BC First Nations and Aboriginal Maternal, Child and Family Strategic Approach

Originally Drafted: August 2013
Preamble

In the years after signing the Tripartite First Nations Health Plan and the BC Tripartite Framework Agreement on First Nations Health Governance, the Tripartite partners have worked together to develop strategic approaches and tools for the various Health Actions strategy areas. This joint work has brought together a wealth of information and enabled the Tripartite partners to develop relationships and create new opportunities for collaboration throughout the initial years of the Tripartite process.

With the historic transfer of Health Canada First Nations and Inuit Health Branch programs and services to the First Nations Health Authority on October 1, 2013, the path forward is now to shift towards a renewed focus on supporting the work and priorities of the regions. As regions, sub-regions and communities go forward with their planning processes, the documents created by the FNHA and Tripartite partners can provide information and tools that may inform or assist in the development of the plans. They also create a starting point for discussion and lay out for consideration potential opportunities or key areas for work.

Through the process of dialogue and collaboration that will take place as we move forward through planning cycles, it is expected that these documents will be in a continual process of evolution as we work together, share knowledge and learn lessons through implementation.
A TRIBUTE TO CANDACE RObothAM

The winter of 2012 brought great sadness as we collectively learned of the sudden passing of Candace Robotham, our dearest colleague, friend, mother, sister, teacher and mentor. In keeping with the traditions of her home at Seabird Island First Nation, four seasons were spent collectively respecting and honouring her spirit with silence and reflection. It is now with renewed energy and inspiration that we begin to celebrate her life, and in so doing pay tribute to her memory.

Candace and I first met as professional colleagues through First Nations HeadStart on Reserve Regional Advisory Committee. I recognized her instantly as a friend. We both valued and cherished our families and the well-being of our children more than anything else in the world. Our similar commitments to improving services for First Nations children in British Columbia brought us closer and closer together, and we quickly came to live each day as loving friends.

The world is full of people who will go their entire lives and never truly live a single day. Candace did not intend on being one of them. She chose to study hard and fill her life with meaningful work. She combined her academic expertise of Nursing, Child Psychology and Early Childhood Education together with her loving commitment as a First Nations mother. She brought the best of herself to all things. Candace’s widespread professional commitments were nothing short of amazing. She was equally as comfortable working at government policy tables as she was on the front lines. Few people are able to be effective in both environments. Candace not only believed she could move mountains; she helped others to believe that they could as well. Ever generous with her time and knowledge, she was always ready to teach others. Candace taught those in her community to fly on eagles wings.

Losing Candace was especially tragic and significant to Health Canada because of her outstanding contributions to the field of First Nations Early Childhood Development in British Columbia. She evaluated programs and provided advice and recommendations for improvements. Candace demonstrated strong leadership as she coordinated federal and provincial programming in order to enhance Early Childhood Education initiatives at Seabird Island and other First Nation communities.
For the BC First Nations Head Start On Reserve Program, Candace was an integral member of the Regional Advisory Committee (RAC). She provided invaluable guidance and support to the First Nation Head Start communities in the South West region of the province and to her RAC colleagues.

Candace evaluated each of Health Canada's Fetal Alcohol Spectrum Disorder (FASD) sites within British Columbia and provided advice and recommendations for improving this very important program that continues to see positive benefits for First Nations people. Candace was a member of Health Canada's Maternal and Child Health (MCH) planning committee and Chair of the Strategic Council. She organized the BC Maternal and Child Health Training Forum as well as teleconferences and face to face sessions with community coordinators. Her numerous contributions to MCH included her work on the development of the MCH Orientation Manual, the Home Visitor Toolkit and other key health service delivery projects.

In the Tripartite MCH cluster work, Candace was chair of the MCH Committee from its inception in July 2008. Candace provided direction and support with a clear and consistent vision of healthy First Nation communities that allowed significant progress to be made over time.

In addition to her work with Health Canada, Candace was a core member of the First Nations Early Childhood Development Council (FNECDC). Her enthusiasm for solving complex problems in changing environments was exceptional.

She was also selected to sit on the First Nations, Urban Aboriginal and Metis Early Childhood Development Steering Committee Reinvestment Initiative. Candace also dedicated countless volunteer hours as she took on the great responsibility of advocating for First Nations children and loved it. She soldiered on through difficult times with a natural perseverance.

As we remember Candace here again, may we take comfort in knowing that her contributions have made a significant difference in the lives of many. May she always be remembered as a natural leader bringing sunshine and light. May we allow this tribute to act as an echo of the soft sounds of Candace’s footsteps during her short walk across this Earth. As we move forward, may we truly value the impact of her tracks through the snow. And may we also work, as Candace did, for the benefit of all the children who will follow the path she blazed.

Now let us remember her kind heart and brilliant mind, may we all live as Candace lived: as loving family members, as strong leaders, as compassionate educators, but mostly as loyal friends.

Gila`kasla
Pamela Lee Lewis
WeWaiKai Nation
# Table of Contents

A Tribute to Candace Robotham ...................................................................................................................... 3

Introduction .................................................................................................................................................. 7

In the Time of the Old Ones .......................................................................................................................... 8

Section 1: Background ................................................................................................................................... 10

The Social and Aboriginal Determinants of Health ......................................................................................... 10

The Seven Directives – Consensus Paper ........................................................................................................ 13

Transformative Change Accord and First Nations Health Plan ...................................................................... 15

Timeline of What First Nations and Aboriginal Communities Have Told Us .............................................. 16

Section 2: Beliefs, Values, Principles & Wellness Framework ........................................................................... 19

A Framework for Maternal, Child and Family Wellness .............................................................................. 20

Section 3: Strategic Directions for the Future ............................................................................................... 22

Approach - Overarching Goals ..................................................................................................................... 23

Approach - Strategic Directions .................................................................................................................... 23

1. Strategic direction: ensure that meaningful collaborative planning, knowledge sharing and timely and consistent communication occurs with and for first nations and aboriginal communities .............................................................................................................. 24

2. Strategic Direction: Increase First Nations and Aboriginal community control and leadership in collecting information and monitoring trends in maternal, child and family health ................................................................. 27

3. Strategic Direction: Develop a culturally competent workforce, culturally safe services and culturally appropriate resources in maternal, child and family health .......................................................................................... 29

4. Strategic Direction: Promote holistic pre-pregnancy planning, pregnancy, birthing and post-birth health and wellbeing for First Nations and Aboriginal mothers, children and families .......................... 32

5. Strategic Direction: Improve access to continuous and well-connected services and resources across pregnancy planning, pregnancy, birthing and post-birth care for First Nations and Aboriginal mothers, children and families ........................................................................................................ 35

6. Strategic Direction: Promote and support safe environments and healthy early childhood development for First Nations and Aboriginal infants, children and families ......................................................... 39

Section 4: Measuring Success .......................................................................................................................... 43

Appendix A: Summary of Key Priorities Defined by Communities .............................................................. 45

Appendix B: Tripartite Maternal Child and Family Health Strategy Area: Our Progress, Learning and Achievements to Date ........................................................................................................................................ 53
INTRODUCTION

The Maternal, Child and Family Health Strategic Approach (called the Approach from now on) was developed with input from First Nations and Aboriginal\(^1\) community members, First Nations Health Directors and the Tripartite Maternal, Child and Family Health Strategy Table and Planning Committee members from across BC.

This Approach has been developed to encourage discussions within the regions around strategic directions and actions in maternal child and family health. This Approach has also been developed to support and complement the existing maternal, child and family oriented work that is currently happening at local, regional and provincial levels in British Columbia. This Approach is not meant to be prescriptive. It is recognized that First Nations and Aboriginal community\(^2\) contexts, priorities and needs are different and that partners will look to this document and use it in different ways that will support and complement work already in place.

This Approach encourages shared efforts in identifying common priorities, bringing together resources, developing policies and using best practices to ensure that First Nations and Aboriginal mothers, children and families in BC are served by effective, efficient and empathetic systems that honour the diversity of community, family, and individual customs, values and beliefs.\(^3\) Identifying strong models and approaches to care, promoting improved access to services and ensuring the availability of culturally relevant and safe resources and services are all important parts of this work. This Approach aims to ensure that First Nations and Aboriginal mothers, children and families are supported to reach and maintain excellent physical, mental, emotional and spiritual health and wellness outcomes.

Much of the Tripartite work discussed in this Approach has occurred within the past 3 to 5 years. It is important to celebrate these initial successes and achievements in the area of maternal, child and family health for First Nations and Aboriginal communities in BC. Our work is just beginning and will continue to grow.

\(^{1}\) First Nations and Aboriginal is used throughout this document, indicating that the topic is inclusive to all First Nations, Métis and Inuit people (urban, rural and remote) in British Columbia regardless of their age or where they live.

\(^{2}\) The use of the terms community or communities throughout this document includes First Nations (on-reserve and off-reserve) at home and away from home and Métis and Inuit peoples. The definition of community refers to a collectivity with shared identity or interests that has the capacity to act or express itself as a collective.

\(^{3}\) Note alignment with: *A Path Forward – BC First Nations and Aboriginal People’s Mental Wellness and Substance Use 10 Year Plan. A Provincial Approach to Facilitate Regional and Local Planning and Action.*
IN THE TIME OF THE OLD ONES

The Maternal, Child and Family Health Strategy Area is grateful to Sheila A. Nyman, Traditional Healers Advisory Committee member, for sharing her story with all of us.

The ways of the Syilx (Okanagan) People, my Ancestors:

Wai (hello) my name is Sheila Nyman, I am a mixed woman from the Okanagan Nation, we are known as the Syilx people. My maternal family is from the Lower Similkameen, and my 2x great grandfathers were French men. I identify myself as a Syilx woman, we believe we are from the land, we have been on this land since the beginning of humans living here; the teachings of our natural laws have been passed down orally through stories from one generation to the next. According to the writers in “Who we are – Syilx laws and evolution” (2004-08), our Elders have told us that, “understanding the living land and teaching our young generations how to become a ‘part of it’ is the only way we, the Syilx, have survived.”

I have been taught that in the time of our old ones, before contact, every individual within our community had a role and held a place of importance; we each had a job to do that would contribute to the overall wellbeing of everyone. Throughout Syilx Territory the care and wellbeing of the whole community was paramount to our leaders, this required incredible organization and skills. Our old people knew that if someone was lost then their role would need to be filled, so others would be taught and then given the roles that were now empty, we understood the importance of being ready to fill those roles. Babies were cared for up to the age of three by the mothers of one or two families in the community, this was their role. There was no need for baby sitters, day care or for the moms to become overwhelmed with their many tasks. This whole family of baby care people would work together to provide food, diaper changes and all that goes into the care of the babies. Grandparents watched over the other children up to about age eleven / twelve; they heard the stories, learned the songs, dances, medicines, fishing, basket weaving, tanning, sewing, hunting, etc. and learned all that was required to become healthy and skilled community members. Young adults stayed with the aunts and uncles and learned how to perform their ‘specialized’ tasks so that they could take on the role they would have in the community when it was time.

Training started off with what was managable for their age and gradually got more complex and harder as the child grew and learned. Never did our people use a heavy hand in teaching the children, in this way they were eager to learn and take on more, they would build on each task they became good at. Children could not fail, they learned through success, this was encouragement to become good at all things with no fear of failure later.

Each child grew up learning about their importance to the community and their responsibility to their teachers and the other people within their community. They would learn this too from the teacher mentors that guided them into the ways of communal life. Another of the Syilx laws is that we are each responsible to everyone else in the community, each of us are a healthy part of the ‘whole’ family. The adults had the responsibility to model and teach from the earliest age that our actions are always connected to the others within the community. In this way we learned that we needed to think about what impact everything we did...
had on our people, it was not OK to hurt any member of our community. Our love, health and wellbeing was
tied to each other, we knew this with every fiber of our being before we became an adult. We understood
our connection to our family and extended family, our community, the whole nation and our land which
included every living thing on it. This too was the law of the Syilx people.

According to our oral history we did not have orphans because the whole family accepted the role of
teaching, loving and providing for every child. That way every child / person grew up knowing that they had
the right to family, teachings, security and love, no one was left out! Including those not yet born! It was
known that all Syilx people were important and must be cared for. One of our most outstanding laws is to
learn to live and work in harmony with everyone, to share with the community. The story of turtle,
‘Cepcaptik,’ teaches us to think of everyone not just ourselves as in a collective. To have more than others is
to have power and control over them, the teaching is that, it is not OK to have more while others go without
in the family or community. People stay strong together, when there is plenty we all share it and enjoy it, the
same goes with hardship, and we face it as one. One heart, one mind! We are connected with everything in
creation and to each other; we are all a part of the circle. For our community’s health and well-being we
must keep the circle balanced.

