caesarean sections, stillbirths, and preterm births as well as development of type II diabetes for the mother.[19] Aboriginal women are also at increased risk for gestational diabetes due to the higher prevalence of obesity. It has been shown that children born to mothers who had gestational diabetes are at greater risk of becoming overweight and/or developing gestational diabetes and type II diabetes themselves.[20] Receiving a diagnosis of gestational diabetes can be very difficult for Aboriginal women since the recommended diet may be expensive or otherwise inaccessible, due to location and availability of fresh produce, food products, supplements, and vitamins.

Arising from the 2002 OFIFC report, *Child Hunger & Food Insecurity Among Urban Aboriginal Families*, the urban Aboriginal community is experiencing deplorable rates of food insecurity which is impairing their ability to maintain healthy and nutritious diets. The consequences of poor health status and inadequate nutritional intake for Aboriginal women during pregnancy not only directly affects their health status, but may also have

[16] National Aboriginal Health Organization (2008). *Celebrating Birth: Aboriginal Midwifery in Canada*. Ottawa: NAHO. P. 118

[17] Carmen Ng. (2012). *Obesity Among Off-Reserve First Nations, Métis and Inuit Peoples in Canada's Provinces: Associated Factors and Secular Trends*. Thesis Submission: University of Toronto

[18] Ibid.

[19] World Health Organization (2015). Women and Children's Health in the Post-215 Development Agenda. Retrieved from: http://www.who.int/pmnch/media/news/2013/exec_sum_food_security.pdf

[20] Smylie. (2011). p. 4

a negative impact on birth weight and early development.[21] Low birth weight is a major determinant of mortality, morbidity and disability in infancy and childhood, and also has a long-term impact on health outcomes in adult life. Therefore determining adequate and effective methods of addressing food insecurity and healthy eating habits among urban Aboriginal mothers and families can have widespread positive results in child health.

While the benefits of breastfeeding are indisputably positive for infants and mothers, Health Canada reports that significantly fewer off-reserve Aboriginal mothers initiated breastfeeding (77.8%) in comparison to non-Aboriginal mothers (88.0%). Aboriginal women, in fact, had the lowest breastfeeding rates in all of Canada.[22] Breast milk meets the nutritional needs of the infant and has irreproducible properties that protect against illness and disease for both mothers and children.[23] Breastfeeding helps to forge a bond or closeness with the newborn infant and is associated with lower risks for postpartum depression.[24] And the economic benefits to both the family and healthcare system are unquestionable. The family would save through reduced formula costs and take less time off to care for sick infants and children, while the government would save through the generation of healthy Aboriginal babies and children.

It is estimated that urban Aboriginal women carry a disproportionate burden of postpartum depression in comparison to non-Aboriginal women.[25] The impacts to the child and caregiving activities include compromises to feeding practices – most especially breastfeeding, sleep routines, child health and wellbeing visits, vaccinations and safety practices.[26] A number of risk factors have been identified for postpartum depression, including a history of depression, lack of support system, low self-esteem, relationship problems, and low socioeconomic status.[27]

## Access to Health Care

The structure of the Canadian health care system has allowed for the creation of multiple barriers in the accessibility of health programs and services by urban Aboriginal people in Ontario. The responsibility for the health of urban Aboriginal people is fragmented between two levels of Canadian government – federal and provincial. The *Indian Act, 1876* established that registered Indians, their bands and the system of

[21] World Health Organization. *Feto-Maternal Nutrition and Low-Birth Weights*. Retrieved from: http://www.who.int/nutrition/topics/feto_maternal/en/

[22] Health Canada. Breastfeeding Initiation in Canada: key Statistics and Graphics (2009-10). Retrieved From: http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/prenatal/initiation-eng.php

[23] Office of the Surgeon General (US); Centers for Disease Control and Prevention (US); Office on Women's Health (US). The Surgeon General's Call to Action to Support Breastfeeding. Rockville (MD): Office of the Surgeon General (US); 2011. The Importance of Breastfeeding. Available from: http://www.ncbi.nlm.nih.gov/books/NBK52687/

[24] Ibid.

[25] Smylie. (2011). P. 6

[26] Field, Tiffany. (2009). *Postpartum Depression Effects on Early Interactions, Parenting, Skills, and Safety Practices: A Review*. Infant Behaviour Development Journal. 2010. Feb: 33(1): 1

[27] Public Health Agency of Canada. *The Human Face of Mental Health and Mental Illness in Canada 2006*. Retrieved from: http://www.phac-aspc.gc.ca/publicat/human-humain06/6-eng.php

reserves were the responsibility of the federal government, but the delivery of health care to the non-reserve Aboriginal population is the responsibility of the provincial and territorial governments. The federal government negotiates with bands on the delivery of health care services to on-reserve status Indians through health transfer payments. It also provides non-insured health benefits (NIHB) to cover prescription drugs, dental and vision coverage to all status/registered Indians and Inuit, regardless of where they live. Systemic issues arising from NIHB include denied approval of services, not having NIHB coverage, front-end personal financing, and long wait lists for services. In many situations First Nations and Inuit children are unable to receive necessary health care because they are caught between two levels of government who are fighting over who is responsible to pay for their care. Additionally, this health system fails to adequately address the health care needs of the Métis or First Nations and Inuit people who are either not registered or not living on reserve/traditional territory. They do not have equitable access to the culturally-appropriate health services offered on-reserve while experiencing the inaccessibility of mainstream health services.

Aboriginal women are reporting a number of barriers in their attempts to access mainstream (i.e. non-Aboriginal) prenatal health care services, including financial barriers, the nature of programs and individual perceptions. Aboriginal women in urban areas reported poor access to culturally-relevant, community-based services, "notwithstanding the geographic proximity to advanced care obstetrical facilities that urban residence provides".[28] Just because mainstream prenatal services are offered in their residential locations, it does not mean that Aboriginal women consider them to be accessible as Aboriginal patients. In the *Strong Women, Strong Nations* report, the cost of transportation, child care or prenatal classes are listed as examples limiting Aboriginal women's abilities to access prenatal care. Programs which are directed towards married rather than single caregivers can be stigmatizing to Aboriginal single parents.

