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Mothers' experiences of supporting the healthy development of their infants' indigenous identities

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Abstract

What constitutes an Indigenous identity in Canada is complex, influenced by numerous socio-political factors and policies. Developing a positive Indigenous identity begins long before birth, continues throughout early childhood, and has been associated with long-lasting health benefits. This article describes how mothers experience the complexities of supporting the development of their infants' Indigenous identities within an urban, off-reserve environment as it relates to their health and well-being.

Methods: Using interpretive description methodology and the Two-Eyed Seeing framework, this study integrates both Western and Indigenous ways of knowing. Interviews were undertaken with 19 Indigenous mothers, five primary care providers and seven providers of early child development services. Data analysis was collaborative between both authors.

Results: Results describe how pregnancy and parenting catalyse mothers' involvement in the development of their infants' Indigenous identities. Four themes were identified:

a) complexities of identifying as Indigenous;
b) self-disclosing in mainstream health services;
c) forced identifying through "flagging"; and
d) Indigenous-led services promote health *and* identity.

Conclusions: Culturally safe health-care environments help mothers to feel secure in disclosing their Indigenous identities. Clinicians can then better support mothers by providing culturally safe care and linking families with Indigenous community resources for cultural knowledge and support alongside health promotion programming.

Keywords: Indigenous identity, indigeneity, parenting, infant, mothers, health promotion, cultural safety.

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Introduction

What constitutes an Indigenous identity is complex, influenced by government-driven socio-political factors and policies (Alfred & Corntassel, 2005). Many Indigenous people acknowledge the development of one's Indigenous identity as beginning before birth and being primarily shaped during early childhood (National Inquiry of Missing and Murdered Indigenous Women and Girls [MMIWG], 2019). Supporting the healthy development of one's Indigenous identity during infancy has been demonstrated to have a multitude of health benefits for children lasting into adulthood (Halseth & Greenwood, 2019). In this article, we will deconstruct how Indigenous identity is perceived by Indigenous mothers, the complexities they encounter when self-disclosing to health providers and services, and how these shape their experiences of supporting the healthy development of their infants' Indigenous identities in an urban centre in Ontario, Canada. Suggestions for Indigenous-led and mainstream service providers are offered to further support mothers living in urban, off-reserve areas in promoting the development of their infants' Indigenous identities, thereby also supporting their health and well-being.

Defining Identity

One's identity can refer to many things, including the agency of an individual or the shared behaviour of a collective group (Oysermen et al., 2012). The literature describes identity as multifaceted, including investigations of Indigenous identities; ethnicity; nationality; language; and religious identification (Neale, 2017; Peters & Anderson, 2013; Van Herk et al., 2011). Identity can be further distinguished by personal and social attributes such as age, name, education, illness, where you live, and socioeconomic status (Office of the Privacy Commissioner of Canada, 2016).

In Canada, the concept of an Indigenous identity was federally introduced in 1867 through the Indian Act, a paternalistic and gender-biased policy that continues to disrupt culture for the purpose of mystifying and assimilating Indigeneity into mainstream society (Hanson, 2009). The Indian Act has historically disproportionately disadvantaged First Nations mothers and their infants through limitations such as recognising First Nations "status" through blood quantum and the enforced adoption of colonial names and titles (Native Women's Association of Canada, 2010). Despite several adaptations to the Indian Act made through Bills C-31 (1985) and C-3 (2011), this gender discrimination persisted until just recently (Government of Canada, 2018). One example includes women who lost their Indian status by marrying a non-Indian man prior to 1985. These women only became eligible for reinstatement of their status with the enactment of Bill C-3 in 2011 and their children with the full enactment of Bill S-3 in 2019 (Government of Canada, 2018; Crown-Indigenous Relations and Northern Affairs Canada, 2019). Furthermore, the Indian Act and the Canadian constitution limits Indigeneity to just three groups—First Nations, Inuit, and Métis peoples (Hanson, 2009). These groups disregard the vast and unique differences that exist amongst Indigenous communities across Canada. For example, more than 50 Indigenous Nations live in over 600 First Nations, Inuit, and Métis communities in Canada, each with their own distinct cosmology or world view (Statistics Canada, 2018; Wilson, 2018).

