TREND SETTING IN MANITOBA: THE CHALLENGE OF DESIGNING THE FIRST NATIONS MATERNAL CHILD HEALTH *STRENGTHENING FAMILIES* PROGRAM IN MANITOBA

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ABSTRACT / RÉSUMÉ

Research surrounding home-visitation programming emanates primarily from programs implemented in North American mainstream / non-Aboriginal populations. As such, designing a program in a manner that is reflective of the cultural and contextual differences between Aboriginal and non-Aboriginal peoples are a challenge. It requires trying to balance evidence found in mainstream research while attempting to maintain Aboriginal cultural integrity which includes First Nation governance and empowerment. Manitoba Child Health a Canadian First Nations on-reserve home visiting program; Strengthening Families (MCH-SF) is the Manitoba regional component. This paper reviews how MCH-SF has incorporated several core elements from mainstream programs while responding to cultural integrity: MCH-SF is First Nations driven, supportive of self-governance, and formulated within a collaborative context; it involves the voices of families, and abides by the principles of self-determination; finally, it is engaged in continuous exploration of the underlying principles and theoretical perspectives guiding the program.

La recherche entourant les programmes de visites à domicile porte principalement sur les programmes mis en œuvre auprès de la population en général (non autochtone) en Amérique du Nord. C'est pourquoi la conception d'un programme qui reflète les différences culturelles et contextuelles qui existent entre les Autochtones et les non Autochtones constitue un défi. Elle doit tenter d'atteindre un équilibre entre les observations faites dans le cadre de la recherche habituelle tout en veillant à maintenir l'intégrité culturelle des Autochtones, ce qui comprend la gouvernance et l'autonomisation des Premières nations. Manitoba Child Health est un programme canadien de visites à domicile dans les foyers des Premières nations, dont Strengthening Families est la composante régionale au Manitoba. Cette communication examine comment le programme a intégré plusieurs éléments essentiels tirés des programmes réguliers tout en tenant compte des particularités culturelles. Ce programme axé sur les Premières nations appuie l'autonomie gouvernementale. Il a été élaboré en collaboration, tient compte des points de vue des familles et respecte les principes de l'autodétermination. Enfin, il joue un rôle actif dans l'exploration continue des principes sous-jacents et des perspectives théoriques qui le guident.

INTRODUCTION

The research surrounding home-visitation programming emanates primarily from programs implemented in North American mainstream/non-Aboriginal populations. As such, there is very little research regarding such programming within a Canadian First Nations context, and it cannot be readily assumed that program research which targets non-Aboriginal populations is applicable to First Nations; i.e., health is not a 'one-size-fits-all' concept. As the (Royal Commission on Aboriginal Peoples, 2006) states: "(T)he causes and dynamics of ill health among Aboriginal people are not the same as among non-Aboriginal people — and because illness is not the same, prevention, cure and care cannot be the same either." Therefore, because First Nations- specific research for this type of programming is still in its infancy, questions are abound upon attempting to design a program of this kind. What should a First Nations home-visitation program look like? What are the theoretical underpinnings of such programming within First Nation cultural contexts? What are the meanings that First Nation communities hold for particular maternal and child health events?

This article describes the challenges involved designing the Manitoba the First Nations Maternal Child Health *Strengthening Families* (MCH-SF) home-visitation program within the context of limited First Nations research from which to draw and build upon. It speaks to the difficulty of needing to balance mainstream program design and research while attempting to maintain Aboriginal cultural integrity, including First Nations governance and empowerment.

We will begin by providing some background regarding home-visitation programs within a mainstream context and then provide an overview of programming in a First Nations context. Next we will introduce the First Nations Maternal Child Health (MCH) program in Canada, and then respond more specifically to its Manitoba regional component: *Strengthening Families*.

HOME-VISITATION PROGRAMMING AND "MAINSTREAM" POPULATIONS

Home-visitation programming for mothers and children is a widespread early intervention strategy in most industrialised nations. It is typically offered free-of-charge, voluntarily, and embedded within comprehensive maternal child health and social systems (Council on Child and Adolescent Health 1998).

The goals associated with home-visitation programs vary considerably. As outlined by (Council on Child and Adolescent Health 1998), home-visitation programs began in the United States in the late 19th century. Public health nurses and social workers provided in-home education and health care to women and children, primarily in poor urban environments. At the beginning of the 20th century, the New York City Health Department implemented a home visitor program, using student nurses to instruct mothers about breastfeeding and hygiene. In the late 20th century, home-visitation programs have focused on families with special problems such as premature or low-birth-weight infants, children with developmental delay, teenage parents, and families at risk for child abuse or neglect (Council on Child and Adolescent Health, 1998).

