



## **Developing a Vision for the Health of Aboriginal Children and Youth**

**Report of a workshop held June 6, 2003**

Final: October 20, 2003

## Background

Since June 2002, the Canadian Paediatric Society has been consulting with national groups working in Aboriginal health to determine the need for dialogue around child and youth health issues, the best way to approach such a gathering, and the extent to which other organizations would be willing to be involved. After a number of meetings with national Aboriginal health groups, the result was a proposal to bring together the major stakeholders in Aboriginal child and youth health, with the goal of exploring solutions and building connections that will benefit children and youth in First Nations, Métis and Inuit communities.

As a lead-up to this major gathering, we formed a pilot group—including representatives from national Aboriginal health organizations, the Canadian Paediatric Society, and Health Canada—to help define the goals and scope of the event (see Appendix 1 for participants). We used an innovative tool called PATH (Planning Alternative Tomorrows with Hope) to encourage participation by all involved. PATH is a creative planning tool used by groups who want to work toward change and has been used by aboriginal communities.

Participants met for a one-day workshop in Ottawa on June 6, 2003. In preparation, they received background information on the project and the PATH process, as well as an exercise asking them to talk to children and elders about notions of health. Participants were also invited to bring resources and share information about their organizations.

This report provides both the detailed notes from the PATH process, as well as some comment on the emerging themes and suggested next steps.

There was general consensus that a second one-day session, providing more focus, would be required before beginning to plan a larger gathering. Most participants expressed enthusiasm and a willingness to continue their involvement.

There was also agreement that several key groups who were unable to attend this session should be involved in the next steps, including the Aboriginal Nurses Association of Canada, the National Aboriginal Health Organization, and the Métis National Council.

## Project Goals

This pilot planning process is a prelude to a much larger gathering of diverse stakeholders. As such, we are working to refine the goals for a summit or symposium on the health of Aboriginal children and youth.

Currently, the working goals of the summit—which continue to evolve—are to:

- Develop a national vision for the health of Aboriginal children and youth that all stakeholders can commit to advancing.

- Improve collaboration between national groups working in health that will enhance the health and well-being of Aboriginal children and youth.
- Develop and enhance new relationships between organizations that are committed to respectfully working together to improve the health of Aboriginal children and youth.
- Promote a climate for change and positive action.

## Emerging themes

During the first part of the June 6 meeting, participants discussed their vision of a future where Aboriginal children and youth in Canada are growing up in healthy, culturally-based environments. The goal of this discussion was to create a picture of a future that national organizations concerned with the health and well-being of Aboriginal children and youth can work toward creating. The only restrictions on ideas for the dream were that they be positive and possible. Ideas were diverse and ranged from the community to organizational to societal levels.

Several themes emerged from this discussion:

- **Healthy communities:** Participants spoke about the critical need for a healthy community and environment, in the broadest sense. The elements of a healthy community are many and varied, including: the physical environment (clean water, safe roads, appropriate housing), an engaged citizenry (people who have positive attitudes toward and are prepared to take responsibility for creating safe and healthy environments for children and youth), appropriate and accessible services for all children and youth, strong community ties that reinforce culture and traditions, as well as spirituality. Strategies for improvement should involve leveraging assets and maximizing strengths that already exist within communities.
- **Healthy families:** Participants cited the critical importance of identity, pride, and self-esteem for children and youth. These qualities, essential to good health, must be nurtured and supported in family, community and societal contexts. Equipped with a healthy sense of self, Aboriginal children and youth will be better able to manage adversity and maximize their own sense of success and well-being. Strong families play a key role in developing children's resilience.
- **Inequity in health and health care for Aboriginal children and youth:** Aboriginal children and youth face serious discrepancies in their experience of health and health care. The reasons are varied, and include racism, which affects so many aspects of Aboriginal people's lives. This is true both at the individual (practitioner-patient/client) and societal levels. There is a need both to acknowledge this experience, better define or articulate the tangible expressions of racism in health and health care, as well as to develop strategies to overcome and eliminate racism in health and health care. There is also a need to integrate traditional medicine practices into the health care of Aboriginal children and youth, to respect it as an asset rather than see it as a barrier.