Historically, identity in an Indigenous context has been rooted in the land, air, and water, with Indigenous peoples referring to their traditional territories and resources as having an important contribution to their sense of self (Williams, 2018). Indigenous peoples' identities are culturally learned, shared, and patterned and can also be referred to as a spiritual connection through traditions, practices, languages, histories, families, and ways of knowing (Fiedeldey-Van Dijk, 2019). King, Smith, and Gracey (2009) define Indigenous identity as it relates to health as "inherently social and includes major elements

of cultural identity and the crucial bond with the land and natural environment" (p. 77). For some Indigenous people, the principle of identity is believed to be passed on to infants through the waters of motherhood (Anderson, 2010; Williams, 2018). Birthing traditions carried out by some communities demonstrate their belief of this passing on of identity through cultural welcoming songs, naming ceremonies, and returning the placenta to Mother Earth (Wiebe et al., 2015).

Indigenous mothers experience risks associated with disclosing their Indigenous identity to health-care providers, including being flagged during pregnancy to alert child protection services of the anticipated birth and child apprehension which can be evidenced by the alarmingly high rates of Indigenous children in government care compared to non-Indigenous children (National Inquiry of MMIWG, 2019, Statistics Canada, 2016). There is also a growing body of literature regarding Indigenous identity as a social determinant of health, further solidifying the link between identity, health, and well-being (Bourassa & Peach, 2009; Buse et al., 2018; Koolahdooz et al., 2015). With the increased movement of Indigenous people to urban areas, Indigenous women can struggle to build a sense of community and belonging, as Indigenous people are often scattered across a city (Drabble & McInnes, 2017). Research involving Indigenous mothers in urban areas in Canada indicates that intergenerational trauma, along with the dominance of Western culture and ongoing systemic barriers, result in patterns of health inequities and challenging life circumstances (Wright et al., 2019a).

The findings presented here are part of a larger study exploring how Indigenous mothers experience selecting and using health services to meet the health needs of their infants (under two years of age). This article focuses on how Indigenous mothers described the development of their infants' Indigenous identities as they relate to their health and well-being.

About the Authors

The first author is Grand River Kanyen'kehá:ka/Mohawk and resides on Six Nations Reserve #40 in Ontario. She holds a nursing degree and a Master's degree in public health and is currently a PhD candidate at McMaster University. The second author is of European ancestry and has worked with the first author and members of the Indigenous community in Ontario, Canada, in community-engaged research for more than eight years. This community-engaged study was collaboratively designed and conducted by these two authors, staff at the Hamilton Indigenous Friendship Centre, and Indigenous mothers.

Methods

This qualitative study used interpretive description methodology and applied the Two Eyed Seeing Framework (Bartlett et al., 2012) to ensure both Western and Indigenous ways of knowing were integrated throughout the research process. The study was approved by the Hamilton Integrated Research Ethics Board, McMaster University Family Medicine Program, and Mohawk College Research Ethics Board and received approval from community partners at the Friendship centre. A full description of the methodology can be found in Wright et al. (2019a).

Data Collection

Briefly, our understanding of how mothers promote their infants' Indigenous identities and how they perceive these identities to support their infants' health and well-being was informed by mothers and health providers living in Hamilton, Ontario, Canada. Mothers were recruited through flyers, word of mouth, and by staff at the local Indigenous Friendship Centre. Participant mothers were included in the study if they self-identified as Indigenous, were caring for an infant less than two years of age and lived in Hamilton. All mothers participated in an in-person interview with one or both authors. Data collection continued until data redundancy was apparent and the themes demonstrated information power or were otherwise comprehensive of the phenomenon (Malterud et al., 2015). Following data collection and initial data analysis, all mothers were invited to attend a discussion group, and eight participated. The discussion group allowed researchers to share initial findings for mothers to affirm or dispute, as well as to probe for additional details relating to developing concepts and themes. All mothers

agreed with the findings and did not ask for any data to be removed. Community partners, including staff at the Friendship Centre and Indigenous mothers, have participated in knowledge dissemination activities.