Over the past 20 years research has grown substantially to support the effectiveness of home-visitation programming of all types towards improving an enormous array of health and social outcomes, including prenatal, postnatal and long-term effects for children and their mothers. For instance, home-visitation programs aimed toward "high-risk" families is said to be premised on epidemiological studies that point to greater health risks associated with social and economic disadvantages to infants (i.e., injury, abuse, neglect, health problems and a reduced likelihood of prenatal healthcare) (Hodnett & Roberts 2007). Studies in the United States report benefits of home-visitation programming ranging from health improvements to moms and their infants and more supportive home environments (Olds *et al*. 2004b; Olds *et al*. 2004a) Other benefits of programs of this nature can include: lowered dependence on welfare and Medicaid, reduction in the use of substances, less arrest and incarcerations of the mothers (Olds *et al*. 2007) and efficient tracking of abuse and other causes of childhood injury for children birth to three years of age (Duggan *et al*. 2000; Stone *et al*. 2006).

In Manitoba, since 1999, the Healthy Child Manitoba Office has been funding and coordinating the province-wide *off-reserve* home-visiting program *BabyFirst* (now known as Families First). An important goal of the Manitoba program is to reduce the incidence of child maltreatment: "The maltreatment of children presents a significant threat to healthy child development. Given the devastating impact of maltreatment on children, it is imperative to prevent the occurrence of child abuse and neglect" (Brownell *et al*. 2007).

HOME-VISITATION PROGRAMMING AND FIRST NATION COMMUNITIES

For more than thirty years, Canadian provinces and territories have been strengthening their maternal and child health programs because they have had such positive effects on the lives of children, women and their families. Almost 20 years ago, Dr. C. Henry Kempe suggested that to ensure a child's right to comprehensive care, every pregnant woman should be assigned a home health visitor to work with their

family until the child begins school (Council on Child and Adolescent Health 1998). Yet prior to 2004, and the introduction of the First Nation Maternal Child Health Program (National and Regional), there has been no comprehensive approach to the delivery of maternal and child health care services in First Nation on-reserve communities that compares to what is available to families throughout the rest of Canada.

Historically, First Nation communities were not given the flexibility to develop community-driven frameworks nor adequate resources to implement anything beyond emergency or crisis response treatment (a.k.a. 'taking out fires'). To exacerbate the situation is the wide health disparity that exists between Canadian Aboriginals and their non-Aboriginal counterparts.

Across Canada, First Nation individuals face various health and social risks that have been shown to contribute significantly to overall differences between First Nation and other Canadians in mental and physical health and social outcomes (Guimond 2008). Current mortality rates for all age groups are higher among First Nations than other Canadians (Guimond 2008). Fertility of First Nation adolescents is seven times higher than for other Canadian youth. The rate is estimated to be as much as 18 times higher for girls under the age of 15 years (Guimond & Robitaille 2008). Elevated morbidity rates of childhood illnesses in First Nation communities include gastro-enteritis, otitis media, respiratory infections and childhood-onset Type II non-insulin-dependent diabetes (Martens 2002). Gestational diabetes and high birth weights are more common in First Nation communities (Harris *et al*. 1997). Lower immunization rates (MacMillan *et al*. 1996; Tarrant and Gregory 2001) and higher prevalence of FASD ((Burd & Moffatt 1994) have been recorded in the health literature. In essence, within broader conceptualizations of health offered through population health promotion frameworks, research has validated that regardless of the health, economic, or social circumstance First Nation people fare worse than all other Canadians.

Low participation rates in existing prenatal care services for women on-reserve further informs the extent of health disparity and/or risk. For instance, a 2002 evaluation of the Canada Prenatal Nutrition Program (Andersson *et al*. 2003) found that while 90% of First Nations women living on-reserve had "theoretical" access to prenatal care counselling and other services, only about 50% of on-reserve women we're taking advantage of these services. Moreover, it was found that prenatal care service uptake among First Nations women was concentrated among those considered to be lower risk levels, including: women who lived in non-remote communities; women who had graduated from high school; women who felt cared for during pregnancy and/or whose partners were supportive; and women who had access to child care. Among those women considered for the purposes of that study to be the most "vulnerable," only one in five were accessing any form of prenatal counselling. The 2002-03 Manitoba Regional Report of the *First Nations Regional Longitudinal Health Survey* put the rate of participation in prenatal counselling/class attendance among First Nations women in that province at just 23%; that report did not include analysis by social risk factors. By way of comparison, as many as 60% of Canadian women attend some form of childbirth education class (Enkin 2008).