It is my understanding that these teachings are very similar across many of our Indigenous Nations; we are
all a part of the circle. Colonization and the impacts of the Residential School have all but destroyed us, we
are still here and it is time to remember who you are and come back to the circle.

All my relations,
Written by Sheila A. Nyman (2013)
(Stands Strong like a rock Bear Woman)
SECTION 1: BACKGROUND

THE SOCIAL AND ABORIGINAL DETERMINANTS OF HEALTH

It is commonly recognized that the physical, mental, emotional and spiritual components of individual and community health and wellness are influenced by the environmental, economic, political, social, and cultural contexts in which people live.⁴

The social determinants of health⁵ are particularly important as foundational elements of individual and community wellness. The environments that infants and children grow up in, the wellness of their care givers and the experiences of infants and children in their first years of life have a significant impact on their long-term health and developmental outcomes. The social determinants of health influence how an individual, family or community is able to live, work and play which in turn influences health and wellness. Sufficient income, access to high quality and culturally appropriate educational opportunities, adequate and affordable housing, healthy and sufficient food supplies, and strong social and cultural connections are all vitally important determinants to achieve optimal health and well-being.

As highlighted in a Canadian Centre for Policy Alternatives’ report, approximately 40% of Indigenous children currently live in poverty in Canada, with a disproportionately higher ratio of poverty (50%) experienced by First Nations children, particularly when living at home (on-reserve).⁶ It is important to note that determinants (such as poverty) are influenced by broader systemic factors including local, provincial and national policies, legislation, institutional and funding structures and priorities. Access to resources, programs and services are also influenced by these factors. In summary, there is a clear connection between health, home, work, play, community and the broader systems of influence. This understanding of the connections across multiple environments aligns with both the World Health Organization’s work around Healthy Settings⁷ and the BC Ministry of Health's work...

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⁵ The social determinants of health include factors such as income and social status, education, gender, sexuality, race, employment and working conditions, access to appropriate health services, housing and physical environments. They interact in complex ways, and their modification can influence health and vulnerability to illness.


towards Healthy Families BC\textsuperscript{8}. In order to effectively address the social determinants of health, collaboration with and advocacy across multiple sectors (both public and private) is of key importance, particularly for maternal, child and family health, due to the multiple sectors involved. Supportive environments for First Nations and Aboriginal people enable positive health behaviors and choices and ultimately improve health outcomes. Opportunities for ongoing collaborative work towards a holistic understanding of health and wellness are highlighted throughout this Approach.

In addition to the disproportionate impact of the social determinants of health on Aboriginal populations, there are also unique determinants of health that have a profound and over-riding impact on the health of Aboriginal peoples. These Aboriginal determinants include direct and indirect experiences of colonialism, racism, historically high levels of First Nations child apprehension, residential school experience, land appropriation and Indian hospitals continue to impact First Nations and Aboriginal people today, often in an inter-generational way.\textsuperscript{9} Some of the effects of these determinants include learned violence, mental health and substance use challenges, loss of language and cultural identity, loss of emotional security and family connections, loss of traditional parenting practices and a loss of knowledge and practice of First Nations and Aboriginal culture and traditions.\textsuperscript{10} Many of these determinants intersect and can have a significant cumulative impact on mothers, children and their support systems.

Being aware of these social and Aboriginal-specific determinants of health and working together to build upon strengths and resiliencies are all actions that everyone can take to improve culturally competency and trauma-informed work. It is important to recognize that action on all determinants of health in an effort to improve the wellness of First Nations and Aboriginal people resides primarily outside of health care system, and ultimately outside of health programs and services as well. Ensuring access to traditional lands, teaching and use of local language, incorporating traditional knowledge and practice and increasing community-based First Nations decision making are all meaningful ways to promote health and wellness in a historically and culturally relevant way.

\begin{thebibliography}{9}

\item A Path Forward – BC First Nations and Aboriginal People’s Mental Wellness and Substance Use 10 Year Plan. A Provincial Approach to Facilitate Regional and Local Planning and Action
\end{thebibliography}
“The Aboriginal worldview highlights concepts of wholeness, balance, the importance of relationships with [self], family, community, ancestors, and the natural environment. An individual's identity, status, and place in the world are tied to the family, and to one's ancestors' traditional territory and the community. Each of these elements has implications for the design and delivery of healing programs”.

Smye & Mussell, 2001

The above quote powerfully captures the connection between the holistic context and understanding of health and how health care planning and delivery can be better designed to meet the needs of First Nations and Aboriginal peoples. The diagram below, developed as a living visual document that will change with further community engagement, is a depiction of the First Nations Health Authority's vision: Healthy, Self-Determining, and Vibrant BC First Nations Children, Families, and Communities. This diagram illustrates the importance of understanding the internal and external factors that affect individual, family and community wellbeing through a holistic perspective and medicine wheel model. Many of the concepts included in this diagram are based from traditional knowledge. “Although the diagram appears in layers, it is important to acknowledge that in fact all words in each circle are interconnected with each other, and the components of other circles. In addition, all circles themselves are connected and responsible for each other. Ultimately, all of these factors are important and need balance to achieve wellness.”

11 First Nations Health Authority. FNHA Internal Updates, July 11, 2013.
THE SEVEN DIRECTIVES – CONSENSUS PAPER

Since 2008, BC First Nations have been involved in a process of community engagement to guide the work in First Nations health governance. Through more than 120 regional and sub-regional caucus meetings, and extensive community engagement activities, First Nations in BC have developed the following seven directives. These directives describe the fundamental standards and instructions for the new health governance relationship. They were set by First Nations leadership at Gathering Wisdom for a Shared Journey IV in 2011.

All seven directives are meant to be considered and acted upon as a collective in relation to maternal, child and family health work.

Directive #1: Community-Driven, Nation-Based
- The Community-Driven, Nation-Based principle is overarching and foundational to the entire health governance arrangement.
- Program, service and policy development must be informed and driven by the grassroots level.
- First Nations community health agreements and programs must be protected and enhanced.
- Autonomy and authority of First Nations will not be compromised.

Directive #2: Increase First Nations Decision-Making and Control
- Increase First Nations influence in health program and service philosophy, design and delivery at the local, regional, provincial, national and international levels.
- Develop a wellness approach to health including prioritizing health promotion and disease and injury prevention.
- Implement greater local control over community-level health services.
- Involve First Nations in federal and provincial decision-making about health services for First Nations at the highest levels.
- Increase community-level flexibility in spending decisions to meet their own needs and priorities.
- Implement the OCAP (ownership, control, access and possession) principle regarding First Nations health data, including leading First Nations health reporting.
- Recognize the authority of individual BC First Nations in their governance of health services in their communities and devolve the delivery of programs to local and regional levels as much as possible and when appropriate and feasible.

Directive #3: Improve Services
- Protect, incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into all health programs and services that serve BC First Nations.
- Improve and revitalize the Non-Insured Benefits program.
- Increase access to primary care and other allied health care in First Nations communities.
- First Nations will work collectively to improve all health services accessed by First Nations. through the creation of a First Nations Health Authority and supporting a First Nations population health approach.
- Support health and wellness planning and the development of health program and service delivery models at local and regional levels.

Directive #4: Foster Meaningful Collaboration and Partnership
- Collaborate with other First Nations and non-First Nations organization and governments to address social and environmental determinants of First Nations health (e.g. poverty, water quality, housing, etc.).
- First Nations will create opportunities through working collaboratively with federal, provincial, and regional partners.
- Foster collaboration in research and reporting at all levels.
- Support community engagement hubs.
- Enable relationship-building between First Nations, regional health authorities and the First Nations Health Authority to align First Nations health care priorities and community health plans where applicable.
Directive #5: Develop Human and Economic Capacity
- Develop current and future health professionals at all levels through a variety of education and training methods and opportunities.
- Leverage additional funding and investment and services from federal and provincial and educational institutional sources for First Nations in BC.
- Develop economic opportunities to generate additional resources for First Nations health programs.

Directive #6: Be Without Prejudice to First Nations Interests
- Ensure there is no impact on Aboriginal title and rights or the treaty rights of First Nations, and be without prejudice to any self-government agreements or court proceedings.
- Ensure there is no impact on the fiduciary duty of the Crown.
- Ensure there is no impact on existing federal funding agreement with individual First Nations, unless First Nations want the agreements to change.

Directive #7: Function at a High Operational Standard
- Demonstrate accountability through clear, regular and transparent reporting.
- Make best and prudent use of available resources.
- Implement appropriate competencies for key roles and responsibilities at all levels.
- Operate with clear mutually agreed upon governance documents, policies, and procedures, including for conflict of interest and dispute resolution

TRANSFORMATIVE CHANGE ACCORD AND FIRST NATIONS HEALTH PLAN

A number of key documents have informed the work of the Tripartite Maternal, Child and Family Health Strategy Table and the development of this Approach. The Transformative Change Accord: First Nations Health Plan (TCA: FNHP, 2006) and the Tripartite First Nations Health Plan (TFNHP, 2007) set out three initial actions that have informed the work of the MCH Strategy Area to this point:

1. Ensuring vision, hearing and dental screening for First Nations and Aboriginal children (Health Action #10)

2. Improving access to the full range of maternity services for First Nations and Aboriginal women, bringing birth “closer to home and into the hands of women” (Health Action #21)

3. Addressing results and concerns arising from the BC Coroner’s office Child Death Review Report (Health Action #11)

There are also a number of other TFNHP health actions that overlap with maternal and child health including:
The development of an informational campaign to increase awareness about seatbelt use and safe driving (#14)
- Improving access to services and programs at home (on-reserve) (#7, 8 & 12)
- Workforce development initiatives (#18, 24, 25, 26)
- Cultural competency improvement in Regional Health Authorities (#19)
- ActNow programming (#7).

All of these health actions identified priorities to initially guide Tripartite work. Additional maternal, child and family health priorities are also required for a holistic approach to well-being for First Nations peoples and communities and have also been incorporated into this Approach.

**TIMELINE OF WHAT FIRST NATIONS AND ABORIGINAL COMMUNITIES HAVE TOLD US**

In addition to the TCA: FNHP and the TFNHP, a number of key information sources, agreements and conversations with First Nations and Aboriginal peoples in BC have informed the development of the strategic directions within this Approach. The following is a timeline of these important milestones:

<table>
<thead>
<tr>
<th>Date</th>
<th>Agreement/Engagement</th>
<th>Key Outcomes for MCH Strategy Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2005</td>
<td>BC First Nations Submission on the Blueprint for Aboriginal Health *</td>
<td>Indication of health priorities for BC First Nations, inclusive of those relating to maternal and child health</td>
</tr>
<tr>
<td>November 2006</td>
<td>Transformative Change Accord: First Nations Health Plan and First Nations Health Plan Memorandum of Understanding</td>
<td>Identified 3 key Health Actions as priorities for initial Tripartite maternal and child health work</td>
</tr>
<tr>
<td>June 2007</td>
<td>Tripartite First Nations Health Plan</td>
<td>Confirmed the Federal Government’s participation within the Tripartite process</td>
</tr>
<tr>
<td>May 2008</td>
<td>Gathering Wisdom II *</td>
<td>Forum for maternal and child health discussion with First Nations community representatives</td>
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<tr>
<td>September/October 2008</td>
<td>Health Directors Forum *</td>
<td>Discussion with Health Directors of desired changes in Maternal and Child Health</td>
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<tr>
<td>Date</td>
<td>Event</td>
<td>Description</td>
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<tr>
<td>November 2009</td>
<td>Gathering Wisdom III *</td>
<td>Forum for maternal and child health discussion with First Nations community representatives</td>
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<tr>
<td>July 2010</td>
<td>Tripartite First Nations Health Plan: Basis for a Framework Agreement on Health Governance</td>
<td>Confirmed a non-binding political agreement that set out broad outlines for negotiations to develop a legal agreement on First Nations health governance and the creation of a BC First Nations Health Authority</td>
</tr>
<tr>
<td>May 2011</td>
<td>Gathering Wisdom IV Resolution on Consensus Paper: BC First Nations Perspectives on a New health Governance Arrangement Maternal and Child Health Strategy Area engagement *</td>
<td>Set the 7 Directives as the standards for how the new health governance structure must operate and endorsed the signing of the Tripartite Framework Agreement Forum for maternal and child health discussion with First Nations community representatives</td>
</tr>
<tr>
<td>October 2011</td>
<td>Tripartite Framework Agreement on First Nations Health Governance</td>
<td>Legally binding document that established the process for the transfer of the First Nations Inuit Health Branch Pacific Region to the new First Nations Health Authority</td>
</tr>
<tr>
<td>March 2012</td>
<td>Health Directors Training and Networking Event, Health Actions World Café *</td>
<td>Discussion with Health Directors of successes and gaps within maternal and child health</td>
</tr>
<tr>
<td>May 2012</td>
<td>Gathering Wisdom V Resolution on Consensus Paper: Navigating the Currents of Change, Transitioning to a New First Nations Health Governance Structure Maternal and Child Health breakout sessions and table *</td>
<td>Affirmed the creation of the First Nations Health Authority and set the standards for the structure and authority of the First Nations Health Authority Forum for maternal and child health discussion with First Nations community representatives</td>
</tr>
</tbody>
</table>

* See appendix A for summaries of the information provided by these community engagement opportunities
Extensive detail about what communities have told us from many of the forums and documents listed above can be found in appendix A. Priorities that BC First Nations and Aboriginal community members have raised is reflective in the development of the strategic directions in this Approach. The key beliefs, values and principles in this document have guided the Approach and the breadth of issues that need to be addressed through collaboration with the involvement of multiple partners (First Nations and Aboriginal leadership and community members, Provincial and Federal Governments, Regional Health Authorities, non-profit organizations and other partners).