Health providers were recruited through posters, email invites, and word of mouth to participate in the study if they provided care for Indigenous mothers and infants in the city. Data from interviews provided additional contextual details to augment our understanding of the mothers' experiences. All interviews were conducted by the second author either in person or by telephone.

Data Analysis

All interviews and the discussion group were audiotaped and transcribed verbatim for data analysis purposes. Data was analysed collaboratively by both authors, guided by the Two-Eyed Seeing framework. A thorough description of this process has been published elsewhere (Wright et al., 2019). Briefly, both researchers familiarised themselves with the data by reading the transcripts numerous times before beginning to categorise concepts and eventual themes using coding techniques suggested by Saldana (2016). Working at first independently, the researchers then met many times over the period of several months to review coding structures and evolving themes. The first author (VanEvery), having Indigenous knowledge and lived experience, contributed an Indigenous "eye" to the analysis and provided cultural insights into nuances found within the transcripts not apparent to the second author. The second author (Wright) contributed a Western (mainstream) "eye" to the analysis and her nurse practitioner (clinician) expertise to facilitate bridging Indigenous ways of knowing to clinical applications for mainstream health providers.

Results

This study included 19 mothers, five primary care providers and seven providers of early child development services. Each mother was asked to self-identify as First Nations, Inuit, or Métis at the outset of the study as part of meeting the inclusion criteria. During the interview, mothers were then asked to identify an affiliation with a more specific nation or federally recognised band. Mothers were informed that this was voluntary, and all mothers chose to identify to the best of their knowledge. Fifteen mothers identified as First Nations, two mothers identified as Métis and another two mothers did not know their specific nation or band. As these mothers come from both First Nations and Métis communities, they will collectively be referred to as Indigenous and as First Nation or Métis when referring to a specific mother. See Table 1 for a presentation of the demographic details of the participant mothers.

Table 1 Demographic Information: Participant Mothers

Variable	Category	Frequency (%)
Age	<25 years	5 (26)
	26-30 years	8 (42)
	>31 years	6 (32)
Number of Children	First-time moms	5 (26)
	2-5 children	14 (74)
Education	Less than high school	9 (47)
	Completed only high school	3 (16)
	Some college/university	7 (37)
Marital Status	Single/Separated	9 (47)
	Married/Common-law	10 (53)
Indigenous Identity	First Nations	15 (78)
	Mohawk	6 (32)
	Tuscarora	3 (16)
	Onondaga	2 (11)
	Cayuga	1 (5)
	Ojibway	2 (11)
	Oji-Cree	1 (5)
	Blackfoot	1 (5)
	Métis	2 (11)
	Inuit	0 (0)
	Unknown	2 (11)

Note: N=19

Table adapted from Wright et al. (2019a).

The health providers were recruited to add additional context to the mothers' experiences. All early child development service providers identified as First Nations along with one primary care provider. The remaining primary care providers were non-Indigenous. The early child

development service providers worked at the local Friendship centre and Indigenous women's centre. The primary care providers provided care in clinics and public health programs.

The following results provide a preliminary understanding of how pregnancy and parenting catalyse mothers' involvement in the development of their infants' Indigenous identities. The four themes identified include:

a) complexities of identifying as Indigenous;
b) self-disclosing in mainstream health services;
c) forced identifying through "flagging"; and
d) Indigenous-led services promote health *and* identity.

The findings help to inform health-care delivery that is supportive of the development of infants' Indigenous identities, thereby encouraging health and wellness for Indigenous infants and their families.

