

Promising Practices in First Nations and Aboriginal Maternal and Child Health Programs: Community Perspectives on What Works



A Report on the Findings from the BC Tripartite First Nations
and Aboriginal Maternal and Child Health Working Group

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My apologies in advance for any errors or omissions

Note: The resources referred to in this report are ones that were mentioned during the participant interviews and represent only a sample of the many excellent resources that MCH programs draw from. It was beyond the scope of this project to include a comprehensive list.

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Executive Summary

The purpose of this report is to provide advice and recommendations to the BC Tripartite First Nations and Aboriginal Maternal and Child Health Strategy Table (Strategy Table) on the key elements of a promising practice in maternal and child health (MCH)—what works, what does not work and what we need to do to improve and accelerate positive changes. The information in this report represents the perspectives of interview and group discussion participants who are health directors and maternal child health program coordinators from First Nations communities, as well as health authority and government staff responsible for implementing maternal and child health and early child development programs in BC.

Supporting parents and children is a priority for First Nations communities in British Columbia (BC). Every year, approximately 662 young women under the age of 25 will give birth to their first child.¹ In fact, teen pregnancy is about four times higher among First Nations girls than among other girls in BC. Many of these young mothers will not be prepared or be properly supported to be successful at raising healthy and happy children. And many of the young men who are to become fathers will also struggle, and will not likely have the skills to parent effectively, or to support their families. On top of individual personal challenges, social and historical factors (such as the inter-generational impacts of residential school) conspire to undermine sincere efforts to parent well. This situation has devastating consequences—child apprehensions, abuse, neglect, high rates of infant mortality and preventable disabilities.

Research has shown that MCH programs and early childhood development (ECD) programs—such as family visiting programs—help parents improve their parenting skills, reduce the maltreatment of children, enhance the mental health of children and improve a family’s chances at economic self-sufficiency.^{2,3}

Most importantly, women and men describe the experience of becoming a parent as a chance to “turn things around.”⁴ So compelling is this experience that one could argue that there is no more powerful a time to support people to make big life changes—to heal the devastating effects of inter-generational trauma and to prevent it from continuing into a new generation.

Becoming a parent is rocket fuel for change, providing women and men with the motivation and energy to create a new generation of families that are healthy and loving and are living the best life possible. Excellent MCH initiatives build their programs around this transformative vision.

The participants who contributed to this report emphasized that people and the positive relationships they create are at the heart of excellent programs and services—first and foremost the relationships between families and helpers, and then expanding out to the relationships among the staff on the MCH multidisciplinary team and with community partners and funding agencies.

This report highlights community-based, holistic, culturally grounded approaches, rather than recommending specific program models. No

1 BC Ministry of Health. (2011). *First Nations client file: 2011 Projected first-time mothers* [Briefing note]. Victoria, BC: Author.

2 Waddell, C., Catherine, N., Hougham, K., & Sheehan, D. (2015). *The BC Healthy Connections Project: A scientific overview* (Report for the BC Healthy Connections Scientific Team). Vancouver, BC: Children’s Health Policy Centre, Simon Fraser University.

3 Canada’s Public Policy Forum. (2014, November). *Building leaders: Early childhood development in Indigenous communities: Research paper*. Ottawa, ON: Author. Retrieved from http://www.pppforum.ca/sites/default/files/Building%20Leaders%20research%20paper%20-%20Final_3.pdf.

4 From p. 46 of Smith, D., Varcoe, C., & Edwards, N. (2005). Turning around the intergenerational impact of residential schools on Aboriginal people: Implications for health policy and practice. *Canadian Journal of Nursing Research*, 37(4), 38–60.

one model will work for every community, plus communities develop innovative models that are just right for them when they are allowed the flexibility to be creative, rather than when they are directed by government or funding agencies to implement a particular model. Although no specific model is recommended, “Liz’s Story” is woven throughout the document as an example of how the Nuu-chah-nulth Tribal Council developed their program model—Mother’s Story.

Contributors to this report also emphasized that MCH programs should be available to all pregnant women and families with young children, should provide support until the children reach the age of at least 6 years and should be offered to families regardless of where they live in BC. In addition, the program components should be delivered through a combination of home visits and group activities.

The participants identified three core elements and four enabling factors that create promising practices in MCH programs.

Three core elements

1. A woman-centred and family-centred approach: This approach recognizes that each woman is the expert on her own life, acknowledges that each family is unique and therefore welcomes all families of different shapes and sizes, not requiring families to fit into a “box” in order to receive support.

In this approach, fathers have an integral role to play in raising healthy children—as do grandparents and extended family members. The approach also meets families where they are at on their healing journey, focuses on their strengths and gifts, acknowledges their efforts and gives them credit for making positive changes.

2. High-functioning and collaborative teams: Such teams are led by servant leaders who are emotionally intelligent, are culturally competent, build the capacity of others and are excellent collaborators and connectors. An effective helper has done her own healing work and transformed

her own painful life experiences into wisdom. Helpers should be well trained and have the skills to do their job. Participants emphasized that excellent training for family visitors can take several forms and is not limited to a university education. The lived experiences of a helper have value and enhance the helper’s capacity to connect and build relationships with families.

The members of high-functioning teams are self-aware and practise good self-care. A multidisciplinary team includes community health nurses, physicians, child health specialists and staff from other health promotion and ECD programs. Participants reported that midwives and doulas are extremely valuable in improving birth outcomes, providing continuity of care and bringing birth back to the community. In addition, Elders, cultural advisors and traditional healers are essential team members.

Staying connected to the multidisciplinary team through regular meetings, case management and collaborative planning takes time and energy, but is well worth the effort to improve client care.

3. A holistic and flexible program model: Interview participants appreciate aspects of several program models and have drawn from a number of programs to create what works best for their community. They agreed that excellent programs are community based, are culturally safe, integrate trauma-informed practices and put into action the values of friendliness and hospitality. Holistic models incorporate Indigenous language and cultural teachings, and view becoming a parent as a sacred journey. Activities in these programs are focused on four themes: healing the self and healing relationships; creating healthy and loving families; connecting with others and building community; and learning new skills and realizing dreams.

Recognizing that healthy children are raised by healthy parents, program staff offer a variety of opportunities and methods for personal healing of trauma, abuse, neglect, addictions and family violence, and support the family to stay on a healing path. Holistic programs support mothers

to have healthy pregnancies, have positive birth experiences, breastfeed and form strong attachments to their babies, as well as learn about infant care, child development and positive parenting practices. Programs also provide opportunities for parents to make new friendships and contribute to their community by learning about their culture and participating in community events. In addition, holistic models help parents to realize their dreams by supporting them to return to school and pursue their professional goals.

Four enabling factors

1. Organizational and community leadership:

Interview participants talked about how organizational culture can impact the MCH staff and program effectiveness. They spoke about the benefits of a supportive and positive organizational culture, and a community's leadership that is engaged and supports the program goals.

2. Partners and resources: Interview participants strongly believe that governments and health authorities have a shared responsibility for maternal and child health programs. Successful MCH programs flourish when they are supported by partners that share resources and collaborate on services. Participants stressed the importance of developing excellent relationships with health service administrators, public health nurses and other health authority staff.

3. Research and evaluation: Interview participants expressed the need to collect data that tell a “meaningful story”—and to move away from collecting “outputs” and “lists of activities” that do not inform program development or support continuous improvement. They are keen to learn more about the short-term and long-term impacts and outcomes of their programs, and are concerned that current evaluation frameworks are not the most useful tools to accomplish this goal. The participants expressed interest in partnerships with universities and community action researchers to design evaluation frameworks and

research studies that would measure and monitor the outcomes that are important to the community.

4. Funders' processes, policies and leadership:

Effective health promotion strategies such as MCH programs are developed in true collaboration with communities. Communities create innovative and effective programs when funders allow flexibility in both how program models are implemented and how the program dollars are applied. Interview participants appreciate clear direction, consistent support and commitments to funding over the long term—such as 10-year agreements.

Recommendations

Communities in BC are offering excellent MCH programs that meet, and in many cases exceed, the standards for promising practices outlined in the public health literature. However, the health disparity gap that continues to exist between First Nations families and other families in BC is wide, plus is narrowing only slowly, likely because these programs have limited coverage. Making more MCH and ECD programs available would support more families to thrive, which in turn would help close the health disparity gap. We're doing the right things—we're just not doing enough of them.

To help increase coverage and narrow the gap, the contributors to this report recommended action in six areas:

1. Address funding and service inequities.
2. Increase investments in MCH and ECD programs.
3. Study existing promising practices in BC.
4. Provide training and support.
5. Allow communities flexibility.
6. Collaborate on planning and coordinate services.

The contributors to this report sent a clear message that if we make a commitment now to invest our time and resources—to heal families—we can make things better. We can “turn things around.”

Introduction: How This Report Was Developed

This report was commissioned by the Tripartite First Nations and Aboriginal Maternal and Child Health Strategy Table (Strategy Table) in British Columbia in August 2012⁵ and was funded through the Health Services Integration Fund (HSIF).

The Strategy Table established the First Nations and Aboriginal Maternal and Child Health Promising Practices Working Group (working group) to guide the development of this report. The working group included representatives from the First Nations Health Authority, the regional health authorities, the BC Ministry of Health, Simon Fraser University's Children's Health Policy Centre, and health directors and maternal and child health coordinators from First Nations communities.⁶ Participants in the working group were drawn from each of the five health authority regions and represented both urban and rural/remote communities. Each had extensive experience delivering and managing maternal and child health programs.⁷ The Healthy Women, Children and Youth Secretariat of the BC Ministry of Health acted as the administrative lead for the project.

The Contributors to the Report

Approximately 50 people contributed their ideas to this report, either as a member of a group discussion or in a one-to-one interview.⁸ The interviews and group discussions were conducted over a 2-year period starting in October 2012 through to December 2014.

Working group members	23
Individual interviews and group discussions with MCH coordinators and health directors from 14 First Nations communities in BC	24
TOTAL	47

The participants were of three types and were consulted in the following ways:

- Working group members: Four all-day in-person meetings in Vancouver and three teleconference discussions. Twenty working group members attended each of the four in-person meetings and 10 working group members participated in each of the teleconferences.
- MCH coordinators: Individual telephone interviews with 14 communities. The interviews ranged from 60–90 minutes in length. The interviews encompassed 20 participants, since in some communities the coordinator invited the family visitors to participate in the interview. In addition, ideas were gathered during one 2.5-hour in-person MCH coordinator meeting in Vancouver. The meeting had 15 participants.
- Health directors: Individual telephone interviews with four health directors. The interviews ranged from 60–90 minutes in length.

The Interview Questions

The individual interviews and the group discussions were guided by four main questions about promising practices:

⁵ At the time, the Strategy Table comprised representatives from the interim First Nations Health Authority, First Nations and Inuit Health – BC Region, regional health authorities and the BC Ministry of Health. Additional proposal partners were the Provincial Health Services Authority, the BC Association of Aboriginal Friendship Centres, the First Nations Health Directors Association and Simon Fraser University's Children's Health Policy Centre.

⁶ See Appendix A for the working group membership.

⁷ The working group met eight times during the past 2.5 years—three teleconferences and five in-person all-day meetings. During these meetings, the members shared their ideas, experiences and recommendations, reviewed the material coming from the interviews and literature search, and provided guidance to the consultant on this report.

⁸ Attention has been paid to not counting participants twice, as some people participated in an individual interview as well as in the working group discussions or at the MCH meetings.

1. What works well in your program?
2. What does not work so well?
3. What are the “must-haves” in an excellent MCH program?
4. What are your recommendations to the funders of MCH programs?

The Process for Validating the Findings

While the interviews and group discussions were still in progress, the rough data were organized as responses to the four questions. The responses were then presented in a draft document to the working group at the October 30, 2013 in-person meeting for discussion and validation. Later, the data were reorganized into themes and presented to the working group at the May 9, 2014 in-person meeting and at a MCH coordinators’ meeting on June 11, 2014. Both the working group and the coordinators validated the themes during these meetings. Subsequent drafts of the report were discussed at working group meetings and distributed to the Strategy Table and the Provincial Advisory Committee for the BC Healthy Connections Project for their feedback.

The Limitations of the Interview and Group Discussion Process

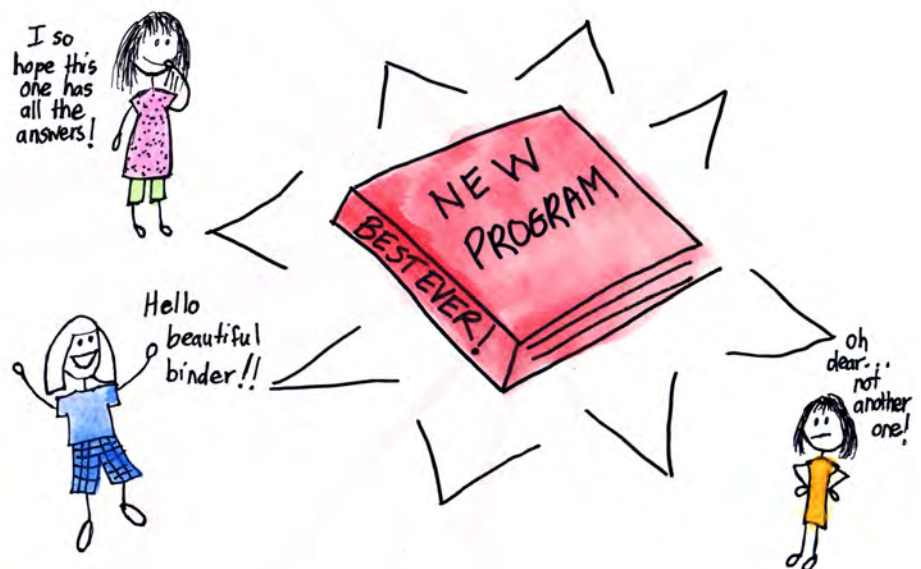
The interview participants for this report were largely drawn from communities that deliver the federally funded, Health Canada Maternal Child Health Program, although six interviews were conducted with communities that do not receive Health Canada funding, but offer similar MCH programs and services funded through other federal or provincial initiatives. It was beyond the scope of this project to cast a wider net to include representatives from all of the many MCH and ECD programs currently being implemented in BC.

A Note about the Use of Terms

For the purpose of simplicity, all of the people who contributed their ideas to this report, whether it was in an individual interview or in a group discussion, are referred to as *interview participants* or simply as *participants*.

The term maternal and child health (MCH) is used in two ways in this report. First and foremost, it is used as an overarching term to describe programs and services that serve pregnant women, parents, and their children and families. The term is also sometimes used to describe the specific federally funded Health Canada MCH Program.

Although the focus of this report is on MCH programs, the report sometimes refers to both MCH and ECD programs in the same context, given that there are several points of connection between these programs—they share a common goal of supporting families, and some of the MCH and ECD programs are interlinked and share staff.



The Need for This Report

“We are turning it around. ... We are going to be better parents for our children because we are healing. And our children won’t experience the legacy.”⁹

In his 2007 report on the health and well-being of Aboriginal people, Dr. Perry Kendall, BC’s Provincial Health Officer, stated that “the health of infants and children has been internationally accepted as an indicator of the health and well-being of a population.”¹⁰ Not surprisingly, the population health literature echoes the teachings of our Ancestors and Elders that “families are the heart of our culture. If our families are not healthy and strong, the Nation is not healthy and strong.”¹¹

Although many First Nations families in BC are healthy and strong, many are not. This report is intended to bring to the forefront the reality of those families that are not thriving—and to remind governments, health authorities and other funding

agencies that investing in MCH and ECD programs would greatly improve the lives of these families.

The participants who contributed to this report intend it to be an optimistic document that inspires hope and offers practical suggestions for developing effective programs. First, though, it is important to look at some disturbing facts about why these programs are needed.

The Statistics—They Tell a Sad Story

Every year in BC, about 662 young First Nations women (25 years and under) become mothers for the first time.¹² In fact, teen pregnancy is about four times higher among First Nations girls than among other girls in British Columbia. Many of these young mothers will not be prepared or be properly supported to be successful at raising healthy and happy children.

The statistics tell us that First Nations women:

- Have twice the rate of substance abuse problems.
- Are twice as likely to receive inadequate prenatal care.
- Are twice as likely to live in the poorest neighbourhoods.
- Experience four times the rates of neonatal and post-neonatal infant mortality in their families.¹³

And sadly, many of the young men who are to become fathers will also struggle, and will likely not have the skills to parent effectively or to support their families. In her research, Dr. Jessica Ball, professor in the School of Child and Youth



9 From p. 46 of Smith, D., Varcoe, C., & Edwards, N. (2005). Turning around the intergenerational impact of residential schools on Aboriginal people: Implications for health policy and practice. *Canadian Journal of Nursing Research*, 37(4), 38–60.

10 From p. 69 of BC Provincial Health Officer. (2009). *Pathways to health and healing—2nd report on the health and well-being of Aboriginal people in British Columbia: Provincial Health Officer's annual report 2007*. Victoria, BC: Ministry of Healthy Living and Sport.

11 This concept came up several times during discussions in the working group. Members shared that teachings in almost every Nation express this wisdom.

12 BC Ministry of Health. (2011). *First Nations client file: 2011 Projected first-time mothers* [Briefing note]. Victoria, BC: Author.

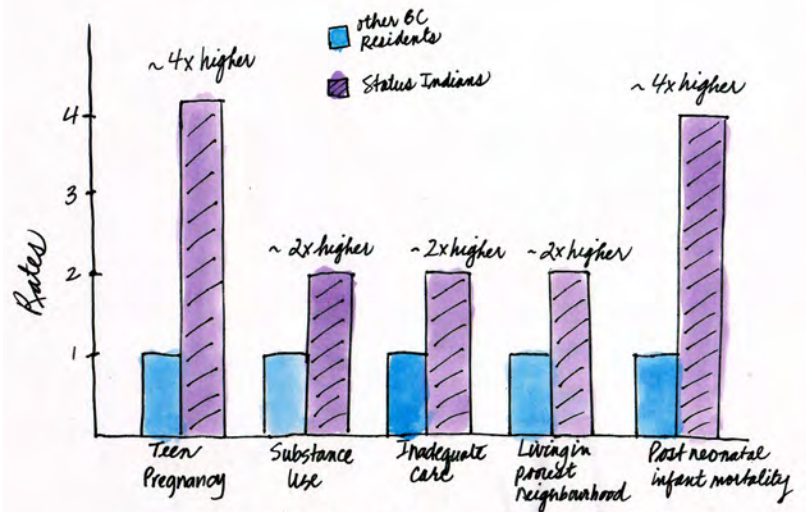
13 Information adapted from pp. 69–75 of BC Provincial Health Officer. (2009). *Pathways to health and healing—2nd report on the health and well-being of Aboriginal people in British Columbia: Provincial Health Officer's annual report 2007*. Victoria, BC: Ministry of Healthy Living and Sport.