Urban Aboriginal women's experiences within and perceptions of the mainstream health care system are preventing them from seeking out the maternal care they require. The Health Council of Canada study, *Understanding and Improving Aboriginal Maternal and Child Health in Canada*, found there to be a clash of values between Aboriginal and western approaches to health and childbirth. Western medicine tend to view health issues in isolation which contrasts with the Aboriginal view of health of incorporation of the cultural, family, and community contexts.[29] For some Aboriginal women, pregnancy and motherhood can be a time of connection or re-connection with their heritage and culture, and they may want the option of integrating traditional practices, ceremonies, and medicine into the pregnancy and birthing process. But they are finding it difficult to both communicate their desire for traditional practices to their doctors and to obtain maternal-newborn care that is culturally relevant.[30] They feel that health care providers do not listen to them and do not provide them with an adequate amount of time during

[28] Smylie. (2011). p. 7

[29] Health Council of Canada. *Understanding and Improving Maternal and Child Health in Canada*. Health Council of Canada. (2011). P. 5

[30] Ibid.

consultations.[31] Furthermore, Aboriginal women are reporting being afraid to seek out care because of fears of racism, being judged for behaviours, appearing ignorant, and that they might reveal something which could lead to encounters with the child welfare authorities.[32]

Given these barriers and concerns regarding health and maternal care, research indicates that many Aboriginal women do not receive adequate prenatal care in the form of visits to family physicians or obstetricians, or prenatal classes.[33] Consequently, urban Aboriginal women tend to seek out Aboriginal-run health services and Friendship Centres where they feel more comfortable and culturally safe. Understanding that providing equitable maternal care for urban Aboriginal women requires that services be culturally safe, respectful, and aware of the experiences and history of Aboriginal people.

Sexual Health

Many Aboriginal people, especially youth, find themselves in situations that increase their risk for negative health and socio-economic outcomes due to their sexual practices. The OFIFC released *Tenuous Connections – Urban Aboriginal Youth Sexual Health & Pregnancy* in 2002, a study examining the views and experiences of urban Aboriginal youth on sex, sexuality, pregnancy, and sexual practices and behaviours. Of the Aboriginal youth interviewed, it was reported that 62% of youth were sexually active by age eleven, and more than 50% reported little to no use of contraceptive.[34] Many urban Aboriginal youth were sexually active before the age of 15 (70%) and did not have the knowledge, means, or maturity to practice or negotiate for safe sex.[35] Alcohol and drug use are major factors in the sexual practices of Aboriginal youth. It is reported that many youth are engaging in sexual activity when their ability to make choices and take responsibility is impaired. In addition, youth are reporting that drug and alcohol impairment heavily influenced their decisions to use (or, in most cases, to not use) contraceptives during sexual activity, increasing their risks for pregnancy and sexually transmitted infections (STI).

Early motherhood increases the vulnerability of young Aboriginal females and their families who are already at a socio-economic disadvantage. Aboriginal woman who were mothers under the age of twenty had higher rates of unemployment, increased reliance on social assistance and experienced greater levels of poverty.[36] While not impossible, teenage parenthood also significantly made educational achievement much

[31] Kurtz, Donna *et al.* 2008, Silencing of Voice: An Act of Structural Violence – Urban Aboriginal Women Speak Out About Their Experiences with Health Care, *Journal of Aboriginal Health*
[32] Health Council. p. 7
[33] Smylie. (2011). p. 7-8
[34] Ontario Federation of Indian Friendship Centres (2002). *Tenuous Connections: Urban Aboriginal Youth - Sexual Health and Pregnancy*. OFIFC: Toronto. p. 11
[35] Ibid. p. 11
[36] Garner, R., Guimond, E., Senécal, S. (2013). *The Socio-Economic Characteristics of First Nation Teen Mothers*. The International Indigenous Policy Journal, 4(1). Retrieved from: http://ir.lib.uwo.ca/iipj/vol4/iss1/9

more difficult, which can have long-term repercussions of limiting both employment options and income levels over a life time. For urban Aboriginal children, living in poverty impacts on their health through increased risk of food security, housing instability, lowered success rate in school, behaviour and emotional problems, depression, and family dysfunction.[37]

By engaging in sex without contraceptives, Aboriginal youth are at increased risk for STIs, which can severely complicate pregnancy and may have serious effects on both the woman and her developing baby. HIV can be passed from mother to child during pregnancy, labour and delivery, or through breastfeeding. However, if diagnosed before or during pregnancy, medication can be administered lowering transmission rates to less than 2%.[38] Passing syphilis to a developing baby has been linked to serious health problems of premature births, stillbirths, and death shortly after birth.[39] Untreated surviving infants tend to develop problems in multiple organs, including the brain, eyes, ears, heart, skin, teeth, and bones. Infants infected with Hepatitis B (HBV) have a 90% risk of becoming chronic (lifelong) carriers of HBV and are at increased risk for developing chronic liver disease or liver cancer later in life.[40] Untreated Chlamydia and Gonorrhea infections have been linked to pregnancy complications of miscarriage, preterm birth, low birth weight, and premature rupture of the membranes surrounding the in utero baby.[41] Pregnant Aboriginal women need to be made aware of the risks in regards to STIs, and to have proper access to STI testing, and transmission-preventative care.

Young Aboriginal mothers garner the attention of child welfare agencies at increased levels, due to the greater perceived risk of neglect and abuse. The relationship to neglect emerges with the supposition that Aboriginal adolescent mothers are "more disposed to substance abuse while pregnant and are less likely to be properly nourished or breastfeed their babies."[42] The need for focused action is paramount as today, Aboriginal children make up over 18% of the total number of children in care, despite only being 2.8% of the population in Ontario.[43] This is particularly disturbing given the statistical trend showing that adolescents who have been involved in the child welfare system are more likely to become pregnant teenagers,[44] continuing the generational cycle of socio-economic disadvantage.

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[37] Best Start Resource Centre. (2012). *Why am I poor? First Nations Child Poverty in Ontario*. Toronto, Ontario, Canada: Author. p. 30

[38] Centre for Disease Control and Prevention. STDs and Pregnancy: CDC Fact Sheet. Retrieved from: http://www.cdc.gov/std/pregnancy/stdfact-pregnancy.htm

[39] Ibid.

[40] Ibid.

[41] Ibid.

[42] Ordolois, E. (2007). *A Story of their own: Adolescent Pregnancy and Child Welfare in Aboriginal Communities*. First Peoples Child and Family Review. Vo. 3:4, p. 30-41

[43] Office of the Child and Family Service Advocate. (2014). *Ontario Child Welfare Report 2014*. Retrieved from: http://www.oacas.org/newsroom/releases/2014/2014_child_welfare_report.pdf

[44] Ordolois. (2007).