Complexities of Identifying as Indigenous

Identifying as Indigenous proved to be very complex for mothers in this study, including complicated structures such as surnames, identifying with government recognised Indigenous groups, and obtaining government-recognised First Nations status. First, mothers described complexity rooted in the concept of surnames, historically instituted as a colonial practice. When forced to assume surnames by settlers, many Indigenous people adapted European words. This practice eventually evolved to include practical surnames in relation to place, animals, and skills (Gone, 2013). These surnames are now recognisable as distinct to Indigenous people, complicating confidentiality as health providers often assume Indigeneity based on these common surnames. One First Nation mother noted how she felt like she could be recognised as Indigenous by her last name and appearance, and she believed it played a role in the health care provided to herself and her children:

> When I was looking into my history of my last name.… It is Indigenous to Canada, there is no [surname] outside of my First Nation Community. When we look at my husband's [last name] or his cousin's last name, [last name], these aren't European names. They are not even Native American names like [surname]. It is because that [man] was a good [surname] back in the day and worked with iron. Like I looked into all this…You hear [surname], you know that is a Native American person. You look at me, and you can totally tell I'm Native.

Second, the complexities of identifying as government-recognised Indigenous groups were evident when asking the question, "Do you identify as First Nation, Inuit, or Métis?" This question was problematic for some mothers who did not wish to identify with these limited categories and preferred to identify in more personally meaningful ways. One participant explained:

> Interviewer: Do you identify as First Nation?
>
> Participant: Not all the time. I don't really like to be labelled like that. Especially when they say that I am Aboriginal. I hate that term. There is nothing wrong with me. It's not like as if they're saying like, there is the original, you know, and then there is the "ab" original. Like as if there is something wrong with us.

When the researcher asked how she preferred to identify, the mother answered by identifying herself according to geography (her traditional territorial lands), her nation, and her language: "I am Native… [Lake name] First Nation. My language is Oji –Cree."

Third, First Nations mothers in this study also noted challenges in obtaining proof of band affiliation while living in the city, as is required to secure government recognised First Nations "status". Staff at Indigenous-led programs in the city helped mothers to navigate this process, adding administrative challenges for staff, and sometimes causing a shift in focus away from providing health promotion programming and care.

Stories like these challenge conventional government-enforced concepts of Indigenous identities. Mothers experienced disclosing their Indigenous identities as a complex intersection of surnames, band affiliation, and obtaining government-recognised First Nations status. While some mothers feared that assumptions about their Indigenous identities based on their surnames could result in racist and discriminatory health care, others resisted government-defined

Indigenous groups or band affiliations and opted to identify in more personally meaningful ways.

Self-Disclosing in Mainstream Health Settings

Mainstream health providers who participated in this study shared that the Indigenous identity of mothers they cared for was primarily shared through self-disclosure. Health providers who were unable to assume the Indigenous identities of patients based on a commonly associated surname or on-reserve address reported encountering ethical challenges when asking mothers to self-identify. Some providers did not feel it was appropriate to ask mothers to identify, so they did not ask this question at all, which meant that mothers were not given the opportunity to identify and, consequently, missed the potential benefit of being linked with Indigenous-specific services they may have otherwise been referred to had this information been known to health providers.

> Interviewer: How do you determine if the moms are Indigenous?
>
> Participant: I actually don't ever ask. They self-identify.... I will always offer if they identify. I let them know that there is an [Indigenous] program.

Another provider shared: "Families aren't always identified and don't always self-identify as Indigenous. So, I could have worked with more and not even known." Organisational processes and policies differed from service to service, with the majority of mainstream services not having a formal process to identify Indigenous clients.

While identifying as Indigenous in health settings was not legally required, health providers acknowledged this could be beneficial in building supportive relationships with Indigenous mothers and infants.

> As a Nurse Practitioner if they [mothers] weren't aware of supports, then I would [link them with Indigenous supports]. Like I have had two since I have been here in 2015, who they didn't have status cards. So, I said, "Do you know you're able to get one?" … and then they didn't have a family doctor either, so I referred them to [the Aboriginal health access centre] to get one.