Care at the University of Victoria in BC, has called our attention to the negative inter-generational effects of colonization and residential school experienced by Aboriginal men—and the support they need and deserve in order to heal and realize their potential to contribute to the well-being of their children. She reported that “Aboriginal men are the most socially excluded in Canada with higher unemployment, homelessness, injuries, incarceration, and suicide, and lower education and life expectancy than all other Canadians.”¹⁴

Aboriginal fathers are less likely to live with their children—although twice as many Aboriginal fathers as non-Aboriginal fathers are raising their children alone.¹⁵ But in spite of these challenges, the First Nations and Métis men in Dr. Ball’s study said they are determined to learn to parent well and to become loving fathers. In fact, 40% of the men believed they were part of the “turn-around generation” and would heal the legacy of abuse and neglect.¹⁶

One of the heartbreaking consequences of not helping parents to turn around the inter-generational impacts of residential school is that many families have lost custody of their children. Dr. Cindy Blackstock (Gitxan), Executive Director, First Nations Child & Family Caring Society of Canada, has reported the following:

- There are three times more First Nations children in child welfare care now than there were at the height of Residential School.
- First Nations kids are 6 to 8 times more likely to go into child welfare care than non-Aboriginal children.
- This overrepresentation is largely caused by factors beyond the control of individual parents: poverty, poor housing, underfunded education, substance misuse and, in many cases, lack of access to safe drinking water.¹⁷



Information adapted from "Pathways to Health and Healing, 2007"

The Early Years of a Child's Life Are a Unique and Precious Time of Growth

It is well known that the first 6 years of a child's life are a unique and precious time for healthy growth and development. It is a critical period for establishing parent and child attachments and family bonding. In these early years, children develop a sense of whether or not they are loved and belong to a healthy family and a culture that matters. The way in which a child is cared for during these early years deeply influences whether the child will flourish as an adult or struggle to live a healthy and fulfilling life.

The tragedy is, as Dr. Charlotte Waddell, principal investigator for the BC Healthy Connections Project, has highlighted, that mental disorders are the leading problem for Canadian children. At any given time, 12.6% of Canadian children are experiencing mental disorders, with clinically significant symptoms and impairment. Compounding the tragedy is that at least four common childhood mental disorders (anxiety, conduct disorder, depression and substance abuse) are preventable.

The adverse consequences of this situation for children are that most mental disorders that start in childhood will persist into adulthood, resulting

14 From p. 373 of Ball, J. (2012). "We could be the turn-around generation": Harnessing Aboriginal fathers' potential to contribute to their children's well-being. *Canadian Journal of Paediatrics & Child Health*, 17(7), 373–375.

15 Ibid, p. 373.

16 Ibid, p. 375.

17 From para. 4 of First Nations Child & Family Caring Society of Canada. (2015). *FNCARES First Nations Children's Action Research & Education Service*. Retrieved from <http://www.fncaresociety.com/fncares>.

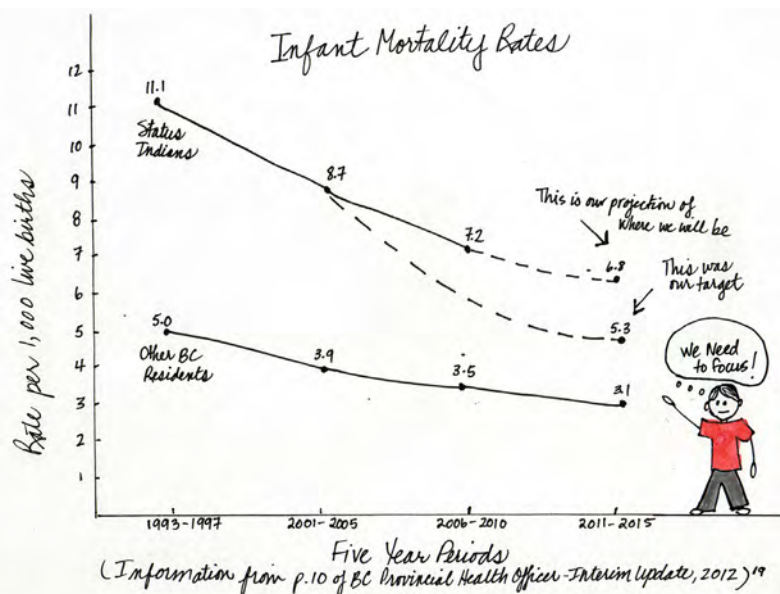
in reduced life chances in such areas as education and employment. They also result in increased physical illness and mortality. The adverse consequences for society are that mental disorders are the main cause of lifelong disability and lost human potential. The annual costs are estimated to be around \$50 billion in Canada.¹⁸

We Set an Improvement Goal, but We Are Not Meeting It

In 2005, the BC provincial government and First Nations signed *The Transformative Change Accord: First Nations Health Plan*. This seminal document set a target to reduce the gap in infant mortality rates between First Nations and other British Columbians by 50% by 2015. Unfortunately, we are not closing the gap.

In the 2012 interim report, Dr. Kendall reported:

“While infant mortality rates for Status Indians declined from 2001–2005 to 2006–2010, current projections indicate that there may be only a small improvement by 2015, and the target reduction will not be met. If no changes are made to address these rates, the decreasing trends for both



Status Indians and other BC residents are projected to level off, leaving a persistent gap between the two groups.”¹⁹

Dr. Kendall’s report is telling us that we must take action! If we want to reduce infant mortality and address all the other maternal and child health issues connected to infant mortality, we have to redouble our efforts.

The good news is that this action is possible.

We Have the Skills and Knowledge to Make Things Better

We know how to improve the health of families. We may not have *all* the answers, but we know enough about what works to take informed action. A number of studies over the past 10 years have described programs and services—such as home visiting programs—that have made and continue to make a difference.²⁰ And many national and provincial organizations are dedicated to improving maternal and child health.

As stated by James Anaya, former United Nations Special Rapporteur on the rights of Indigenous peoples, in his May 2014 report,

“It bears noting that there exist a number of laudable government education programs, some of which have demonstrated success. The Aboriginal Head Start in Urban and Northern Communities program has shown achievements in eliminating disparities between aboriginal and non-aboriginal children in terms of school readiness; *unfortunately, this program reaches less than 10% of aboriginal children* [italics added].”²¹

Our Elders and traditional people have much wisdom to share. Their teachings and support have transformed and healed the lives of many families. Our culture provides a deep source of

18 The information in the above section is taken with permission from a presentation in 2014 by Dr. Charlotte Waddell, Children’s Health Policy Centre, Simon Fraser University, Vancouver, BC.

19 From p. 10 of BC Provincial Health Officer. (2012, October 4). *The health and well-being of the Aboriginal population—Interim update: A report from the Provincial Health Officer, prepared in order to meet the reporting requirements of the 2005 Transformative Change Accord*. Victoria, BC: Author.

20 Waddell, C., Catherine, N., Hougham, K., & Sheehan, D. (2015). *The BC Healthy Connections Project: A scientific overview* (Report for the BC Healthy Connections Scientific Team). Vancouver, BC: Children’s Health Policy Centre, Simon Fraser University.

21 From p. 8 of Human Rights Council, United Nations General Assembly. (2014, May 7). *Report of the Special Rapporteur on the rights of indigenous peoples, James Anaya, on the situation of indigenous peoples in Canada*. Retrieved from http://www.ohchr.org/Documents/Issues/IPeoples/SR/A.HRC.27.52.Add.2-MissionCanada_AUV.pdf.

strength and knowledge on how to live healthy and happy lives—how to live in a “good way.” We have lots of practice-based evidence and experience from First Nations communities and Aboriginal organizations that have been implementing programs, in some cases for more than 30 years! They have learned a tremendous amount about creating effective services and supports, and have witnessed powerful healing in families over time.



Parents Are the Key

Most importantly, women and men describe the experience of becoming a parent as a chance to “turn things around.”²² No matter how they may be neglecting and harming themselves, in all the ways we humans do when we are suffering and want to escape our inner and outer realities, they feel a profound responsibility to stop and to make things better. They see parenthood as a sacred task. They view parenthood as a time to heal, to put things in order, to get back on the healing path.

So compelling is this desire that one could argue that there is no more powerful a time in our lives to make changes—to quit smoking and drinking, to eat well, to take care of our bodies, to get more education and training so that we can support our child, to heal past traumas and wounds, to mend broken relationships, to connect with our culture—to realize our potential. To become the person we think worthy to raise our precious children.

There are certainly other turning points in our lives when we are motivated to make changes. Perhaps the untimely death of a loved one from cancer makes us want to quit smoking once and for all, or the grind of poverty pushes us to summon our courage to take the leap to go back to school. These are all critical turning points.

But the journey into parenthood requires us to look at *all* of these changes at once. This one big life transition holds within it the potential for many changes and transformations. We see examples of changes everywhere we look—women and men cleaning up their lives, reaching out for help, doing their best to “turn things around.”

Many times they succeed. And many times they cannot sustain the change. The responsibility and the demands of parenthood can bring the most mature, sophisticated and prepared person to their knees. It is a daunting task—physically, mentally, emotionally and spiritually demanding.

So how, then, are the young ones to do it without help? The answer is they cannot. They cannot succeed without the love, encouragement and support of family and friends. They cannot make things better without the guidance and assistance of skilful helpers and responsive systems and services. They need all of these supports.

The cost of not turning things around is very high. Addictions, abuse, anxiety, poverty and despair continue into a new generation, children are seriously

²² From p. 46 of Smith, D., Varcoe, C., & Edwards, N. (2005). Turning around the intergenerational impact of residential schools on Aboriginal people: Implications for health policy and practice. *Canadian Journal of Nursing Research*, 37(4), 38–60.

harmed, perhaps born with preventable disabilities that challenge them for a lifetime. Everyone suffers.

We know this. But despite our knowing, there are still not enough maternal and child health programs and supports available, and several that do exist are underfunded or not adequately supported in other ways.

It's Time to Tell a Better Story: A Call to Action

The purpose of this report is to describe, from the perspective of the coordinators and health directors implementing these programs, what

works, what does not work and what we need to do to improve and accelerate positive changes—to make wise use of this profound time to “turn things around.”

The participants who contributed to this document hope this report will act as a catalyst to increase the support of and investment in current programs and to fund communities that are without programs.

We can do this. If we make a commitment NOW to invest our time and resources—to heal families—we can make things better. We can “turn things around.” We can tell a better story.



Defining a Promising Practice

The concept of a “promising practice” or “best practice” is not new, although in the past we might not have used these specific terms to describe our efforts at creating and delivering high-quality programs that make a positive difference.

Every Nation has stories and teachings for both women and men on how to live well, how to take of each other and the earth, how to raise healthy children, and how to create a harmonious family and community and a just society.

The truth is—as our Elders tell us—communities have provided love and support and teachings to families for thousands of years. Indigenous children and families flourished prior to contact with the settlers from Europe—and many people and communities flourish now.

First Nations communities and Aboriginal organizations in BC have been delivering ECD and MCH programs for well over 30 years. Several communities in BC have almost 60 years of experience in providing services and supports to families—implementing programs long before federal or provincial funding was available. Both the federal and the provincial governments have been funding ECD and MCH programs since the early 1990s.

Dozens of provincial and national organizations are dedicated to providing research, advocacy and policy advice on this subject, and a number of documents have been published on best practices or on promising practices. Among them, at least

four seminal national reports on promising practices in Indigenous communities have been published in Canada and the US since 2010.

In Canada, the Health Council of Canada produced the report *Understanding and Improving Aboriginal Maternal and Child Health in Canada* in 2011,²³ while in 2014, the National Collaborating Centre for Aboriginal Health released *Strong Women, Strong Nations: Aboriginal Maternal Health in British Columbia*²⁴ and in November 2014, Canada’s Public Policy Forum produced the research paper *Building Leaders: Early Childhood Development in Indigenous Communities*.²⁵

In addition, the U.S. Department of Health and Human Services released a comprehensive report in September 2014 titled *Assessing the Evidence of Effectiveness of Home Visiting Program Models Implemented in Tribal Communities*.²⁶

The ideas on promising practices from the participants interviewed for the current report align with and echo the research described in these publications on what constitutes a promising or best practice.

Health Council of Canada’s Definition

The Health Council of Canada has defined a promising practice as “a model, approach, technique, or initiative that is based on Aboriginal experiences, which resonates with users of the practice, and [which] results in positive changes in people’s lives.”²⁷

23 Health Council of Canada. (2011). *Understanding and improving Aboriginal maternal and child health in Canada: Conversations about promising practice across Canada*. Toronto, ON: Author. Retrieved from http://publications.gc.ca/collections/collection_2011/ccs-hcc/H174-23-2011-eng.pdf.

24 National Collaborating Centre for Aboriginal Health. (2014). *Strong women, Strong nations: Aboriginal maternal health in British Columbia*. Prince George, BC: Author. Retrieved from <http://www.nccah-ccnsa.ca/Publications/Lists/Publications>.

25 Canada’s Public Policy Forum. (2014, November). *Building leaders: Early childhood development in Indigenous communities: Research paper*. Ottawa, ON: Author. Retrieved from http://www.ppforum.ca/sites/default/files/Building%20Leaders%20research%20paper%20-%20Final_3.pdf.

26 Mráz Esposito, A., Del Grosso, P., Kleinman, R., Sama-Miller, E., & Paulsell, D. (2014, September). *Assessing the evidence of effectiveness of home visiting program models implemented in Tribal communities: Final report*. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from http://homvee.acf.hhs.gov/HomVEE_Tribal_Report_2014-57.pdf.

27 From p. 17 of Health Council of Canada. (2011). *Understanding and improving Aboriginal maternal and child health in Canada: Conversations about promising practice across Canada*. Toronto, ON: Author. Retrieved from http://publications.gc.ca/collections/collection_2011/ccs-hcc/H174-23-2011-eng.pdf.

The Health Council of Canada continued: “A promising practice has the following attributes:

- Is acknowledged to positively advance Aboriginal health status.
- Is inclusive of the interests and experiences of many people.
- Is valued and supported by relevant stakeholders.
- May be well known and/or has a history of success.
- Is adaptive—recognizing the importance of community context for successful implementation.
- Ideally, is evaluated.”²⁸

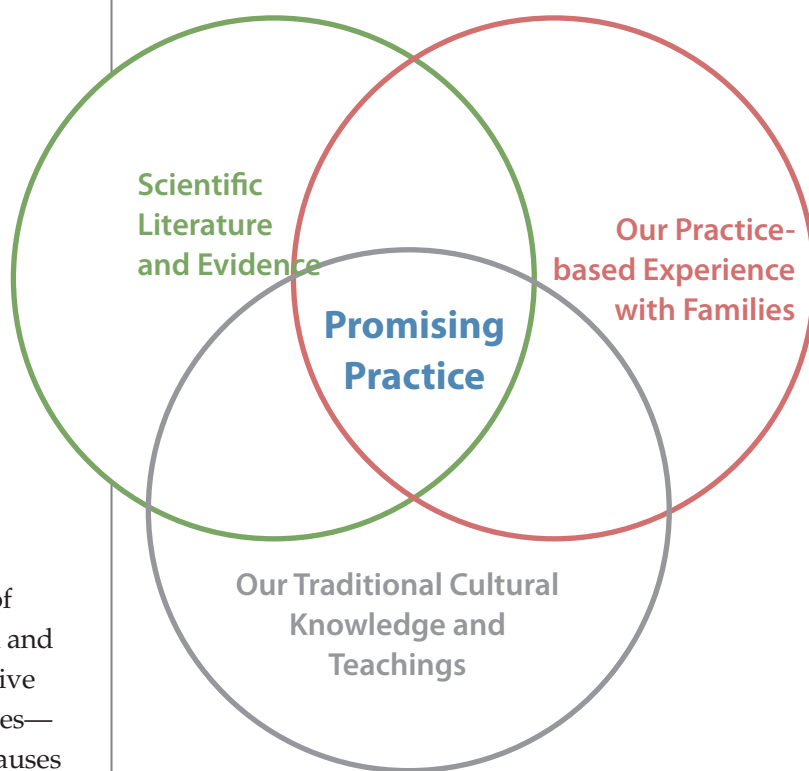
Interview Participants’ Definition

The participants interviewed for this report emphasized that a promising practice must be grounded in social determinants theory and take into account that the current poor health of Indigenous people is inextricably connected to the many devastating effects of colonization. As Maori scholar Mason Durie pointed out, “the results of colonization were consistently cataclysmic from which a common pattern emerged: loss of culture, loss of land, loss of voice, loss of population, loss of dignity, [and] loss of health and well-being.”²⁹ The participants said that effective programs must address these underlying causes—what Sir Michael Marmot referred to as the “causes of the causes.”

He said: “The causes of the causes reside in the social and economic arrangements of society: the social determinants of health.”³⁰

The participants also emphasized that promising practices are created at the community level and are context specific—what works beautifully in one community might not work in another community. This is in part because an effective promising practice is rooted in the community’s cultural teachings and values, as well as in “evidence-based” interventions from the public health field.

To summarize, the participants defined a promising practice in general as the convergence of three aspects: traditional and cultural knowledge and teachings, scientific literature and evidence, and their practice-based experience working with families.



²⁸ Ibid.

²⁹ From p. 1138 of Durie, M. (2004). Understanding health and illness: Research at the interface between science and Indigenous knowledge. *International Journal of Epidemiology*, 33(5), 1138–1143.

³⁰ Marmot, M. (2011, October). *Social determinants of health: What doctors can do*. Inaugural address given at the British Medical Association’s annual meeting, London, England.

Promising Practices in Maternal and Child Health

Excellent MCH programs grow out of a compelling and inspiring vision. The Skidegate Health Centre's program is one example of designing a program around a compelling vision, as well as a family-centred approach. The program staff build on the parents' strengths and let the parents know that they are there to help them realize their dreams. The program's vision is as follows:

"Id Gidgalang Daagwiiyah

Our Strong Children

Inspiring Greatness in families, to live their best life.

"In Maternal Child Health, the hope is that we will be standing side by side with mothers and families as they find their own strength. To listen to families' dreams, help those set goals for themselves and link them up with the resources they want and need."³²

Interview participants strongly believe that in order to realize their vision, MCH programs and services need to:

- Be available to ALL pregnant women and families with infants and young children, provide support until children reach the age of 6 years and be offered to families regardless of where they live in BC.
- Be delivered through a combination of individual family visits, as well as through group activities.
- Provide family assessments, referral services and case management as part of the program activities.



Participants reiterated that at the heart of an excellent program is the relationship of the client and the helper. They appreciate a good program curriculum, but said that even best practice models will fail if they are not implemented by the right staff—they insisted that having good people is without question what makes programs successful.

The next section of the report addresses the main components that interview participants believe are foundational to programs that would be considered promising practices.