- **The impact of social exclusion on meaningful participation by Aboriginal organizations:** While social exclusion certainly affects individuals, it also affects Aboriginal-led organizations working in child and youth health. Social exclusion has served to disrupt relationships between Aboriginal and non-Aboriginal health care organizations and health care practitioners. Aboriginal organizations have often been excluded from important processes, or involved too late in the process to allow for a meaningful contribution. Participants envisioned a new relationship where Aboriginal people take a lead role in addressing health issues and establishing relationships with non-Aboriginal healthcare providers and organizations. These new relationships would be characterized by reciprocity, respect and a balance of power. Smaller organizations may also find it difficult to manage all the needs of their clients/communities/networks. Despite knowing what the issues are, they may be constrained by a lack of resources.
- **The role of the health community:** Participants cited many ways that the health community can contribute toward improving the health status of children and youth. One is to help improve the links between professionals working in child and youth health and the community, increasing their understanding of Aboriginal perspectives of health. Another is to encourage and support Aboriginal students to enter into professions that will support healthy children, youth and families, including medicine, nursing, social services, and others. Still another is to promote continuity of care in Aboriginal communities.
- **The role of the voluntary sector:** While participants did not discuss at length the role of the voluntary sector, clearly this is a sphere of influence for the groups involved in this process. An engaged sector, aware of the health needs of Aboriginal children and youth and committed to a collaborative process to improve health outcomes, could make a significant difference. The sector could also contribute to more effective health care advocacy: There is a need to develop broad-based, strategic and coordinated efforts—led by Aboriginal organizations—to advocate for public policy changes that will benefit child and youth health (eg., non-insured health benefits, national injury prevention strategy, etc.). National voluntary sector organizations could also help support the development of voluntary sector organizations at the community level.

Please see Appendix 2 for the detailed notes captured during this process, and Appendix 3 for a visual representation of this part of the PATH.

## Related themes and goals

In addition to the major themes that emerged, there were a number of threads that formed part of the discussion.

- **Education:** Culturally-based education that is accessible at the preschool, elementary and high school, and university levels is critical. As well, Aboriginal knowledge and history needs to be integrated into the education of all Canadians, including health care professionals.

## People to enrol

Participants identified a number of Aboriginal groups in Canada that should be involved in subsequent steps (see Appendix 2). Perhaps during the second session, the discussion could be focused around:

- Revisiting the original list that was brainstormed, critically assessing what each organization could contribute to the process.
- Specific individuals, both among these groups as well as in other areas, who should be involved.
- Non-Aboriginal groups working in child and youth health, with whom collaborative relationships could be developed (identifying groups where there has been a history of success as well as those who need to be engaged).

## Next steps

The workshop on June 6 and this report are the first steps in what will ultimately result in a larger gathering on both Aboriginal and non-Aboriginal groups working on child and youth health.

Participants agreed that a second session was necessary before planning the larger gathering. During the next workshop, to be held in the fall of 2003, we will focus on specific aspects of the symposium/summit, such as working themes, people/organizations to be involved, scope, scale, and so on.

The main criteria for the next workshop are that it continues to remain focused on the health of children and youth, and that it builds on the work of the first meeting.

Participants should also think about the level of involvement they wish to have in subsequent stages of the project. As this is a collaborative process, we hope that the organizations involved to date will see themselves as integral to the next steps.