Alternatively, Indigenous-led organisations provided clients with the opportunity to identify as Indigenous at first contact. A Nurse Practitioner from a local Aboriginal health access centre (AHAC) shared their process for identifying Indigenous clients:

> … when they come in, they can basically fill out this form and it provides their demographic information and whether they identify as First Nations, Inuit, or Métis, or, if they are involved in a partnership with someone who is First Nations, Inuit, or Métis. Priority always goes to those that identify or those in a relationship, and in particular if they have children.

Indigenous-led organisations also demonstrated their priority for creating safe spaces for families. As shared by a nurse practitioner from the local AHAC, "we offer safe spaces for mental and physical health…and flexibility and a non-judgmental approach". Similarly, a First Nations staff member at the Indigenous Friendship centre shared that most of her clients:

> …really need someone to talk to…that little bit of encouragement. Somebody to stand in your corner and be like," you got this!". Some need that time to feel safe that they can cry…Allowing them to be individuals…everyone to have their journey.

These services prioritised caring for the entire family, particularly those with young children to optimise care and promote healthy outcomes. Individuals and families were likely to self-identify as Indigenous to administrative staff and health providers at this clinic because the clinic explicitly identifies itself as an Indigenous-led organisation providing culturally safe health care. This likely contributed to a feeling of safety that may be missing at other mainstream health-care organisations.

Forced Identifying Through "Flagging"

Another discourse of disclosing Indigenous identity in health settings related to mothers who were involved with child protection services. Mothers described being "flagged" or "profiled" prior to delivering their infants as how many of these organisations were able to identify them while still in the hospital. In many cases, child protection services also knew of their Indigenous identity from previous interactions. Mothers perceived this knowledge as having had a direct influence on the care they and their infants received, both in hospital and after discharge home. One mother shared that her previous

involvement with child protection services had led to her being flagged as a high social risk in a subsequent pregnancy, despite having had her previous file closed and the independent care of her infant resumed.

> I think that kind of stuck with me unfortunately. It like leaves a mark on you, that no matter [if you're] clean five years, five babies, and all my babies live with me; paediatrician's like "you're good to go", you know; good relationships with their teachers; my older three are getting awards; but it still sticks with you. Their [medical] charts, right? They open it up and are like "hmm." And I am like, "Whatever. You can't live through half of what I have lived through, and I am here." (As cited in Wright et al, 2020 and Wright et al., 2019b).

Regardless of the hard work she had done to meet the demands of child protection services, this history followed her into a subsequent pregnancy, and she believed this influenced the care she received from health providers during and after the birth of her next child. The process of forced identification through flagging or birth alerts has been identified as a racist and discriminatory process largely impacting Indigenous women and as a factor contributing to missing and murdered Indigenous women and girls (National Inquiry of MMIWG, 2019).

Indigenous-Led Services Promote Health *and* Identity

Mothers promoted the healthy development of their infants' Indigenous identities by accessing Indigenous-led programming within the city which provided a social connection to Indigenous culture. Most commonly, these services included the Indigenous Friendship Centre and AHAC. First, mothers described Indigenous-led programs as comprehending Indigenous knowledges and delivering culturally safe programs. These programs helped to strengthen the development of their infants' Indigenous identities while also contributing to their health. The care mothers received from these organisations promoted trusting relationships and met socially driven health inequities, while also recognising the impacts of historical, intergenerational, and ongoing trauma. These trusted settings facilitated access to culturally safe health promotion, which was important to mothers who had had negative experiences with public health-care services. As one mother shared: "I don't trust outside of my native community, and it sucks because I grew up in this city." One of the staff at an Indigenous-led organisation explained that discovering a common First Nations identity between herself and her clients contributed to building a relationship with the family: "I have asked the partners if they're First Nations too.... It seems to.... That it kind of sets a tie with you and them right away."

Another First Nation health provider elaborated on how she integrated culture for Indigenous mothers in her program by highlighting the teachings of the *Good Mind*:

> If you want your baby to not be in stress, then we also have to be aware of how we are feeling. Part of that emotional part. It fits in spiritually, too. Mentally that we have a strong mind, and we can get through. So, to be able to bring that part in. They're not going to find that going to a regular prenatal class.