32 From Skidegate Health Centre. (n.d.). *Maternal Child Health Program* [Pamphlet]. Skidegate, BC: Author.

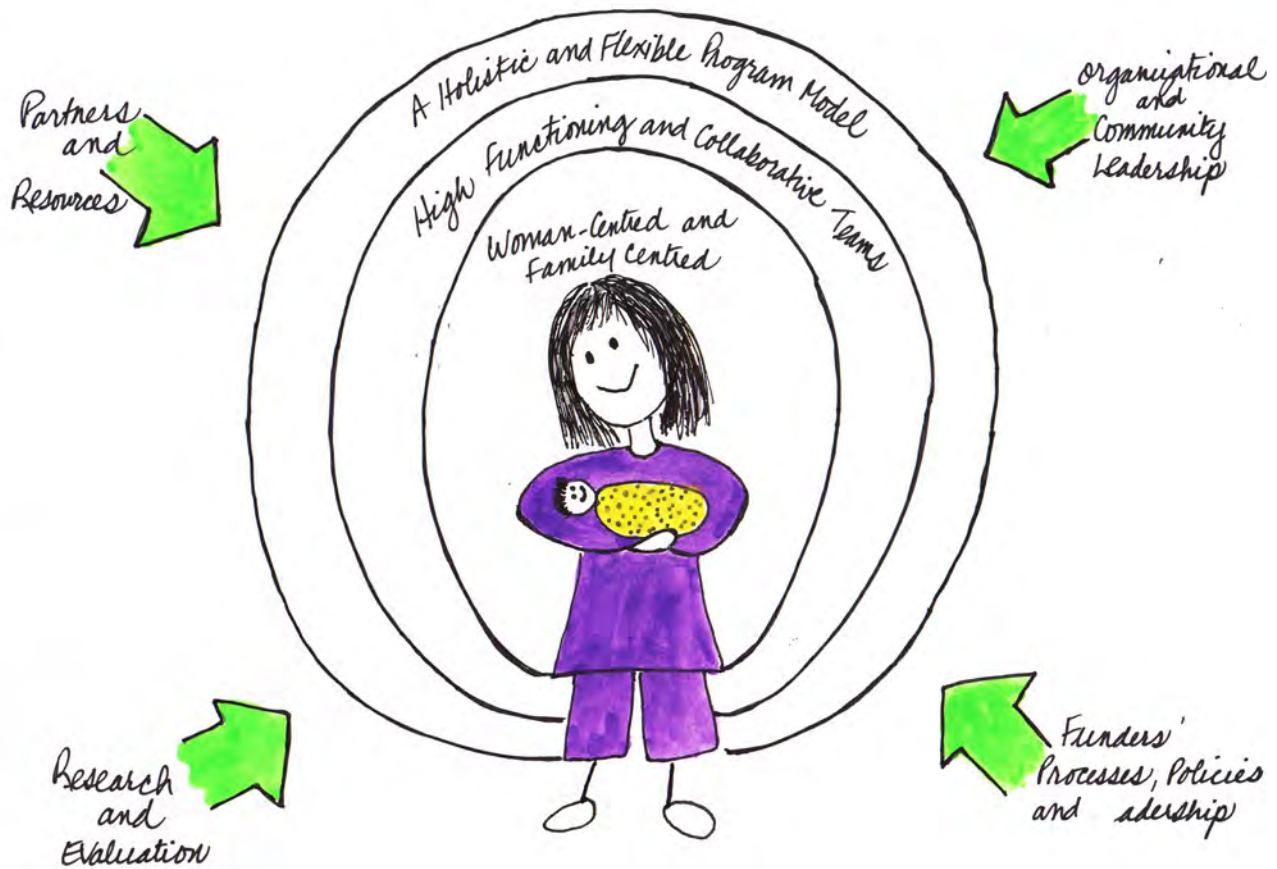
Three Core Elements and Four Enabling Factors

The diagram below captures the components of a promising practice in maternal and child health from the perspective of the participants interviewed for this report.

The three labels within the concentric circles around the mother describe the *core elements* that

are required to qualify an MCH program as demonstrating promising practices. The four labels outside the circles reflect the *enabling factors* that support a promising practice.

Each of the three core elements and the four enabling factors is discussed in the following sections.



The Three Core Elements of a Promising Practice MCH Program

As already indicated, MCH programs that embody promising practices have three core elements:

1. A woman-centred and family-centred approach
2. High-functioning and collaborative teams
3. A holistic and flexible program model.

1. A Woman-Centred and Family-Centred Approach

Interview participants described how they are continually amazed and inspired by women coming forward during their pregnancies and committing to make big life changes. They see many women who were previously neglecting themselves or “partying” stop everything once they find out they are pregnant. These women reach out for support to take better care of themselves, to put their life in order and to become loving parents. As one participant said,

“Sometimes we talk about best practices and interventions as if our programs and binders and tools have some kind of power in and of themselves to change women—almost as if the woman herself was irrelevant or an empty vessel that we poured information into—and WE changed her. This is so arrogant. It is actually the woman herself who changes—and her partner and family who are making the changes. They are doing the work.”

The late Canadian researcher Dawn Smith and her colleagues spoke about this issue in their article on a new care paradigm. They introduced the concept of “empowerment evaluation.” They wrote:

“Evaluation would ideally acknowledge and facilitate the significant efforts of Aboriginal individuals and communities to ‘turn things around.’ In contrast, colonizing approaches to evaluation attribute positive changes solely to health service organizations, and position Aboriginal communities and individuals as passive objects in care.”³²

Smith and colleagues went on to say how acknowledging the woman’s efforts includes appreciating her strengths and telling her so: “Positioning care to acknowledge progress and appreciate strengths may improve early access to and relevance of care during pregnancy and parenting for Aboriginal people.”³³

Interview participants agreed with this approach. They shared several examples of how they reflect a woman’s strengths back to her and encourage her, including the following comment:

“It’s easy for a woman to get discouraged. She might be dealing with shame or guilt—or issues around abuse and self-hatred. As a helper, I let her know I believe in her, that I can see her strength even when she doesn’t. I’ve been where she is and I remember how scared and unworthy I felt. I would light up when my counsellor said she thought I was strong and had courage—that I could be a good mom. It really helped me believe in myself. I want to do this for the moms I work with—remind them they can do it.”

32 From p. 324 of Edwards, N. C., Martens, P. J., Varcoe, C., & Smith, D. A. (2007). “Making a difference”: A new care paradigm for pregnant and parenting Aboriginal people. *Canadian Journal of Public Health*, 98(4), 321–325.

33 Ibid.

Interview participants said that seeing the woman as the centre of the program changes how program staff will recruit her to the program and how they support her and her family to stay in the program, no matter what. Specifically, they said:

“Some programs have ‘rules’ that scare people away, or set them up for failure. In our program, you can never ‘fail’ or get kicked out—you are always in the program. No matter what you are going through, we can work it out. Isn’t that the whole purpose of our services?”

“If you know what’s going on in a woman’s life and with her family, if you stay connected with her, you can hold her accountable for her participation in a good way. You don’t have to get punitive. You can have an honest talk. You can say: ‘Here’s what I need from you. I want a text if you can’t make your appointment or a Facebook message, etc.’ And I also try to pay attention to what’s going on in her family—there might be a family crisis and that’s why she didn’t call or didn’t show up. We rarely have a no-show.”

“If you really get how big a deal this is for women and how many good things can happen at this point in a woman’s life, you want to connect with every pregnant woman and young family out there! You want to do everything you can to help her NOW. It upsets me so much when we miss these opportunities because we don’t have enough staff or time. I hate that people still fall through the cracks.”

“A family-centred way of working means knowing who the important people are in that woman’s life. I have found there always seems to be one person in a woman’s life who is kind of a rock for them—or somebody they can turn to or run to. It might be an aunty or a granny, but it is usually a strong woman who has her life together. It’s like she provides a

safe shelter for people. If you ask women, they will tell you. I wish we could do more for these people—buy them bigger houses or something ... [laughs] ... seriously, they are the unseen helpers. They usually have a house full of people they are helping.”

“The woman’s family makes all the difference. I’m not saying women can’t make the changes without family support because I have seen women do it—but it is so hard to make changes when everyone in your life is drinking or being ‘dysfunctional.’ It’s so much better if a woman’s partner and her family are on board with her. That’s why I try to connect with her family—but this isn’t always possible. She may not want it, or we might not have the time—she’s our top priority. It would be great to have more help to make sure we can involve the family.”

“We do what we can to have family events and groups so that the whole family is learning together and working together.”

“I say you can work with women and families at this stage—when they are so open and ready to change all sorts of issues—or you can wait and try to put a broken family back together. Why do we wait until families are really hurting and in crisis before we help them?”

A family-centred approach means being able to offer support to parents no matter where they are on their healing journey. Sometimes parents are unable to overcome their addictions, or are unable to care for their children for other reasons and need to place their children in foster care. In these situations, a family-centred approach includes helping the parents maintain a sense of dignity and hope. One participant said:

“Things don’t always work out as planned. Some parents cannot raise their children. I was helping parents who were developmentally delayed and also

struggling with addictions. They did their best, I think, but they did not have the skills to raise their little girl. In this situation, I saw my role as helping them come to terms with this without hating themselves or getting caught up in rage or feeling like victims. My hope for them was to encourage them to have a role in their daughter's life—even though she was being raised by foster parents. I always let them know that I did not think they were 'bad people'—that I knew they were good people, that they loved their child."

A family-centred approach includes supporting families with complex needs—which might require arranging extra visits or spending additional time connecting parents to other services for themselves or for their children, as one participant reported:

"One of the moms I work with has ADHD and really struggles to remember her appointments and to get to appointments on time. She's also exhausted, as her little boy is very demanding and has several health issues. She does her best, but it's pretty difficult for her to connect with all the doctors and services she needs for her son. Part of my role is as a 'system navigator,' which fits within our role as home visitors to provide case management—this just entails a whole lot more time and effort when there are special needs involved."

Fathers

Interview participants emphasized that family-centred means including fathers, grandparents and extended family members. They spoke about the valuable role of fathers, and the importance of helping to restore the role of men in raising healthy families:

"We are now offering a men's support and parenting group, and it is very successful."

"We've incorporated more fun events that appeal to men. We have a men's wellness day, for example."

"I am seeing more and more fathers support their partners during pregnancy and really being there for the baby. I think this is a powerful indicator that things are getting better."

"We really need the dads. Everyone needs them to step up and take their role as fathers seriously. I think part of the problem is many of them do not have good role models of what it is to be a man and a father—many of them were just young children when they were abandoned by their fathers."

"Although our focus is on the mothers, that does not mean we don't value the fathers. We totally value the fathers and respect their role. We want them to be fully involved—but that's not always how it works. Sometimes the young men don't want to be involved—or don't know how to be involved—so we have to do our best to support the mother, and keep finding ways to make our program appeal to fathers as well. We always keep the door open for fathers."

"Our Elders have come into the groups to speak about the traditional roles and responsibilities of men in the community and the special role of fathers. This has been helpful and inspiring—we're restoring our culture by teaching our young men."

"Our goal is to hire a male family visitor. We know we could reach more fathers if we had a man connecting with them."

"I would be very interested in taking more training on the needs of young men and



how to adapt our programs to increase the involvement of fathers.”

There is a growing awareness of the critical role of fathers in contributing to their children’s well-being.³⁴ Projects such as the Indigenous Fathers project led by Dr. Jessica Ball have helped service providers and policymakers better understand the needs of fathers and how to support them to take up their parenting role and realize their potential to be loving fathers.³⁵ Dr. Ball reminds service providers to be both patient and persistent in their efforts to involve fathers—it takes time—and fathers want different supports than do mothers. For example, the majority of men in her study men said that rather than starting with peer support groups involving sharing personal stories, they wanted concrete information in plain language on child development milestones, oral health, how to make healthy meals, how to get children ready for school, how to help girls and boys through puberty, and ideas for affordable recreation.³⁶ In addition, Sarah Moselle and Dr. Ball have co-authored a report on Aboriginal father involvement programs in Canada that outlines successful approaches and practices in these programs.³⁷

In February 2011, the National Collaborating Centre for Aboriginal Health hosted a national showcase on fatherhood titled *With Dad: Strengthening the Circle of Care*.³⁸ Albert Pooley, founder of the Native American Fatherhood and Families Association,³⁹ gave a riveting presentation on fathering and the central role of the family in Indigenous culture:

“The heart of our Native American culture is family. It’s not the food, it’s not the

language. It’s the family—that’s the heart of our Native people. What happens to someone when their heart stops beating? They die. ... When our families are gone, our culture is gone. We can eat all the Indian food and sing all the Native songs ... it doesn’t mean too much if our family is gone. We tell fathers this ... a lot of our men and women walk away from family responsibilities—some run from it. If you walk away from your responsibilities, you are damaging your family, you are destroying your family ... not only are you destroying your family, you are killing your culture. ... When you start coming back to your family, it takes courage to do that. ... When you start making the repairs ... you are being a true Native person ... because you are starting to repair what is at the heart of our Native people, which is family.”⁴⁰

Grandparents and Extended Family

Interview participants also spoke about the role of grandparents and extended family members:

“We are very involved in the care of our granddaughter, but when the public health nurse came to visit, she asked why we were there. I told her we were the paternal grandparents—that this little girl was our son’s child. The nurse didn’t seem to feel we had any rights or much say in how our grandchild was cared for. This was very upsetting and discouraging, especially since the mom and the maternal grandparents are actively struggling with addictions. We have been taking care of our granddaughter

34 For more information on Indigenous fatherhood, see the Early Childhood Development Intercultural Partnerships website: <http://www.ecdip.org/fathers/>.

35 Ball, J. (2012). “We could be the turn-around generation”: Harnessing Aboriginal fathers’ potential to contribute to their children’s well-being. *Canadian Journal of Paediatrics & Child Health*, 17(7), 373–375.

36 Ibid, p. 375.

37 Moselle, S., & Ball, J. (2013, March). *Aboriginal father involvement programs: National scan*. Ottawa, ON: Health Child Development Section, Public Health Agency of Canada. Retrieved from <http://www.ecdip.org/docs/pdf/Aboriginal%20Father%20Involvement%20Programs%20National%20Scan.pdf>.

38 National Collaborating Centre for Aboriginal Health. (2011, February). *With dad: Strengthening the circle of care* [National showcase]. Ottawa, ON: Author. Retrieved from http://www.nccah-ccnsa.ca/286/With_Dad__Strengthening_the_Circle_of_Care.nccah#1.

39 For more information on Albert Pooley and the Native American Fatherhood and Families Association, see <http://nativeamericanfathers.org/>.

40 From Pooley, A. (2011, February). *Fatherhood is leadership—The most important kind of leadership*. Presentation given at the National Collaborating Centre for Aboriginal Health’s national showcase, *With Dad: Strengthening the Circle of Care*, Ottawa, ON. A video of the presentation can be viewed at http://www.nccah-ccnsa.ca/286/With_Dad__Strengthening_the_Circle_of_Care.nccah.

every weekend since day one—and we are completely devoted to her—but because we didn't fit into the 'box' of who is family, this nurse saw us as a nuisance."

"I am the aunty and I ended up getting temporary custody of my sister's two children. I have been supporting my sister since she got pregnant, and I have been looking after the children every week for 5 years. But the ministry didn't include me in the family meetings until it came to apprehending the children. I really wished I was included earlier."

Supporting Non-Traditional Families and Two-Spirited Parents

A family-centred approach welcomes all families of different shapes and sizes, and does not require families to fit into a "box" in order to receive support. One MCH coordinator talked about working with a young lesbian who was pregnant with her first baby. This young woman had not told her doctor or any of the public health staff about her sexual orientation, and she was very nervous about disclosing it to the coordinator for fear that child protection authorities would be called. The MCH coordinator stressed how good MCH programs welcome "non-traditional" families, and women and men of all sexual orientations:

"This young woman showed tremendous courage in disclosing her sexual

orientation. I felt very honoured that she trusted me. I was so happy I could tell her she had nothing to worry about—that child protection services had no reason to be involved or take her baby. I was glad to be able to talk about her rights, to explore her fears and help her



Key Points on a Woman-Centred/ Family-Centred Approach

What Works

- Each woman is the expert on her own life.
- Every woman has hopes and dreams, which provide the vision and the energy for her to make powerful changes.
- Every parent and every family has strengths and skills that they can draw on to live a good life and to parent in a loving and effective way.
- Fathers have a unique and critical role in raising healthy children, as do grandparents and extended family members.
- The life transition into parenthood is a profound transition and an unparalleled opportunity in a person's life for healing, change and growth.
- People and communities are active participants in creating change, not "passive objects" to be acted on by experts and interventions.

What Doesn't Work

- Over-focusing on the woman's challenges or weaknesses.
- "Pathologizing" a woman and her family—seeing her as her disability and not seeing her as a whole person.
- Falling into the trap of thinking that YOU as the helper can change the woman, forgetting that you are just the facilitator—she is the one who does the work.
- Forgetting that a lot of change is "invisible." The inner changes parents make might not translate into action right away.

build her sense of self. At the next visit, she brought along her partner—who was a terrific support to her and very excited to become a parent."

2. High-Functioning and Collaborative Teams

The interview participants had volumes to say on the issue of creating a strong team of culturally competent, kind and skilful caregivers. One participant summed it up: *“The people and the teams we create are the most valuable resource we have. Human beings—not binders of information—make the program and create the relationships.”*

A high-functioning team is critical to the success of the program. The members of a high-functioning team connect and communicate on a regular basis and welcome constructive feedback from each other. High-functioning teams and effective helpers also engage in ongoing education and training—they continually reflect on and seek to improve their practice.

Three Critical Decisions

A study by Mittelmark and his colleagues⁴¹ reviewed four large-scale health promotion programs in the US for lessons that might guide the development of future community-based programs. They summarized three key lessons learned from studying these “exemplar” programs:

1. The most critical decision in the genesis of a community-based program is the selection of the community organizer.
2. The most critical intervention is the training of that person.
3. The most critical resource is the technical support provided to that person.

Interestingly, Mittelmark et al. found that the community leaders in these initiatives did not have to be public health professionals, as long as they were provided with the right training and support. It was more important that they were perceived as leaders in the community, had a history of community involvement, were motivated by the goals of the project and possessed substantial administrative ability.

Choosing the Right People to Implement the Program

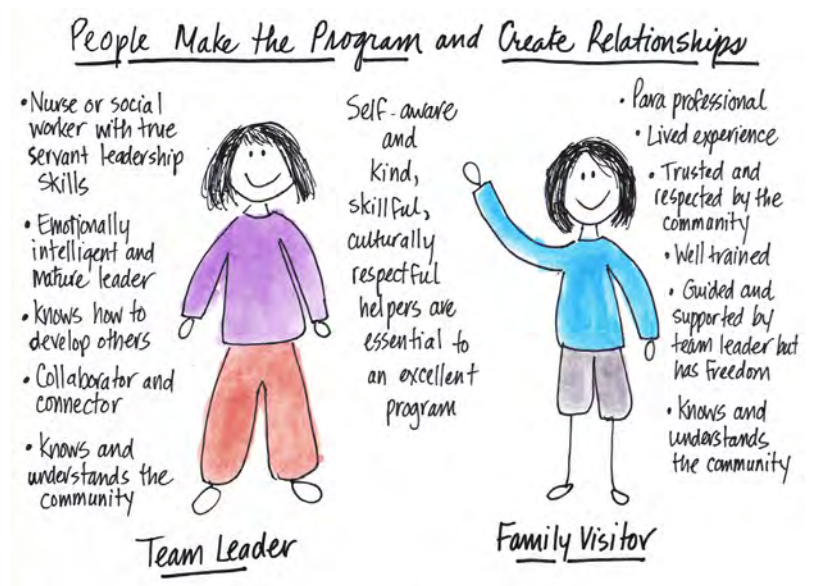
Without hesitation, the interview participants said that taking the time to recruit, train and support the right people and putting resources into team development represented time and money well spent—and a wise investment in building community capacity; as one participant said, *“the maternal and child health team has a critical role in supporting family and community healing.”*

A frequent comment went something like this one:

“Just because you have a university degree doesn’t mean you will be the right person for our health centre. We want our staff to be skilled and trained, but there are lots of ways to do this. The most important thing is that they are kind and are very good to our people, and they understand our community and the people want to visit them.”

The interview participants said that successful programs hire people who are culturally respectful, excellent at developing relationships and trusted by the community.

Participants also said they look for certain skills and qualities for their team leaders and family visitors.



41 Mittelmark, M., Hunt, M., Heath, G., & Schmid, T. (1993). Realistic outcomes: Lessons from community based research and demonstration programs for the prevention of cardiovascular diseases. *Journal of Public Health Policy*, 14(4), 437–462.

Team Leaders/Servant Leaders

The term *servant leader* came up several times in the interviews and discussions covered in this report. Participants agreed that high-functioning teams are led by “servant leaders,”⁴² who build the capacity of their team members and facilitate an environment of trust and respect in which people feel safe to be authentic, take risks, make mistakes, learn and grow.