In broad strokes, here are the next steps:

- Review and comment on report (participants: deadline August 8, 2003)
- Set date and specific format for next meeting (participants, by August 8, 2003)
- Apply for additional funding for second session (CPS, summer 2003)
- Second workshop (September/October 2003)
- Planning for larger symposium/summit (2003-2004)

## Appendix 1: Participants in June 6 workshop

<p><b>Ms. Cindy Blackstock</b> (facilitator) Executive Director First Nations Child &amp; Family Caring Society of Canada</p>	<p><b>Ms. Anna Blauveldt</b> (regrets) Director of Children and Youth Division First Nations and Inuit Health Branch</p>
<p><b>Ms. Candice Cartier</b> Communications Assistant Canadian Paediatric Society</p>	<p><b>Ms. Marie Adèle Davis</b> Executive Director Canadian Paediatric Society</p>
<p><b>Ms. Veronica Dewar</b> Pauktuutit Inuit Women's Association</p>	<p><b>Ms. Claudette Dumont-Smith</b> (regrets) Aboriginal Nurses Association</p>
<p><b>Mr. Duane Morrissette</b> (regrets) Métis National Council</p>	<p><b>Mr. Alfred Gay</b> (morning only) Policy Analyst National Association of Friendship Centres</p>
<p><b>Ms. Margaret Horn</b> Executive Director National Indian &amp; Inuit Community Health Representatives Organization</p>	<p><b>Mr. Richard Jock</b> (regrets) Executive Director National Aboriginal Health Organization</p>
<p><b>Ms. Kathy Langlois</b> Director General Community Health Programs Directorate First Nations and Inuit Health Branch</p>	<p><b>Ms. Tina Martin</b> Policy Analyst Assembly of First Nations</p>
<p><b>Ms. Elizabeth Moreau</b> Director, Communications &amp; Public Education Canadian Paediatric Society</p>	<p><b>Dr. Kent Saylor</b> Representing the First Nations &amp; Inuit Committee of the Canadian Paediatric Society</p>
<p><b>Ms. Joyce Spence</b> (facilitation) First Nations Child &amp; Family Caring Society of Canada</p>	<p><b>Dr. Vincent Tookenay</b> Native Physicians Association in Canada</p>

## Appendix 2: Notes from the PATH

### Touching the dream

- Clean water
- Promoting wellness
- Aboriginal inclusion in the design and delivery of programs
- Elimination of racism + (suppression, silence on Aboriginal experience in the interests of majority)
- Encourage parental responsibility: an understanding of how their actions affect children's outcomes
- Self-esteem
- Spirituality
- Moral standards
- Strong community ties
- Elders re-educate regarding traditional values and beliefs (as community and personally identified)
- Strong and proud personal identity
- Children being provided proper guidance and teachings to do activities at proper time and place
- Culturally appropriate programs, day care centres
- The family unit: healthy relationships, healthy home, balance, extended family, alcohol- and drug-free
- Community accepts and promotes responsibility for safety: healthy home, physical environment, environment, water, smoking, equipment (cribs, stairs), dusty roads (reduction of asthma), off-road vehicle, automobile and bike safety.
- Role models for healthy lifestyles for children: traditional balanced diets, practice of cultures, healthy physical lifestyle
- Changes in attitudes about: safety, health-related outcomes (eg., smoking), that promote health and safety knowledge and responsibility at personal, family and community levels
- Learning effective strategies to reduce and manage racism: am I a victim, or do I say "so what?"
- Boundaries
- Good access to health care
- Good nutrition
- Mental health and wellness
- Success in education
- Prevention measures
- Intervention programs

- FAS knowledge: understand the connection between behaviours and long-term outcomes; understand how to promote a high quality of life for FAS children/youth/adults
- Counsellors, drug rehab, access to physical resources
- Training for CHRs
- Links between health professionals and community, cultural sensitivity through relationships and across time in relationship building
- Traditional medicine: understanding of use alone and in tandem with western medicine
- “Aboriginal 101”: orientation for health care providers, decision makers, researchers at all levels of the health care system
- Continuity of care and care providers for Aboriginal clients
- Programs to promote more Aboriginal students entering health care professions
- Social services: eg. Dreamcatchers’ Youth Program (DYP)
- Programs that are culturally-based, not just culturally appropriate
- Services for special needs children: speech, OT, physio, behaviour, ramps, hearing impaired, daycares are accessible to all children in need.
- Education that deals with learning and behaviour problems, truancy and supports good teachers
- Suicide prevention programs
- Positive media images for Aboriginal peoples – especially children and youth to promote positive self-identity, community pride and to reduce racism.