This teaching is a reminder that an infant's health depends on the mother's health. First Nations health providers' use of culture to promote the development of a strong Indigenous identity was one way to foster Indigenous mothers' and their infants' sense of belonging in the city. One provider explained:

> We try and do a lot of cultural things too with our programs, so I think that brings them in a lot too. They want to learn more about their culture, and they don't have anywhere else to go to learn those things.

Indigenous-led programming supported Indigenous mothers in ways that respected the diversity of Indigenous identities. Program providers attempted to learn about each mother's community and nation, including their beliefs and traditions, to integrate these lessons into their services for both mothers and infants. One provider explained her approach to tailoring care for urban Indigenous mothers, recognising the diversity of Indigenous peoples and providing information geared to the way each individual identifies:

> We kind of try and switch it up, and do different cultural things, based on the people that come to our centre. So, if they are a different nation, then

> we will try and provide different activities and stuff for them as well.

Mothers described how these programs supported the intersection of Indigenous identity with culture and health. Many mothers who were invested in learning about their culture also believed that knowing who they were and where they came from helped to form the foundation of their infants' identities. A First Nation health provider shared her beliefs on this foundational understanding and how she incorporated this into her prenatal programming:

> All of the classes have traditional teachings with them. Like, the first class for prenatal, it really is, like, to find out who they are and where they come from. Like, what cultural stuff they know, because a lot of them really don't know a lot. I think if you know who you are and where you come from, and your background, it makes everything else easier. Because you start to realise why you do things and we look at where they came from, what their family was like and maybe what they would like to see different. How to achieve that. (As cited in Wright et al. 2019c)

Mothers commonly reported accessing cultural programming for exposure to traditional foods, games, crafts, activities, social gatherings, and Indigenous knowledge. The cultural teachings and lessons mothers learned from these programs—such as drumming, dancing, smudging, cedar teas and baths, beading, ceremonies, and wearing a leather bracelet, among others—often also supported their infants' health needs. One mother noted how her culture supported her healthy communication with her infant and older children:

> When we pray, every night I pray with my babies individually. You know, I tell them to ask the creator, ask the creator to give you a good mind and good heart. Help you speak good words and use your hands to do good things.

Indigenous-led services were extremely important to Indigenous mothers as they represented community hubs that provided culturally safe health promotion programming that integrated culture and traditions. This meant that services dually supported mothers in promoting the healthy development of their infants' Indigenous identities as well as contributing to their infants' health and well-being. Simultaneously, programming that integrated culture to promote the health of infants also enhanced access to and the use of services.

Discussion

This study is unique as it describes how mothers' experiences of identifying as Indigenous within health services and the subsequent care, they receive can impact the development of their infants' Indigenous identities, health, and well-being. The results presented here give voice to the experiences of Indigenous mothers through sharing their stories of engaging with both Indigenous-led and mainstream services while supporting the health needs of their infants. Mothers consistently described the positive role of culture in developing their infants' identities and how Indigenous-led programming uniquely supported this development through culturally safe care practices. Noting the complexities of identifying as Indigenous in mainstream health settings, mothers described how self-identifying might result in racist and discriminatory care which contributed to negative health-care experiences. Conversely, culturally safe spaces, such as those commonly provided by Indigenous-led organisations, were necessary for mothers to feel secure in disclosing their own Indigenous identities and those of their infants. The following discussion outlines the importance of supporting the development of infants' Indigenous identities, the unique abilities of Indigenous-led programming in providing this essential support, and the policy implications for the disclosure of Indigenous identity in mainstream health settings.