The Robert K. Greenleaf Center for Servant Leadership has described this concept in the following way:

“A servant-leader focuses primarily on the growth and well-being of people and the communities to which they belong. While traditional leadership generally involves the accumulation and exercise of power by one at the ‘top of the pyramid,’ servant leadership is different. The servant-leader shares power, puts the needs of others first, and helps people develop and perform as highly as possible.”⁴³

The centre has elaborated on the servant leader concept:

“The difference manifests itself in the care taken by the servant—first to make sure that other people’s highest priority needs are being served. The best test, and difficult to administer, is: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society? Will they benefit or at least not be further deprived?”⁴⁴

The interview participants were of one mind when it came to the critical role played by the MCH team leader, as the following comments indicate:

“The manager can make or break this program. It’s so important to hire the right person.”

“My supervisor is excellent. She understands the challenges of my job and she makes herself available to problem-solve issues as they come up and she supports me. She offers suggestions without micro-managing. She lets me do my job in my own way.”

“Our team leader is a kind person, but she is burnt out and over-extended, and I don’t think she is very effective in her position anymore—I don’t feel I can go to her for support—I feel I would just add to her load. I think if she took better care of herself, it would be better for all of us.”

“I think our health director is an exceptional leader. She has created an amazing team. She shares information freely, she keeps us in the loop and she asks for our opinion and advice about program changes. We learn from each other, we support each other—we’re not afraid to screw up; we know we will talk it through and learn from it.”

“A team leader needs to be self-aware and able to say what they don’t know. They need to have the confidence to hire really smart and capable people instead of trying to be everything to everybody. I respect my manager when she is open and vulnerable and turns to us for our expertise.”

“A few years ago, we had a team leader who was not suited for this job. She was educated and experienced, but she didn’t have the type of personality for this work. I guess you could say she didn’t have the emotional intelligence you need to be a leader of a health team—she was more of a ‘command and control’ type person. Anyway, we all felt down and discouraged—and I think our program suffered.”

42 Robert K. Greenleaf Center for Servant Leadership. (n.d.). *What is servant leadership?* [Online]. Retrieved from <https://greenleaf.org/what-is-servant-leadership/>.

43 Ibid, para. 4.

44 Ibid, para. 3.

Family/Home Visitors

The participants interviewed for this report emphasized the extra-special role that a family visitor plays in some families, and commented that some programs have named their family visitors in their language:

“The family visitor is a key helper and often fills the role of the ‘missing relative.’”

“*Hnis’u* means ‘special aunty/the one I hold dear’ in Heiltsuk in Bella Bella.”

Indeed there are several dimensions to the role of family visitor. Several participants referred to the “many hats” that the family visitor must wear—for example:

“I think family visitors are basically a maternal and child health ‘life coach.’ We provide education and support in so many areas of a woman’s life and on a huge range of issues, including how to grocery shop, keep your home clean, prenatal and health education, breastfeeding, early childhood education, sex education, crisis counselling, family advocate, system navigator, parenting skills, trusted listener and shoulder to cry on—and more.”

Interview participants believe that both paraprofessional and professional home visitors can be effective. The helper’s ability to form relationships is what counts. Participants stated that lay professionals are sometimes more effective in their positions than “credentialed” staff because the former have “street cred”—especially if the helper herself was once a young mother in need of support and the community has witnessed her overcome challenges and go on to create a loving family.



A study by Johns Hopkins University on the Native American home visiting program the Family Spirit Program came to similar conclusions. The researchers reported,

“Family Spirit is also the first program to provide clear evidence of the effectiveness of paraprofessionals as home visitors. The use of Native paraprofessionals is essential in reservation communities where there is a shortage of nurses and cultural barriers to non-Native home visitors.”⁴⁵

The Helper–Client Relationship Matters the Most

Two Australian studies on home visiting programs address the central role of the helper–client relationship. In the first study, which was conducted with young Indigenous mothers, the author stated:

“The critical thing in recruiting the most appropriate nurses to the Liverpool program was to have the mother of a young child on an interview panel. All the mother had to answer was the question: would you be happy to form a relationship with this person and have them in your home?”⁴⁶

The second study interviewed young mothers and asked their perspective on the program. The researchers reported:

“The findings indicated the role of a trusting relationship between nurse and participant as well as shared decision making was central to program engagement and led to participant perceptions of increasing control over their role as parents. However, *a clear distinction was made by the mothers: that they engaged in a relationship, not a program* [italics added].”⁴⁷

Providing the Right Training and Support

All the participants agreed that excellent programs are implemented by well-trained staff. The participants are passionate about professional

45 From para. 3 of Johns Hopkins Center for American Indian Health. (2013, January 13). *Family Spirit Program overview*. Retrieved from http://www.jhsph.edu/research/centers-and-institutes/center-for-american-indian-health/Research_and_Programs/Current%20Projects/Family_Services/FS%20Program%20Overview%201-2014.pdf.

46 From p. 13 of Sweet, M. (2008, July). Caring for the disadvantaged: A time of opportunity and challenge. *Australian Nursing Journal*, 16(1), 12–13.

47 From p. 191 of Paton, L., Grant, J., & Tsourtos, G. (2013, February). Exploring mothers’ perspectives of an intensive home visiting program in Australia: A qualitative study. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 43(2), 191–200.



development and are committed to lifelong learning. They place a high priority on developing new skills and keeping their MCH and ECD knowledge current. The following comments capture their impressions of their training experiences so far and the ways that the training could be further refined:

"I am so grateful for the provincial meetings in Vancouver. I benefit from meeting the other coordinators and learning about their programs. I also have to say, it means a lot to me to stay in a hotel and have our meals provided. These meetings are an important form of self-care for me. Like most of the people on my team, we work super-long hours and then we go home to family responsibilities—cooking, cleaning, taking care of our children and probably catching up on email and work. When I come to Vancouver, I catch up on sleep in my nice quiet room and I am so grateful to just focus on me. I return to my community refreshed and recharged."

"Communities with experience in delivering MCH programs could act as mentors to communities that are just starting out. We could guide and support them. I would like to see our funder explore a community mentorship initiative."

"Don't create random training programs. The training agenda needs to be directed by the coordinators—we know what we need."

"I think we should concentrate on developing a 5-year training plan. We need to take a methodical and systematic approach."

"I'm not a big fan of sending our staff to conferences, but I will support it if there is a training component as part of the conference."

"The approach we take to training in our health centre is everyone gets trained in multiple areas and can function in many roles. This creates a lot of flexibility in our organization because people are able to move around and go where they perform the best—'get the right people on the bus and in the right seats.' I also see this as a good sustainability practice because we are not tying our staff to one funding stream. If funding in one area is cut, we don't have to lose staff—we can move them to where they are needed."

"Training staff who live in the community is a form of community development and an investment in the community."

"We believe the CHR [community health representative] still has a valuable role. We've created a pathway so that she can develop more skills—we start with home support worker training and then move on to LPN [licensed practical nurse] training. These staff members come out of it with so many skills and can do a million things."

They're not afraid to take someone to the hospital or provide health education to mothers. We get so much value out of a staff person like that."

"Every budget should include professional development. If you are worried people will have their training paid for and then leave, you can address this by asking for a 2-year commitment, and if they leave before then, have a pay-back plan."

Interview participants had several suggestions on the types of training topics that would be helpful. The following chart captures the training workshop ideas mentioned during the participant interviews and discussions; however, it is not intended to be a comprehensive list.

MCH Program Topics	Helper Skills	Team/Leadership Skills
Infant and child development	Motivational interviewing	Communication and conflict resolution
Pregnancy, birth and breastfeeding	Solution-focused brief coaching	Leadership training
Working with doulas, midwives and the multidisciplinary team	Life coach/health coach training	Reflective practice
Positive parenting practices	Addictions and recovery	Team building
Family violence and intimate partner abuse	Self-care for caregivers	Research and evaluation
Children and families with complex and special needs	Trauma-informed practices	Program development
Holistic health, women's health, sexual health and self-care	Cultural competency	Human resources training—job descriptions and hiring processes
Understanding the change process and developing new habits	Understanding the change process and supporting people through change	Understanding the change process and supporting teams through change
Family planning	Facilitation training and adult education methods	Facilitation training and adult education methods
Father involvement	Working with sexual abuse survivors	Positive performance review
Mental health and postpartum depression	Communication, difficult conversations and conflict resolution	Working with funders and other partners
Positive play for children and families	Understanding loss: death, dying and grieving	Community development
Effects of video games and screen time on children	Working with anxiety and depression	Report writing and making presentations
School readiness for children	Working with suicidal clients and crisis intervention	Understanding and working with social media
Traditional and cultural parenting practices	Traditional and cultural practices for helpers	Traditional and cultural leadership practices

Participants talked of the challenge of leaving their community to complete training sessions as well as the cost of training. They offered the following suggestions:

“There are lots of skilled and experienced people in our organization and in our area who could provide some great training. Sometimes we forget to look at our own people.”

“I would like to see more partnering with other agencies—especially with the health authority. We could save a lot of money and avoid duplication if we did joint training sessions, or at least invited each other to the sessions we host. For example, almost everybody is taking leadership training and communication training. We could piggy-back on each other—and at the same time we would be getting to know each other better and be collaborating.”

“It is expensive to send staff to conferences—both financially and also the time and service cost of them being away and unable to see clients. It would be great if conferences would integrate training sessions, ideally with credits, so that staff could network and also get valuable training. It would be a much better use of everyone’s resources.”

“I would like to see more online training that we could do without having to leave home.”

Collaboration with a Multidisciplinary Team

MCH program coordinators and family visitors cannot provide all of the services needed by their clients. An MCH program team functions as a small team within a larger multidisciplinary team. The multidisciplinary team might include community health nurses, physicians, dentists, dental therapists, child development specialists, midwives, doulas, mental health and addictions counsellors, play therapists, foster parents and Ministry of Children and Family Development (MCFD) staff—as well as staff from other health

promotion and early child development programs such as the Children’s Oral Health Initiative, the Canada Prenatal Nutrition Program, the Aboriginal Head Start on Reserve initiative, the Aboriginal Infant Development Program, the Aboriginal Supported Child Development program and the Fetal Alcohol Spectrum Disorder (FASD) Program. The composition of the team varies between communities, as not all communities have the funding to offer the full range of health promotion and early child development programs.

An essential skill required by MCH staff is the ability to assess and understand the needs of the families they work with and make appropriate referrals, and then to follow up with their clients to make sure they are receiving the services. Sometimes family visitors do this by acting as a case manager and connecting directly with the other care providers working with the family (with the client’s permission). Often a family visitor drives her clients to their appointments—and may attend the appointment with them—and she follows up with them afterward to find out how things went.

The interview and discussion group participants remarked on the incredibly complex environment in which MCH and ECD programs are delivered. They identified that one of the challenges for staff working in a community program is how to avoid becoming overwhelmed by this complexity and





falling into the trap of working in a “silo” and disconnecting from other programs that are also serving the client.

The participants fully endorsed the idea of creating practices that shift them from working in silos to working in “circles.” But they emphasized that working as a multidisciplinary team is easier said than done, even when everyone supports the concept. Other challenges include simply finding the time to meet on a consistent basis, agreeing on the appropriate release of information forms and on processes that honour client privacy and confidentiality issues, and developing information-sharing agreements, not just within the organization, but also with other organizations such as the health authorities. It takes considerable time and effort to collaborate with other care providers and the staff of other programs in resolving the issues and coming up with clear protocols, but it is well worth the time and effort.

Access to Specialists

Participants expressed a serious concern about the lack of access to specialists in some rural and remote areas—especially for services concerning the assessment and support of children with disabilities:⁴⁸

“There are not enough FASD workers. This is especially problematic in the North,

where there are long travel distances between clients. There are not enough parenting classes or support for parents affected by FASD. For example, you might support a mom who is FASD affected but her child is not, or you might support a mom who is not affected but her child is, or you could support a family where both the mother and the child are affected. Each of these situations requires a unique approach—one size does not fit all. One other critical factor is that parents who are FASD affected don’t ‘age out’—they will need support for their whole lives.”

“I think we should have the MCH family visitor and the FASD program mentor work together. I think this could help reduce the stigma for moms—we could facilitate group visits with moms from both programs.”

Some remote communities use Telehealth as a way to connect with physicians and specialists without having to travel long distances. To define the term,

“Telehealth is the use of communication technologies, such as videoconferencing, to deliver health, and educational services from a distance. This will allow health care professionals to deliver some services remotely using technology. Devices such as exam cameras, stethoscopes, portable ultrasound machines and ophthalmoscopes can be attached to videoconferencing units to enhance clinical sessions.”⁴⁹

During one of the group discussions, participants referred to the primary care partnership project between the Northern Health Authority, Carrier Sekani Family Services and the First Nations Health Authority.⁵⁰ The partners are working with Dr. John Pawlovich⁵¹ and Telehealth technology to bring physician and specialist services—including

48 Is this an example of where collaboration between strategies can occur? For example, pp. 32–33 in the “Strategic Direction N” section of *A Path Forward: BC First Nations and Aboriginal People’s Mental Wellness and Substance Use—10 Year Plan* list several actions to support people living with FASD. See http://www.health.gov.bc.ca/library/publications/year/2013/First_Nations_Aboriginal_MWSU_plan_final.pdf.

49 From para. 2 of First Nations Health Authority. (n.d.). *What is eHealth?* Retrieved from <http://www.fnha.ca/what-we-do/ehealth>.

50 For more information on the primary care project, please see the Carrier Sekani Family Services website: http://www.csfcs.org/web/?page_id=155.

51 For more information on Dr. Pawlovich’s perspectives on Telehealth and First Nations communities, see <http://www.youtube.com/watch?v=yePVzYQaWw8>.

child health specialists and paediatricians—into rural and remote areas. The project is supported by a collaborative primary care steering committee with representation from each of the organizations. Over time, the committee was able to establish an information-sharing agreement that facilitated access to health record databases. The process required patience and perseverance—getting to know each other as people first, and appreciating and respecting each other’s differences and ways of working. The project has resulted in improved services for communities.

Elders, Cultural Advisors and Traditional Healers

The participants felt strongly that if programs are to be grounded in culture, Elders, cultural advisors and traditional healers need to be essential members of the multidisciplinary team. These team members provide a critical role in guiding the program design—including teaching the language, incorporating traditional ways in the program activities, supporting and advising the staff, and offering support to the families.

Participants said that families deeply appreciate learning the cultural teachings from Elders on traditional parenting methods and traditional roles of mothers and fathers. Elders and traditional healers contribute to family healing in many ways, including through holding ceremonies, teaching parents about traditional medicines and

reconnecting families with the land. (These ideas are further discussed in the Holistic and Flexible Program Model section of this report.)

The participants reported that they draw strength and inspiration from the Elders, cultural advisors and traditional healers they work with:

“We really lean on our Elders for guidance. We include them in everything we do—especially in the group activities.”

“Just having the presence of an Elder in our team meetings can bring a sense of calm. I feel we all focus and communicate better when they are at the meeting.”

“One of the big gaps in our program is that we don’t have healthy Elders and traditional healers to call on. Residential school really hurt our small community, and as a result we just don’t have many people who know the language and the teachings. I would love to work with other MCH programs that would be willing to bring their Elders to our community.”

“Our Elders have taught a lot to all of us—including to our physicians. They have a way of speaking to professional staff that gets to the point without putting the person on the defence. They can give feedback about culturally safe care that I would not be able to communicate. We really need them on our multidisciplinary teams.”

Teams Need Good Physical Environments and Space

Participants also talked about how physical space can either facilitate or undermine collaboration with multidisciplinary teams:

“You need the right space to support working as a team. Our organization does not have enough space, and the staff work out of several different locations. This makes it hard sometimes to meet and collaborate. As the saying goes, ‘out of sight, out of mind.’”



“We don’t really feel like we have a proper ‘home’—which can send the wrong message about the program not being valued or a priority.”

“The issue of proper space is HUGE. You have to have a combination of private meeting space as well as rooms for groups. And the staff need quiet and confidential spaces to meet with clients in person and by telephone. I don’t know who came up with the ‘open space’ concept, but it did not work for our organization.”

“We work in a space where the doctors and the mental health workers are just down the hall. This makes all the difference. I often just pop in to see the nurse or talk to the play therapist. We can sometimes sort through a problem in minutes that would have otherwise taken days and many confusing emails to solve.”

My Story: How Transforming My Nursing Practice Really Meant Transforming Me

By Liz McKay

When I first began working for the Nuuchahnulth Tribal Council (NTC) as a young, blonde-haired, blue-eyed new nurse graduate, I travelled with the late Ray Seitcher—(?ii wa nuk)—who became a dear friend and mentor along the way.

I couldn’t wait to teach the Nuuchahnulth people what I knew about maternal and child health care. At one of my first prenatal group classes, I spent hours preparing handouts and information about pregnancy, nutrition, lifestyle factors, breastfeeding. ... I had handouts and exercises and activities and lots of notes. It was going to be the best prenatal class ever and I would be able to use my professional nursing skills.



The women were going to love this class! During the class, Ray walked by.

On our way home, he asked me, “So how was your day?” I excitedly shared with him about all the women who came to the class. He was quiet for a bit and then said, “It’s good what you are doing, but you know, it also makes me sad, because before nurses came to Nuuchahnulth communities, our people looked after all the needs of our pregnant women. They supported and advised our pregnant women, helped them to know what to do and what not to do, what to eat and not to eat, how to look after the afterbirth and how to soothe the infants. The babies were usma ... our precious ones. Do you know,” he said, “why all the women came to the session? ... Each of them receives food coupons if they attend the prenatal class.”

I had a moment of quiet and reflection. I thought about what he was saying to me and I asked him, how can I learn more—how can I do better? “Go and visit the Elders,” Ray said. “Get to know them.” This may have been one of my first reflective practice moments—an opportunity to think about what had really happened during my prenatal class, to decide to explore and learn more and really make a difference by learning from the people and changing the way I practised. My life-long learning journey had begun.

Interestingly, this moment in time as a new practitioner was also the beginning of transforming care at NTC. My supervisor, Jeannette Watts, listened to my story and my emerging perspective and decided to undertake and commit to a transformation of health care with Nuuchahnulth communities by focusing on nursing in a Nuuchahnulth way. A community-wide consultation and collaboration process began with Elders, community-based workers, leaders and cultural advisors. Slowly we began to shift our practice from being nurse/expert-based to being more in tune with and appreciating the gifts and strengths of our moms and families. This led to changes in our understanding of the impact of Nuuchahnulth

Key Points on High-Functioning and Collaborative Teams

What Works

- The team leader is a servant leader who knows how to build the capacity of others.
- The helper and the relationship she forms with the woman and her family are at the heart of any effective MCH program.
- A skilled helper knows how to tap into the parents' hopes and dreams and helps them use that energy to create change.
- An effective helper focuses on the parents' strengths and skills, and helps them draw energy from these positive qualities in order to face and overcome personal challenges.
- An effective helper has done her own healing work and transformed her own painful life experiences into wisdom.
- The lived experiences of a helper have value and enhance the helper's capacity to connect and build relationships with the parents.
- Helpers should be well trained and have the skills to do their job. Excellent training can take several forms and is not limited to a university education.
- Skilled helpers are emotionally intelligent and culturally competent.

- Effective helpers are self-aware and practise good self-care.
- Elders, cultural advisors and traditional healers are essential team members.
- Staying connected to the multidisciplinary team takes time and energy, but is well worth the effort to improve client care.

What Doesn't Work

- Over-focusing on the woman's challenges or weaknesses.
- "Pathologizing" a woman and her family—seeing her as her disability and not seeing her as a whole person.
- Falling into the trap of thinking that YOU as the helper can change the woman, forgetting that you are just the facilitator—she is the one who does the work.
- Forgetting that a lot of change is "invisible." The inner changes parents make might not translate into action right away.

nulth history, culture, language, life experiences, traditional knowledge, values and beliefs on the client's experience of the way we deliver care.