It is important as the above partners continue to work together in this strategy area that the Approach is continually revisited, revised and validated to ensure its relevancy over time.
SECTION 2: BELIEFS, VALUES, PRINCIPLES & WELLNESS FRAMEWORK

“We had ceremonies to prepare young girls and boys for adulthood responsibilities. We had “Coming of Age” ceremonies to teach the young ones how to be young women, men and to be in relationships together. These ceremonies also shared what the responsibility is of bringing babies into the world and of being parents.”

Lucy Barney, Lilooet Nation, RN, MSN
Chair, Tripartite First Nations and Aboriginal Perinatal Planning Committee,

KEY BELIEFS AND VALUES

(Developed from community engagement input and the guidance of the Maternal, Child and Family Health Strategy Area)

- **Respect** for diversity and individual lived experiences
- **Holistic** programs and services which are inclusive and provide seamless care across a continuum
- **Strengths-based and wellness** approach
- **Upstream and prevention** oriented focus
- **Balance** by incorporating the principles of the Four Directions Medicine Wheel
- **Responsiveness** to community voice and community driven process (working with and for First Nations and Aboriginal communities)
- **Collaborative** planning and service provision
- **Equitable health** for all
- **Inclusive** care focused on families, not just individuals
- **Recognition** that healthy women and children are an essential component and foundation of healthy communities
- **Forward-focused** by anticipating and meeting the needs of future generations

OVERARCHING PRINCIPLES

(Aligned with principles from: *A Path Forward: BC First Nations and Aboriginal People’s Mental Wellness and Substance Use – 10 Year Plan*, p. 24) These overarching principles are meant to be incorporated throughout all maternal, child and family health strategic planning, implementation and evaluation efforts.
Recognize that culture, traditions, and language are the foundation to healthy individuals, families, and communities.

Support approaches that ensure First Nations and Aboriginal people receive safe and effective care from health providers.

Find ways to address travel and funding barriers that make it hard for First Nations and Aboriginal people to access and reach maternal, child and family health programs and services.

Build and strengthen capacity among First Nations and Aboriginal communities to support women, children and families.

Build on successes and opportunities as defined by First Nations and Aboriginal communities.

Make sure that services and programs are kept local, where possible.

Support broad, collaborative multi-system approaches that address social and economic determinants of health.

Build and strengthen partnerships and collaboration among First Nations and Aboriginal communities, regional, provincial, and federal systems and non-governmental organizations, improving coordination and leveraging innovations and resources.

Encourage and support health and human service providers to work in a manner that is culturally safe and respects individual customs, values, and beliefs.

Recognize that the social determinants of health have a key role in maternal, child and family wellness and empower communities and leadership to address these determinants through inter-sectoral (as well as interdisciplinary and multidisciplinary) collaboration and action.

Encourage approaches that are based in and build on individual, family, community, and cultural strengths.

Reduce stigma against First Nations and Aboriginal mothers and care givers who have mental illness and/or substance use issues.

Recognize that maternal, child and family health and wellness can be both gender and sex specific (including both men and women, trans-gendered, lesbian, gay, bisexual and two-spirited, queer and questioning individuals). Programs and supports may need to be modified to support these populations.

Support healthy infant and child development through health promotion, health protection, and early childhood education for all children, as well as early identification and interventions when children are identified as vulnerable or in need.

A FRAMEWORK FOR MATERNAL, CHILD AND FAMILY WELLNESS

The Maternal, Child and Family Wellness Circle framework can be used to guide well-grounded planning and action across the continuum of health programs and services. This framework was created through a process of building a common understanding amongst the Tripartite representatives and partners of an holistic view of family and child health and wellness. The First Nations Health Authority, First Nations and Inuit Health Branch of Health Canada, Ministry of Health and partner organizations all shared perspectives from their own systems, perspectives and what they have heard from community during the development of this framework. This is an evolving framework that can be used by individuals, communities and regions to help frame, communicate and identify opportunities to engage in collaborative work.
Maternal, Child and Family Wellness Circle

Background

- The Maternal, Child and Family Wellness Circle provides a framework that can be used to guide the development of health priorities and goals that align with this wellness circle across the continuum of care. This framework was created through a process of building a common understanding amongst the Tri-partite representatives and partners of an holistic view of maternal, child and family health and wellness. The First Nations Health Authority, First Nations and Inuit Health Branch of Health Canada, Ministry of Health and partner organizations all shared perspectives from their own systems and what they have heard from community during the development of this framework. This is an evolving framework that can be used by individuals, communities or regions to help frame and communicate about their own work.

Legend:

- Focus of our work: The wellness circle begins in the middle with the family and child. Family has been defined broadly and inclusively to acknowledge the varying understandings and realities of families and care givers. Through pregnancy and after birth, mothers and babies have a unique relationship that is important to recognize. Fathers, immediate and extended family members and friends are also central to child development and the wellness of the family as a whole.

- Community support across the life course: Communities are important supporters for parents and children and critical to their wellbeing. A healthy community is made up of a range of generations from babies to elders and each contribute their own strength to the larger community and those within it, emphasizing the importance of wellbeing across the life course.

- Foundational components of health and wellness: Four components - Spiritual, emotional, mental and physical. All four components must be satisfied and in balance inorder for mothers, children and families to be well.

- Determinants of health and wellness: Cultural, social, environmental and economic factors influence health and wellbeing just as much if not more than availability and access to health services. They have the power to keep people well, but their absence can result in sickness. Inequity within these determinants causes gaps in health outcomes between First Nations and Aboriginal people and non-Aboriginal people in Canada. Addressing the determinants of health and wellness requires collaboration among many different sectors such as health, education, and economic development that have often been siloed in the past.

- Scope of our work: All First Nations and Aboriginal people in BC are entitled to accessible, quality and culturally-safe maternal and child health services and supports, no matter where they live.

- Pathway of care: This pathway represents a continuum of care as a mother, child or family's health and wellness needs increase and the health services required become more specialized.

- Elements of care: The four elements of care represent different levels or tiers of supports for health and wellness.
Elements of Care: Definitions

Holistic Wellness
Culture, language, values, traditions, spirituality, world views, and the environment are essential elements for the promotion of health and well-being. Elders play a critical role by serving as carriers of knowledge, teachers, and role models. Some of the practices and ceremonies include the use of Traditional Healers, storytelling, prayers, smudging, river cleansing, healing circles, sweat lodges, pipe ceremonies, sun dances, fasting, feasting, winter ceremonies, and burning ceremonies. A holistic approach encompasses more than just the individual. It must also consider relationships with and impacts of the family and community.

Community Care
Community and family are placed at the core of the lives of First Nations and Aboriginal people. Ideally, the community has the skills and capacity to support all community members through their teachings of culture and their traditions, supported by the western knowledge of health promotion through early intervention, illness prevention, and reduced health, social, or other harms. This stage of support for First Nations and Aboriginal people with some form of vulnerability to a mental wellness and/or substance use problem also requires linkage to services and service providers.

Integrated Care
This component refers to the co-ordination of personal support networks, including family and community, with components of the health care system, like case management. Integrated care may include multi-disciplinary teams of supporters and care providers that can facilitate collaboration among local, provincial and federal services in a manner that provides cultural safety.

Specialized Care
Care for mothers, children or family members experiencing severe and complex health issues. This is inclusive of after-care efforts and support networks to ensure access to a range of care options that build on the treatment experience and address key social determinants of health areas (e.g., housing, employment, education, living conditions, and social support).
SECTION 3: STRATEGIC DIRECTIONS FOR THE FUTURE

Based on the Transformative Change Accord: First Nations Health Plan and Tripartite First Nations Health Plan health actions statements; What First Nations and Aboriginal communities have told us (Appendix A) and the Tripartite Maternal Child and Family Health strategy area`s achievements and experience to date (Appendix B), three overarching goals and six strategic directions have been suggested and are outlined below. Also outlined below is the importance of each strategic direction, current Tripartite work that supports each direction, and opportunities for action and next steps.

APPROACH - OVERARCHING GOALS

The following overarching goals summarize the long-term focus of the Maternal, Child and Family Health Strategy Area and are foundational to ongoing collective work:

- **Increase First Nations and Aboriginal community influence over health system transformation.**
- **Expand partnered leadership and collaborative efforts to improve health outcomes for First Nations and Aboriginal mothers, children and families.**
- **Improve cultural safety and respect for First Nations and Aboriginal traditional practices in the health care system.**

APPROACH - STRATEGIC DIRECTIONS

The six strategic directions outlined below in this Approach show the different focal areas of work that complement each other and contribute towards the achievement of the overarching maternal, child and family health goals mentioned above.

These strategic directions are not presented in order of importance, but rather move from a system level to a service level in focus. They are meant to be flexible and responsive and will evolve as community needs and priorities change over time. Each strategic direction will be discussed in more detail, highlighting the significance of each focal area, the successful work that has occurred to date, in addition to suggestions for ongoing and future actions.

1. **Ensure that meaningful collaborative planning, knowledge sharing and timely and consistent communication occurs with and for First Nations and Aboriginal communities**

2. **Increase First Nations and Aboriginal community control and leadership in collecting information and monitoring trends in maternal, child and family health**

3. **Develop a culturally competent workforce, culturally safe services and culturally appropriate resources in maternal, child and family health**

4. **Improve access to continuous and well-connected services and resources across pre-pregnancy planning, pregnancy, birthing and post-birth care for First Nations and Aboriginal mothers, children and families**
5. Promote holistic pre-pregnancy planning, pregnancy, birthing and post-birth health and wellness for First Nations and Aboriginal mothers, children and families

6. Strategic Direction: Promote and support safe environments and healthy early childhood development for First Nations and Aboriginal infants, children and families

1. Strategic direction: ensure that meaningful collaborative planning, knowledge sharing and timely and consistent communication occurs with and for first nations and aboriginal communities

**Importance**

The planning, implementation and evaluation of maternal, child and family health programming and services for First Nations and Aboriginal communities should be informed and driven by communities themselves. This is grounded in the Consensus Paper directives, the first directive being: Community Driven, Nation Based. Effective engagement, knowledge sharing and communication are important to ensure that health services are meeting local needs while being responsive and adaptable to change over time. Timely and consistent communication is also important to support increased awareness in communities regarding the resources and services that are available to support maternal, child and family wellness and improve access.

The Reciprocal Accountability graph below summarizes an engagement pathway that was developed with guidance from the seven directives of the Consensus Paper and can be used as a guide for engagement work with First Nations partners. This pathway was formally passed by the Chiefs in 2011. The engagement pathway underlines the importance of systematically valuing, collecting, summarizing and validating local knowledge, experiences and input in order to make community-driven decisions related to maternal, child and family health policy, program and services.

**Successes**

Successful examples of effective engagement in the maternal, child and family health strategy area include forums that have been hosted at Gathering Wisdom and with the First Nations Health Directors to inform the development of the MCH oriented health actions in the Tripartite First Nations Health Plan in addition to the development and verification of this Approach itself. This engagement pathway has also been followed to gather feedback on the creation of culturally appropriate maternal, child and family health information resources. Key partners in effective
engagement, knowledge sharing and timely and consistent communication include Community Engagement Hubs\textsuperscript{13}, Regional Health Liaisons and the First Nations Health Directors Association\textsuperscript{14}.