The relationship between alcohol, drug use, sexual activity and pregnancy bears greatly in mind considering the devastating impact fetal alcohol spectrum disorder (FASD) can have on the life of an Aboriginal person and their family. Fetal alcohol exposure can alter brain metabolism, causing permanent brain damage, and is the primary cause of preventable developmental disability in Canada.[45] The persistent link between FASD, mental illness, and substance abuse has been termed a "triple threat" - FASD often leads to mental illness which in turn increases the susceptibility of an individual to alcohol and drug abuse.[46] Since FASD is completely avoidable, the most important factor towards preventing future cases lies in Aboriginal community awareness of the risks of alcohol consumption during pregnancy, treatment of existing alcohol abuse issues in women and communities, and reducing the risk factors associated with substance abuse.

Family Violence

Family violence has a profound impact on the health and wellbeing of urban Aboriginal children and families, and special attention is required to address these issues. Violence against Aboriginal women is occurring at alarmingly high rates with long lasting impacts on their health and wellbeing. The negative health associations of family violence on women include psychological trauma, acute physical injuries, chronic health problems, unwanted pregnancies, and miscarriages, all of which hinder the abilities of women to participate fully in society. Violence on pregnant women significantly increases risk for low birth weight infants, pre-term delivery and neonatal death and also affected breast-feeding postpartum.[47]

The effects of family violence on Aboriginal children is just as destructive. Children who experience or are exposed to violence are at heightened risk of being apprehended by the child welfare system. Further to that, due to the impact that violence and abuse has on the physical and psychological health of the mothers, Aboriginal children are at greater risk for apprehension for reasons of neglect and parental substance use.[48] Violence and victimization have profound negative effects on the mental and physical development of children and youth's identity and self-perception. It is in the first 18 months life that children develop trust, self-esteem, emotional control and the ability to have positive relationships with others later in life.[49] The unstable and eruptive environment contributes to unhealthy feelings of stress, mistrust, low self-esteem,

[45] Public Health Agency of Canada. (2008). *Fetal Alcohol Spectrum (FASD) Prevention: Canadian Perspectives - Multiple Approaches to FASD Prevention.* http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/fasd-etcaf/publications/cp-pc/index-eng.php.

[46] N. Hall, Cunningham, M., and Jones, S. (2010). *Towards a Provincial Strategy: Advancing Effective Service Provider Practices in Fetal Alcohol Spectrum Disorder.* Prepared for FASD ONE.

[47] Sarkar. N. N. (2008) "The impact of intimate partner violence on women's reproductive health and pregnancy outcome. " *Journal of Obstetrics and Gynaecology*, 28(3), p. 266-271

[48] National Collaborative Centre For Aboriginal Health (2013). *Aboriginal and Non-Aboriginal Children in Child Protection Services*. Public Health Agency of Canada: Victoria, p. 2

[49] Public Health Agency of Canada. *What Makes Canadians Healthy or Unhealthy?* Retrieved from: http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php

anxiety, anger and helplessness. Children who experience or witness violence are more likely to repeat the cycle of violence as adults, as victims and victimizers.

Parenting

The loss of traditional forms of child-rearing have left many urban Aboriginal parents without the necessary knowledge, skills, resources and support networks needed to raise healthy children. Colonization has eroded family structures and community networks around parenting and child rearing. While adolescent pregnancy is something of an accepted norm in certain urban communities, the primary caregiver responsibilities falls largely on the shoulders of the mothers. Many young Aboriginal mothers do not feel adequately supported by their families and/or their partners.[50] Currently, Aboriginal women are more likely to be lone parents with 18% of Aboriginal women aged 15 and over heading families on their own; and lone-parent families headed by Aboriginal women tend to be larger, with twenty-two percent having three or more children.[51] Longitudinal analysis has revealed that children in single-parent families had lower odds of being reported in excellent or very good health. This is partially explained by factors exacerbated in single-parent families such as increased poverty, maternal distress, and lower social support.[52]

Aboriginal women, because of compounding issues of racism, sexism and colonialism, are being stigmatized as “bad mothers”. It is estimated that there are now more Aboriginal children and youth in the child welfare system than there was at the height of the residential school system and the child welfare interventions of the 1960s (aka “60s scoop).[53] This heightened involvement with the child welfare system has led to the portrayal of Aboriginal women as “bad mothers”, which blame women for the difficulties they face as Aboriginal mothers “without recognizing the roots of those difficulties in the history and current structures of colonialism and racial oppression”.[54] It also reduces of the role of the social determinants of Aboriginal health.[55] This stereotype serves to rationalize why Aboriginal children are in an impoverished state, to legitimize their continued apprehension into the child welfare system, and to undermine the traditions and practices of Aboriginal parenting.

The role of the father in Aboriginal families has been critically diminished, with high numbers of Aboriginal children being raised in single-mother headed households. The

[50] *Tenuous Connections. (*OFIFC). p.11
[51] Statistic Canada - 2006 census data
[52] Rayner, Jennifer Lynn, "Differentials in Physical Health Outcomes among Children in Single-Parent and Dual-Parent Families" (2013). *University of Western Ontario - Electronic Thesis and Dissertation Repository.* Paper 1085. http://ir.lib.uwo.ca/etd/1085
[53] Blackstock, C. (2003). First Nations child and family services: Restoring peace and harmony in First Nations communities. In K. Kufeldt & B. McKenzie (Eds.), Child welfare: Connecting research, policy, and practice (pp. 331-342).Waterloo, ON: Wilfrid Laurier Press.
[54] Irvine, Kathleen (2009). *Supporting Aboriginal Parents: Teachings for the Future*. National Collaborating Centre for Aboriginal Health: BC. p. 2
[55] Ibid.

positive involvement of fathers' in their children's lives is important to the wholistic development of healthy children. However many Aboriginal men have had negative experiences with their own fathers or did not have a father present during their upbringing, and this has left them with limited positive personal experience to draw upon. Furthermore, problems with substance abuse, mental health issues and difficulty sustaining relationships with partners can influence their ability to maintain involvement in their children's lives.[56] In finding supports for fathers, many parenting programs and services are dominated by and geared towards mothers, creating exclusionary spaces and invisible roles for fathers in the care of their children. Finding the means to remedy father absenteeism in urban Aboriginal communities is important because children who have had little to no contact with their fathers is associated with considerable negative health outcomes later in their life.[57]

The portrayals of Aboriginal mothers as "bad mothers" and Aboriginal fathers as "dead beat dads" fails to consider the efforts that many Aboriginal parents are making to deal with the day-to-day realities created by the structural inequalities of the social determinants of Aboriginal health.[58] It creates a "deficit lens" where Aboriginal parents are evaluated as irresponsible, neglectful, dysfunctional and incompetent.[59] With this perspective, programming, supportive services and resources are designed to fix the problems and deficits of Aboriginal parents who are frequently considered to be the helpless victims of their life circumstances.[60] Programs which disempower Aboriginal parents will not effectively address structural issues negatively impacting Aboriginal parents and children. By providing strengths-based, community-driven, cultural programming, services and resources for Aboriginal parents, the health and wellbeing of Aboriginal children will be substantially improved.