One very important outcome was learning that pregnancy and birth are about family and community celebration. What women talked about most was the meaning of being present at baby welcoming ceremonies, Nana-ya-aks sa, and receiving the gift of a baby blanket from the nurse on which was inscribed, "The Nu-chah-nulth nurses welcome you." We learned that what meant the most to the moms was not a clinical nursing intervention but a trusting, caring relationship in

which who she is and what her hopes and dreams are for her pregnancy and baby better reflect what is most important.

3. A Holistic and Flexible Program Model

It was clear from the interviews and group discussions that participants have done a lot of thinking about program models and curricula. Many have worked in a variety of family support roles including social work and nursing, as well as in grassroots community and outreach settings. They are experienced in a number of



programs areas and have been trained in a range of approaches and models.

Interview participants were reluctant to endorse one specific model as “the best model” because they appreciate aspects of several models and have drawn from a number of programs to create what works best for their community. However, they did agree that excellent programs have the following in common:

- Are community based
- Provide cultural safety
- Integrate trauma-informed practices
- Promote friendliness and hospitality.

Community Based

Mittelmark et al. found that the program leaders of successful health promotion initiatives understand the community development process and know how to do it well. The authors said that less successful initiatives and programs focus too much on the actual content or specific interventions of the program, and not enough on the choice of the leader or the implementation process. They advised that “materials come and go, and new and improved interventions are always around the corner. The enduring lesson from the exemplar programs is that the core of a successful program is the community organization process.”⁵²

The participants interviewed for this report take a similar view. They spoke at length about how program staff need to get away from focusing on “binders of information,” “checklists” and “prescriptive programs.” They restated the importance of working with the community to develop the program, as the following comments demonstrate:

“The only way to develop a program that works is to spend time with the community members who want the program or service and who will use it. You need to understand their particular situation and their unique needs—and even then, you still have to be flexible and open to changing your program activities, as one family might need more support with mental health issues or addictions, for example, while another mom might want help with going back to school. We are continuously adapting and refining our program model and curriculum. Our coordinators and family visitors have to think on their feet and be willing to change things up to the last minute, to make it meaningful and helpful for our clients.”

“It doesn’t matter how well a program model worked somewhere else. You need to try it out in your own organization and community first. You might have to change some things to make it work.”

“We spent time talking with Elders and people in the community who are respected and have lived here a long time—as well as former staff in the health centre. We asked them for their advice on what they thought was important. They gave us great advice.”

“We go back to them on a regular basis. It helps us to keep checking in to see if we are on track. And we ‘tune in’ to the community gossip. People talk and a program will develop a reputation over time. We want to make sure we have a

52 From p. 455 of Mittelmark, M., Hunt, M., Heath, G., & Schmid, T. (1993). Realistic outcomes: Lessons from community based research and demonstration programs for the prevention of cardiovascular diseases. *Journal of Public Health Policy*, 14(4), 437–462.

good reputation—that people trust us and know that we have a good program—and that our team respects confidentiality and knows what they’re doing.”

“You can’t transplant something and expect it to grow if you don’t pay attention to the unique conditions of your own environment. You need to listen to community members to figure out the best approach.”

“I think it helps to think of the whole community as your client.”

Cultural Safety

The following definitions of cultural safety come from the Health Council of Canada’s 2012 report, *Empathy, Dignity, and Respect: Creating Cultural Safety for Aboriginal People in Urban Health Care*:

1. Cultural safety is an outcome, defined and experienced by those who receive the service—they feel safe.
2. Cultural safety entails respectful engagement that can help patients find paths to well-being.
3. Cultural safety is based on understanding the power differentials inherent in health service delivery, as well as institutional discrimination, and on recognizing the need to fix these inequities through education and system change.
4. Cultural safety requires acknowledgement that all people are bearers of culture—there is self-reflection on one’s own attitudes, beliefs, assumptions and values.⁵³

The Health Council of Canada also stated:

“Culturally safe care involves building trust with Aboriginal patients and recognizing the role of socioeconomic conditions, history and politics in health. It also requires communicating respect for a patient’s beliefs, behaviours and values. As well, culturally safe care ensures the client or patient is a partner in decision making.”⁵⁴

Interview participants had many thoughts about what it means to implement a culturally relevant program model and practise in a culturally safe manner:

“‘Culture’ is not just about specific traditions and practices—it is a ‘way of being’ with people, respecting everyone as a unique individual with unique gifts. Our ceremonies and our teachings are really about showing us how to be good human beings and how to treat each other well.”

“We can never really ‘know’ another person and what their journey is about—so practising in a cultural way means respecting people where they are, and not assuming that if you are an expert in a health field and a professional, you are also an ‘expert’ on someone’s life.”

The following were common themes in the interviews, and provide examples of how the interview participants view cultural safety and how they integrate culturally safe practices into their MCH programs:

- At the heart of practising in a culturally safe manner is cultivating the ability to create trusting and respectful relationships where people feel understood and cared for.
- The cultural competency training offered by the Provincial Health Services Authority is an excellent resource.⁵⁵
- In addition to the above training, participants stressed that professionals need to meet with the Elders and traditional/cultural people in their community and learn the values and the teachings of the community. As one participant said, “*There’s no course, there’s no book, there’s no online training that’s going to truly educate you. You ‘gotta be there’ to learn; you need to spend time with the Elders and the people on the land.*”
- Respecting the rhythms and cycles of the community is another very important way to

53 From p. 6 of Health Council of Canada. (2012, December). *Empathy, dignity, and respect: Creating cultural safety for Aboriginal people in urban health care*. Ottawa, ON: Author. Retrieved from http://www.healthcouncilcanada.ca/rpt_det.php?id=437.

54 Ibid, p. 6.

55 For more information on the Provincial Health Services Authority’s Indigenous Cultural Competency Training Program, see <http://www.culturalcompetency.ca>.

practise cultural competency—for example, being aware of when there has been a death or a funeral is being held and not expecting the program to go on “as usual” when these events are happening, and also understanding when people will be away fishing or hunting or at logging camp. Program schedules need to reflect and accommodate community rhythms.

- Helpers must understand both community dynamics and inter-family dynamics. There are often good reasons when women struggle to be in the same group with each other—there may be long-standing family conflicts, or unhealed wounds. MCH programs need to be sensitive to these realities.
- One coordinator stressed the importance of knowing the history of the community and the families she worked with. She said: “*I carry the family trees in my head.*”

Trauma-Informed Practices

The following definitions of trauma are taken from the 2013 *Trauma-Informed Practice Guide*.⁵⁶ The guide was developed on behalf of BC’s Provincial Mental Health and Substance Use Planning Council in consultation with researchers, practitioners and health system planners across the province:

“Intergenerational trauma describes the psychological or emotional effects that can be experienced by people who live with trauma survivors. Coping and adaptation patterns developed in response to trauma can be passed from one generation to the next.”⁵⁷

“Historical trauma is a cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma. These collective traumas are inflicted by a subjugating, dominant population. Examples of historical trauma include

genocide, colonialism—such as Indian hospitals and residential schools—slavery and war. Intergenerational trauma is an aspect of historical trauma.”⁵⁸

“Trauma-informed services take into account an understanding of trauma in all aspects of service delivery and place priority on the individual’s safety, choice, and control. Such services create a treatment culture of nonviolence, learning, and collaboration.”⁵⁹

The participants spoke about the effects of inter-generational trauma on the women and families they work with. They also stressed the value of developing trauma-informed practices and making them an element of any model:

“Every day I see the effects of residential school in my community—sometimes it shows up as mean gossip, or violence in the home, or addictions, or despair, or just that terrible feeling that you aren’t good enough or you don’t belong.”

“I think a hugely important part of our job is to help people understand trauma and the effects of trauma. It’s incredibly empowering for people to learn how trauma has played a role in their addiction, for example, or why they struggle to have a good relationship or to parent. People don’t feel ‘crazy’ or ‘flawed’ when they learn about trauma.”

“The workshops we have attended on trauma have helped us enormously. It’s helped us take better care of ourselves as workers—and it’s given us some insights and skills so we can be more effective with our families.”

Friendliness and Hospitality

Basing programs on friendliness and hospitality might seem like common sense, but interview

56 Change Talk Associates. (2013, May). *Trauma-informed practice guide*. Victoria, BC: Provincial Mental Health and Substance Use Planning Council. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf.

57 Ibid, p. 6.

58 Ibid, p. 6.

59 Ibid, p. 12.



participants said they are frequently surprised at the unfriendliness of many service providers and the negative effect this has on clients. In fact, they reported that some clients will not go to their medical or dental appointments—even though they may have a very good relationship with their care provider—because they find the reception desk staff unwelcoming and judgemental.

Participants said it is essential to provide training to the front desk/reception staff on how to be welcoming and friendly—including how to deal constructively with difficult and/or distressed clients.

The interview participants had some additional suggestions:

“Our health director has oriented all of the health centre’s staff in providing friendly service and how to create a welcoming environment. We pay attention to what might seem like small things—but actually they can make a big difference. We have lots of seats in the waiting area and toys for the kids, a water cooler—sometimes we even have some snacks or healthy treats. There are beautiful posters on the wall and some plants, and a general homey and warm, comfortable atmosphere.”

“The person who answers the phone or greets the client has a lot of influence as to whether or not the client will use our services and programs.”

“Friendliness and hospitality are core traditional values. It’s always been our way to create a welcoming environment and to offer food and to treat people with kindness and respect. This is extended to everyone.”

“We try to make our support groups and our family activities inclusive and as friendly as possible. We know it can be intimidating for some parents to come out of their homes and participate. We always have food!

“Small things such as smiling and telling someone how good it is to see them really help create a good atmosphere.”

What Is the Best Environment to Connect with Families?

The interview participants were critical of programs that require visits to always take place in the client’s home. They gave a number of examples of why MCH programs should not be confined to home visiting only. For instance, insisting that individuals open their home to a family visitor fails to demonstrate either cultural respect or trauma-informed care. Child protection issues aside, the decision to invite someone into the home must remain with the parent.

As well, mothers have expressed privacy concerns about visits in the home when other family members are present. The mothers cannot be open and honest if they are worried about being overheard. Sometimes, they simply do not want to worry about being judged or evaluated on the state of their home—and sometimes, they simply appreciate being able to “get out of the house” for their visits.

Interview participants also reported that making a home visit is not always practical or a good use of time when, for example, they have just spent several hours travelling with the mother to a medical appointment—or when the mother has recently participated in a group. The participants stressed the importance of providing

socializing/connecting and relationship-building opportunities for both mother and child during group visits.

Family visitors have also raised safety concerns for themselves. It is not always safe to visit a home where there is criminal activity, hostile family members or the potential for violence.

Participants commented on the pros and cons of connecting with clients in different environments:

“Some of the best visits I’ve had with a mom have been in my car while we are driving to an appointment 5 hours away from home. We can cover a lot of ground in that time and it feels safe and private. I think there’s something about sitting side by side, facing forward that helps as well—it kind of takes the pressure off that a person feels when someone is sitting right across from them, face-to-face in a room.”

“In my experience, parents really like it when I take them out for a coffee or a snack. It is a form of self-care for them, a small little get-away—it can make them feel special. And I find we can get into very open conversations during these times. It doesn’t feel like ‘teaching’—it feels like an adult conversation where we are both learning from each other.”

Please tell me about your hopes and dreams.



“You can learn a lot about a family and how they are coping when you visit them in their home. I have never pushed my way into a home, but I do put time into building trust with my clients so that they will invite me into their home. I think I have been able to better support a family because I have seen how they are functioning—or not—in their home environment. I think home visits are important.”

“I visit families in their homes but I also believe it is really important for moms and dads to get out of their homes and socialize with other families in a good way. I think our support groups and our family events provide a place for parents to do fun things, learn new things and see how other people parent their kids and how other kids are doing. Some of my moms have been very isolated, as they worry their child will behave badly or have a temper tantrum in public and people will judge them. That’s why these groups are so important. Parents will see that every kid can throw a temper tantrum or cry—it’s OK, we’re all in this together. And these parents can also see how different parents handle situations. Group settings provide tons of teaching and learning opportunities.”

The bottom line is that communities need to decide for themselves how to most appropriately connect with families so that their approach satisfies both the needs of the parents and the best balance of home, group and individual visits.

Essential Program Components

The interview participants put forward a number of curriculum components as the “must haves” in an excellent maternal and child health program. These components are grouped under four themes:

- Healing the self and healing relationships
- Creating healthy and loving families
- Connecting with others and building community
- Learning new skills and realizing dreams.

Healing the Self and Healing Relationships

The interview participants sent a resounding message that healthy children and healthy families begin with healthy parents. They were passionate about providing parents with support and opportunities for personal healing. One of the participants expressed it very clearly:

“You can’t realize your potential as a parent, and be the most effective and loving parent you can be, unless you have done your own personal healing. It won’t really matter how many parenting courses you take—you will still struggle to be an effective parent if you haven’t resolved your issues. Being a loving parent starts with loving ourselves and healing ourselves.”

The participants said that parents were dealing with many painful emotions such as shame and self-hate, stemming from their own personal experiences of abuse and neglect when they were children. Parents want to learn practical skills and tools for self-forgiveness and self-compassion, and for recovery from depression, anxiety and addiction. They are eager to learn positive methods of self-care and self-soothing, as well as healthy habits such as restorative sleep patterns, nourishing food, physical exercise and positive forms of recreation for themselves and their children (i.e., not just video games and TV).

Participants said that effective programs draw from a variety of traditional and contemporary healing and therapeutic modalities—and that healing happens in many ways. What matters most is finding the approach that resonates with the client.

The participants offered the following examples of what’s worked well in their programs.

Support during family visits: The participants said that one-to-one visits provide an excellent setting for family visitors to practise deep listening, use “coaching conversations,” employ motivational interviewing techniques and ask inspiring questions such as, “What are your hopes and dreams for yourself and for your child? What are your deepest

longings? What matters most to you?” As well, participants spoke about some of the ways during these encounters they teach self-care and self-soothing methods that help the parent cultivate inner resources and develop self-reliance:

“I have found it very rewarding to teach my clients simple but really effective ways to manage their stress and their difficult emotions. I love introducing them to journaling, mindfulness practices and creative visualization, for example.”

“Self-care includes getting enough rest, eating well and doing some form of physical activity. You need to take care of your body in order to heal and be well.”

“I like to use the Medicine Wheel when I’m working with my moms. It provides a great visual about taking care of ourselves, emotionally, mentally, physically and spiritually.”

“Parents rarely get asked about their hopes and dreams. It’s as though some parents believe they don’t deserve to dream. I am deeply touched by how they respond—sometimes with tears, sometimes with excitement. And even if they can’t tell you what they want for themselves, they always can tell you about the wonderful things they want for their children.”

“One of our ‘struggles’ in our program is in working with moms to look at family planning. One thing I have found that is so helpful is to help moms see that using family planning may make it easier to reach their dreams for themselves and



envision a future that is different from the present. One mom talked about how much she wanted to work and go back to school to be a role model for her daughters. It was so neat how the conversational energy shifted when we started looking at what her hopes, dreams and aspirations were.”

Culture and ceremony: The healing power of culture is an integral theme of MCH programs. MCH staff do their best to link parents with Elders and traditional healers, and provide opportunities for families to participate in cultural events and ceremonies. Participants said that they have witnessed powerful examples of personal healing when families reconnect with their culture and with their spirituality:

“Our Elders have done so much for our families by sharing the teachings and using ceremony and cultural ways to transform abuse and despair within families. They help parents get in touch with their true identity and help them get on the healing path.”

“Drumming and singing and dancing are powerful forms of healing.”

“Clients have told me that they receive healing and support from their Ancestors. They feel the presence of their Ancestors encouraging them to get well and be good parents.”

“Spirituality is a powerful force for change.”

Family violence services: Several of the interview participants recalled the training in intimate

partner violence they had recently completed. They said the workshop had reinforced for them how essential it was for children to be raised in an environment free of violence and abuse. They believe MCH programs can support families to



develop constructive ways of expressing difficult emotions and learn respectful, non-violent ways of dealing with anger and conflict by connecting them with counselling and group programs that focus on intimate partner abuse and family violence.

One of the participants cited Cowichan Tribes and the program developed by the Kwun’atsustul Counselling Team at Ts’ewulhtun Health Centre as an excellent example of an Indigenous approach to addressing intimate partner abuse:

“The community developed its own First Nations Family Violence Prevention/ Intervention program. They offer support for the entire family. There are separate circles for the women, the men, youth and children, but they all meet on the same night at the same time. They begin with prayers and sharing a meal together while an Elder shares his/her teachings. The focus is on safety first, which has been established earlier through intake interviews and assessments, as well as supervision throughout the evening. Each group is facilitated by a female and a male facilitator and an Elder. Our Elders are an integral part of the program and provide teachings and guidance. Aside from relationship abuse topics, the central core component is on colonization and history and effects of residential schools. The curriculum program includes the best practices from the ‘mainstream’ for working with community members who use violence in relationships—as well as our cultural teachings. They work in partnership—in other words, share facilitators with other community service providers, including the RCMP, to make sure women and children are safe and that families have the resources they need to change.”

Residential treatment programs: Interview participants said that addiction poses a significant challenge for many of the families they work

with. They believe that MCH staff can support families to overcome addiction by encouraging them to attend residential treatment centres and healing centres. They mentioned that the process for getting into these programs can be very overwhelming and complicated, and that clients need help with the application process and with the logistics of attending the programs. All of the participants agreed that clients saw becoming a parent as a perfect time for them to face their addictions and seek help:

“Many of the clients in our program want to put addictions behind them and be clean and sober to raise their children. Learning that they are going to become a parent is a real motivator for them to go into treatment.”

Counselling: MCH program staff recognize that some of their clients are overcoming complex personal and mental health issues and need more support than the family visitor alone can provide. In these situations, participants said they help connect families with counsellors and therapists who practise in a culturally safe and trauma-informed way:

“I act as an advocate to get moms and dads into counselling. They are so ready and open to counselling when they are about to become parents. Also, for some moms, pregnancy and childbirth can bring up painful memories of past sexual abuse. I want them to get the help they need to heal from past traumas.”

“Some parents want couples counselling to sort out issues and learn better ways of communicating and dealing with conflict.”

Recovery support groups: Not all clients want to attend residential programs, plus not all communities have easy access to residential or healing centres. In these situations, participants said it can be helpful to connect families with support groups such as AA 12-step recovery groups, sexual abuse survivors groups and groups for people

healing from anxiety and depression. And as one participant mentioned, support groups can provide a practical alternative to leaving the community: “The mothers in our program find it easier to attend recovery groups than to go into a residential treatment program because they don’t want to be away from their kids for a long period of time.”

Holistic practitioners: Interview participants said that more and more of their clients want to work with holistic practitioners and holistic healing modalities such as massage, somatic bodywork, meditation and yoga. They said it is a real pleasure to witness the excitement of parents who want to try new ways of healing:

“Moms love it when we host ‘holistic’ workshops on topics such as sound therapy or aroma therapy or bodywork. They really appreciate exploring healing and self-care through these methods.”

“Our baby yoga was a hit!”

Creating Healthy and Loving Families

The interview participants said that the main components of all good MCH programs support mothers to have healthy pregnancies and positive birth experiences, to breastfeed and form strong attachments to their babies, and to learn about infant care and child development. Good MCH programs also teach parents positive parenting practices. But the participants clarified that the difference between good MCH programs and promising practice programs is that the helpers in the latter programs keep their focus on the parents’ vision of a healthy and loving family life. The parents’ healthy behaviours are how they will realise their vision of “turning things around” and healing inter-generational trauma.