## Sensing the Goal

- Non-Aboriginal organizations participating in Aboriginal health care initiatives (and reciprocal) and Aboriginal organizations having equal access to assets
- Effective advocacy considers how issues are developed, presented, who is there, in partnership (Aboriginal and non-Aboriginal), and the position of the person/organization delivering the message
- Development of key health messages and priorities (led by Aboriginal people)
- View of health care is not done in isolation. Rather it is holistic and includes the child’s health, environment, and family.
- Resources for parents that identify resources, how to access, and what to do in accessing them .
- Community communication that bridges native and non-native systems
- Non-insured health benefits should not be a barrier to getting appropriate services (pre-application for services and medications should not be required)
- Education campaign for decision and policy makers on Aboriginal health and peoples
- Greater admissions of Aboriginal students to medical school (criteria that looks beyond grades); more native physicians on admissions committees; advocate or vice dean of admissions who is Aboriginal
- Knowledge-based gathering involving the parties
- Issues are recognized as a priority in health care community and by decision makers (strategic plan...it will happen)
- Linking between the services on certain issues

- Orientation to understanding of what and who can do what (i.e: teachers, social workers, nurses, physicians, CHR, occupational therapists, dentists etc)
- Process: recognition from Royal College of speciality of Aboriginal health
- Roundtable with Aboriginal leaders, government to address education, housing, other issues
- Promote and retain culture
- Need for collaboration outside agency to those that are involved in decision making on health care issues.

## **Grounding in the Now**

- Need to build and affirm children's resilience: confidence/self/identity needs affirmation
- Access to services is sporadic
- Safe and secure family supports are needed
- Lack of sufficient information and community responsibility for health
- Communities in poverty
- Lack of service access and opportunity
- Large numbers of single parents
- Substandard physical environments (roads, housing)
- Lack of understanding among national non-Aboriginal health organizations of Aboriginal history, focus: Aboriginal involvement often an afterthought.
- Problems regarding access to materials and education: don't always get to people in the communities.
- Need for communications strategies at a national organizational level
- Outreach and collaboration is not supported by government funders: organizations cannot, or are limited in participation in collaboration activities due to lack of financial support.

## **Identifying People to Enrol on the Journey**

- Canadian Association of Paediatric Health Centres
- Federal and provincial governments
- More Inuit organizations: ITK, others?
- Native Women's Association of Canada
- Native Mental Health Association
- National Native Teachers Association
- Métis National Council
- Aboriginal Nurses Association
- Financial resources for organizations to collaborate
- Non-Aboriginal health care NGOs if appropriate
- Royal College of Physicians and Surgeons of Canada
- Canadian Public Health Association

- Aboriginal Recruitment Coordination Office (ARCO)
- Grassroots: parents, teachers, elders, day care providers
- Government programs: Brighter Futures, Head Start, other services providers for children

## Planning the First Steps

- Establish contact with each other (distribution of e-mail addresses) and use contacts and relationships as tools for information dissemination
- Support a clearinghouse of information (NAHO?)
- Recognition of national organizations that provide bursaries, awards, etc., to people who are helping improve the health status of Aboriginal children and youth
- Meet with Canadian Medical Association regarding medical school admissions and orientation for all paediatricians and medical schools
- Identify factors/elements to encourage Aboriginal people to work in communities (look at community selection process for admission)
- Education on financial process for government, including senior bureaucrats and decision makers
- Develop a group or forum on how to support stronger family unit/community environment (to meet separately and together)
- Look at integrating summit into existing event or scheduling immediately prior or thereafter to maximize participation (eg., NAHO conference) (Must ensure child health care focus is not diluted in larger event)
- Distribute minutes of June 6 meeting to all participants (including those not able to attend); revise with feedback; plan second session

## Appendix 3: Touching the Dream