## CHILD HEALTH ISSUES

Aboriginal children in Canada report the greatest disparities in health outcomes, despite being citizens in one of the most affluent and developed countries in the world. Canada ratified the Convention on the Rights of the Child in 1991, recognizing that *all* children (under 18) have specific rights in the areas of protection, provision, and participation. In almost all health status indicators and the determinants of health, Aboriginal children fall well below the national averages for Canadian children.[61] By all accounts, Canada is failing Aboriginal children and their abysmal health conditions are a manifestation of that failing. Their health status is not a product of biological determinants, but of social conditions and access to societal resources. As the fast growing segment of the

[56] Jessica Ball. (March 2008). *Policies and Practice reforms to promote positive transition to fatherhood among Aboriginal young men*. Horizons. p. 53
[57] Ibid.
[58] Irvine. (2009). p. 2
[59] Ibid.
[60] Ibid. p. 3
[61] Unicef. (2009). Canadian Supplement to the State of the World's Children 2009: *Aboriginal Children's Health: Leaving No Child Behind*. Unicef: Toronto. p. iii

Canadian population, the health of Aboriginal children serves as a reflection as to how Canada treats its most vulnerable population.

Infant Mortality Rates

Infant mortality rates among Aboriginal people, while in decline since the 1970s, remains comparatively higher in regards to the non-Aboriginal population. Post-neonatal death is the death of children aged 29 days to one year and are more likely to reflect social and environmental factors (e.g. malnutrition, infectious diseases, unsafe housing conditions). In the First Nations on-reserve population, the risk for post-neonatal death was 3.5 times higher than the non-First Nations population.[62] The First Nations off-reserve comparative rate was 3.6 times higher for post-neonatal death.[63]

Risks of Obesity

Aboriginal children and youth in Canada have much higher rates of obesity and overweight, putting them at greater risk for further health problems. In a study of First Nations children aged 4 to 19, disturbing rates of obesity prevalence were documented: 64% of female children and 60% of male children were reported as being obese.[64] Obese children are more likely to become obese adults and have an increased chance of developing serious health issues, including heart disease, breathing problems, high blood pressure, various types of cancer, arthritis and other joint problems, bone problems, gall bladder disease, high cholesterol, certain reproductive disorders, problems with self-esteem, depression, and social isolation, and youth-onset Type II diabetes.[65]

A range of factors, including early life events, family feeding practices, food insecurity and colonization practices and policies, have been categorized as contributing to high rates of obesity in Aboriginal families.[66] Early life events can include having an overweight or obese mother, having a mother with diabetes, and not being breastfed. The knowledge and beliefs of the caregiver on physical activity, healthy weight, food and nutrition can affect the eating and exercise habits of the children, determining their likelihood of becoming obese. Limited access to traditional foods and food-gathering practices is linked to the prevalence of obesity in Aboriginal children.[67] The correlation between the consumption of traditional foods and better health is a result of the higher nutrient value of traditional foods and the physical activity associated with the gathering of those foods.[68]

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[62] Smylie, Janet, et al (2010). *A Review of Infant Mortality Rates in Canada: Striking and Persistent Aboriginal/Non-Aboriginal Inequities*. Canadian Journal of Public Health 2010;101 (2):143-48.
[63] Ibid.
[64] J. Reading. *The Crisis of Chronic Disease among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy*. (2012) Centre for Aboriginal Health Research, p. 53
[65] NAHO. (2012). P. 3
[66] Ibid. p. 1
[67] Ibid. p. 3
[68] J. Reading. (2012). p.33

## Poverty

Poverty is prevalent for Aboriginal families living in urban settings. Unicef reports that in urban centres with fewer than 100,000 people, approximately 43 per cent of Aboriginal children under the age of 15 were found to be living in low-income families, compared to 17.4 per cent for non-Aboriginal children. For larger cities with more than 100,000 people, this contrast is even more evident, with 50 per cent of Aboriginal children under age 15 living in low-income housing, compared to 21 per cent of non-Aboriginal children.[69] Accepting that poverty rates are predictors of long-term health issues in children, the rampant rates of poverty among urban Aboriginal families places children at high risk. While not all children with low socioeconomic status grow up to be adults with low socioeconomic status, it is generally accepted that childhood origins can shape adult health, behaviours, and circumstances.[70] Recurrent stress responses triggered in early life by adverse social environments can initiate enduring physiological changes, such as alterations in lipid metabolism and the accumulation of body fat, the development of hypertension, and the development of insulin resistance that leads to Type II diabetes, and cardiovascular disease.[71]

Many urban Aboriginal families are falling victim to food insecurity, finding themselves unable to provide diets that are adequate to support good health in both children and adults. The OFIFC *Child Hunger* report found that 79% of respondents indicated that they worried about running out of food, 35% of their children had gone hungry, 42% of parents skipped meals, and 48% were using food banks. The report found that hungry children are more likely to get colds and viruses, to have a compromised immune system, to have anemia, sore stomachs and headaches. Food insecurity is linked to a number of mental health issues including low self-esteem, inability to concentrate, shame, moodiness and behavioural problems in children.[72] Another outcome of living in a food insecure crisis state is the loss of control over the types of food served and consumed. Cheap, processed, pre-prepared meals are being chosen for individuals and families over fresh, prepared, healthy meals because they are more affordable, accessible, and easier to serve. This is leading to situations where urban Aboriginal children are being overfed but undernourished, contributing towards flourishing obesity rates.

## Respiratory Health

Aboriginal children are more likely to develop respiratory tract infections, such as bronchitis, bronchiolitis, pneumonia and croup, than non-Aboriginal children in Ontario. In fact, a study of South Western Ontario Aboriginal communities found that the incidence of lower respiratory disease among Aboriginal children was almost three

[69] Unicef. (2009). Canadian Supplement to the State of the World's Children 2009: *Aboriginal Children's Health: Leaving No Child Behind*. Unicef: Toronto. p. 39-40
[70] J. Reading. (2012). p. 48
[71] Ibid. p. 48
[72] OFIFC. (2003). *Child hunger & Food Insecurity Among Urban Aboriginal Families*. Toronto: OFIFC.

times that of the non-Aboriginal children.[73] This is especially troublesome for the long-term health of Aboriginal children as respiratory infections have the potential to turn into chronic conditions and cause permanent lung damage, due to the weakening of the pulmonary system.