Interview participants said that pregnancy and childbirth entail a profound experience for a woman, and depending on how she is supported, the experience can either erode or build her confidence in her body, in her sense of self and in her ability to parent. One of the participants

recalled how the power of this experience was expressed in a teaching shared by an Aboriginal midwife she worked with who told her: *“Birth is the most important ceremony of our life.”*

Interview participants said that sometimes care providers can lose their perspective of the “big picture,” and when they do, they reduce pregnancy and childbirth to a medical issue to be managed clinically. They can become overly focused on “checking off items on a list” and running parents through appointments quickly, rather than sharing the decision making and educating parents along the way. In these situations, parents are likely to feel they have been “handled, evaluated and processed,” rather than guided through and encouraged in a life-changing experience. And as one of the participants remarked, *“It isn’t just the clients who miss out. Care providers who practise in this way miss an incredible opportunity to make a positive difference.”*

Other participants echoed the need for the helper to tune into the needs of the client and provide care that helps parents build their skills:

“The goal of our program activities are to help parents gain skills and knowledge—and to start trusting in their own capabilities. Many of our moms are quite dependent on the medical system and health professionals. We are trying to help them become active participants rather than passive patients.”

“It’s not about my agenda as a nurse. It’s about what the client wants. Does she feel supported and heard? Did she get what she needed? Does she feel lighter?”

Interview participants highlighted a number of program activities that they consider to be effective in helping build healthy and loving families.

Prenatal care and support for childbirth: A primary goal of MCH programs is to connect women as early as possible in their pregnancy

with a family physician or a midwife, and in some cases with specialists such as obstetricians. Several family visitors are also trained as doulas and provide support during birth.

The participants commented on the valuable contributions that midwives and doulas make:

“Midwives are an incredible resource. Midwives are central to how we are going to turn things around and bring birth back to the community.”

“The Elders tell us that there were several traditional midwives ‘back in the day.’ We now have a midwife on staff, and this will help so much with continuity of care.”

“Having a doula support the mother makes a huge difference to her birth experience, especially if she doesn’t have a midwife. Doulas are a great ‘coach’ to fathers as well and can act as a communication bridge between the hospital staff and the parents.”

Good relationships with physicians and the local hospital are essential. Participants spoke about the importance of meeting with hospital staff and maintaining strong relationships—for example: *“Our partnerships with physicians and with the local hospital are very important. We meet with hospital staff fairly often and we take parents on visits to the hospital to help prepare them.”*

The birthing process doesn’t always go smoothly, however: *“Last year, two of our families had bad experiences at the hospital. Two physicians came to our health centre later to interview the families and to address their negative experiences.”*

Another goal is to “[bring] birth closer to home.”⁶⁰ Interview participants reported that many pregnant women must leave their rural communities 4–6 weeks before their due date to give birth in cities. They said that this practice can have a very damaging effect on family cohesion

60 From para. 1 (“What Are Some of the Issues for First Nations Communities” section) of First Nations Health Authority. (2015) *Maternal, child and family health*. Retrieved from <http://www.fnha.ca/what-we-do/maternal-child-and-family-health>.

in several ways. Not only does it rob women of the support they need during a life-changing experience and put them at risk of increasing their depression and anxiety, as well as increasing the chances of relapse in their addictions, but also it prevents them from having friends and family close by to share the joy of having a baby.

The participants spoke about the value of women giving birth in their own community:

“Babies were born here until 1999. Now all the moms go to Vancouver to give birth. It’s a sad state of affairs to have people die here but not be born here.”

“You really have to be in touch with your power as a woman to give birth here in the community and to go against the ‘social norm’ of having your baby in the city.”

“We’re hoping that creating a multidisciplinary team with midwives at the centre of the team, as well as using Telehealth technologies, will eventually support women giving birth here in their own community.”

Prenatal classes: Programs can usefully provide prenatal education during family visits or connect parents with prenatal classes. Sometimes the family visitor is trained as a childbirth educator and facilitates the classes; at other times, the MCH team works with the community health nurse or a health educator. Each community is unique in how it approaches prenatal education. One participant reported:

“We offer prenatal circles twice a year. We help parents make a birth plan—we give them the opportunity to talk through fears and concerns and ask questions about what will happen. We teach dads how to take blood pressure and also use the Doppler so they can listen to their baby’s heartbeat—they like having a hands-on role. Children are welcome; we provide

Hi! I'm Lynn. I'm 30.

I'm Veronica. I'm 16.



healthy snacks and a ‘good food bag’ for parents to take home.”

Support for the emotional journey of pregnancy and birth, and healing postpartum depression: Interview participants recognize the profound emotional changes that mothers experience during pregnancy and childbirth. Participants said they pay close attention to the emotional and mental health of their moms and keep an eye on them for signs of postpartum depression—which can become very serious and debilitating, especially for women who have a history of anxiety, depression or suicide attempts.

The participants described the emotional challenges some mothers face and the ways family visitors can help mothers to overcome them:

“I have used the BC Perinatal Services guide *Celebrating the Circle of Life*⁶¹ for my own training as a helper, and I shared it with the parents I work with to help them understand the emotional changes they are going through—and some ways to move through them.”

“We work with our mental health team and also the family physicians to get fast referrals and help for moms who are having a hard time. We take this seriously—we know how bad postpartum

61 BC Mental Health & Addiction Services. (2011). *Celebrating the circle of life: Coming back to balance and harmony*. Coquitlam, BC: Author. Retrieved from http://www.perinatalservicesbc.ca/NR/rdonlyres/361F0C20-FDC5-499E-AC8D-D0F2A0494597/0/Circle_of_Life_FINAL_CompleteGuide_March2013.pdf.

depression can be—and we know that it can affect the attachment between the mom and the baby. Sometimes moms need medication and sometimes they just need more support. Mostly I have found it's a combination of both."

"Fathers need emotional support too—for themselves as they make adjustments, and also on how to be with their partners. It can be terrifying for them to see their partners struggling and they can feel powerless. I spend time with dads, texting them and also in person—encouraging them and suggesting some simple things they can do to help."

"Looking after a newborn is exhausting. The lack of sleep and the sleep disruption erode mothers. This is even harder on moms that have other children at home. Exhausted moms can become depressed moms, and so we try to get home support in to ease the burden a little."

Breastfeeding support: A key goal of MCH programs is to increase the number of mothers who breastfeed their babies, since breastfeeding offers many health benefits to babies and also contributes to strengthening the attachment between mothers and their babies.



The participants outlined the types of breastfeeding assistance they give women: "Breastfeeding is important to us. We spend a lot of time educating the moms and helping them—especially during the early weeks when it can be quite tough. One hundred percent of our moms breastfeed for the first 4 months, and a high

percentage are still breastfeeding after 6 months. We are collecting more stats on this and want to be able to help moms continue even longer."

"We loan breast pumps and encourage moms to 'pump and dump' before they go out, in case they end up drinking, so that their babies still have good breast milk."

"Our coordinator is a lactation consultant, which is an added bonus for our program because she trains our family visitors to support moms and she is there as a resource if one of our moms is having difficulties and needs more coaching."

"There are lots of things that can undermine breastfeeding. For example, we've had moms who had no problem establishing breastfeeding when they were in the hospital, but when they get discharged and have an 8-hour (or more) bus ride back home, they feel self-conscious about breastfeeding in public; they lose their confidence. So this is another example of where providing transportation makes a big difference."

Infant care and child development support:

MCH programs offer education on infant and child development during family visits and in group programs. Where it is possible, the MCH staff work closely with the Aboriginal Infant Development Program,⁶² the FASD mentors and Aboriginal Supported Child Development advisors,⁶³ and the Canada Prenatal Nutrition Program.⁶⁴

The participants believe it helps to model practical ways that parents can connect with their children and encourage their children's development:

"Our Aboriginal Infant Development worker is fantastic at establishing relationships with parents. She has a gift for educating parents in gentle ways that

62 For a program description, see the Aboriginal Infant Development Program website: <http://aidp.bc.ca/>.

63 For a program description, see the Aboriginal Supported Child Development website: <http://ascdp.bc.ca/>.

64 For more information, see the Public Health Agency of Canada website: <http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/cpnp-pcnp/index-eng.php>.

help them bond with their babies and form strong attachments. For example, she teaches them baby massage, which is an amazing way to comfort and connect with their babies—and also helps reduce their fears about handling their babies and not knowing what to do. She teaches them about skin-to-skin contact and eye contact and cuddling and how all of this is essential for bonding and feels wonderful. This is especially comforting for moms who don't breastfeed and also for dads—it shows them a beautiful and simple way to connect and attach.”

“I take moms swimming once a month so that they have to hold onto their kids and not their phones. My motto is, play with your kids and not your phone.”

“I think there is a general lack of tolerance for infant and toddler behaviour in public—and also an over-concern with kids getting hurt during normal and healthy play. We encourage active play because we know it is essential for healthy development and it is simply fun! We say, ‘We would rather see a child with a broken arm than with a broken spirit.’”

Parenting classes: Priority outcomes for MCH programs are to support parents to cultivate strong and loving attachments with their children, develop effective parenting skills, practise positive forms of discipline and reduce/eliminate harsh parenting—with the ultimate goal of eliminating child abuse and neglect and cultivating healthy, happy and loving families.

A range of programs and classes are on offer, the participants reported:

“We’ve used a couple of different parenting programs. Last year, we offered the Growing Great Kids™ program.⁶⁵ Even though it’s a great tool, we hardly ever use



it now because doing prescriptive weekly visits just doesn't work for our families. It works better if they can be flexible.”

“Both our program coordinator and our home visitor are certified facilitators of the Growing Great Kids program. We’ve found this to be an excellent resource.”

“We have facilitated the Mother Goose program,⁶⁶ but are happy to say we ‘morphed’ it into a Haida program, with peers teaching peers the language and teachings.”

“One of the motivators for our parent-child play groups was that we were seeing more babies with ‘flat head syndrome,’ which is partly caused by babies sleeping on their backs and also because of spending too much time on their backs in general. We wanted to inform parents about this and let them know that picking their babies up more often and playing with them and having tummy time is really important.”

“Bringing Elders into the parenting groups has been very successful. For example, young mothers have greatly appreciated learning from female Elders about the teachings on being a girl, menstruation and entering womanhood, and pregnancy and

65 For more information, see the Growing Great Kids website: <http://www.greatkidsinc.org/ggk-p36.html>.

66 The National Parent-Child Mother Goose Program, Toronto, ON. For more information, see <http://nationalpcmgp.ca/>.

childbirth. Young fathers have appreciated hearing the stories from older men about what it means to be a husband and a father. Both women and men in the groups have benefited from learning the cultural teachings about becoming parents—for example, learning that we did not hit and punish our children.”

Family planning: Participants emphasized that pregnancy and childbirth are an “awakening experience” for many women and offer an incredible opportunity for women to take charge of their sexual and reproductive health. This opportunity includes knowing what their options are for contraception and how to space their pregnancies and plan the number of children they want to have, according to some of the participants:

“The conversations about birth control and family planning are sensitive conversations but are crucial conversations. We know that the number of children women have and the spacing between their children have a huge impact on their ability to ‘live their best life.’”

“Some of our moms have cognitive challenges—FASD, for example—and they need quite a bit of support to get on birth control and stay on it. It’s a multi-step process. We have found a lot of success with the IUD.”

“Talking about abortion is still a ‘taboo’ subject in our community. Some of the staff have barriers to talking about it as well. I believe women have the right to know all of their options—so we do talk about it, but we keep it ‘quiet,’ as it is still such a sensitive subject.”

“The way you talk about family planning matters. We take a positive approach. We help moms see that it is much easier

to realize life goals—like going back to school—if you plan your family.”

Assessments: The Ages and Stages Questionnaire, Second Edition (ASQ II), is a foundational tool for many MCH and ECD programs. Dr. Jessica Ball has conducted a review of the culturally appropriateness of the ASQ II in Aboriginal Head Start programs in BC and found “a general consensus among practitioners in programs serving Aboriginal young children and families in BC that the ASQ works well with parents and is culturally appropriate.”⁶⁷ Dr. Ball also reported:

“The ASQ II is a parent-completed system of monitoring child development from the ages of 4 to 48 months in the areas of communication, gross motor, fine motor, problem solving, personal-social [and] overall. ... The ASQ II is a fast, simple tool for involving and educating parents in monitoring of their youngster’s development [and] identifying children who require further assessment.”⁶⁸

Regarding the ASQ, one participant commented:

“I think the ASQ is very good. But I think we could do a better job of coordinating our assessment processes so that we are not making families go through the same tools with multiple providers. And I wonder if we are using the same tools and if we are collecting comparable information and can compare and measure changes? I would like this to be a training topic and discussion at our provincial events.”

Vision, hearing, oral health and language development screening: The Tripartite First Nations and Aboriginal Maternal and Child Health Committee has worked in partnership with First Nations communities and government to develop vision and hearing screening, as well as oral health screening and a dental varnishing program

67 From p. 1 of Ball, J. (2008). *Culturally appropriate implementation of the Ages and Stages Questionnaire in Aboriginal Head Start programs in BC: Findings and recommendations*. Retrieved from <http://www.ecdip.org/docs/pdf/ASQ%20report%20phase%20%20final.pdf>.

68 Ibid, p. 8.

in partnership with the Children's Oral Health Initiative. MCH program staff connect parents with these screening services, which are offered both in the community setting and in hospitals and public health units. The First Nations Health Authority website has a description of these programs, as well as several resources for download.⁶⁹

Well baby/well child clinics: Interview participants said hosting well baby/well child clinics is an effective way of helping parents keep to the immunization schedule, check in on the health of their children, and learn more about childhood illnesses and healthy development. MCH program staff may also connect parents with local public health units to attend similar well baby and immunization clinics.

Referrals: As mentioned in the section on multidisciplinary teams, the MCH staff need to be skilled at understanding the needs of the families they work with and be able to refer families for additional services and supports. In order to do this effectively, MCH staff must have good knowledge of the services and programs available in their area and develop good relationships with other care providers. The MCH team members refer families to services offered in their own health centres, such as home support and play therapists, as well as services outside of their community, such as child development specialists, psychologists and paediatricians.

Participants spoke about the complexity of the health care system and the important role MCH staff play in connecting parents with the providers and services they need—for example, one participant said:

“It is difficult for anyone trying to figure out the health care system and where you go for what. It is totally overwhelming for parents to navigate the system. People don't know what's available, and sometimes they don't know how to ask for what they need. A good home visitor helps a family connect with the right care providers and other services.”

Involvement of child and family services:

Continuing on the theme of high-functioning multidisciplinary teams, interview participants said that it is important for MCH staff to maintain good relationships and communication with the child and family services agencies in their communities, as well as with the MCFD. Under the Child and Family Services Act, anyone who believes a child is in need of protection is required to report their concerns to a child welfare agency. MCH staff take this responsibility seriously, while at the same time addressing the fear some of the families have that if they participate in the MCH program, their children are at increased risk of being taken away from them by child welfare agencies.

Although MCH programs do their best to help parents develop positive parenting practices and support families to thrive, not all parents are able to take care of their children. There are situations where it is in the best interests of the child to be placed in foster care. As mentioned in the section on a woman-centred and family-centred approach, MCH staff play a supportive role with parents in these situations, participating in meetings with child welfare agencies, helping the parents achieve the changes they need to make in order to have their children returned, and in some cases helping the parents to come to terms with the reality that their children will be raised by foster parents.

Participants outlined what they see their role to be when child welfare agencies are also involved with the families in the MCH program:

“We want our families to know we have a good working relationship with child and family services—but we do not want them to think the MCFD has us ‘in their back pocket.’”

“We need to reassure families that we respect their confidentiality and we won't break that unless their children need protection.”

“It's pretty easy for a parent to get completely demoralized when their children go into care. I see my job as helping them reconnect with their strengths and

⁶⁹ For more information on maternal, child and family health programs and for resources available as downloads, see the First Nations Health Authority website: <http://www.fnha.ca/what-we-do/maternal-child-and-family-health>.

use the experience as a ‘wake-up call’ to get back on their healing path.”

“I think it’s important to help parents make peace with not raising their children if that’s how it has to be—to help them not be overwhelmed by shame, but to do what they can to still be involved and to remember that the most important thing is to focus on what’s best for their child.”

Help with food: Interview participants spoke about the many ways they help parents feed their family with nutritious food. Almost all the gatherings and events serve food, and programs offer food vouchers, food to take home and monthly good-food boxes. As discussed in the next section on the program element concerning building community, MCH programs also provide opportunities for parents to learn about nutrition and traditional food preparation through community kitchen initiatives, community gardens and other food security initiatives. One participant commented: “Food is huge! Families need lots of support feeding their families. Groceries can be incredibly expensive in remote communities. Providing food and teaching about food and cooking are an integral part of a good program.”

Help with transportation: Participants stressed the central importance of transportation in the success of a program and in their work helping parents connect with the services and supports they need:

“Transportation is a HUGE issue and a big barrier, as most families do not have vehicles, so providing transportation or driving moms to their appointments is important if we want them to get good prenatal care, for example—and to participate in groups and get them to specialist appointments.”

“I don’t know if funders realize how critical it is for families to have access to either public transportation or some other

form of transportation. In our community, we are absolutely dependant on vehicles. The hospital and other services are only 10 kilometres away, but they might as well be on another planet, as parents cannot access them without a vehicle.”

Car seats, infant and toddler clothing, supplies and equipment: MCH staff help parents obtain the supplies and equipment they need to raise their children, including strollers, cribs, change tables and car seats. Some of the family visitors are also car-seat technicians and said:

“It is expensive to purchase all the stuff you need to raise a child—car seats alone cost anywhere from \$100–450, and you need to keep upgrading as your child grows. Our program helps parents share car seats and other baby equipment.”

“We had a contest to win a car seat and it was a lot of fun!”

Program posters, pamphlets and resource material: Participants work closely with Elders and cultural advisors to incorporate the language and the teachings of their Nation in the pamphlets, posters and information they share with families.

The participants draw from a number of maternal, child and family health resources, including those that have been developed in BC through the work of the Tripartite First Nations and Aboriginal Maternal and Child Health Committee and in partnership with Perinatal Services BC, an agency of the Provincial Health Services Authority, as well as the National Collaborating Centre for Aboriginal Health. The resources cover topics such as safe sleep and sudden infant death, parenting and fatherhood, birthing and doula support, post-partum depression, health and wellness screening including vision, hearing and dental screening—and help to guide some of the MCH program activities.⁷⁰

In addition to these resources, participants found the BC Aboriginal Childcare Society resources on

70 To learn more about these resources, see the First Nations Health Authority website: <http://www.fnha.ca/what-we-do/maternal-child-and-family-health>.

traditional parenting and FASD very helpful,⁷¹ as well as the resources on women, girls and alcohol produced for service providers by the Coalescing team⁷² at the British Columbia Centre of Excellence for Women's Health.⁷³

Texting, Facebook and social media: Several of the participants rely on texting and Facebook to stay in touch with their clients and to share program information. Although they are aware that social media can be a “double-edged sword” and nasty things can happen on Facebook, they considered that when well monitored, it is an incredibly helpful tool:

“We have a closed Facebook group for our clients and it works quite well. Moms like to communicate this way and feel comfortable saying what's going on for them and giving and receiving support. I know you have to be careful with Facebook, but so far it's enhanced our program.”

“Texting is the reality now. Sometimes I call a mom on the phone and she doesn't answer. But then I send her a text and she responds immediately. Some people just feel more comfortable talking by text. I don't fight that—I try to work with it.”

“I know we want to be careful about our use of technology and we need to be wary of too much screen time, but we also need to use the tools that make sense. I know it's sometimes hard to find a balance—we want parents to put their phones away, but we also need to stay connected.”