> "Perhaps more than any other group in Canada, Aboriginal people need the benefits to individuals, families and communities that are afforded by giving children a strong start in intervention during the "early years" is key to improving long term health status and to breaking the cycle of poor health in Canada's Aboriginal population. Early intervention to support neurobiological development influences the integrity of the biological pathways that are essential to life-long health and vitality. Research results have demonstrated that the quality of maternal child health care has immediate and long lasting effects on health status and quality of life across population groups and settings. This forms a foundation for other health programs (such as programs targeted at fetal alcohol syndrome, prenatal nutrition, immunization, early childhood development, etc.) to achieve maximum impact" (Smith 2002).

Indeed, according to the principles of the Canada Health Act (1984), Aboriginal people deserve access equal advances in health care practice. "Yet current maternal child health care in on-reserve First Nation communities falls short of the standards set for the majority of the country" (Smith 2002).

DEVELOPING A CULTURALLY APPROPRIATE FIRST NATIONS HOME-VISITATION PROGRAM

It is evident that there is a definitive need for home-visitation programming in Canadian First Nation communities; however, the research towards understanding *how* to design a program in a manner that is effective in responding to this need is limited. Similarly to the (Royal Commission on Aboriginal Peoples 2006) outlined above, the implications derived from (Smith 2002) review is: "that

delivery of maternal child health care is significantly different in Aboriginal versus non-Aboriginal populations… The reality of the health status, cultural and contextual differences requires that maternal child health care policy be very flexible and responsive to the unique situation, history, culture, strengths and readiness of each community." In addition, the results from Smith and colleagues (Smith *et al*. 2007) study show that evaluation of outcomes of care for pregnant and parenting Aboriginal people must recognize and appreciate the unique experiences of individuals, families and communities within a broader historical context of Aboriginal people's lives. Yet how exactly do we turn the understanding that there are cultural and contextual differences between Aboriginal versus non-Aboriginal populations into a home-visitation program?

There is some research available regarding a movement beyond theoretical responses towards programming models. For instance, home visits utilizing the peer support model in Manitoba First Nation communities through the Canadian Prenatal Nutrition Program were successful in terms of building rapport between nurses and paraprofessional home visitors and in terms of implementing healthy pregnancy practices. In some communities in Manitoba, the program has encouraged participation in traditional Aboriginal childbearing practices (Eni 2005).

Further, a randomised, open trial of 57 Aboriginal households at the Six Nations Reserve in Ohsweken, Ontario evaluated a home-visit intervention program that focused on the promotion of healthy lifestyles in the community. The study reported some positive changes associated with the household-based intervention, e.g., changes in dietary practices and activity patterns (Anand *et al*. 2007).

Via analysis of chart audits and qualitative research technique, Martens evaluated the effectiveness of two breastfeeding initiatives at Sagkeeng First Nation (Manitoba): a prenatal instruction program delivered by a community health nurse and a postpartum peer counselor program for breastfeeding women. She discovered a significant increase in breastfeeding initiation rates with program participation, greater satisfaction and confidence with breastfeeding, with fewer problems and more information (Martens 2002).

Reflecting on the research, it becomes apparent that a First Nations home-visitation program design must begin with an understanding that mainstream literature may not have all the answers; i.e. a response to cultural and contextual appropriateness is essential.

A NATIONAL OVERVIEW OF THE FIRST NATIONS MATERNAL CHILD HEALTH PROGRAM

On September 13, 2004 at the Special Meeting of First Ministers and National Aboriginal Leaders, the Prime Minister announced additional funding for programs that promote the health status of Aboriginal people. The First Nation Maternal Child Health Program (MCH) was one of the programs announced at that meeting. The program was introduced by the federal government in response to disparities in childbearing and infant health of First Nation women compared to other Canadian women and children.

MCH is a First Nations on-reserve home visiting program. Supervised by public health nurses, paraprofessional home visitors work with families and offer support, advocacy and education to childbearing women, new moms and their families. The MCH program supports a comprehensive delivery approach through partnerships with: Elders; Canada Prenatal Nutrition Program – First Nations and Inuit Component (CPNP – FNIC); Fetal Alcohol Spectrum Disorder (FASD); nursing services; Home and Community Care; Oral health; and, other community-based programs. With MCH, First Nations have an opportunity to design and deliver approaches to family and community health that are proactive, preventative and strategic. Furthermore, program designers are able to explore both contemporary and traditional Aboriginal approaches to health care.