\textsuperscript{13} “Community Engagement Hubs (CeH's) are groups of First Nations communities who agree to plan, collaborate, and communicate to meet their nation's health priorities. CeH's also provide a vehicle for First Nations Communities to partner with the First Nations Health Council to implement the Tripartite First Nations Health Plan. CeH's are collaborations between First Nations communities working through one agreed upon organization. The formation of CeH's encourages natural collaborations based on tribal and geographical factors, and provides resources to existing capacity. There are currently 32 community hubs representing 175 First Nations.” (Source: \url{http://www.fnhc.ca/index.php/engagement_process/community_hubs}).

\textsuperscript{14} “The FNHDA is a professional association that represents and supports health directors and managers working in BC First Nations communities. Collectively, BC First Nations Health Directors have a wealth of information, capacity, and solutions to the population health issues in First Nations communities. The Association supports education, knowledge transfer, professional development and best practices for health directors and managers of First Nation Health Providers; and acts as an advisory body to the FNHC and FNHA on research, policy, program planning and design related to administration and operation of health services in First Nation communities.” (Source: \url{http://www.fnhda.ca/about/welcome/}).
Suggested Actions

a) Strengthen the inclusion of traditional knowledge and practice in engagement
b) Respect different ways of knowing and communicating knowledge
c) Ensure that engagement, sharing and communication is inclusive and reflective of the diversity of voices in community
d) Establish regular, commonly understood and accepted engagement and communication pathways
e) Promote the understanding and practice of communication as a two-way process
2. Strategic Direction: Increase First Nations and Aboriginal community control and leadership in collecting information and monitoring trends in maternal, child and family health

**Importance**

What and how health information is collected, interpreted, shared and stored are all important factors related to health knowledge and information. Strong work in this focal area is driven and completed by First Nations and Aboriginal communities and follows the Ownership, Control, Access and Possession (OCAP) Principles\(^{15}\). Developing and maintaining local capacity in First Nations and Aboriginal communities to complete health research and health planning work is essential.

Good qualitative (descriptive) and quantitative (number-based) information is important to inform, monitor and evaluate health service planning and implementation that is both responsive to community needs and effective in improving health and wellness. Within the Transformative Change Accord: FNHP, this document highlights a number of indicators as starting points for ongoing monitoring and measurement of progress related to First Nations and Aboriginal health. Rates of infant mortality, childhood obesity and the number of practising certified First Nations health care professionals are examples of indicators that were initially selected for ongoing reporting.

**Successes**

Many successes have already been achieved related to the gathering and use of First Nations and Aboriginal health knowledge and information via various community forums (see Appendix A) that have informed Tripartite work that has occurred to date. In an effort to shift towards wellness oriented health knowledge and information collection, the Regional Health Survey \(^{16}\) provides some wellness indicators specific to First Nations health. The Tripartite Health Knowledge and Information strategy area is continuing to work on further developing wellness indicators – some specific to maternal child and family health. A Provincial Health Officer’s Report on Aboriginal Women’s Health is also being prepared with Tripartite participation. The First Nations Health Authority hopes to

\(^{15}\) “The First Nations Principles of OCAP (ownership, control, access, and possession) means that First Nations control data collection processes in their communities. First Nations own, protect and control how their information is used. Access to First Nations data is important and First Nations determine, under appropriate mandates and protocols, how access to external researchers are facilitated and respected. The right of First Nations communities to own, control, access, and possess information about their peoples is fundamentally tied to self-determination and to the preservation and development of their culture. OCAP allows a community to make decisions regarding why, how and by whom information is collected, used or shared.” (Source: http://www.rhs-ers.ca/node/2).

\(^{16}\) “The RHS is a national health survey that is fully directed and controlled by First Nations. It is longitudinal in nature gathers information about health, wellness, health determinants, and about the concerns and issues of First Nations living in First Nations communities across Canada. The RHS first went into the field in 1997 in 7 regions. Afterwards, the survey expanded to include all regions as well as adopting a longitudinal design.” (Source: http://www.rhs-ers.ca/node/11)
incorporate a focus on wellness and highlight the voices and stories of First Nations and Aboriginal women throughout this report.

The Tripartite Health Knowledge and Information strategy area has developed an Aboriginal Administrative Data Standard to provide guidelines for First Nations and Aboriginal data collected within the health system. This strategy area has also developed a Tripartite Data Quality and Sharing Agreement (TDQSA) and First Nations Client File (FNCF) to facilitate the sharing and linkage of data between Tripartite partners. The Aboriginal Administrative Data Standard is not yet widely implemented, resulting in continued lack of consistent and comparable First Nations and Aboriginal identifiers within data sets. Continued work in this area is led by the Health Knowledge and Information Strategy Area, in collaboration with the other strategy areas.

Beyond these successes, much work remains. Data currently collected within the health system is primarily sickness based and is therefore misaligned with the First Nation Health Authority's focus on wellness as summarized by the First Nations Perspectives on Wellness diagram (referenced earlier in the Approach). A formal shift in framing and planning with a wellness focus is soon to take place with the development of regional wellness plans that will identify community-selected health priorities unique to each region based on quantitative and qualitative information. There may also be an opportunity to link the First Nations Client File (FNCF) with other available databases (e.g., Perinatal Services BC database) to develop First Nations specific perinatal indicators to support ongoing monitoring efforts.

**Suggested Actions**

a) Establish regular, commonly understood and accepted ways to gather and share health knowledge and information

b) Develop wellness-based indicators to follow trends in First Nations and Aboriginal maternal child and family health

c) Identify and share promising and best practices, challenges and gaps in health knowledge and information gathering and sharing in the area of First Nations and Aboriginal maternal, child and family health

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17 “The Tripartite Data Quality Sharing Agreement (TDQSA) is an agreement that was signed in April 2010 between the province of BC (represented by the then Ministry of Healthy Living and Sport and the Ministry of Health Services), the federal government (represented by First Nations Inuit Health, BC Region) and First Nations (represented by the First Nations Health Society) to ensure federally and provincially held information on First Nations is shared to facilitate health research and reporting. The agreement allows for the creation of a First Nations Client File using an annual extract of Aboriginal Affairs and Northern Development Canada’s (AANDC) Indian Registry. Access to the AANDC Indian Registry is made possible through a memorandum of understanding (MoU) between the BC Ministry of Health and AANDC.” (Source: http://www.fnhc.ca/index.php/health_actions/health_knowledge/)
d) Enhance information gathering through different approaches (personal reflection, discussion groups, photo voice)

e) Prioritize relevant, culturally appropriate and community driven research priorities to guide partnerships with research partners

f) Advocate for the wide implementation of the Aboriginal Administrative Data Standard and support for integration of technologies that will aid consistent and long term information gathering and management

“We have made 'hand washing' modules compulsory, but what could be more meaningful than ensuring that all health professionals are expected to have at least a basic understanding of cultural competency and how to make their practice meaningful.”

S.H., Indigenous Cultural Competency Training Program Participant

3. Strategic Direction: Develop a culturally competent workforce, culturally safe services and culturally appropriate resources in maternal, child and family health

Dr. Evan Adams, Deputy Provincial Health Officer for Aboriginal Health
Importance

Currently there is an abundance of evidence to show that First Nations and Aboriginal people do not receive the same quality of health services nor experience the same quality of health on par with the general population in BC. Many of these reported differences are both unacceptable and unnatural – much can be done to improve health care experiences and health outcomes. As key points of action, First Nations and Aboriginal people need a range of culturally safe services and supports that respect their unique and varying customs, contexts, traditions and beliefs provided by culturally competent staff.

Cultural competency entails having the knowledge, self-awareness and skills to work appropriately with individuals from other cultures. For health care professionals and community partners, this requires an understanding and appreciation of the social and historical context of people who they work with and how their actions, words and approaches to their work can be modified accordingly to respect and meet an individual’s needs in the best way possible.

Cultural safety in health care includes the engagement of individuals, families, and communities to take charge of their own health decision making and well-being. Achieving cultural safety requires that health institutions and service providers move beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships and self-awareness of one’s own culture as they apply to health care. Cultural safety implies that the health-care practitioner has knowledge of the cultural practices of his/ her client, has made sure that both the physical space and personal behaviours are welcoming and treats the client as an equal in the health partnership. Ultimately, it is only the client who can decide if the care was safe.\(^{18}\) Sacred space within a hospital or clinic is another example of how health settings can create cultural safety, as a designated room can be reserved for individuals and families to partake in spiritual or traditional practice to support health and wellness.

Within Tripartite work, there has been a strong call for a more inter-disciplinary and culturally competent workforce operating in the area of maternal, child and family health to increase local capacity to provide quality, culturally safe maternity services closer to home. Implicit in this vision is the desire for a growing First Nations and Aboriginal health workforce that can incorporate traditional methods in practice, including working with Elders to provide services; incorporating language and culture in service delivery and facilitating traditional birthing and parenting practices. Having holistic, culturally competent and skilled community health supports that positively engage families are particularly important to develop the long term positive relationships and safe environments needed to provide good continuity of health care that spans generations.

This strategy area also seeks to support primary care providers, midwives, doulas, acute care nurses, public health and community health nurses and allied health providers both at home and away from


Page 30 of 60
home (on and off reserve) to better support the needs of all First Nations and Aboriginal community members. Particular effort has been directed to providing culturally competent and accessible care as close to home as possible in rural and remote communities. Increasing awareness of and enrollment in the Indigenous Cultural Competency Training hosted through the Provincial Health Services Authority’s Aboriginal Health team is one strong component of this work. Consistent and ongoing training efforts, support for sustainable practice change and assessment of progress in culturally competent knowledge and care over time are all essential components of this work.

Having health resources that are grounded in First Nations and Aboriginal understandings of health and wellness is also an important part of making health information more acceptable and understandable within communities. Health service provider familiarity with the content and approach of these culturally appropriate resources and their effective use with First Nations and Aboriginal families is essential to ensure health information and service is provided in the best way possible.

**Successes**

Some progress has been made towards the strategic direction of culturally competent workforce development. The Aboriginal Doula Initiative led by Perinatal Services BC and supported by the Maternal and Child health strategy area has trained Aboriginal Doulas who provide emotional support and companionship to women and their families throughout the birth process. Fifteen Doulas that were trained in this initiative are working towards final certification; some are interested in further pursuing midwifery and nursing careers.

The TCA: FNHP and TFNHP have a strong focus on workforce development through a number of action items, increasing the number of First Nations and Aboriginal health professionals and paraprofessionals. The implementation of this strategic priority should therefore link in with the Tripartite Health Human Resources Strategy Area and work being done at a Provincial level regarding Health Human Resource Development.

Successful work regarding increasing access to culturally appropriate health information is also a major part of Tripartite collaboration to date. The Maternal and Child health strategy area partners have produced numerous culturally appropriate resources to support pre-natal to post-natal care, including these examples:

- The Art of Birth: Supporting Aboriginal Women During Childbirth DVD. An informational DVD that speaks to the Tripartite Aboriginal Doula Initiative led by Perinatal Services BC.
- Maternal Child Dental Health DVD – An informational video for parents and guardians developed in collaboration with FNHA and Seabird Island Health Centre.
- Celebrating the Circle of Life: Coming Back to Balance and Harmony. A pre and postpartum health education resource that was developed by partners Perinatal Services BC and the BC Mental Health & Addiction Services.

Additional work extending from the resources listed above involves the needed engagement of health care providers and targeted education to understand and appropriately use these resources.
The strategy area is currently assessing opportunities for sharing and creating hands-on opportunities to become familiar with and apply many of the resources that have been produced. Ongoing gaps and needs for new, culturally appropriate resources are continually being identified and are addressed by this strategy area.

**Suggested Actions**

a) Promote maternal, child and family health careers among First Nations and Aboriginal people
b) Develop strategies for improving the cultural competency of the existing and future maternal, child and family health workforce and services across BC
c) Incorporate cultural competency curriculum in the training of maternal, child and family health practitioners
d) Promote a more culturally competent workforce in all regional health authorities and partner organizations through Indigenous Cultural Competency Training and other complementary approaches
e) Promote planning and development of sacred space in community and acute health care facilities
f) Advocate that health information and education resources applying to maternal, child and family health services are culturally appropriate for First Nations and Aboriginal peoples and promote the incorporation of cultural and traditional practices

Provide educational opportunities for both health practitioners and community members around culturally appropriate health resources to increase meaningful usage.