“I think the time of ‘binders’ and ‘booklets’ is coming to an end. Both parents and providers use their iPads and their iPhones to access information. I think we need to use social media more effectively—Facebook and Instagram

and apps that help us communicate and connect. It would be great to create short little educational videos we could post on our website or on YouTube that give a description of our project, as well as teaching about healthy pregnancies and parenting, for example.”

Connecting with Others and Building Community

Interview participants emphasized that all program activities should help parents connect to and contribute to the larger community. They said that explicitly making the link between becoming an effective and loving parent and the larger vision of healing their community and revitalizing their culture motivates and inspires parents.

To this end, the participants make use of every opportunity to praise parents and let them know that all the changes they are making—quitting smoking, not yelling or parenting harshly, feeding their children nutritious meals, expressing affection openly—all of these actions are making both the family and the Nation strong. One participant added: “Our Elders are great at helping young parents understand that parenthood is a sacred journey and that families are the heart of our culture.”



71 To learn more about these resources, see the BC Aboriginal Childcare Society website: http://www.acc-society.bc.ca/files_2/resources-and-information.php.

72 For information on the Coalescing team and on resources for women, see British Columbia Centre of Excellence for Women's Health. (2007). *Coalescing on women and substance use: Linking research, practice and policy* [Project findings]. Retrieved from <http://www.coalescing-vc.org/index.htm>.

73 For more information, see the BC Centre of Excellence for Women's Health website: <http://bcccewh.bc.ca/category/post/alcohol-fasd-prevention/>.



Interview participants offered the following examples of cultural ways that help parents connect with other community members in a positive way and build community.

Baby welcoming ceremony:

Parents love the community baby welcoming ceremony. This ceremony is a real celebration of life—and it places the parents and the child in the community and lets them know they belong. It is also a chance to celebrate the strengths of the family and share cultural knowledge and teachings. Plus it

is fun! As one participant reported, “Our baby welcoming ceremony is profound. I can’t even express how much it means to the families and the community as a whole. It is one of the most powerful experiences a family can have, I think.”

Learning the language: Learning the language is highly valued and considered critical to culture and identity—as is learning the songs and dances. According to one participant,

“We only have a few Elders who know the language, and so it is very important to us that they are part of our program and can teach the parents and the children. It is so incredibly healing to hear the little ones speak. It just melts your heart and lifts your spirits.”

Traditional skills and participating in ceremonies and feasts: Parents appreciate learning cultural and traditional skills such as how to smoke and can fish, how to sew, how to weave baskets and how to carve. They also appreciate learning how to prepare for feasts and other important ceremonies that they may not have learned from their parents.

Two participants talked about the value of learning by doing:

“The moms wove beautiful cedar head bands for their babies in one of our groups. It was a time of sharing and laughter, and they felt so good about what they made.”

“It gives me great pleasure to teach the young ones how to prepare and set up for feasts because I know I am helping to restore our culture. Even some of the parents who would normally have a difficult time with learning seem to pick up what to do and how to participate really easily. They are learning by doing and this is the old way—the way our Ancestors did things.”

Connecting to the land: Interview participants said that parents want to learn about their traditional territory and the ways their ancestors lived. Parents find that connecting to the land and learning about local plants and medicines and how to hunt is very healing and empowering.

Describing the remarkable benefits of connecting with the land, the participants said:

“My son is a young father and he is developmentally delayed. There are so many things he feels he cannot do—but when he is on the land, or hunting with his father, he feels at home; he feels happy, and that he has skills. Being on the land helps him feel whole, and that he has a place in this world and something to offer.”

“In the past, we have tried different program models, but now we have made our own program that is linked to the seasons. We organize our activities so they are in harmony with what should be happening at that time of year. For example, one of the hunters came in with a bear leg and we invited people to come in and learn about it. We had a great response—people are craving their culture.”

“We have an annual canoe trip and family camp. It is wonderful!”

Healthy fun and recreation: Interview participants emphasized that good programs provide opportunities for parents to make friends with people who are also on the healing path and committed to living a healthy lifestyle. They spoke about supporting parents to find ways of having

fun with their children, as well as with other adults who nurture a sense of belonging and a shared purpose. They offered many examples of what has worked in their communities:

“The parents in our community fundraised to go to Wolf Lodge—they needed to get involved, they needed to ‘buy in.’ It was a really empowering experience for them to work together to make something good happen.”

“We found parents stayed home in the winter, and we wanted to get them outside and connecting with other families. So we started two programs—every Wednesday we have a healthy breakfast program and on Thursdays we have an all-day Crash-N-Bump program, which is a super-gym of swings, baby centre, bouncy castles designed to work all of the child’s systems—for example, vision, motor skills, balance. The kids LOVE it. About 100 children attend, which is basically everyone.”

“Instead of going into a home and saying ‘You shouldn’t watch TV,’ you need to create an alternative. It took us 2 years to raise the \$20,000 that we needed to create the Crash-N-Bump gym—it was a big investment for a big reward. We pay six community men to assemble it every week, and this is money well spent, as it provides some work and the men feel really good about being part of this project.”

“Parents are scared about walking alone in our community because of bears, and so creating a walking group has helped get people out and connect with each other.”

“We offer family days at the lake, Elders’ dances, potlucks, self-care days for parents, family picnics—and ‘cabin fever’ days in the winter. All of these help families get out and have fun and contribute to their well-being and to community building.”

Creating healthy community norms: Participants discussed how difficult it can be for parents to change their lifestyle and stay on their healing path if they live in a community where there is lots of drinking and drug use, too much bingo playing and too few opportunities to have fun without alcohol. They expressed their admiration for the families that are creating new community norms:

“Our parents love the New Years in July dance, where we have fun without drinking. It is an important way for them to model healthy behaviour for their children.”

“In 1951, there was a mothers’ petition against bootlegging in our community. The community is now using this as an inspiration to get support around reducing drug and alcohol abuse and help for people to change. They are walking around the community to get people to sign and then they will bring it to the Band Council. The names of the mothers who led the original petition are the family names of modern mothers leading this petition—which really makes these women feel connected to a larger vision of community healing.”

Learning New Skills and Realizing Dreams

Interview participants said that excellent MCH programs support parents to develop their skills in a number of ways—including the ways





*Creating loving homes that
are alcohol and drug free*

discussed in the previous section on the program element concerning building community—as well as encourage them to complete their high school education, join pre-employment groups, participate in training programs, enrol in college and university, and apprentice in trades programs. Also, the participants encourage parents to volunteer at community events and cultural events, as they believe all of these activities build the confidence of parents, help them cultivate a sense of purpose and increase their chance of realizing their dreams. For example, participants talked about the value of teaching life skills and helping parents learn skills that will eventually lead to their economic self-sufficiency:

“Knowing how to keep your home organized and clean, learning how to grocery shop and prepare meals, understanding how to open a bank account and manage your money—all these skills are essential skills for living, and they need to be learned.”

“The social determinants are issues—lack of gainful employment, poverty and poor housing. But despite the despair, there are many great things happening—lots of cultural revitalization, learning the language and cultural camps—and the sense of community belonging among the people is huge.”

“A big community goal for us is to get everyone off income assistance. We know

how important it is for people’s overall health and mental health and happiness to be able to provide for themselves and their families.”

“We are happy to say that we offer almost no programs during the day because most of our parents are either in training, in school or at work!”

“Keeping parents in school is a priority. Our high school has a daycare, which really helps.”

“Our moms really enjoy learning how to sew and make cloth diapers and breast pads. These activities have a practical purpose and give them a sense of accomplishment.”

“Everybody needs a sense of purpose and to believe they have something to offer and that they matter. People don’t want to be dependant on social assistance and feel like they can’t take care of themselves. There are very few jobs in our community, so this is not an easy problem to solve. But we have found that if you start with the basics—taking care of yourself, taking care of your home, learning some skills like sewing, cooking, art, whatever—these skills give parents something to build from. And of course we do our best to connect parents with programs and educational opportunities as well.”

Several interview participants referred to the research on the social determinants of health and how health and well-being are connected to employment and education. They interpreted this research to mean much more than simply encouraging people to go to school so that they could get a job and earn money to pay their rent. Participants felt strongly that the healthiest and happiest people are those who have a chance to develop their skills and gifts, find their purpose and contribute to the world in a meaningful way—to realize their dreams and to live their best life, as the Skidegate MCH program put it.

Spotlight on Mother's Story: Nuu-chah-nulth Nursing Program

By Jeanette Callahan

The Mother's Story approach to care in the Nuu-chah-nulth Nursing Program represents a partnership between a pregnant woman and her nurse. It is a strengths-based and client-centred approach to the care of prenatal women and their families, and includes a focus on the hopes and dreams of the mother-to-be and her family for a healthy pregnancy and a positive birth experience.

The late Ray Seitcher (*?ii wa nuk*) helped to shape the Mother's Story approach to care by mentoring nurses to appreciate and acknowledge Nuu-chah-nulth ways of looking after pregnant women, honouring family teachings that support and guide women preparing for birth, and giving their babies the best possible start in life. As a result of extensive community consultation including meetings with Elders and community health nurses, a Nuu-chah-nulth philosophy of care was introduced into the Nuu-chah-nulth nursing framework alongside the standards of nursing practice, to guide the partnership approach that nurses use in their maternal and child health work in Nuu-chah-nulth territory.

The mother leads the way in the Mother's Story by helping the community health nurse to understand the woman's life experiences and personal health description, including her health story as she was growing up, what life has taught her (that may also help her in her pregnancy), and what her hopes and dreams are for her pregnancy and her baby's life. The hopes and dreams give shape to the creation of goals that the mother describes and activities that the woman identifies to help her reach her goal. The nurse's role is to support the mother-to-be to follow through with the care plan and her goals. When the woman achieves each small step, she receives a special note from the nurse celebrating her success and encouraging her to continue with her next goal.

If a mom has challenges with lifestyle issues (such as smoking or using) and wishes to do something about them, the Community Health Nurse (CHN) works with the mom to identify what she can do and asks how the nurse can help. For example, if someone is using in the house where a woman is pregnant and the woman knows how unhealthy that is but feels reluctant to discuss boundaries with the user, the nurse will do a role play with her on the spot and will help her to develop a way to express her needs and wants in that situation. The CHN will follow up at the next visit to see whether the client was able to use the new skills and how they worked; the nurse will check in on the client's progress and continue to support her.

Using the same example, the mom may have been asked during a prenatal visit if she would like to hear the baby's heartbeat. She is able to listen to the heartbeat, and a recording is made and the mom can take it home with her. The purpose of having the recording is to be able to use it in reminding the mother and other household members that there is a baby on the way. They can listen together and it works very well as a harm reduction tool—for example, household members will go outside to smoke rather than smoke in the home, or if there is conflict in the home and the risk of escalating anger, the heartbeat is often played and it impacts how household members behave. These are two examples of working in partnership with the client based on her priorities.

Something unique in the Mother's Story is the electronic health care charting with the expectant mother. Her personal health description, her life lessons, her hopes and dreams, and her goals and activities are charted with the woman so that she can identify her priorities, see and understand her progress, and perceive that the care is relevant and meaningful to her and her family.

The Mother's Story includes the creation of a birth plan focusing on the mother's preferences and priorities for whom she would like to have at her birth, as well as ways to manage labour

pain, preparations for Maamush (breastfeeding) and any particular cultural practices she would like to include. One traditional practice is keeping the afterbirth. In the Nuu-chah-nulth way, the afterbirth is often buried with items that are relevant to the hopes and dreams for the baby (books—in the hope that the baby might be a good learner; sewing needle—to be able to make traditional baskets; tools—to become a carver). The afterbirth is often buried under a tree, as a reminder to the baby of his/her roots and in the hope that the baby will always return ‘home,’ no matter where life may take the child.

It isn't always possible to do everything exactly as set out in the birth plan, but it helps the expectant mom to prepare for the birth, to consider how she would like to have her birth go, and to choose the culturally supportive practices and people she would like to have around her.

The Mother's Story also provides the opportunity for the new parents to share their birth story during the nurse's first visit after the baby is born. Telling the story of the birth—how the baby was when he/she first came into the world, whom she looked at, when he first cried—ensures these special moments receive attention in the birth story record and sets the stage for helping the family to learn about and support the baby to have the best possible start. The birth story also helps the nurse focus on what is important to the parents in the care and support of their new infant.

The Mother's Story reflects the celebration of birth and precious new life. The Nuu-chah-nulth nurses participate in this celebration by presenting each new baby with a special baby blanket engraved with “The Nuu-chah-nulth nurses welcome you,” given to the baby and family at the first baby visit or at the quarterly gatherings of Nana-ya-aks sa (baby welcoming ceremonies).

Liz McKay reflects on some of the hopes and dreams women have shared in the Mother's Story approach to care. “All of them are different and

Key Points on a Holistic and Flexible Program Model

What Works

- Excellent services are based on community development and community empowerment approaches, rather than on specific models.
- Excellent services may draw from several models to create the program that best suits the community.
- Although “one size does not fit all,” effective models have key elements in common: they are holistic, trauma informed, rooted in culture, responsive/adaptive to the community context and client centred.
- Programs are most successful when they are developed or adapted by the community itself.
- Excellent models incorporate cultural teachings and view becoming a parent as a sacred journey.

What Doesn't Work

- Requiring communities to implement a specific program model, which although considered a best practice in the public health literature, might not be a fit for the community.

it's inspiring to see what moms accomplish,” says Liz McKay. “I have clients who still wave and say hello when they see me and who are proud to share their ongoing stories of success, like going back to school, finding meaningful employment, living clean and sober lives, bringing back the teachings with the help of their Elders and discovering the joy of parenting.” Liz reminds us that as the late Dawn Smith, a well-known nurse researcher, said, “when care is relevant and meaningful to Aboriginal pregnant and parenting families, this approach to care is helping to turn around the intergenerational impact of residential school.”

The Four Enabling Factors That Support Promising Practices

The interview participants described four key enabling factors that increase the chance that a promising practice will be created and will thrive:

1. Organizational and community leadership
2. Partners and resources
3. Research and evaluation
4. Funders' processes, policies and leadership.

1. Organizational and Community Leadership

According to Lencioni (2012), “healthy organizations have a clear vision and purpose, low staff turnover, high morale and minimal politics.”⁷⁴

Interview participants talked about how organizational culture can impact the MCH staff and affect how well the program functions and shared some of their positive and negative experiences:

“It’s only recently that our organizational culture feels healthy—and it’s such a relief to see these positive changes. In the past, it was a terrible environment, with gossiping and mistrust and staff not working together. The clients really suffered, I think, because they could feel it too and they didn’t trust some of the staff.”

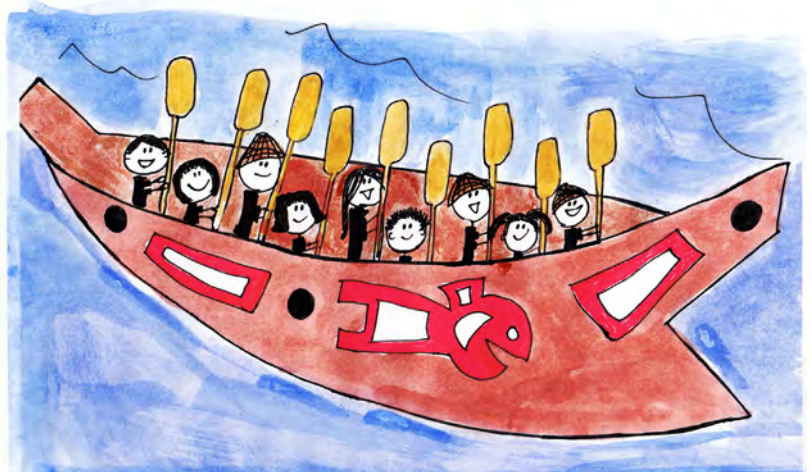
“Our jobs can be very stressful, but that’s not what makes me want to quit. It’s the crazy work politics and lateral violence. You can’t do good work in that type of atmosphere.”

“Our health centres need to be healing places. They need to look that way and feel that way, and the staff need to behave in ways that promote healing—that includes not only how we treat our clients, but also how we treat each other.”

Many of the organizations that deliver MCH programs and services have been encouraged to become accredited and have either completed or are in the process of completing the Accreditation Canada process. Participants support their organizations becoming accredited but with some cautions, as one participant indicated:

“We are getting accredited, but there are some risks to formalization. We don’t want good things to stop because of people’s risk aversion. As organizations become more ‘bureaucratic,’ it can create conflicts between Indigenous ways of working and contemporary ways of working. For example, how do we only pay for 8-hour shifts when we want our family visitor to attend a birth that might mean she is ‘working’ for more hours than that? We support work–life balance, but we also know how important it is for families to receive support at key turning points—if a child is removed from the home. The support is so helpful in these moments

Programs thrive in organizations and communities that have supportive leadership, a clear vision and work together.



74 From p. 6 of Lencioni, P. (2012). *The advantage: Why organizational health trumps everything else in business*. San Francisco, CA: Jossey-Bass.

and the opportunities so rich for modelling how to communicate, deal with conflict and advocate for oneself. Organizational policy needs to be flexible enough to allow these good things to happen.”

Interview participants highlighted the benefits of engaged and healthy leadership:

“I meet with our Chief every day. He is completely informed and engaged with our health programs, without micro-managing or interfering. The people see him meeting with me and they watch him visiting and speaking with people in the health centre ... it makes them feel good to see him there.”

“Our health director is excellent at showcasing our work and making sure the leadership and the community understand what we do. She’s helped all of us learn how to make presentations and speak at meetings. I am proud of what we do, and I am glad the community members support us.”

“Don’t hide anything from your community—tell them everything about your program. I explain it all at our AGA. You need the leadership and the

community members to understand what you are doing and to support it.”

Seabird Island Band is a good example of how political and community leadership has led to a holistic vision for healthy families, with measureable positive outcomes:

“Our community has healthy babies. No children are born with FAS and there is support for children with learning disabilities. Along with a concentrated, longterm campaign of zero tolerance for drugs and alcohol and elimination of the dealers (and associated crime), the community has focused on the healing centre for youth and families. Members’ self-esteem is high and they choose healthy lifestyles.

“Children are raised without fear or economic poverty and they have opportunities to achieve all they can. Soccer is played under the lights until 10 p.m. The recently held 43rd Elders’ gathering celebrates the balance of cultural, spiritual, emotional, mental and physical well-being. The Elders’ complex is a centre for housing and services where retired teachers can sit in their chair telling stories and listening to traditional music with their great grandkids.”⁷⁵



2. Partners and Resources

Interview participants strongly believe that governments and health authorities have a shared responsibility for maternal and child health programs. Successful MCH programs flourish when they are supported by partners that share resources and collaborate on services.

Participants stressed the importance of developing excellent relationships with health

75 From paras. 1 and 2 (“Healthy Lifestyles” section) of Seabird Island Band. (2015). Our mission and vision. Retrieved from <http://www.seabirdisland.ca/page/our-mission-and-vision>.

service administrators, public health nurses and other health authority staff:

“The health authorities are key partners—we need to have excellent relationships with health service administrators, public health nurses and other program staff. This is true for working with government departments like the MCFD, as well as non-profit organizations like the Friendship Centres.”

“Provincial and regional formal agreements are important—we need these high-level documents to set the direction and keep everyone on track and accountable. But relationships need to be established at the local level. We put these high-level documents into action at the local level—otherwise it’s just words.”

“The best ways to form partnerships and really get to know each other are simple ways. It’s not always effective to spend thousands and thousands of dollars hosting provincial conferences and meetings. I have found the best way is still people meeting people in simple ways, over coffee to problem-solve, at local meetings and in shared training sessions.”

