‘We could be the turn-around generation’: Harnessing Aboriginal fathers’ potential to contribute to their children’s well-being

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Links between children’s well-being and their mothers’ health, literacy, and behaviours are widely understood and accepted. Canada, similar to many other countries, has made longstanding investments in maternal and child health programs. Yet, both research evidence and conceptualization of the social determinants of health provide a solid rationale for securing fathers’ involvement in their children’s health and development. Research shows that although children can thrive without a father’s involvement, regular contact with a positively involved father is strongly associated with good developmental and health outcomes (1), as shown in Figure 1.

Practitioners may agree with the idea of involving fathers in prenatal education and children’s health, development and education; however, there has been little policy support, public health program investment, or practitioner preparation to support fathers’ transition to parenthood, or their positive involvement. Lack of effort, or success, is especially unfortunate in regard to Aboriginal fathers. There is evidence of poorer health outcomes among Aboriginal children compared with non-Aboriginal children on almost every health indicator (2) and poorer overall quality of life (3). As Grand Chief of the British Columbia First Nations Summit, Edward John has said, “Fathers and grandfathers may be the greatest untapped resource in the lives of Aboriginal children and youth” (4). The present article urges practitioners to recognize the contributions that fathers can make to children’s well-being, and to tap into Aboriginal fathers’ potential as contributors to the care and development of Aboriginal children. At the same time, the sociohistorically conditioned challenges facing many Aboriginal fathers must be recognized, so that efforts to harness their potential are understood as part of a long-term, multigenerational process of healing and strengthening Aboriginal families.

Distinctiveness of Aboriginal families

As a population, Aboriginal men are arguably the most socially excluded in Canada, with higher unemployment, homelessness, injuries, incarceration, and suicide, and lower education and life expectancies than all other Canadians (5). While some Aboriginal families are typical of many non-Aboriginal families, population level findings indicate that many Aboriginal families are unique in a variety of ways. There is a higher rate of common law unions, higher levels of mobility and more children younger than 14 years of age within Aboriginal households compared with non-Aboriginal households (6). Aboriginal men are less likely to be coresident with their children; greater than one-quarter of Aboriginal children are living in lone mother headed households (6). At the same time, there are twice as many Aboriginal fathers (6% of households) shouldering the responsibility of raising children alone compared with non-Aboriginal fathers (3% of households) (7). With a higher rate of Aboriginal parents who live separately, there are more Aboriginal fathers who are the sole caregivers of their children when they take turns with their ex-partners in caring for children. It is more common for Aboriginal men to have children with several different partners, and for fathers to live in households and be partly responsible for the care of children to whom they are variously related, including children with different mothers, their current partner’s children, children who spend part of each week or part of each year living with them, and so on (8). As well, continuing a culturally traditional pattern, many Aboriginal families do not conform to a typical Euro-Western nuclear family structure; children may be raised by their grandparents or by a number of different relatives in ‘circles of care’ (9,10). Thus, when practitioners want to engage a child’s primary caregivers, it is important to ask who is involved in the child’s direct care over a given period of time and to ask a father about his varying roles in a way that conveys sense of responsibility in which a biological connection may not be so important. It is also critical to be aware of the enormous diversity among Aboriginal families, including the fact that some are thriving and some Aboriginal fathers are role models of positive father involvement.

Using a sociohistorical lens

A recent inaugural study of First Nations and Métis fathers of young children in Canada underscored the importance of understanding the historical conditions that account for challenges facing many Aboriginal families and fathers (8). Among the 80 fathers who came forward to be interviewed about their fatherhood journeys, virtually all pointed to the long series of colonial interventions, illustrated...
in Figure 2, which effectively disrupted Aboriginal family and community life and traditional modes of subsistence, child rearing and health promotion. The Indian residential schools delivered a final, devastating blow to Aboriginal peoples, causing a disruption in the intergenerational transmission of Indigenous cultural knowledge, languages, parenting and social care (11). Three-quarters of the fathers in the research study reported having to address mental health and substance abuse challenges related to developmental trauma – issues that interfered with their ability to remain in relationships with women with whom they had children. While fathers who volunteered to participate in the study were not necessarily representative of all First Nations and Métis fathers, the healing process needed for many Aboriginal fathers to become positively involved in family life has been documented by First Nations scholars as part of the Aboriginal Health Foundation program of research (12) and the First Nations Regional Health Survey (13). Fathers in the recent study emphasized the need for health care practitioners, social workers, and teachers to learn about colonial history, the Indian Act, and social policies that continue to affect many Aboriginal children and families and their access to services (Figure 2).