Mental Health

The Urban Aboriginal Task Force (UATF) highlighted the need to investigate and understand the many interrelated challenges that urban Aboriginal children and youth face in Ontario due to the observation that the prevalence of addictions, mental health issues, and suicide likely point to a variety of unmet mental health needs. The limited research and data available in the area of children's mental health suggest that 15 to 21 percent of Canadian children and youth are affected by mental health issues, with significantly higher rates for Aboriginal children and youth.[74] In Ontario, more than 500,000 children and youth are estimated to live with at least one diagnosable mental health disorder, with the prevalence of Fetal Alcohol Spectrum Disorder (FASD) estimated to be as high as 20 percent among Aboriginal children.[75]

The overall Aboriginal suicide rate is up to fifty times (e.g. Sioux Lookout, Ontario) higher than that of non-Aboriginal populations and the suicide rate for Aboriginal youth aged 15 to 24 is five to six times greater than that of non-Aboriginal youth. Suicide is clearly linked to mental health issues like depression as well as trauma, including childhood sexual or physical abuse, rates of which are estimated to be significantly higher among Aboriginal populations.[76,77] While youth suicide rates are not evenly distributed across communities, the generalized youth statistics are sobering. Aboriginal girls are 7.5 times more likely to commit suicide than non-Aboriginal girls, and Aboriginal boys are 5 times more likely to commit suicide than non-Aboriginal boys. Overall, Aboriginal males have the highest rates of suicide of any group in Canada.[78]

Sexual Health

Aboriginal youth are at high risk for a number of sexually transmitted infections (STI) due to the increased likelihood of high risk behaviour. Health research has confirmed the higher STI prevalence rates among the Aboriginal youth population.[79] Chlamydia is estimated to be almost seven times higher among First Nations adults than in the

[73] J. Reading. (2012). p. 96
[74] Ministry of Health Promotion and Sport, *Aboriginal Problem Gambling Needs Assessment and Environmental Scan* (Toronto, ON: MHPS), 12.
[75] Ministry of Children and Youth Services, A Shared Responsibility – Ontario's Policy Framework for Child and Youth Mental Health, 2006.
[76] Feedback to the Ontario Human Rights Commission's *Minds that Matter: Report on the consultation on human rights, mental health, and addictions*.
[77] *First Nations, Métis and Inuit Children and Youth: Time to Act*, National Council of Welfare Reports, 2007
[78] Submission to the Mental Health Commission of Canada: Recommendations for the Improvement of Mental Health in the Urban Aboriginal Community 2010
[79] FNIGC. (2012)

broader Canadian population.[80] The trend in the general Canadian population for reported HIV and AIDS cases has been declining since 1994; conversely, the annual number of reported HIV and AIDS cases among Aboriginal people has risen dramatically. In 2011, Aboriginal people made up 12.2% of new HIV infections and 8.9% of those living with HIV in Canada, despite only representing 4.3% of the total Canadian population.[81] HIV prevalence rates unevenly impact Aboriginal youth with almost one-third (31.6%) of the positive HIV test reports from 1998 to 2012 being attributed to Aboriginal youth aged 15 to 29 years old.[82]

The need for intervention is urgent for the Aboriginal population as the contraction of an STI can have serious long-term consequences beyond the immediate impact of the infection itself. All cervical cancers and an estimated 85% of anal cancers are caused by HPV[83] and the Society of Obstetricians and Gynaecologists (SOGC) estimates that 75% of Canadians will contract at least one Human Papilloma Virus (HPV) infection in their lifetime.[84] Some STIs can increase the risk of HIV acquisition by three times or more. HIV diminishes the body's immunities making the body more susceptible to other conditions that may be life-threatening, and long term exposure to HIV treatment (such as highly active antiretroviral treatment or HAART) is showing to have numerous associated side effects, including heart disease, obesity and comorbidities complications.[85]

## CULTURE-BASED APPROACHES TO CHILD HEALTH

### Approach to Access to Services

Aboriginal people in Canada have a right to access culturally-appropriate supports and services as affirmed by Section 35 of the Constitution (1982). The health, including maternal and child health, of urban Aboriginal people is greatly impacted by their lack of or limited access to appropriate, timely, and equitable health care. Appropriate, timely and equitable health care is being defined here as health services, programs, providers and institutions that: are culturally appropriate, culturally safe and accessible; are provided in a suitable timeframe that does not cause undue hardship, suffering or escalated risk; and give equal opportunity to individual's to obtain health care based on their perceived need.

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[80] FNIGC. (2012)

[81] Canadian Aboriginal AIDS Network (2015). At a Glance: HIV/AIDS Epi Update. Retrieved from: http://www.caan.ca/2012-positive-test-results-for-hiv/at-a-glance/

[82] Ibid.

[83] National Cancer Institute. *HPV and Cancer*. Retrieved from: http://www.cancer.gov/cancertopics/causes-prevention/risk/infectious-agents/hpv-fact-sheet

[84] Society of Obstetricians and Gynaecologists. *Incidence and Prevalence of HPV in Canada*. Retrieved from: http://www.hpvinfo.ca/health-care-professionals/what-is-hpv/incidence-and-prevalence-of-hpv-in-canada/

[85] Cahill, S., Valadéz, R. (2013). *Growing Older with HIV/AIDS: New Public Health Challenges*. Am J Public Health. 2013;3(3):e7-e15.

Improving the Aboriginal maternal and child health requires equitable access to culturally appropriate health care, services and programs for Aboriginal women, men and children. Aboriginal women are best supported by culturally based approaches to health that encompasses the wellness of family and community, as well as the individual, and have expressed a preference for culturally appropriate health services. Aboriginal women need unmitigated access to health care, especially in the areas of maternal, and sexual and reproductive health care. This includes uncomplicated access to obstetricians and gynaecologists, prenatal classes, condoms and contraceptives, culturally-safe sexual health clinics, abortions and reproductive services, and safe, comfortable and confidential sexual health testing (e.g. Pap tests, pregnancy tests, and HIV and STI tests).

Culturally appropriate and culturally safe health care begins with the belief that urban Aboriginal people need to be treated with respect and dignity in the health care system, to feel that their issues are being heard and their needs are being met. All Ontario health professionals, organizations and agencies who deliver services to Aboriginal people must recognize that Aboriginal communities have different beliefs, cultural practices, languages and history that influence not only their health but their actions regarding their health care. Furthermore, health agents must understand their roles and responsibilities in reducing barriers, providing culturally appropriate and safe care that empowers Aboriginal people and communities to address their health and wellbeing. Cultural competencies of health care providers must include a knowledge and understanding of the social determinants of health and the barriers they create to health care.