Developing an Indigenous Identity from Birth

Bendo et al., (2019) advocate for a strong Indigenous identity as central to a child's development of self and happiness and as critical within a society that constantly challenges Indigeneity as inferior. Yet other research has demonstrated that Indigenous identities in Canada have been "constructed, shaped and lived in the politicised context of contemporary colonialism" (Alfred & Corntassel, 2005, p. 597). Consequently, this colonised socio-political environment disrupts the development of Indigenous infants' identities from birth. Mothers in this study related identity

development as a process that begins before birth and remains active as their infants grow and absorb who they are from their environment. Western theories of identity development such as Erikson's Stages of Psychosocial Development (Erikson, 1950) and Phinney's theory of Ethnic Identity Development (Phinney, 1996), describe the process of identity development as occurring during adolescence rather than infancy. Phinney (1996) suggests that young children first integrate an identity that is primarily based on the views of their parents, environment, and/or society and cannot fully embody this identity until they undergo an exploration phase during adolescence or early adulthood. These theories fail to account for the importance Indigenous people place on identity being passed on to infants from family members and ancestors at birth; a thorough exploration of developmental phenomenon from the perspectives of Indigenous people has not yet been addressed.

The development of Indigenous identity from early childhood has been demonstrated in the literature to support the future health and well-being of children as they progress into adulthood. Yet Canada's colonial history is riddled with the attempted destruction of these identities through the removal of Indigenous children from their homes under race-based policies, such as residential schools and the Sixties Scoop, as an attempt to integrate Indigenous children into the dominant society (Wilk et al., 2017). The effects of this trauma on children who were left without cultural practices and family relationships have been associated with psychopathology and negative health outcomes (Bombay et al., 2014). Halseth and Greenwood (2019) argue that identity formation during early childhood is linked to a child's future healthy physical, cognitive, emotional, and social development, and positively associated with improved health literacy, identity formation, self-esteem, and self-worth in later life. As supported by the experiences of mothers expressed in this study, healthy identity development is further promoted when Indigenous cultural supports are available in local communities to build upon the strengths of children in their own environments, thereby increasing confidence, parental nurturing, a sense of belonging, and cultural awareness in early learning experiences (Priest et el., 2012). Research with Māori youth in New Zealand also suggests that supporting and developing a strong identity needs to be initiated in early years to protect children from poor mental health (Williams et al., 2018). Likewise, a strong Indigenous identity has been linked to increased self-esteem, academic success, emotional and psychological well-being, and resiliency in the face of racism and discrimination (Hovey et al., 2014).

Recognising Distinctiveness and Meeting Unique Needs

Mothers in this study described positive early learning experiences when Indigenous staff at Indigenous-led programs integrated distinct cultures into infant programming. Similarly, mothers who were previously disconnected from their home communities emphasised the importance of staff assisting them to reconnect and learn about their culture. A review by Smylie and Smylie & Firestone (2015) found similar findings—effective programming strategies used by Indigenous-led services included community leadership, participation, and the integration of local Indigenous values, beliefs, knowledge, skills, and practices. In contrast, a "pan-Indigenous approach" can lead to diluting distinct Indigenous cultures and conveying a single Indigenous world view and culture (Best Start Resource Centre, 2012). These types of approaches can further contribute to the complexities of developing an Indigenous identity in urban areas where Indigenous people may search for resources to help them connect with their distinct Indigenous communities. Using a pan-Indigenous approach can result in Indigenous mothers and infants learning about a culture that does not align with their own (Best Start Resource Centre, 2012). Local Indigenous services should ensure that clients are aware of which communities inform their traditional programming and cultural practices such that mothers are cognisant that they may participate in activities that are not in keeping with their own (Best Start Resource Centre 2012). Likewise, Indigenous-led organisations, like those highlighted in this study, can adopt practice policies to prioritise identifying the specific cultures of their clients, including assisting those searching for their home communities to rediscover their ancestry, as well as tailoring

programming to address these unique differences.