3. Research and Evaluation

Interview participants expressed the need to collect data that tell a “meaningful story”—and to move away from collecting “outputs” and “lists of activities” that do not inform program development or support continuous improvement. They were keen to learn more about the short-term and long-term impacts and outcomes of their programs, but were concerned that current evaluation frameworks are not the most useful tools to accomplish this goal.

The participants expressed interest in partnerships with universities and community action researchers

to design evaluation frameworks and research studies that would measure and monitor the outcomes that were important to the community.

Canada is fortunate to have researchers such as Colleen Varcoe, Nancy Edwards, Annette Brown and the late Dawn Smith who have provided valuable insights into designing evaluation frameworks that reflect the values of Aboriginal people and capture the program outcomes that are relevant to communities.⁷⁶ The evaluation themes that were important to the communities they studied included:

- Acknowledging progress over the long term.
- Using a strengths-based approach.
- Recognizing relevant outcomes—such as progressing along a healing path, building strength and capacity, and making improvements over consecutive generations.⁷⁷

Interview participants recommended that MCH program staff and funders look at the “Integrated Framework” developed by Dawn Smith et al. for an example of relevant indicators and outcomes.⁷⁸

Despite the number of reports that have been published and the extensive quantity of administrative data and outputs collected by funding agencies, promising practices and best practices in home visiting programs in Indigenous communities here in Canada and in the US have not been adequately captured in the literature. For example, in *Assessing the Evidence of Effectiveness of Home Visiting Program Models Implemented in Tribal Communities*, the September 2014 report for the U.S. Department of Health and Human Services, the authors stated, “The research literature on home visiting models for tribal communities is in its infancy. Much more work is needed to develop well-specified home visiting program models for tribal communities and to test their effectiveness.”⁷⁹

76 From p. 322 of Edwards, N. C., Martens, P. J., Varcoe, C., & Smith, D. A. (2007). “Making a difference”: A new care paradigm for pregnant and parenting Aboriginal people. *Canadian Journal of Public Health*, 98(4), 321–325.

77 Ibid, p. 324.

78 Ibid, p. 324.

79 From p. 35 of Mrasz Esposito, A., Del Grosso, P., Kleinman, R., Sama-Miller, E., & Paulsell, D. (2014, September). *Assessing the evidence of effectiveness of home visiting program models implemented in Tribal communities: Final report*. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from http://homvee.acf.hhs.gov/HomVEE_Tribal_Report_2014-57.pdf.

The Home Visiting Evidence of Effectiveness (HomVEE) project reviewed approximately 24 Indigenous program models in the US, Canada, Australia and New Zealand, and found that only one program model—Family Spirit⁸⁰—met the U.S. Department of Health and Human Services’ criteria for an “evidence-based early childhood home visiting service delivery model.”⁸¹ Specifically, the review stated: “The Family Spirit studies showed favorable effects in the domains of child development and school readiness, maternal health, and positive parenting practices.”⁸²

The HomVEE team also reported:

“The HomVEE review only includes program models that use home visiting as the primary mode of service delivery and aim to improve outcomes in at least one of the eight domains specified in the statute. These domains are (1) maternal health; (2) child health; (3) positive parenting practices; (4) child development and school readiness; (5) reductions in child maltreatment; (6) family economic self-sufficiency; (7) linkages and referrals to community resources and supports; and (8) reductions in juvenile delinquency, family violence, and crime.”⁸³

Possible Indicators and Outcomes

Interview participants spoke about the value of developing evaluation frameworks, gathering meaningful data and monitoring program impacts:

“Let’s not wait. Let’s select some current programs to evaluate and study, so that we can publish findings and contribute to the ‘evidence.’”

“Over the years, we have worked on several evaluation frameworks with relevant indicators and outcomes. Part

of the problem is that we don’t formalize these frameworks and put them into use. Let’s look at some of the good work we have already done, revise it if necessary, and then train MCH program staff in collecting and analysing the data.”

“We had recently had the first birth in our community in 80 years! This is a telling indicator and should be captured in our evaluations.

“Keeping track of the number of children in care is a great indicator. Twelve years ago, we had 45 children in care. Today, there are zero children in care.”

“We can collect more meaningful data through electronic health record databases—such as Mustimuhw⁸⁴—that would inform program design and better capture program outcomes. If every community was using this system, we could get a more comprehensive picture and we could compare data.”

“I would like to see indicators like, How many women are breastfeeding openly in public? How many families report feeling happier? How many families have changed bad habits like drinking, using drugs and quitting smoking? How many people go into the methadone program? How many parents are in school or working?

“I think we could use some of the indicators and outcomes that were described in the HomVEE review—and also, I think, the BC Healthy Connections Project indicators and outcomes on decreasing child injuries, for example, would be good.”

80 For more information on the Family Spirit Program model, see the Home Visiting Evidence of Effectiveness website: <http://homvee.acf.hhs.gov/Implementation/3/Family-Spirit-Program-Model-Overview/60>.

81 From p. 1 of HomVEE. (2014, September). Tribal home visiting programs: Review of the evidence. Retrieved from http://homvee.acf.hhs.gov/HomVEE_brief_2014-58.pdf.

82 Ibid, p. 2.

83 Ibid, p. 1.

84 Mustimuhw (pronounced Moose tee mook) is a Coast Salish word meaning “all of the people.” It was selected by Cowichan Tribes Elders as the name for the community electronic medical record. For more information, see <http://www.mustimuhw.com/>.

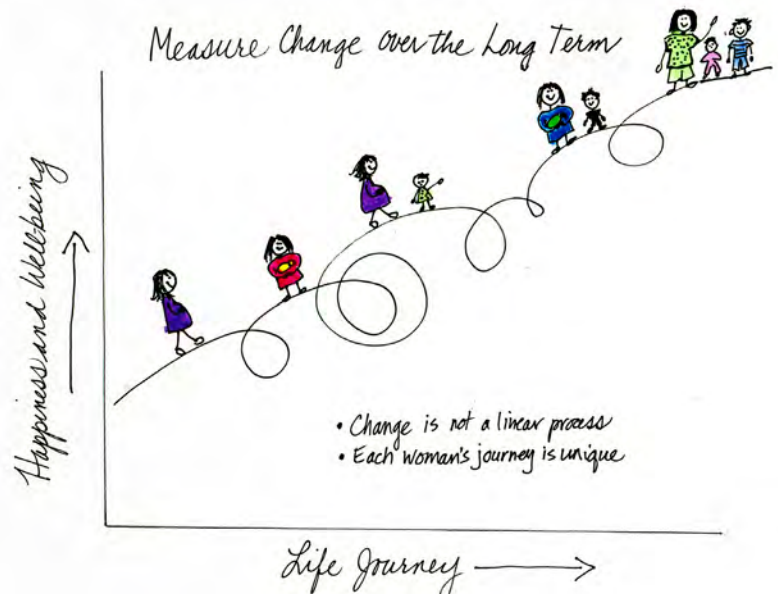
“I think we should develop some indicators and outcomes for our funders as well, as we know their actions can support or undermine the effectiveness of MCH and ECD programs. How about monitoring their staff changes, communication processes, collaborative decision making and flexibility?”

Partnerships with Researchers: Liz’s Story Continues

As we made progress over time in our Nuu-chah-nulth cultural advocacy model of care, we began to share what we were learning with others. Specifically, at a Canadian public health conference a young nurse researcher approached us with an interesting proposal. She said, “I am very aware of the serious statistics in maternal child health care in the Aboriginal population, but I rarely have heard of positive and celebratory ways of working with vulnerable populations. I would like to work with you and further explore what you are doing and how it makes a difference to Nuu-chah-nulth people and potentially all Aboriginal people.”

We engaged in a working partnership with Dawn Smith, and the Nuu-chah-nulth Tribal Council (NTC) nursing program became one site of the focus of her PhD thesis in nursing. Her results shed light on the emotional intelligence and heart knowledge aspects of care embedded in the Nuu-chah-nulth way of nursing. Dawn’s data analysis ultimately showed that “community involvement in program design implementation and evaluation improved participant satisfaction, early access and participation in care, and that this enhanced women’s health behaviours such as improved nutrition, decreased tobacco and alcohol consumption, and feelings of mastery related to infant care.”

Dawn Smith’s results further showed that when care is oriented “to respond to Aboriginal peoples’ priorities, [it] facilitates relevant outcomes, acknowledges the time required for change on deeply embedded determinants of health ... and when providers and organizations are positioned



to work in partnership with Aboriginal people toward their vision, preferences and priorities, such an approach can transform the impact of the history of residential school, turn around the intergenerational impacts of colonization, and shift the goals and expected outcomes of care.”

NTC’s example of transformation of care demonstrates that programs developed and supported by Aboriginal people at the local level generate positive impacts and outcomes over time and have tremendous future potential. Why is it that so few people know and accept these published results, and why are such results not more known in the Aboriginal health and research community?

This is precisely why research partnerships with Aboriginal communities are so important—so that governments and health authorities begin to truly partner in order to learn what outcomes are important to Aboriginal people, to begin to accept and celebrate their wisdom, intelligence and capacities to steer and direct future health care, and to “educate” the non-Aboriginal population from an Aboriginal worldview.

4. Funders’ Processes, Policies and Leadership

Effective health promotion strategies such as MCH programs are developed in true collaboration with communities. Communities create innovative and effective programs when funders allow flexibility in both how program models are

implemented and how the program dollars can be applied—flexibility is essential. As the participants commented,

“We can really stretch our dollars and provide a lot of service when we are allowed to figure out the best ways to run our programs, and are not restricted and confined by narrow program rules about how we should use the funding. This really has to be sorted out at the local level. People in headquarters make general, high-level provincial and national guidelines, and they don’t have the on-the-ground experience to know how we need to combine funding sources to make services work in the context of our community and with our unique blend of resources.”

“In addition to offering funds, look at ways that services can be implemented more effectively. Work at a local level to plan services, and find links and ways of sharing resources.”

Interview participants sent a strong message about how important it is for communities to know whether or not they will be funded from year to year. The insecurity of not knowing whether or not MCH programs will be renewed makes it extremely difficult to establish a reliable service in the community, and to plan, monitor and evaluate, a point that all the participants agreed on:

“Multi-year agreements—ideally for 10 years—would make a huge difference. We could plan properly and recruit and retain staff more effectively—and we could provide consistent and dependable services to our community. You can’t make a big impact in the short term—the outcomes we want for healthier families occur over the long term—so we need commitment from our funders for the long term.”

“It has a really negative effect on our morale to hear funders say ‘We’re going

to Treasury Board and you may lose your funding.’ We need to hear them say ‘The work you are doing is important—we value it—and it is forever.’”

Interview participants expressed concern over the disparities and inequities between communities—some communities having no funding at all—and also inexplicable differences in contribution agreement amounts between communities who do receive funding. It is not clear to the participants what the rationale is for the current funding model; for example, one participant commented:

“It’s never been made clear how Health Canada determines who gets funded and how much they should receive. Is it based on population? Is it based on need? My concern is that I don’t think it has been properly thought out. I would like to participate in developing a new funding model.”

Interview participants felt strongly that investments in MCH and ECD programs should be increased. They encouraged governments to pay attention to the lessons coming out of national studies, such as the evaluation of the Canadian Prenatal Nutrition Program, which concluded, “*Healthy child development programs have been shown to be among the most cost-effective public health interventions as they lead to a wide range of beneficial health and social outcomes.*”⁸⁵

Participants thought that funders should target funds to improve the wages and benefits of program staff. They are concerned that current low wages make it difficult to recruit and retain staff:

“The work we do in these programs can change lives. We spend a lot of time and effort training our staff and building our team, but we don’t have the funding to offer competitive wages to our nurses, and I believe our family visitors are underpaid. The government has an opportunity to send a message about the value of these

85 From para. 1 (“Cost-Effectiveness” section) of Public Health Agency of Canada. (2010). *Summative evaluation of the Canada Prenatal Nutrition Program 2004–2009: Executive summary* [Archived file]. Retrieved from http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2009-2010/cpnp-pcnp/summary-resume-eng.php.

programs by providing the resources to increase the wages of the MCH staff.”

Participants also stressed that competitive, proposal-driven processes place certain communities at a significant disadvantage. They questioned the value of using these types of processes for MCH and ECD programs and asked:

“Is there a better way to use resources wisely and get services to where they will have the most impact without making communities compete for money or requiring them to enter into contrived partnerships?”

“The competitive, proposal-driven process doesn’t work in my opinion. It doesn’t put resources where they are needed and it disperses resources so widely they don’t have the impact they could have. Communities in need get left out and communities that have the money to hire consultants to write great proposals end up getting the funding. I think we need to come up with a better way. These are essential services in my opinion. Would we make cities compete to see who gets an emergency room and who just has to make do?”

Consistent and coordinated leadership from funders makes a big difference for the community. In the past, there has been lots of turnover and program disruption. Interview participants hailed the benefit of having dependable and consistent program staff who provide clear direction and are available to problem-solve:

“When the program was first launched, our community applied for the program money because we really needed the services. What we didn’t realize was the funder had nothing to offer beyond that—no leadership, no guidance, no support with training or curriculum development. We never really knew what they expected from us and we couldn’t turn to them for guidance.”



“I would appreciate more consistent leadership. There has been a lot of turnover at the management level of this program. Sometimes it feels like we get reset to zero every time a new program manager starts.”

“I have really appreciated calling the Vancouver office and getting a person on the phone who knows the program and can help me trouble-shoot. It feels really good to get this support, especially when you are working in a remote community. It might sound simple, but having a person pick up the phone (not get her voicemail) and listen is essential—and better yet, when they call me and ask how it is going and offer to help.”

Communities feel burdened and confused when governments launch separate initiatives and requests for proposals for programs that appear to have the same goals and serve the same population. Interview participants urge funders to collaborate and plan services with other government ministries and funding agencies with the purpose of reducing confusion and competition and to make better use of limited resources. They are encouraged by collaborative planning processes coming out government such as the BC provincial Early Years Centres initiative, which encourages a “‘one government’ approach to coordinate cross-ministry partnerships in conjunction with communities.”⁸⁶

86 From para. 1 of Province of British Columbia. (2015). *Early Years Centres*. Retrieved from http://www.mcf.gov.bc.ca/early_years/centres.htm.

Six Recommendations

Going forward, six main recommendations have the ability to significantly improve the situation of MCH programs in First Nations and Aboriginal communities in BC:

1. Address funding and service inequities.
2. Increase investments in MCH and ECD programs.
3. Study existing promising practices in BC.
4. Provide training and support.
5. Allow communities flexibility.
6. Collaborate on planning and coordinate services.

1. Address Funding and Service Inequities

Determining equity and coverage issues will require an analysis of current MCH and ECD programs and funding amounts to be conducted. The participants interviewed for this report expressed concern that many communities in need of services are not funded. They strongly recommended that funding inequities should be resolved before introducing new programs and services.

2. Increase Investments in MCH and ECD Programs

Investments in MCH and ECD programs pay back in many ways—they reduce preventable human suffering, they support families to thrive—and they accrue savings over time in multiple sectors including education, justice, health and child welfare. Given the evidence, MCH and ECD programs should be available to all families. The recommendation is to look at opportunities to increase funding, shift existing funding and share resources. Participants said that 10 year funding agreements would support communities

to establish consistent and reliable services. In addition, a specific focus on both the short-term and the long-term benefits of increasing the wages of MCH and ECD program staff is warranted.

3. Study Existing Promising Practices in BC

Many excellent programs are currently being implemented in BC First Nations communities. Unfortunately, these program models are often not captured in the public health literature because communities simply do not have the time and resources to study and evaluate their programs. The recommendation therefore is to support communities to partner with universities and community-based researchers, so that they can study their programs and publish their stories in the scientific literature on best practices and promising practices.

4. Provide Training and Support

Providing training to community workers and managers on the core MCH program areas, as well as on topics they identify as important, can help communities to be successful. Communities do not want to reinvent the wheel and appreciate receiving program materials and training in human resources. Participants said they also appreciate receiving clear direction and consistent support from funders. They encouraged funders to continue providing provincial opportunities to train, collaborate with and network with other communities implementing MCH and ECD programs. They recommended establishing a mentoring arrangement in which communities with experience in providing services are able to mentor communities that are establishing new programs.

5. Allow Communities Flexibility

Participants are confident that allowing communities flexibility in both how program models are implemented and how the program dollars can be applied will give those communities the ability to innovate and create cost-effective programs that are just right for them. As well, the participants encouraged funders to look for key practices and community development approaches that are common to all effective programs, and to be less concerned with instituting a specific model. They urged funders to pay attention to the “lessons learned” in the US HomVEE study, which found that “overcoming implementation challenges required programs to be flexible, seek cooperation and support from the community, and hire culturally sensitive staff.”

6. Collaborate on Planning and Coordinate Services

Participants felt strongly that resources could be more effectively combined to reach more families in need if funders improved the planning processes and the coordination of programs across federal government departments, provincial government ministries, regional health authorities (e.g., the MCFD and the MoH), and First Nations communities and Aboriginal organizations.



Conclusion

The evidence shows that if we invest in families, we will improve health status and health outcomes—we know what works! Parents want and need the support and see becoming a parent as a time to “turn things around.” There is probably no better time in a person’s life to make multiple changes all at once. Interventions and services for parents and their children can heal trauma and prevent it from continuing into upcoming generations.

The programs currently being implemented in BC meet, and in several cases exceed, the standards considered best practices in the public health scientific literature. So why is the health disparity gap between First Nations families and other families in BC closing so slowly?

One possible reason for BC not having made better progress in closing the health disparity gap is that there are simply not enough of these

programs in communities. There is very good evidence to suggest that if these programs were more widely available and reached more families, we could accelerate the positive change, close the health disparity gap, and help parents realize their dreams and live their best lives.

The research clearly indicates that investments in MCH and ECD programs pay back in many ways. In addition to the reduction in preventable human suffering, these programs accrue savings over multiple sectors, including decreased use of child protection services, health care services, social assistance programs, and youth and adult criminal justice systems.

We can close the gap. We can turn things around if we invest in these programs and services and supports. We must make this investment a priority. The cost of not doing so is enormously and unacceptably high.

Appendix A: The First Nations and Aboriginal Maternal and Child Health Promising Practices Working Group Members

	NAME	ORGANIZATION
1.	Alma Zukanovic	FNIH, Health Canada
2.	Avery Kelly	BC Ministry of Health
3.	Charlotte Waddell	Simon Fraser University
4.	Cheryl Sauve	Seabird Island Health Centre
5.	Dena Carroll	BC Ministry of Children and Family Development
6.	Denelle Bonneau	Penticton Indian Band
7.	Donna Jepsen	BC Ministry of Health
8.	Donna Moore	Nisga'a Health
9.	Eden Foreman	Heiltsuk Health
10.	Eileen Ruth	Kwadacha First Nation
11.	Ellen Newman	BC Aboriginal Association of Friendship Centres
12.	Jan Tatlock	Island Health
13.	Jeanette Callahan	Nuu-chah-nulth Tribal Council
14.	Joan Geber	BC Ministry of Health
15.	Joanne Woodridge	Vancouver Coastal Health
16.	Kayla Serrato	First Nations Health Authority
17.	Lerinda Wright	Sto:lo Nation
18.	Leslie Fournier	Lower Similkameen Indian Band
19.	Liz McKay	Nuu-chah-nulth Tribal Council
20.	Lucy Barney	Aboriginal Health, Perinatal Services, Provincial Health Services Authority
21.	Nicole Gibbons	First Nations Health Authority
22.	Patricia Hoard	West Moberly First Nations
23.	Rick Kuzyk	FNIH, Health Canada
24.	Tara Nault	BC Ministry of Health