1. Increase the access and availability of culturally-appropriate health care and health promotion programs and services to urban Aboriginal children, men, and women.

2. It is recommended that all health professionals in Ontario undergo Aboriginal Cultural Competency Training (ACCT) in order to understand their roles and responsibilities in reducing barriers, providing culturally appropriate and safe healthcare, and empowering Aboriginal children, youth, adults and elders to address their health and wellbeing. The training must be inclusive of historical and contemporary Aboriginal health issues, and the social determinants of health.

3. Health and social service providers need to be accountable to the services they provide to urban Aboriginal people, ensuring that their service delivery model and organizational policies are inclusive of Aboriginal people. Accountability processes require assessments of program effectiveness and financial expenditures with annual reports to Aboriginal people and governments.

4. Reduce the barriers to maternal, sexual and reproductive information, materials, resources, and services necessary for the realization of positive maternal and sexual health and healthy child development.

The voices of Aboriginal organizations and communities must be central to the development of any health and social strategies or approaches intended to affect change in the lives of Aboriginal children. The importance of self-determination in achieving health equity is articulated clearly by the WHO, which states that health equity depends on the empowerment of individuals and groups to represent their own needs and interests strongly and effectively. The *Aboriginal Health Policy for Ontario,* created in collaboration with the Ontario Ministry of Health, also recognises that Aboriginal people have the right to develop and determine policies, programs and services, allocation of resources, and the selection of representatives on planning bodies in relation to their own health concerns. Services and programs that are delivered to Aboriginal communities by mainstream agencies will continue to underperform as compared to services that are designed, developed, delivered and evaluated by Aboriginal organizations. Aboriginal-developed and delivered policies, programs and services are built upon a foundation of culture and employ a comprehensive and wholistic approach to improve the physical, mental, emotional, and spiritual wellbeing of urban Aboriginal individuals, families, and communities.

5. Aboriginal organizations must have control of health planning and resources management processes pertaining to Aboriginal policies, programs and services.

6. Access to and effectiveness of health programs and services delivered off-reserve will be increased when Aboriginal people and organizations are involved in planning, consultation, delivery and evaluation. This should include equitable funding to support the sustainability of successful programs and services in Aboriginal organizations.

The concept of self-determination extends to Aboriginal individuals, including children, and their choice of health care services. Health empowerment is enabling individuals, families and communities to understand all factors which affect their health and to recognize their own responsibility. This in turn includes respecting their personal choices in determining their own course of treatment and care. Traditional health care providers, including healers, midwives medicine people and elders, continue to have a central and respected role in Aboriginal societies as caregivers who use traditional healing knowledge. Aboriginal and western approaches to health do not need to be seen as dichotomous, but instead should be viewed as complementary methods for achieving optimal health.

The voices of children and their parents must be heard and respected within front-line service delivery, but also at the level of policy and program development. Aboriginal people are the experts on Aboriginal health needs. By integrating their experiences and perspectives into wider strategies, it will be enhancing the effectiveness of any activities and interventions intended to improve their health and social outcomes.

7. An Aboriginal person’s choice of services will be acknowledged and respected in regards to their maternal and child health and needs.

8. The input of Aboriginal children and their parents should be incorporated whenever possible into the development of policies and programs on Aboriginal child and maternal health.

Aboriginal people face many jurisdictional barriers to receiving appropriate access to social services. A critical factor in the delivery of health services to First Nations children in Canada is the prevalence of jurisdictional disputes over which level of government is financially responsible for the costs of providing services. Jordan's Principle puts the child's interests first in any jurisdictional dispute between federal and provincial/territorial governments. When a dispute arises about the provision or payment of a government service (such as health care, education, recreation or another service normally enjoyed by other Canadian children) for a status Indian or Inuit child, Jordan's Principle requires the government of first contact to pay the bill immediately – and then resolve the payment issue later.

Ontario adopted Jordan's Principle in 2009, yet each year, thousands of Aboriginal children continue to be denied government services on the basis of their race and residency.[86] The federal government itself has acknowledged widespread discontent with its response to Jordan's Principle and a 2013 Federal Court ruling criticized the federal government's narrow interpretation and implementation of the principle.

9. The provincial and federal levels of government commit to honouring Jordan's Principle to ensure that First Nations children have equitable health care treatment.

### *Health Promotion and Prevention Services*

The costs placed on the Ontario Health Care system will be reduced if prevention and promotion initiatives are relevant and effective for urban Aboriginal women and children. The OFIFC believes that by reinforcing and expanding preventative measures that address the interrelated physical, mental, emotional and spiritual health of Aboriginal women and children, the potential need and associated costs for maternal-newborn care, complex care coordination and access to specialized pediatric services will be dramatically reduced.

Effective mother, infant and child models of care need to be shaped differently to those targeting non-Aboriginal populations. The ultimate goal is safe and culturally appropriate births and early childhood development that emphasizes a respect for life and the empowerment of women and children. Aboriginal women and children who live in urban settings are more exposed to health programs that provide services and support for the general public, that take a "pan-Canadian approach",[87] but as stated this has shown to alienate Aboriginal people.

[86] Unicef. (2009).

[87] National Aboriginal Health Organization (2011). *First Nations, Métis and Inuit: Respiratory Health Initiatives Environmental Scan*. Ottawa: NAHO. p. 4

10. Health promotion and prevention, and management initiatives must adopt a wholistic, community-based approach that applies to all stages of the life cycle and is reflective of the realities of urban Aboriginal people.

Considering that current evidence suggests that Aboriginal children, youth and adults have high rates of obesity, health promotion and prevention programs must address the risk factors for obesity as well as barriers preventing access to services. This will include determining adequate and effective methods for addressing food security, healthy eating and physical activity in urban Aboriginal children and families.

The OFIFC currently delivers the Urban Aboriginal Healthy Living (UAHL) program and the Urban Aboriginal Healthy Living – Healthy Kids program, programs which are designed to promote and support healthier lifestyles for urban Aboriginal people. While the UAHL program is offered in 28 Friendship Centres, the UAHL – Healthy Kids program is only offered in 14 Friendship Centres. The programs create opportunities for community members to learn about healthy lifestyles and participate in active living activities. The program provides the urban Aboriginal community with hands-on experience through interactive workshops, healthy nutrition information, cooking classes, fitness training, smoking cessation support, sport and recreational activities. It also focuses on youth leadership by encouraging and supporting youth to promote healthy lifestyles amongst their peers and to be healthy living leaders in their community.