“Our Elders say our children don’t come in pieces, so we should look at the whole child.”

*Anonymous*
4. Strategic Direction: Promote holistic pre-pregnancy planning, pregnancy, birthing and post-birth health and wellbeing for First Nations and Aboriginal mothers, children and families

**Importance**

Supporting First Nations and Aboriginal women before, during and after their pregnancies is crucial to ensure that both mothers and their babies to achieve optimal health. With a rapidly growing population and increasing birth rate within First Nations and Aboriginal communities in BC, supporting women in their plans for and journey through pregnancy, birth and motherhood is particularly important work.

In addition, understanding pre-pregnancy, pregnancy, birthing and after-birth health in a holistic way respects the physical, emotional, mental and spiritual experiences of women and the necessity to provide care that meets the needs of and contributes to women's wellness. This strategic direction is large in scope, focusing on the health and wellness of girls and young women as they develop and enter their child-bearing years. Nutrition, cultural practice, community connections, physical activity, healthy relationships, mental wellness (including self-esteem and leadership) and sexual health are all examples of health promotion areas that are important throughout pre-pregnancy to post-birth.

A number of programs currently exist both at home and away from home (on-reserve and off-reserve) to support women and their families before, during and after pregnancy. Building upon the successes of these programs and looking for ways to better connect the services and supports that each provide is an ongoing part of the maternal, child and family health strategy area's work.

Acknowledging and valuing the shared role that mothers have with fathers, family members, friends and other care givers in the planning, pregnancy, birth and first years of a baby's life is central to the Maternal and Child health strategy area.

**Successes**

Current success in relation to the promotion of holistic pre-pregnancy, pregnancy, birthing and post-birth health and well-being includes the training, ongoing support and development of a sustainability model for Aboriginal Doulas. Doulas are crucial in supporting women and their families with the appropriate education and social support necessary to ensure that mothers are well throughout their pregnancy. Doulas exemplify the provision of holistic care as they provide comfort measures during childbirth and build on the role of the traditional aunty. The Aboriginal Doula honours traditional practices and beliefs as well as language and culture to support the needs of the woman and family. Many of the Doulas working within First Nations communities also work within Maternal Child Health Programs.
The Fetal Alcohol Spectrum Disorder (FASD) Mentoring program also supports women by helping them make family planning choices, arrange for and attend medical appointments and help navigate and advocate within the health care system. Many women have told their mentors through this program that they receive better care when there is someone with them at appointments and it is often helpful to have a support person there to assist with understanding medical information.

Work is also occurring to highlight promising practices in current First Nations and Aboriginal maternal child and family health programming that is community driven, nation based and recommendable for adaptation and broader implementation across the province. The Promising Practices working group (formerly Aboriginal Nurse-Family Partnership Working Group) within the Maternal, Child and Family health strategy area is identifying existing MCH programs in BC aimed at First Nations and Aboriginal women and by exploring the need for, viability and acceptability of the use of the Nurse-Family Partnership program for First Nations and Aboriginal women living at home (on-reserve).

Areas for continued work in the strategic priority area include a scan of exemplary models of pre-pregnancy, maternity and midwifery care that currently exist locally, nationally and internationally to inform innovative directions for maternity care planning and service provision. Thinking outside of the box and considering how local health professionals can work to the top of their skill set and in collaboration with allied health providers is an essential part of this work.

Partnership is also being pursued with the Mental Wellness and Substance Use Strategy Area work in planning and supporting for First Nations and Aboriginal women who are pregnant and who use substances. The prevention and management of Fetal Alcohol Spectrum Disorder (FASD) is a health and developmental issue of significant importance in a number of BC First Nations and Aboriginal communities. While many communities have made major strides in addressing both prevention and interventions for infants, children and adults who are affected by FASD, intergenerational trauma and substance use continue to be challenges for many families. It is acknowledged that women who are able to stop using alcohol during pregnancy generally do, but that there is a need to provide specialized and compassionate support to women who are unable to stop using alcohol for complex biological, psychological, social, and spiritual reasons.

Ongoing community-based education, brief intervention tools for health care providers and access to treatment and family planning resources are key to reducing the incidence of FASD. For children and adults that have FASD, there is ongoing work to be done in providing information about FASD to families, communities, educational institutions and health care providers to ensure that the complex needs of people with FASD are met. Developing and strengthening policies, programs and services to meaningfully reach mothers, children and families to prevent FASD and to help support family members living with FASD is an aim that is shared by both the Maternal Child and Family Health and the Mental Wellness and Substance Use Tripartite Strategy Areas.

Opportunities also exist to collaboratively work with girls and young women to identify and define what wellness means to them, to build self-esteem, leadership, personal resiliency and to focus on
traditional teachings and practices. Much of this work is being undertaken within the National Aboriginal Youth Suicide Prevention Strategy programming. The development of comprehensive mental wellness strategies specifically for girls and young women is a future direction connected to these efforts. HIV/AIDS prevention, screening and management initiatives that support pregnant mothers and babies are additional areas for ongoing collaboration in this area.

**Suggested Actions**

a) Support girls and women to be healthy throughout their childbearing years with holistic health promotion and prevention strategies that support a wellness focus (eg. safe sex, healthy relationships, pregnancy planning including contraception access)

b) Support women and families in health promotion and prevention activities supportive of healthy pregnancies (including, but not limited to FASD prevention activities and HIV/AIDS screening)

c) Involve First Nations and Aboriginal women, their partners and families in planning for the birth of a child and post-birth care as well as spacing between pregnancies

d) Promote the importance of father, family and community roles and supports for child bearing, child rearing and family well-being

e) Improve physical, mental, spiritual and emotional health outcomes for pregnant and post-partum First Nations and Aboriginal women and their infants and families

f) Include cultural practices that provide a sense of identity, responsibility and ownership to maternal wellbeing as well as their infants. Cultural practices can include coming of age ceremonies, naming ceremonies and relationship ceremonies. Women are considered givers of life, and the backbone for our communities and should be respected as such in these roles of motherhood.
5. Strategic Direction: Improve access to continuous and well-connected services and resources across pregnancy planning, pregnancy, birthing and post-birth care for First Nations and Aboriginal mothers, children and families

**Importance**

First Nations and Aboriginal people often have a more difficult time accessing health services and continued supports across the spectrum of prevention and health promotion to end of life care. Reasons for this include geographic location, jurisdiction, and the limited availability of services that consider First Nations and Aboriginal customs, values and beliefs, and histories of trauma that may result in distrust of the health system and health care providers. These differences in services are often compounded by other factors related to access, such as gender, sexual orientation, and highly stigmatized diseases such as HIV or FASD.

TCA: FNHP Health Action # 21 is an action item directly related to this strategic direction with a focus on ensuring there is optimal and continued access to maternal, child and family health services, especially for remote and rurally isolated women and their families. All First Nations and Aboriginal community members in British Columbia deserve the same quality and standard of care regardless of where they live. Continuous and well-connected care in this Approach centers upon the communication, coordination and follow up needed to ensure that families are able to transition smoothly among various levels of required health care. Ensuring that a mother, child or family member who enters the health care system continues to be connected to the services and staff that she or he needs whether at home or away from home, in hospital or in community is crucial to ensure improved quality of care and subsequently improved health outcomes.

Access to continuous and well-connected services and resources is particularly important for community members with complex health care needs, who may need to travel for care and typically interact with multiple health care teams at local, regional and provincial levels. Babies and children with long term disabilities and chronic conditions require ongoing and specialized supports; being able to provide seamless care that prioritizes the needs of children first and supports children in their communities as much as possible is a major aim of this strategic direction.

**Successes**

It is acknowledged that a number of federally funded initiatives have operated successfully in many BC First Nations communities for several years and will be transferred to the administration of the First Nations Health Authority in October 2013 (Examples: Maternal Child Health (MCH), Canadian Prenatal Nutrition, Fetal Alcohol Spectrum Disorder and Children's Oral Health Initiative (COHI) programs). These programs focus on health promotion and prevention, serve many families in
multiple communities and work to connect program participants to services both at home and away from home (on and off reserve).19

These programs provide knowledge and education opportunities through the delivery of workshops and information sessions (including nutrition and breastfeeding) in addition to training opportunities for on the ground health providers. Programs also provide direct nursing and health provider support to mothers and families and the facilitation of supportive, culturally responsive early childhood development programming. Further successes include developing networks to provide collaborative support to families with communication and connections between Aboriginal Infant Development, First Nations Headstart On-Reserve and other early childhood support programs. Doula services, breastfeeding, pre and post-natal support, and speech and language supports are also natural partners in this work.

Maternal Child Health family visitors and nurses collaborate with other health staff to support families in accessing necessary services. In several MCH programs, COHI funding has been integrated into the MCH Program as these staff often have strong relationships with families and communities, which makes providing dental education and varnishing a complementary fit. MCH family visitors are often members of their communities and are able to incorporate Elders, cultural teachings and language into the programs they offer. Some innovative practices include the Mother's Story project, cultural parenting classes, mother baby connect programs, baby massage, community kitchens, walking groups, and opportunities to experience cultural teachings and traditional food gathering and preparation.

An example of Tripartite guided work to help improve access and continuity of care for First Nations and Aboriginal mothers, children and families is the Returning Home project, an initiative led in partnership between Child Health BC, Vancouver Island Health Authority and the First Nations Health Authority. This project is for First Nations and Aboriginal children with complex and long term health needs and focuses on working with families who live in rural and remote communities. The aim of this work is to implement culturally appropriate services which will enable an integrated and well-coordinated planning process that promotes continuity of care across primary, acute and community services. In addition, this project promotes interdisciplinary collaboration and communication and provides information and referrals to First Nation communities and Aboriginal organizations.

Ongoing work towards this strategic direction includes Child Health BC’s development of a Tiers of Service Framework which visually maps child-oriented health care services spanning across prevention, primary, secondary (screening), tertiary (acute) and palliative (end of life) components of care. In affiliation with this framework, service planning tools are currently in development.

Another opportunity to improve continuous care for First Nations and Aboriginal mothers, children and families involves the beginning developments of a Provincial Prenatal Public Health Care Pathway. This initiative led by the Ministry of Health and Perinatal Services BC seeks to develop an evidence-informed, consistent continuum of care in collaboration with health authorities that supports public health nurses to provide consistent, quality prenatal assessment, education and follow up to pregnant women and their families. The Ministry of Health has also led the development of an 18 month Primary Maternity Care Action Plan that includes actions from various stakeholders that seek to improve primary maternity care in BC. An assessment of alternative models of maternity care and building doula capacity in BC are components of this plan.

Ongoing partnership with the Ministry of Child and Family Development is also crucial to ensure that there are strong bridges and connections between the programs and services for children and families offered in other sectors (e.g. Aboriginal Infant Development Program and services for children with special needs).

**Suggested Actions**

a) Identifying, addressing barriers and inviting women and children to services which have historically prevented women and children from accessing mainstream health care services

b) Coordinated access to services that acknowledge the physical, mental, emotional and spiritual meaning and experiences of maternal, child and family health

c) Advocating for particularly vulnerable children and their families who face challenges in being connected to continuous, appropriate care

d) Assisting First Nations and Aboriginal women and children in identifying as First Nations or Aboriginal to access services that are available to them and their families (e.g. screening, perinatal support, child safety, substance dependency supports)

e) Increase public health, primary care and community health services and supports for First Nations and Aboriginal maternal, child and family services

f) Improve integrated and coordinated services and supports for First Nations and Aboriginal mothers, children and families

g) Enhance access to regular check-ups and primary care for children throughout their early childhood development

h) Improve specialized support for First Nations and Aboriginal children with serious conditions and complex health care needs (including but not exclusively FASD)

i) Assess and evaluate innovative workforce initiatives that improve access to maternity care and child health services that are closer to home and provide a continuity of care
6. Strategic Direction: Promote and support safe environments and healthy early childhood development for First Nations and Aboriginal infants, children and families

**Importance**

Early childhood development (0-6 years of age) is an extremely important period of the life course with long term impacts on the health and wellness of a child and he or she develops into adulthood. As discussed earlier, social and Aboriginal-specific determinants can impact the growth and healthy development of individual children in their early years, including supportive social, political and natural environments, equitable and interconnected systems and policies (e.g. health care, education) and protective community factors (e.g. food security and cultural practice). Early detection of health concerns and early interventions to support infants and children also assist the long term development and wellness of First Nations and Aboriginal children. For example, an early hearing loss that is identified and supported in the first months of life has the potential to improve a child’s long term hearing, speech, language and learning abilities in the long term.