Most fathers in the study described how they had no experience of a caring father figure in their lives. Many fathers who were involved with their children described having to ‘pull out of thin air’ an image of what it means to love and care for a child and to sustain a positive relationship with their child’s mother and other family members. Yet virtually all of the fathers, including those who were very involved, described their commitment to ‘learn fatherhood’ as a lifelong journey of sustaining positive connections with their children and contributing to their well-being. Some fathers expressed their determination to find ways to be involved despite having few resources, such as a comfortable home, a vehicle, discretionary funds, or connections to social or recreational institutions. It is important for practitioners to consider the potential practical barriers to some fathers’ participation in child health appointments, hospital care and follow-up routines, and to help fathers overcome these if possible, for example, by linking fathers with patient navigators or assisting fathers with procedures to obtain transportation vouchers. Social barriers may include fathers not knowing what is expected of them when entering a health care facility, visiting hours, meals, possible costs for medications, supplies, and specialist visits, and so on. As well, many Aboriginal people in Canada continue to experience racism and social discrimination; some fathers in the study described feeling unwelcome in off-reserve facilities such as well-baby clinics, child development centres, libraries and even playgrounds. Several fathers reported having been asked by practitioners whether they were related to the child they were with, as if their legitimate accompaniment of the child was in question. Significantly, Aboriginal children are more likely than non-Aboriginal children not to have their biological father identified on their birth record (14), and Aboriginal child welfare records are more likely not to include the father’s name (15). Many Aboriginal fathers in the recent study perceived a mother-centric approach in mainstream health, social, education and child protection service systems. They identified a need for practitioners to be more vigilant in ensuring that fathers’ identity and contact information is included in children’s health, school and child welfare records, so that fathers can be notified about critical incidents, informed about care regimens and included in health care decision making, even if this requires extra
effort on the part of health care providers, because fathers may not be co-resident with their children and their children’s mother.

‘We could be the turn-around generation’. This expression of hope was expressed by approximately 40% of the fathers in the research study and also by fathers who participated in a recent national event focused on Aboriginal fathers (16). Overall, the research study pointed to five avenues for supporting Aboriginal fathers to become the ‘turn-around generation’, illustrated in Figure 3.

CONCLUSION

After so many decades of living in the shadows of Canada’s colonial legacies, Aboriginal fathers are calling for more concerted efforts to include them in prenatal programs, decisions about their children’s health care and education, and parenting education and support programs. Yet, support for father involvement falls between the cracks of government ministries at the federal, provincial and territorial levels. With no dedicated funding, there are few examples around the country of programs to support Aboriginal men’s transition to fatherhood and to provide ongoing father education, encouragement and inclusion. However, more Aboriginal organizations such as Friendship Centres and First Nations communities are recognizing the need to promote fathers’ involvement, and there is increasing interest in creating father support and education programs.

Many fathers in the study noted, however, that fathers may be looking for different kinds of support than those that appeal to mothers. Rather than starting with peer support groups involving sharing personal stories, a majority of fathers identified the need for concrete information provided in plain language information handouts that could be available in clinic waiting rooms or handed to them by practitioners. Topics they suggested included information about child development milestones, oral health, how to make healthy, affordable meals and snacks, how to get children ready to learn in school, what to expect as children mature, how to support boys and girls through puberty, and where to take children for affordable recreation that can be accessed by public transit. Fathers emphasized that learning fatherhood takes time and, therefore, health care and other practitioners need to be persistent, patient and creative in their efforts to involve Aboriginal fathers.

Practitioners need to recognize that some Aboriginal fathers are well prepared to become partners with professionals in supporting their children’s optimal health and development, while others may be affected by sociohistorically conditioned socio-economic, educational and personal limitations. Yet the resilience in the face of adversity demonstrated by Aboriginal Peoples as a whole (17), combined with Aboriginal fathers’ desire to become the ‘turn-around generation’ by recreating positive roles for Aboriginal men in raising children, are assets that need to be capitalized on in policies and practices aimed at improving Aboriginal children’s health and development outcomes.

REFERENCES