11. Determine a provincial strategy to address food security and nutrition issues in urban Aboriginal communities.

12. Address the barriers to physical activity in urban Aboriginal communities.

13. Support the expansion of the Urban Aboriginal Healthy Living – Healthy Kids program to all 28 Friendship Centres in Ontario.

Parenting skills are essential for child health and development. By delivering supportive services, resources, and preventative programs that build on the strengths of Aboriginal parents by reinforcing their capabilities, abilities, and potential, we will be addressing the current and future health and wellbeing of Aboriginal children. Parenting programs can promote healthy pregnancy, provide emotional and social supports to parents, enhance confidence and self-esteem of parents and children, strengthen early childhood development, and assist in reducing child behavioural problems.[88] Parenting programs are particularly relevant to the urban Aboriginal population considering the number of new young mothers who require support, information and education in a culturally appropriate manner. Despite the importance of parenting skills, existing programs (including prenatal programs) are often under-utilised for a range of reasons, including culturally inappropriate approaches, avoidance of judgement for poor health habits such

[88] Sudbury & District Health Unit, *Access to Parenting Resources in Northern Ontario: A Report for the Northern Ontario Prenatal and Child Health Survey Consortium*, December 2003, p. vi

as smoking, alcohol and/or substance use, homelessness, stress or depression, or financial reasons.[89]

The OFIFC stresses that parenting programs must address more than motherhood and prenatal care. They must extend to promote positive transitions to fatherhood among young Aboriginal men. It has been argued that 'there is the potential for a new generation of positively involved Aboriginal fathers that urgently needs to be recognized and supported through program and policy reforms".[90] This is where traditional and culturally relevant teachings and programs can draw attention to men's roles in child raising and their contribution to the healthy development of their children as part of a wholistic understanding of the self, family and community.

Aboriginal women and men need the establishment of positive support networks during and after pregnancy to moderate their physical and mental health needs. The Aboriginal Healthy Babies Healthy Children (AHBHC) has made significant inroads in supporting parents in the neonatal, natal and early childhood stages of parenting. The AHBHC program aims to improve the long term prospects of children up to six years of age and includes pre and post-natal screening and assessment, breastfeeding skill development, postpartum support services, home visiting, service coordination and support for service integration. The program focuses on preparation for parenting, early childhood development, emphasizing family empowerment, healthy sexuality/relationships, nutrition and physical health, networking and referrals, and linking parents and families with traditional and cultural teachers.

Over the years there has been significant increases in the number of clients accessing the AHBHC program in Friendship Centres. The OFIFC maintains that the AHBHC program is vital and requires increased resources including administration support and expansion of services. The AHBHC program workers in 14 sites have all reached the recommended maximum of 20 clients and are often working over capacity due to high demand. With a high fertility rate and a young population, it can be expected that this need will continue to rise in urban locations.

14. Support the expansion of the Aboriginal Health Babies Healthy Children program to all 28 Friendship Centres in Ontario.

Empowering youth and adults to make informed decisions about sex, their sexual health, and their actions, they require access to and the delivery of culturally-appropriate, accurate sexual and reproductive health education, which understands the interrelated and complex challenges of urban Aboriginal people. As the Aboriginal population is a relatively young population, with 46% being under the age of 25,[91] making interventions in the area of sexual health among Aboriginal children and youth can have widespread results on multiple generations. In OFIFC study, *Tenuous*

[89] Sudbury & District Health Unit, p. 5
[90] J. Ball. p. 52
[91] Statistics Canada, 2011 National Household Survey, *AANDC tabulations*. Retrieved from: https://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ-AI/STAGING/texte-text/abo_demo2013_1370443844970_eng.pdf

*Connections,* youth participants explicitly stated that they wanted information concerning sexual health, healthy relationships, pregnancy and the realities of teen parenthood. By making sexual education interventions at earlier ages and consistently throughout their youth, Aboriginal children and youth will be better informed and empowered to understand their sexual rights, voice their needs and desires, when they are ready, to engage in healthy, supportive sexual practices.

As Friendship Centres have been delivering quality programs for urban Aboriginal children, youth, and families for years, they have the foundational knowledge of the issues of Aboriginal youth in the area of sexual and reproductive health. Furthermore, the infrastructure of Friendship Centre programming provides a mechanism to increase the delivery of sexual and reproductive health education in a culturally safe setting, if the Friendship Centres had increased capacity support. This can include funding support of Friendship Centre Aboriginal Youth Councils, and training for Friendship Centre staff in sexual health education.

15. Increase access to and the delivery of culturally-appropriate, accurate sexual and reproductive health education to Aboriginal youth, which is informed of their historical and contemporary issues and inclusion of Two-Spirit people

16. Involve and engage Aboriginal youth and organizations in the development and delivery of sexual and reproductive health education.

17. Increase the capacity and funding support of Friendship Centres to effectively delivery sexual and reproductive health education to Aboriginal youth.

The OFIFC recognizes the need for wholistic and culturally appropriate Aboriginal mental health services geared towards children and youth. Friendship Centres, through participant and client-based programming, provide the support the Aboriginal children facing social and behavioural challenges. For example, Awke:go and Wasa-Nabin children's programs are designed to address children's mental wellbeing. The programs address the needs of each individual child via their personalized client action plan, provision of social supports, children in care, health and physical development, institutional interventions, and children with FASD/disabilities. These programs contribute to improving the overall social and emotional health of young Aboriginal people, thus slowing the incidence of mental health issues in the Aboriginal community.

Unfortunately, there continues to be provincial gaps in services and funding allocation towards urban Aboriginal children and youth mental health initiatives. Despite the tremendous increase in the percentage of Aboriginal people living off-reserve, there has been no significant increase in funding to support Friendship Centre children and youth mental health programming.

18. Increase funding to Friendship Centres to allow for increased program delivery to ensure that the mental health needs of urban Aboriginal children and youth

are met, without them having to seek inappropriate services from mainstream organizations.

Addressing family violence requires the coordination of a myriad health and social services to form a support network for Aboriginal women and children. Education and training on family violence in Aboriginal communities would help front line workers and organizations to better address their clients' issues rather than referring them on to a different service provider, and would motivate organizations to create the necessary policy changes to ensure that these services can operate in an interconnected, wholistic manner.