The health care system provides support in the early years through the promotion of breastfeeding and healthy nutrition, immunization, early childhood screening and care for vision, hearing and oral health in addition to education and supports for positive parenting. To support all aspects of a child's early development meaningfully, many different sectors, communities and family members...
have a role to play. The area of early childhood development presents many opportunities for innovative collaboration and holistic programs and services to support children and families.

Working to reduce childhood injury, disability and mortality in First Nations and Aboriginal communities is an important component of supporting safe environments and healthy early childhood development. Injury and loss of life at a young age is disproportionately higher within First Nations and Aboriginal communities when compared to statistics in the general population. Approximately 26% of all First Nations deaths are affiliated with injury compared to 6% of deaths within the general population.\(^{20}\) Unintentional injuries (when a person is hurt by mistake) are the leading cause of potential years of life lost for First Nations and Aboriginal infants and children with rates varying by type of injury and across geographical regions.\(^{21}\) Many cases of childhood injury, disability and death are preventable and avoidable and have a significant and long lasting negative impact on children, families and communities.

Key health actions from the TFNHP related to injury prevention include addressing results and concerns arising from the BC Coroner’s office Child Death Review Report (Health Action #11) and the development of an informational campaign to increase awareness about seatbelt use and safe driving (#14). Injury prevention work has been identified as a major priority area that stretches across many strategy areas.

**Successes**

To date the Maternal, Child and Family Health Strategy Table has worked to support good work in screening for early hearing and oral health. Culturally appropriate resources related to early hearing and dental health have been produced collaboratively (Your Child’s Hearing DVD, Dental Health DVD and Family Path brochure) and discussions are currently taking place to ensure that First Nations and Aboriginal children on reserve continue to have access to hearing and speech language screening and support services upon entering into the school system. In addition, this strategy area has also worked to complete an environmental scan of oral health services in British Columbia for First Nations and Aboriginal children aged 0-7 years. A number of existing oral health print resources for health providers to use with families to promote oral health and prevent cavities were identified by this same working group and offers an opportunity for these resources to be adapted to be more culturally appropriate. An oral health strategy for First Nations and Aboriginal children aged 0-18 and their caregivers is a final product from this initiative. Next steps are to be defined regarding the sharing, priority setting and action in relation to this strategic document, *Healthy Smiles for Life*.


MCH, FASD Mentoring, and COHI programs, as well as other programs like First Nations Headstart On-Reserve provide culturally appropriate education and support for families on various topics, including immunization, dental care, nutrition, pre and postnatal care, infant sleep, breastfeeding, alcohol and substance use during pregnancy, school readiness, injury prevention and home safety. Other MCH programs have worked with community members to ensure that each child has access to a crib in collaboration with the Baby's Own Bed Program.

A number of parenting resources have also been co-developed by the National Collaborating Centre for Aboriginal Health and First Nations Health Authority and seek to contribute to promoting the positive involvement of parents and or other family members in the raising of children – emphasizing the importance of exposing children to culture, language, a connection to land and a holistic view of health and wellness. This parenting resource series includes the following booklets: Family Connections, Growing Up, Parents as Teachers & Fatherhood is Forever.

Work to date in support of reducing First Nations and Aboriginal infant and child injury, disability and death has involved two evidence reviews produced for the First Nations Health Authority that have focused on both the surveillance of and programming for unintentional and intentional injuries. These reviews were completed in the spring of 2013 and have informed ongoing injury surveillance and prevention work that has been led by the primary care and public health strategy area. In 2012 a car seat co-op initiative was funded by the First Nations Health Authority to purchase child car seats to be shared in communities with need. This initiative aimed to build awareness and support increased child car seat use in First Nations communities, contributing towards a reduction in infant and child injury, disability and death due to vehicular accidents. Maternal Child Health programs have provided community education around child car seat safety and several MCH and FASD family visitors are trained car seat technicians. Injury prevention education is also incorporated in both the Aboriginal Head Start and Brighter Futures programs offered at home (on-reserve) to expose children and families to injury prevention messaging and safe practices as early as possible. Another promising initiative in injury prevention and child safety work is the establishment of an Aboriginal community centered injury surveillance system by the Secwepmc communities. Locally based health knowledge and information collection can inform the development and delivery of injury prevention and child safety initiatives that are community driven and locally appropriate.

Health information resources for First Nations and Aboriginal families, including the Honouring Our Babies: Safe Sleep discussion cards and CPT1a brochure, are pieces of work that also support injury prevention. The Safe Sleep cards and facilitator’s guide provide health providers, parents and care givers accessible information to help infants sleep safely. The CPT1a brochure, a resource development for First Nations parents and families, provides feeding guidelines and clinical information to help maintain healthy blood sugar levels in babies and advice for when to seek medical care.
Stemming from the evidence review documents mentioned above, next steps led by the primary
care and public health strategy area involve the development of an injury surveillance and injury
prevention framework to guide ongoing initiatives. The drafting of a data access request regarding
injury surveillance is also a next step related to this work. Expansion of the child passenger safety
programming is another area that has the potential to provide meaningful outcomes in First Nations
and Aboriginal communities in BC. Suggested strategies for communities to develop and sustain
child passenger safety programs have been compiled in a strategic framework that was produced
for the First Nations Health Authority in 2012. Numerous recommendations from this strategic
document can help to direct future work in the area of child passenger safety.

There is much potential for the maternal, child and family health, Primary Care and Public Health
and Mental Wellness and Substance Use strategy areas to work in partnership around this specific
strategic direction.

**Suggested Actions**

- a) Promote and support breastfeeding, healthy nutrition and active play
- b) Promote and support positive parenting, father and family inclusion
- c) Promote and support early childhood immunizations
- d) Ensure access to effective screening and referral services as well as follow-up and
  intervention services for infants and children, especially in rural and remote locations
- e) Support initiatives that are critical to reducing infant and child morbidity and mortality such
  as culturally appropriate safe sleep practices, tobacco-free homes, the reduction of
  environmental contaminants and car seats
- f) Increase community awareness of the importance of early childhood development through
  education and programming.
- g) Promote and support safe environments and safe practices for infants and children
- h) Develop a range of services and supports to promote holistic and culturally safe healthy
  early child development
- i) Build upon the successes and strengths of existing early childhood development programs
  (eg. First Nations Head Start on-reserve, Children’s Oral Health Initiative, Fetal Alcohol
  Spectrum Disorder Mentoring program, Aboriginal Head Start, Aboriginal Infant
  Development Program and Aboriginal Success by Six as examples).
- j) Build upon existing opportunities across sectors to collaboratively support early childhood
development
SECTION 4: MEASURING SUCCESS

This document has suggested a number of strategic directions to guide meaningful work in the area of maternal, child and family health. Each of these strategic directions is broad in scope and can be prioritized and acted upon differently according to each First Nations and Aboriginal community’s context and needs. The monitoring and measurement of success and progress across the strategic directions for maternal, child and family health, therefore, will be unique and locally based as well.

As emphasized by the initial strategic directions in this document, collaborative planning and ongoing two-way communication are key factors in the development of representative and meaningful health plans and accompanying evaluations. How a community defines success, what is measured to assess the impact of local work and who does this measurement are important questions that require culturally and contextually appropriate approaches and collaborative efforts.

A medicine wheel approach to framing the monitoring and evaluation of maternal, child and family work may be most appropriate for some communities. Some communities might prefer the adaption and use of other evaluation methods, such as a logic model with short, medium and long term outcomes. Participatory evaluation and empowerment evaluation are alternative approaches to formulating and measuring outcomes and indicators related to system and population health.
changes. Community mapping as a visual narrative, or other qualitative evaluation methods may be used such as the sharing of stories and other visual methods of providing feedback (eg. photos, drawings, performance, etc.) are other methods of measuring outcomes that may be appropriate, particularly when working with young children who may communicate effectively in different ways.

In partnered work with the Health Knowledge Information strategy area in the future development of wellness-centred indicators, further guidance around potential approaches for monitoring and evaluation will be a part of the Maternal, Child and Family Health strategy area’s ongoing work.

SECTION 5: CONCLUSION

In summary, the Maternal, Child and Family Health Strategic Approach aims to ensure that First Nations and Aboriginal mothers, children and families are supported to reach and maintain optimal physical, mental, emotional and spiritual health outcomes. To do this, all of the strategic directions in this document work towards closing the gap between First Nations and Aboriginal health outcomes when compared to non-First Nations and non-Aboriginal health outcomes. Identifying best practices, promoting improved access to services and ensuring the availability of culturally relevant and appropriate resources and services are all important components of this work. This Approach is meant to guide support and enhance the health planning and evaluation work that is currently happening at all levels. It is meant to be a flexible document, recognizing that First Nations and Aboriginal communities and partners will look to this Approach and use it in different ways. It is intended that this Approach will play an important role in fostering and strengthening partnerships, aligning and coordinating program and service delivery and increasing collaboration on innovative pieces of work that benefit First Nations and Aboriginal mothers, children and families.

Recognizing that everyone has a role in for the long term wellness of First Nations and Aboriginal mothers, children and families, this document highlights the collective responsibility and action needed at the local, regional and provincial levels respectively to effectively address all strategic priorities included in this document. Collaboration and community engagement are essential components of future work in this area – considering that the lives and wellness of mothers, children and their families are influenced by multiple factors and multiple sectors beyond the health care system (eg. education & justice).

In conclusion, it is with great respect and gratitude that all of those who contributed to the development of this Approach are acknowledged for their knowledge, energy and dedication. It is hoped that this document will help to inspire and support the continuation of good work for the health and wellness of First Nations and Aboriginal mothers, children and families.

All our relations.
APPENDIX A: SUMMARY OF KEY PRIORITIES DEFINED BY COMMUNITIES

- Increase and improve culturally safe, holistic and wellness focused services. (Ensure the incorporation of traditional teachings, language, culture, Elder knowledge)
- Build upon community-driven understandings of wellness and models of care
- Focus on wellness promotion and sickness prevention in maternal, child and family health
- Have a family focus to child health. (Eg. Parenting, extended family supports and healthy relationships to ensure early childhood development is prioritized and supported)
- Focus broadly on women's health and wellness, including pre-conception health
- Collect and monitor infant mortality data that includes sudden infant death syndrome (SIDS); shaken baby syndrome (SBS), information from the child death review unit (CDRU); and other causes of child death
- Plan and provide services that span across pre-pregnancy planning through to early childhood development
- Provide screening that looks beyond hearing, dental and vision to other types of screening (eg. Tuberculosis, FASD)
- Bring maternity services closer to home; particularly for mothers in remote and rural areas
- Deliver more training and ongoing support for First Nations and Aboriginal midwives and other care providers such as doulas
What First Nations and Aboriginal Communities Have Told Us

BC First Nations Submission on Blueprint for Aboriginal Health 2005

The BC First Nations submission to the Federal Blueprint for Aboriginal Health in 2005 covered many important health issues for BC First Nations, inclusive of issues related to maternal, child and family health. The following identifies the specific key issues expressed by leaders in their submission. This list is not exhaustive but records issues directly related to First Nations child and maternal health and wellbeing.