MANITOBA OVERVIEW OF THE FIRST NATIONS MATERNAL CHILD HEALTH

STRENGTHENING FAMILIES PROGRAM

The *Manitoba First Nation Maternal Child Health 'Strengthening Families' Program* (MCH-SF) is the Manitoba regional component of the national First Nation Maternal Child Health Program. The program vision is to promote the realization of strong, healthy and supportive First Nations families living a holistic and balanced lifestyle. The program is currently being piloted from only 16 on-reserve communities (Figure 1). The goal of the programmers is to implement on-going and effective programming in all 64 Manitoba First Nation communities.

The MCH-SF program design derives from, and is interlinked with, the concept of collaboration between government, university, local, and regional governance. As such, the program is delivered through funding by Health Canada – FNIH and managed by the Assembly of

FIGURE 1: MCH-SF Program Sites



Manitoba Chiefs (AMC) through consultation by a regionally appointed First Nations Maternal Child Health Advisory Committee (FNAC). The Assembly of Manitoba Chiefs and the First Nation MCH Advisory Committee (FNAC) were adamant that this program be First Nation designed, driven and developed; but what exactly does this entail?

The foundational standards for the MCH-SF program come from several contemporary and/or "mainstream" programs such as: Prevent Child Abuse America; Families First; Growing Great Kids Inc.; and Health Families Arizona. In other words, even though MCH-SF is stabilised within a First Nations community-driven, collaborative approach, several core elements from similar programs designed and delivered in mainstream North American populations were chosen as the foundation for the MCH-SF program. At the same time, this does *not* mean that MCH-SF is in and of itself "mainstream."

The initial idea behind adopting mainstream foundational support into a First Nations program was for lack of alternatives: MCH is the first program of its kind directed towards First Nation communities. Second, it is important to note, a health program of any kind is not static – it is constantly adapting and changing. With this, one of the fundamental challenges in the *continuous* designing of the MCH-SF program is to somehow, and collaboratively, figure out what is a healthy balance between *borrowing* and *developing* methodologies. What aspects of mainstream culture can be incorporated into programming to impact positive First Nation health profiles? What wisdoms are to be revived and cherished within First Nations communities? What should be incorporated into the programs, how, and by whom? In effect, what should First Nation maternal child health program look like? These are all ongoing challenges and ongoing questions. It is pertinent that the program designers keep asking questions, keep searching for answers, and try to adapt and implement changes to the program accordingly.

Towards this end MCH-SF partners are involved in a continuous exploration into the underlying principles and theoretical perspectives guiding the future of the program. Programming content and method are also issues considered as we strive to understand the potential of programming to impact First Nations health. This means not only the delivery of program activities but the impact of *actually* developing activities. In addition, we are continuously exploring principles attached to both forming *and* maintaining meaningful collaboration. This means a collaboration that supports self-determination and self-governance discourses, and acknowledges First Nations social and cultural differences. It also of great importance to expand linkages to not only involve, but also *incorporate* the voices of families living in the communities where programming activities are implemented and *impact* mothers, children and their families. The necessary process of including the voices of individuals and communities situated outside government or mainstream society allows for greater inter-cultural understandings as well as an emerging and continuing alternate set of questions. It enables us to better understand the balance between current ways of life with local traditions and aspirations; discover and revive culture and health within communities; and have communities actively engage in the process of health.

CONCLUSION

The dynamics of health are significantly different between Aboriginals versus non-Aboriginal populations in Canada, as are the cultural and contextual differences from where they arise. With this, the design and delivery of a home-visitation program aimed at First Nations people must somehow acknowledge these differences. The research surrounding home-visitation programming, however, emanates primarily from programs implemented in mainstream populations. The challenge, therefore, in

designing a Manitoba home-visitation program for First Nations communities lies in trying to balance evidence found in mainstream research while attempting to maintain Aboriginal cultural integrity which includes First Nation governance and empowerment.

Although MCH-SF has incorporated several core elements from mainstream programs, it responds to cultural integrity in a variety of ways. It is First Nations driven, supportive of self-governance, and formulated within a collaborative context. It involves the voices of families, and abides by the principles of self-determination. It is involved in the continuous exploration into the underlying principles and theoretical perspectives guiding the program.

The MCH-SF program is not static; rather it is a continuous endeavour whereupon knowledge is being gathered throughout all stages of the design and implementation process. It is hoped that as we work through the challenges and increase our knowledge we will be able to contribute to a body of research that is in desperate need of advancement. With this, it may be possible in the future that First Nations home-visitation programs will no longer be required to look towards mainstream programming and research to establish their foundational standards: First Nation standards will have been designed.

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