Increased investment in integrated, culturally-appropriate preventative and rehabilitative health, substance abuse, and anti-violence services for Aboriginal men is equally important since the roots of violent behaviours frequently lie in the intergenerational effects of trauma. The Kizhaay Anishinaabe Niin program, administered through the OFIFC, continues to provide men a safe place to involve themselves in curative and rehabilitative programming within the Aboriginal community. The program is based on the Healthy Indigenous Male curriculum designed to address issues of family violence, the post-contact changes in attitudes towards women and girls and healthier intimate relationships between human beings through the teachings of: Wisdom, Love, Respect, Bravery, Honesty, Humility and Truth.

19. Increase the coordination of the health, social and cultural needs of Aboriginal children and women who have experienced violence to meet their wholistic needs.

20. Support the sustainable expansion of the Kizhaay Anishnaabe Niin program to all Friendship Centres.

The prevalence of FASD in urban Aboriginal communities is significant and requires complex care coordination among children and adults. The effects of FASD can range from mild to moderate to quite sever and have serious consequences for persons who are affected by this disorder, in addition to their families, caregivers and communities. There is a great need to support the development of a provincial FASD strategy that meaningfully incorporates culturally-appropriate services and supports for Aboriginal people affected by FASD.

21. The OFIFC is calling for a provincial FASD strategy that effectively addresses the needs of urban Aboriginal children, youth, adults, and communities, that acknowledges and respects the importance of a wholistic approach rooted in Aboriginal culture.

22. Increase the access to FASD diagnostic and treatment services for Aboriginal children and youth.

Considering the destructive short and long term impacts of poverty on the health and wellbeing of urban Aboriginal children, increasing the employment and educational opportunities for Aboriginal parents and adults will alleviate poverty's harmful outcomes. Along with improved family health outcomes, employment can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards; each important for health.[92] Poverty creates and exacerbates mental health issues of anxiety, insecurity, low self-esteem and feelings of hopelessness, arising from the lack of control over one's life outcomes, which are felt by children.[93]

23. Increased programming and funding for employment and educational opportunities for urban Aboriginal youth and adults.

## CONCLUSION

Before colonial contact, Aboriginal people had intricate systems and structures in place to support the development and thriving of children, with interrelated methods for generational knowledge transmission and community support. The OFIFC and Friendship Centres are seeking to restore those connections while repairing from the traumas and damages resulting from a history of cultural assimilation, trauma, racism, and exclusion. The challenge will be how to meaningfully incorporate the unique issues of urban Aboriginal maternal and child health into wholistic and collaborative solutions. Addressing the issues of Aboriginal maternal and child health requires actions, strategies and partnerships that extend beyond the realms of health, because health is largely determined by individual and collective social determinants of health.

Urban Aboriginal people, as a whole, experience widespread barriers to services and programs in health, education, employment, and social services, therefore improving the status of Aboriginal maternal and child health will require the involvement of multiple, necessary stakeholders. Addressing presently the negative health outcomes and building on successful solution will have the long-term results of producing happier and healthier urban Aboriginal children, youth, adults and elders.

[92] World Health Organization. (2008). *Closing the gap in a generation: Health Equity through action on the social determinants of health*. WHO: Geneva. p. 72
[93] J. Reading. (2009). p. 13

## APPENDIX 1

### Recommendations

1. Increase the access and availability of culturally-appropriate health care and health promotion programs and services to urban Aboriginal children, men, and women.
2. It is recommended that all health professionals in Ontario undergo Aboriginal Cultural Competency Training (ACCT) in order to understand their roles and responsibilities in reducing barriers, providing culturally appropriate and safe healthcare, and empowering Aboriginal children, youth, adults and elders to address their health and wellbeing. The training must be inclusive of historical and contemporary Aboriginal health issues, and the social determinants of health.
3. Health and social service providers need to be accountable to the services they provide to urban Aboriginal people, ensuring that their service delivery model and organizational policies are inclusive of Aboriginal people. Accountability processes require assessments of program effectiveness and financial expenditures with annual reports to Aboriginal people and governments.
4. Reduce the barriers to maternal, sexual and reproductive information, materials, resources, and services necessary for the realization of positive maternal and sexual health and healthy child development.
5. Aboriginal organizations must have control of health planning and resources management processes pertaining to Aboriginal policies, programs and services.
6. Access to and effectiveness of health programs and services delivered off-reserve will be increased when Aboriginal people and organizations are involved in planning, consultation, delivery and evaluation. This should include equitable funding to support the sustainability of successful programs and services in Aboriginal organizations.
7. An Aboriginal person's choice of services will be acknowledged and respected in regards to their maternal and child health and needs.
8. The input of Aboriginal children and their parents should be incorporated whenever possible into the development of policies and programs on Aboriginal child and maternal health.
9. The provincial and federal levels of government commit to honouring Jordan's Principle to ensure that First Nations children have equitable health care treatment.
10. Health promotion and prevention, and management initiatives must adopt a wholistic, community-based approach that applies to all stages of the life cycle and is reflective of the realities of urban Aboriginal people.

11. Determine a provincial strategy to address food security and nutrition issues in urban Aboriginal communities.
12. Address the barriers to physical activity in urban Aboriginal communities.
13. Support the expansion of the Urban Aboriginal Healthy Living – Healthy Kids program to all 28 Friendship Centres in Ontario.
14. Support the expansion of the Aboriginal Health Babies Healthy Children program to all 28 Friendship Centres in Ontario.
15. Increase access to and the delivery of culturally-appropriate, accurate sexual and reproductive health education to Aboriginal youth, which is informed of their historical and contemporary issues and inclusion of Two-Spirit people
16. Involve and engage Aboriginal youth and organizations in the development and delivery of sexual and reproductive health education.
17. Increase the capacity and funding support of Friendship Centres to effectively delivery sexual and reproductive health education to Aboriginal youth.
18. Increase funding to Friendship Centres to allow for increased program delivery to ensure that the mental health needs of urban Aboriginal children and youth are met, without them having to seek inappropriate services from mainstream organizations.
19. Increase the coordination of the health, social and cultural needs of Aboriginal children and women who have experienced violence to meet their wholistic needs.
20. Support the sustainable expansion of the Kizhaay Anishnaabe Niin program to all Friendship Centres.
21. The OFIFC is calling for a provincial FASD strategy that effectively addresses the needs of urban Aboriginal children, youth, adults, and communities, that acknowledges and respects the importance of a wholistic approach rooted in Aboriginal culture.
22. Increase the access to FASD diagnostic and treatment services for Aboriginal children and youth.
23. Increased programming and funding for employment and educational opportunities for urban Aboriginal youth and adults.