Delivery and Access – Identification of gaps and barriers in service delivery and coverage

- **Cultural Competency** - The lack of cultural competency of many care providers in provincial and regional health services, private practice (physicians), labs, pharmacies, outpatient services is a significant barrier for First Nations people in their attempts to access health services in BC
- **Remote, rural and isolated regions** – Geographic barriers for First Nations in rural, remote and isolated regions of BC are significant with respect to the availability of health services for their people and many have to leave their communities to access basic health care. For example First Nations children with complex health needs are sometimes still placed in care so that they can receive the services that the parents of other children in BC take for granted
- **Gaps in health services** – First Nations women tend to have less access to continuous health care than other women in BC, particularly those living in rural and remote communities

Delivery and Access – Identification of First Nations health human resource and infrastructure requirements:

- **Health Human Resources (HHR)** - Human resource planning and actions must be integrated within a comprehensive approach to support the development of our children and to realize their fullest potential, including critical support for the period from conception to five years.
- **Special efforts should target children who have been enrolled in Head Start** – the oldest of whom are now only 5-6 years away from high school graduation

Sharing in improvements to Canadian Health Care – Identification of existing mainstream initiatives that require participation of First Nations

- **Midwifery Services** - The mainstream health care system must recognize the unique place of midwifery in First Nations communities and the role of midwifery in the holistic view of childbirth. Midwifery is not accessible to most First Nations women living in poverty or in rural areas. Many of our women are forced to leave home to give birth to their babies in regional hospitals, great distances away from their families. This is a form of neo-colonialism that will result in further loss of our culture particularly as it relates to the welcoming of new babies into our Nations.
Promoting health and wellbeing – Identification of priority areas for investment in FN health promotion and disease prevention

- Our children, our women, our families and our elders are priorities
- First Nations aspire to a health care system that is designed and delivered within their own communities by their own people, in keeping with their own unique cultural ways and traditions. Other characteristics include holistic approaches and addressing the determinants of health
- The development of First Nations models of health is a priority for investment in health promotion and disease prevention. The development, testing and publication of FN models based on best practice and Aboriginal perspectives is a priority in health promotion
- Early childhood development is a major priority because it has the largest potential impact and carries the requirement for a major cross-jurisdictional effort
- First Nations women's health from cradle to grave is a priority. Poor access to health care and the lack of programs for these populations result in increased spending in expensive end of health care
- Adopt early intervention as a high priority in First Nations communities


The Transformative Change Accord: FN Health Plan (TCA: FNHP) and the Tripartite First Nations Health Plan (TFNHP) covered many important health issues for BC First Nations inclusive of issues related to maternal and child health. The following summarizes the key issues for maternal and child health expressed in the TCA: FNHP:

Health Promotion and Disease and Injury Prevention

- Early childhood development education and interventions are important for health promotion and disease and injury prevention. First Nations communities currently deliver a range of programs to encourage healthy eating, exercising, avoiding alcohol and drugs and personal safety
- Child health ‘action items’ arising from this priority area were:
  o Aboriginal children under 6 (on and off reserve) will receive hearing, dental and vision screening
  o First Nations and the Province will follow up on the BC Coroner's Service ‘Child Death Review Report’ (2005) recommendation that “all levels of government, educators, parents and Aboriginal leaders and their communities forge new relationships led by Aboriginal people to address the results of the report that clearly illustrate that Aboriginal children are dying at disproportionately higher rates”
  o First Nations and the Province will continue to work with the RCMP, police detachments, Aboriginal organizations, ICBC and others to develop an information campaign to increase awareness about seatbelt use and safe driving
- What will be different by 2015? All First Nations children will regularly receive vision, hearing and dental checks and treatment!
Health Services

- Health services are not always available, accessible or culturally appropriate. Ongoing federal/provincial jurisdictional and funding issues have created gaps in health services. These issues need to be addressed so that First Nations are directly involved in decision-making and have equitable access to quality, culturally appropriate health services.
- Maternal health ‘action items’ from this priority area were:
  - A Maternity Access Project will be implemented to improve maternal health services for Aboriginal women and bring birth “closer to home and back into the hands of women”. This will help reduce the need for First Nations women in rural and remote communities to travel to more urban centers up to two months prior to delivery because of a lack of maternity care in their home communities. The project will have several components including diversity training for care providers; training of birth companions and First Nations and Aboriginal midwives and the creation of a community guide and toolkit. The investment in the program will in the long term be offset by a decrease in costs associated with medical evacuations and transfers, and a reduction in emergency care costs.

Indicators

Relevant indicators from the TCA: FNHP are:

- Decrease the gap in life expectancy at birth between Status Indians and the general BC population by 35% to less than 3 years by 2015
- Reduce the gap in infant mortality between First Nations and other BC infants by 50% by 2015
- Reduce childhood obesity for First Nations in BC

Relevant Maternal and Child Health Issues identified by First Nations participants at Gathering Wisdom Forums

Gathering Wisdom I – April 2007

- First Nations have a vision of “wellness embracing the physical, spiritual, mental, economic, emotional, environmental, social and cultural wellness of the individual, family and community”
- Cultural holistic approach to health – familial and community-oriented not individually based
- Culturally-based, culturally sensitive and culturally centered health system – cultural competency within the system is vital
- Community-driven processes are important – build on program development; support sustainability; allow each community to establish its own priorities and leave flexibility
- Communication between service providers is important – sharing lessons, challenges and solutions
- Women’s and children’s health should be a stand-alone item
- Re-establish language and culture as a part of primary care
- Screening: Broaden hearing, vision and dental screening to include FASD screening and testing for other symptoms of other conditions (TB); address transportation issues; make sure there is a follow up system after screening; focus on prevention and promotion not just screening and treatment; need baseline data on dental care
• Make the Coroner’s Child Death Review Report available to all communities
• Ensure the Maternity Access project works across the lifespan – pre-conception; pregnancy and post-natal support
• Increase emphasis on children and youth

Gathering Wisdom II – May 2008

• Common themes:
  o More must be done to ensure the long term sustainability of this effort (health actions from the TFNHP) and various strategies, initiatives and programs
  o Must be more holistic approaches
• Injury prevention priorities = child safety (youth drinking and preventable accidents)
• Universal early childhood development (ECD) supports – Both the Federal and Provincial governments have been engaged in initiatives to support First Nations and Aboriginal ECD. While the 2005 and 2006 Federal budgets announced significant investments in First Nations early learning and child care there has been a consistent view that funding and other supports are inadequate to address the level of need, particularly for children with special needs in on-reserve and off-reserve First Nations communities. In the areas of universal ECD supports there needs to be minimum standards for programs and services to allow First Nations children to reach their full potential.
• Key issues include:
  o Some services are not funded for non-Status
  o On reserve / off-reserve – can we amalgamate these programs and services
  o Training and education for educators, families and communities
  o Cannot only focus on children – need to support family with basic necessities; need a variety of programs accessible to families and kids
  o Must advocate for ECD funding especially for smaller communities

Gathering Wisdom III – November 2009

• Aboriginal Maternal and Child Health Committee has been established
• Some of the work they have reviewed includes SIDS special report with Child Death Review Unit and assessment tools used by early hearing program
• Work with Shaken Baby Syndrome – Period of Purple Crying
• Act Now Healthy Choices in Pregnancy (HCIP) resources working with the National Collaborating Center for Aboriginal Health
• Baby’s Best Chance DVD – a Provincial best practice resource developed by the Province for service providers to support prenatal education for families
• Need to look at bringing Perinatal health (immediately before and after birth) closer to home working with PHSA (Perinatal Services BC)
• Support the Aboriginal Perinatal Health Advisory Committee
• Doula Curriculum –Traditional birthing practice stories; DONA guidelines for certification; Elders involved in training; existing Aboriginal Doula’s share experiences – Doula training has already occurred in many areas. Need to continue supporting the Advisory Doula Working Group
• Vision, dental and hearing screening progressing well with Province including development of resources to support screening work; vision screening training
Gathering Wisdom V – May 2012

- Access to perinatal and early childhood development programs and services is not adequate in all communities and transportation is a large barrier to accessing services; Head Start programs should last the full day.
- Education is valuable and needed for girls, women and families on a variety of topics that will contribute to increased self-care, sexual health, relationships, prevention and health promotion.
- Women want to give birth within their communities and many are supportive of midwives and doulas.
- Screening services are beneficial, but lacking in communities; oral health is important, but costly and parents need more information about oral health prevention.
- Better methods are needed to help parents track immunizations and ensure that parents are aware of the benefits of immunization.
- Parenting programs should be available and involve both mother and father and help men to better define their roles as fathers and partners; fathers should also be supported to attend appointments with their partners.
- Community-based support people are valuable for guiding women and families through new and difficult situations within the perinatal and new parenthood periods (e.g. peer mentors and care coordinators).
- Women and children should be supported to have positive mental health, especially for those experiencing abuse or trauma.
- Traditional culture, knowledge and practices should be included as foundational pieces in maternal and child health services and programs, and Elders are instrumental in passing these on to other community members.
- Women, children and families should be better supported to access and eat nutritious and be physically active.
- The social determinants of health, including housing, education, poverty, access to clean water and historical trauma, are fundamental barriers to maternal and child health that must be addressed.
- More communication about Health Actions should take place within communities.
- The social determinants of health present large barriers to maternal and child health, including education, housing, access to clean drinking water, intergenerational trauma and poverty.

Health Directors Forums

Health Directors Forum - September 30 to October 1 2008

Discussion of desired changes in Maternal and Child Health

- Provide a united voice to build compassion for women and children; mothers with addictions.
- Fatherhood programs – preparation; supporting mother and self; assisting in child development; resources available; encouraging fathers to attend information sessions.
- Research and information, opportunities available for traditional parenting methods – overcome loss in skills due to intergenerational FAS / Residential school effects.
- Incorporate elder teachings around pregnancy.
- Incorporate and strengthen cultural ceremonies and events around babies – community baby welcoming feasts; blanketing ceremonies.
Incorporate speech and language programs
• Incorporate screening methods – infant child for screening iron, TB
• Address impact of poverty, substance use, remoteness on maternal and child health
• Build community trust in health professionals
• Incorporate e-tools to track baby checks and services
• Incentives for mothers to do regular baby checkups (coupons)
• Use infrastructure – facilitate with municipality, schools and parents to address issues in a coordinated manner (screening)
• Baby wellness programs; wilderness treatment center; health information systems

Health Directors Training and Networking Event  Health Actions World Cafe – March 9, 2012:
Discussion of MCH successes and gaps

• Communities are lacking birth services, speech therapy, parenting supports, and universal provision of MCH services such as FNIH's Children's Oral Health Initiative and immunization clinics
• Barriers to program implementation include high costs and remote locations resulting in long travel distances
• Health directors highlighted some MCH successes, including Seabird Island's MCH program and partnerships that increase accessibility to programs (ie. Friendship Centres and ACTNOW funding)
• A consistent method is needed for sharing information and alerting communities of opportunities for participation (e.g. a place to find out about and apply for initiatives)
• More time is needed for dialogue between the Health Actions Team and community and these discussions should include service providers in addition to health directors
• Health directors had many questions regarding the healthy system transition, including whether all communities will have access to MCH programs after the transition, if front-line workers will be overloaded, if training will be provided for MCH program staff, and how the outcomes will be measured to determine if the health gap is closing.


Concerns were brought forward with regards to

• “Lack of funding” for programs such as maternal health, K-4 and K-5 head start programs and physiotherapy.
• The needs of First Nations children encompass education and nutrition, ActNow programs and all aspects of healthy living. Health planning should involve communication and collaboration with school districts to address children's needs and whether the current programs and services are sufficient to meet those needs.
• There is a general concern that most programs and services are underfunded ie. Mental Health, Addictions, HIV/AIDS, special needs, FASD children, and diabetes.
• Communities have identified a need to increase the amount of health professionals who can stay to work in the communities i.e. doctors and nurses.
• Communities have identified Medical Transportation as an issue. There needs to be an increase to patient travel funds for non-insured health benefits, especially for pregnant mothers who have to travel out of the community for delivery.
• Training opportunities should be based on community need – i.e. nursing, home support, early childhood education
• There is a need to have permanent doctors in the community that are willing to build and maintain a long term relationship with the children and families of the community. Most doctors leave the community for greater pay after gaining the experience and the trust is broken; a stronger commitment needs to be made to stay with the community.
• There are too many FN children in care; there is a need to focus on preventive approaches to this issue.
• There needs to be more services in remote areas. Policies and funding formulas should be revisited, changed and driven by the needs of the community.
• There is a need for additional support for special needs children with real disabilities.
• There is a need for programs to encourage youth involvement in health planning initiatives
APPENDIX B: TRIPARTITE MATERNAL CHILD AND FAMILY HEALTH STRATEGY AREA: OUR PROGRESS, LEARNING AND ACHIEVEMENTS TO DATE

INFANT AND CHILD HEALTH AND WELLBEING:

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| **SCREENING PROGRAMS** | **Early Hearing Programs**          | • Provided recommendations to Provincial Intervention Coordinator of the BC Early Hearing Program on the content and application of hearing assessments.  
• Reviewed the ‘Family Path’ informational brochure regarding early hearing testing and worked with coordinator to ensure these resources are accessible to Aboriginal families.  
• Provided guidance to the development of an Early Hearing DVD intended to increase awareness and understanding of early hearing screening and diagnostic services, especially in rural and remote locations.  
• Your Childs Hearing DVD has been finalized and distributed throughout the Province. |
|                        | **Vision Screening**                | • Provided 3 vision screening training sessions (in Vancouver, Smithers and during the BC Aboriginal Childcare Society Conference.  This was done in partnership with NCCAH.  
• In partnership with NCCAH, developed a vision screening manual directed at First Nation readers which also includes the provincial mainstream manual.  
• Developed protocols, draft letters and guidelines for Health Authorities in collaboration with Health Authorities and the First Nations School Association.  
• Bought 10 Randots, HOTV and SureSight vision screeners which can be loaned to First Nations.  
• Developed vision screening rack cards and posters.  
• Collaborated with NCCAH on a variety of projects – vision screening manual and training, vision screening surveys and reports. |
<p>|                        | <strong>Dental</strong>                          | • Conducted a meeting with BC Dental Association (BCDA), dentists and First Nation communities to talk about dental health                                                                                           |</p>
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| (Lead: Ministry of Health) | • Conducted several meetings with MoH Early Childhood and Screening Manager, PHO Aboriginal physician, FNIH dental consultant, BCDA to discuss dental issues and possible plan of action to support dental survey administration for remote First Nations communities.  
• Reviewed and provided feedback on 2009-10 Provincial First Nations and Aboriginal kindergarten dental survey  
• Completed a storyboard for a DVD outlining a child’s first visit to the dentist.  
• Completed a scan of childhood oral health preventive services for First Nations and Aboriginal children in BC that will inform the development of an childhood oral health strategy; the scan was produced through a partnership between the Ministry of Health, the Regional Health Authorities and Health Canada’s First Nations and Inuit Health Branch  
• Developed a collection of childhood oral health resources to support families and service providers  
• Acquired funding and developed a First Nations and Aboriginal Childhood Oral Health Strategy | |
| Awareness of CPT1a variant and prevention of hypoglycemia (Lead: Ministry of Health) | • In March 2010, the AMCHC invited Dr. Hillary Vallance (PHSA) to discuss both programs.  
• Developing parent and public messaging, supporting the revision of medical guidelines and developing a BC Health File regarding the health impacts of CPT1a variance for First Nations and Aboriginal infants and children.  
• Draft versions of both the CPT1a brochure and clinical guidelines are currently being finalized with introductory letters | |
| EARLY CHILDHOOD DEVELOPMENT | Aboriginal Head Start (FNIHB program) | • In March 2010, 15 new sites were selected and 10 sites attended the Aboriginal Head-start Training. Three additional sites attended orientation in April and two other sites will attend orientation in June.  
• A representative from the BCFNHS Regional Advisory Committee sits on the AMCHC as a linkage. | |
<p>| Returning Home Demonstration Project: | • In October 2009, a two-day meeting was held to review discharge planning for Aboriginal children with complex care needs. The first day was designed for Aboriginal community members and service providers. The second day was designed for key services such as | |</p>
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| **Discharge Planning for First Nations Children with Special Needs**  
(Lead: Child Health BC, PHSA) | | • Discharge Planning for First Nations Children with Special Needs (Lead: Child Health BC, PHSA)  
Vancouver Island Health Authority, Ministry of Child and Families, FNIHB, Provincial Discharge Planners from Provincial Health Service Authority. This was a joint meeting with Child Health BC and FNHA.  
• With direction from the two-day meeting, developed an innovative inter-professional discharge planning model to be trialed as the “Returning Home” demonstration project for communities on Central and Northern Vancouver Island beginning in September 2012.  
• Facilitated a second community meeting to present the discharge planning model back to community and service providers and enable further input into the model.  
• A discharge planning coordinator was hired to develop inter-professional linkages between hospital care providers and community services for the “Returning Home” demonstration project.  
• An informational brochure, introductory video and website for this project have been completed  
• Information gathering protocol for the evaluation of this demonstration project is currently being confirmed |
| **CHILD DEATH REVIEW UNIT** | **Safe Sleep Initiative**  
(Lead: Perinatal Services BC; Past Lead: BC Coroner’s Office Child Death Review Unit) | • Provided feedback, recommendations on, and peer review into the “Safe and Sound: A Five Year Retrospective”.  
• Facilitated discussion and awareness surrounding safe sleep practice during a UBC Learning Circle education session in February 2012.  
• Developed safe sleep discussion cards and a facilitator guide to raise awareness and support service providers in discussing safe sleep practices with new parents to reduce the incidence of sudden infant death syndrome.  
• Currently planning for the official launch and physical distribution of safe sleep resources in print and online.  
• A number of engagement and sharing opportunities with health providers and community members have been scheduled for the fall of 2013 to demo these resources and answer questions. |
**Maternal Health and Wellbeing:**

<table>
<thead>
<tr>
<th>PRIORITY AREA</th>
<th>COMPONENT</th>
<th>ACHIEVEMENTS TO DATE</th>
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| **MATERNITY ACCESS** | **Aboriginal Doula Initiative** *(Lead: Perinatal Services BC, PHSA)* | • Participated in the Aboriginal Doula Advisory Committee and provided input into the development of the proposal to support doula training in BC, as well as input into the final report for the project. Provided feedback on doula curriculum in 2008/09  
• Using the feedback from the 2008/09 training, developed curriculum and provided training to 30 students in the Interior and Vancouver Island regions in the winter of 2011/2012  
• Hired doula liaisons to support the doulas in networking and gaining the practical experience to become certified  
• Developed materials and hosted events to raising awareness of the role and benefits of doulas among health care providers and community members.  
• Currently working to help remaining students complete their doula training requirements  
• Currently conducting an evaluation of the doula training program and doula services. |
| **Maternal Child Health Promising Practices** *(Lead: Ministry of Health)* | • Acquired funding through Health Service Integration Funds to assess the need for, appropriateness and feasibility of expanding and adapting the program, Nurse-Family Partnership in First Nations and Aboriginal communities.  
• Is focused on reviewing information about existing services and programs for First Nations and Aboriginal expectant women in BC and culturally safe and respectful approaches within MCH programs.  
• This initiative will produce a document that highlights promising practices in MCH programs and provides recommendations on programs that should be evaluated and or considered for broader implementation. |
APPENDIX C: GLOSSARY OF TERMS

Aboriginal

Aboriginal is a collective term used to describe the three constitutionally recognized Indigenous populations in Canada – First Nations, Métis and Inuit. While the term Aboriginal is commonly accepted, identifying each of these populations specifically by name is preferable where appropriate. The Approach is inclusive of all First Nations regardless of status or place of residency and all Aboriginal people regardless of their Nation affiliation. See also “Indigenous.”

Community

Community refers to a collectivity with shared identity or interests that has the capacity to act or express itself as a collective. A community may include members from multiple cultural groups. A community may be territorial, organizational or a community of interest. “Territorial communities” have governing bodies exercising local or regional jurisdiction (e.g. members of a First Nations resident on reserve lands). “Organizational communities” have explicit mandates and formal leadership (e.g. a regional Inuit association or a friendship centre serving an urban Aboriginal community). In both territorial and organizational communities, membership is defined and the community has designated leaders. “Communities of interest” may be formed by individuals or organizations who come together for a common purpose or undertaking, such as a commitment to conserving a First Nations language. Communities of interest are informal communities whose boundaries and leadership may be fluid and less well-defined. They may exist temporarily or over the long term, within or outside of territorial or organizational communities. An individual may belong to multiple communities, both Aboriginal and non-Aboriginal (e.g. as a member of a local Métis community, a graduate students’ society and a coalition in support of Aboriginal rights). An individual may acknowledge being of First Nations, Inuit or Métis descent, but not identify with any particular community.

CPT1a

A genetic variant that is common to some B.C. First Nations people and it may increase the chances of a baby or young child having low blood sugar. Along the coast of B.C. and Vancouver Island, 1 in 5 First Nations babies are born with the gene variant. In the interior region of B.C., 1 in 25 First Nations babies are born with the variant. In general, children with the CPT1a genetic variant are healthy and will grow and develop normally.

Cultural competence

Cultural competence refers to a specific set of values, attitudes, knowledge and skills that sensitize and improve sharing of information and assistance between people of different cultural orientations. Cultural competence enables health and human service providers to be respectful and effective in their interactions with people from different cultural backgrounds, including First Nations and Aboriginal people. In an Indigenous context, cultural competence is informed by the
history of colonization, Indian residential schools, Indian Hospitals, the Indian Act, and the ongoing legacy of colonial interference and racism. Becoming culturally competent is a journey, not a destination. It requires improving knowledge about Indigenous issues, engaging in a process of critical reflection, enhancing one's self-awareness and de-colonizing the skills and actions that will lead to positive change. See also “Aboriginal” and “Cultural safety.”

Cultural safety

Cultural safety refers to what is felt or experienced by a patient when a health care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-making and builds a health care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care. Culturally safe encounters require that health care providers treat patients with the understanding that not all individuals in a group act the same way or have the same beliefs. See also “Cultural competence.”

Fetal Alcohol Spectrum Disorder

An umbrella term that refers to a broad number of health outcomes and health effects experienced by an individual whose mother consumed alcohol during her pregnancy. It is not a clinical diagnosis on its own. FASD can include growth impairments, neurological development concerns, distinct facial features and behavioral differences.

Health Care Providers

Health Care Providers is a term that refers to a large group of health professionals who provide direct service or as members of multi-disciplinary teams in hospitals and communities who are involved in the delivery of health care for the identification, evaluation and prevention and treatment of diseases and disorders; dietary and nutrition services; rehabilitation and health systems management, among others. Typically Health Care Providers operate within a professional scope of practice where credentials are established through diploma programs, certificate programs and continuing education.

Holistic

Holistic refers to the concept that promoting, protecting or restoring health requires understanding the individual as an integrated system—including physical, mental, emotional and spiritual aspects—which cannot be reduced to one or more separate parts.

Inequity

Inequity in the health field refers to differences in rates of illness, disease, health outcomes, or access to health care across racial, ethnic, sexual orientation and socioeconomic groups.
Inuit

Inuit refers to the Aboriginal people of Arctic Canada. Inuit communities are primarily located in Nunavut, the Northwest Territories (Inuvialuit), Northern Quebec (Nunavik) and Labrador (Nunatsiavut).

Métis

Métis are individuals who have Aboriginal and non-Aboriginal ancestry, who self-identify as Métis, are distinct from other Aboriginal peoples, are of historic Métis Nation ancestry, and are accepted by the Métis Nation.

Prevention

Prevention refers to measures taken to prevent the onset of illness or disease before it occurs, or to slowing its transmission, progression or effects through early detection and appropriate treatment. Prevention in its broadest sense requires addressing social determinants of health, which create conditions of vulnerability for individuals or populations. Prevention efforts can also be targeted to specific populations who may be at greater risk of illness or consequent harms.

Primary Care

Primary care involves the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same practitioner for routine check-ups and preventive care, health education, and every time they require an initial consultation about a new health problem. Collaboration among providers is a desirable characteristic of primary care.

Social Determinants of Health

Social determinants of health refers to the range of personal, social, economic and environmental factors that contribute the health status of individuals or populations. These factors include income and social status, education, employment and working conditions, access to appropriate health services, housing and physical environments. They interact in complex ways, and their modification can influence health and vulnerability to illness.

Traditional knowledge

Traditional knowledge refers knowledge, information and wisdom that is created, preserved and dispersed in a community. Traditional knowledge is ‘traditional’ not in a sense that it belongs to the past but in the way it is acquired. This information may be rooted in storytelling, ceremonies, traditions, ideologies, medicines, dances, arts and crafts, or a combination of all these. A Traditional Knowledge Keeper is one who passes information from generation-to-generation. In some respects,
everyone in a community or culture holds traditional knowledge because it is collective. Traditional knowledge is determined by a First Nation's land, environment, region, culture and language. People such as Elders and healers usually share this knowledge with others in the community.

**Tripartite Partners:**

Federal, Provincial and First Nations governments

### APPENDIX D: ACRONYMS

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<thead>
<tr>
<th>Acronym</th>
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<tbody>
<tr>
<td>AHS</td>
<td>Aboriginal Head Start</td>
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<td>AHSOR</td>
<td>Aboriginal Head Start On Reserve</td>
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<td>AIDP</td>
<td>Aboriginal Infant Development Program</td>
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<td>COHI</td>
<td>Child Oral Health Initiative</td>
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<tr>
<td>CDRU</td>
<td>Child Death Review Unit</td>
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<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorder</td>
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<td>FNIHB</td>
<td>First Nations and Inuit Health Branch</td>
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<td>FNHA</td>
<td>First Nations Health Authority</td>
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<td>First Nations Health Council</td>
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<td>FNHDA</td>
<td>First Nations Health Directors Association</td>
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<td>MCH</td>
<td>Maternal Child Health</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NCCACH</td>
<td>National Collaborating Centre for Aboriginal Child Health</td>
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<tr>
<td>OCAP</td>
<td>Ownership, Control, Access, Possession</td>
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<tr>
<td>PHSA</td>
<td>Provincial Health Services Authority</td>
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