Creating a Safe Space Promotes Disclosure

Indigenous-led organisations served as key entry points for Indigenous mothers in this study, supporting the development of their infants' Indigenous identities while also gaining access to health promotion services. These organisations promoted accessibility to Indigenous-specific services through providing a safe space where mothers could disclose their Indigenous identities. Indigenous-led programs also appeared to represent an Indigenous community hub in the city with access to diverse Indigenous expertise in Indigenous knowledge and traditions, which further contributed to mothers feeling safe to disclose in these spaces. Indigenous-led organisations were instrumental in assisting the mothers in this study in passing on traditional knowledge and life skills, which help to contribute to their infants' development of identity as well as resilience. Additionally, these organisations were particularly important to the mothers in this study who lived in an urban area where they described otherwise limited access to these types of cultural resources.

Similarly, health providers who emphasised both building trusting relationships along with linking health and well-being with cultural and spiritual practices, contributed to a sense of safety for mothers. This in turn supported the development of their infants' Indigenous identities and promoted a healthy start in life. The availability of culturally safe spaces, however, was key for the mothers in this study to feel secure in disclosing their Indigenous identity to staff and health providers. Both Indigenous-led and mainstream health organisations, therefore, should adopt policies to ensure staff provide culturally safe care and promote safe spaces to enable the sharing of this information that can then benefit clients by augmenting programming and tailoring care to meet the unique needs of Indigenous families.

Although identifying as Indigenous is not a standard intake protocol for most health services in Canada, an individual's personal choice to identify in places where they feel safe and supported can help to establish their sense of self as Indigenous people living in an urban environment (Environics Institute, 2010). Williams-Roberts et al. (2018) suggests greater priority should be given to the development of policies that support Indigenous people in self-identifying in health-care settings. Creating respectful identification pathways while simultaneously communicating how this disclosure can support health providers in linking Indigenous clients with Indigenous-led programming and cultural supports in the community has been shown to be more positively received by Indigenous people (Williams-Roberts et al., 2018). The development of an Indigenous-led framework on which to base these policy changes is an important step towards reconciliation and will help to lay the foundation for a long-term effort to improve the quality of health care and reduce health disparities for Indigenous mothers, infants, and their families.

Strengths & Limitations

This study provides an initial understanding of how Indigenous mothers living in an urban city in Canada promote the development of their infants' Indigenous identities and how they perceive this also relating to their health and well-being. As far as we are aware, this study is the first to discuss the implications of Indigenous-identity development specifically during infancy, and, therefore, the policy implications provided can have a unique impact during this critical period. As the findings reflect a small group of mothers who generally experienced social inequities and the past or present involvement of child protection services, their previous negative experiences may have influenced their perceptions of risk related to identifying as Indigenous and the resulting care they expected to receive. In addition, the experiences of these mothers are not necessarily reflective of mothers living in other areas across Canada, or of Métis and Inuit mothers specifically as they were underrepresented in this group. Furthermore, the process of developing identity spans across a lifetime and while infancy represents an important period of this development when mothers are particularly influential, it reflects only one period of time across the lifespan. Further research to understand the phenomenon of Indigenous identity development during infancy and across the lifespan as it is uniquely experienced by Indigenous children and families

is warranted to better support Indigenous children as they age.

Conclusion

Promoting the development of Indigenous identity during infancy promotes the subsequent health and well-being of children as they age and progress into adulthood. This type of health promotion is one important way that health-care services can support reconciliation efforts (The Truth and Reconciliation Commission of Canada, 2015). One's Indigenous identity has been modified by colonialism, and it is apparent that these aspects continue to influence Indigenous identity today. It is important to consider the cultural, social, and historical contexts of Indigenous peoples when seeking to understand the development of Indigenous identity from infancy to adulthood, as these factors can have significant impacts on this process. Findings suggest that health providers who are aware of the Indigenous identity of mothers and infants can better meet their health needs by integrating culture into services and/or referring families to Indigenous cultural resources in the community. Mothers, however, need to feel safe to disclose their Indigenous identity and that of their infants and feel assured that their disclosure will support their access to services and not result in racist and discriminatory care. In summary, both Indigenous-led and mainstream services can support the development of infants' Indigenous identities while also promoting access to health promotion services through providing culturally safe care.

> Today you are you, that is truer than true. There is no one alive who is youer than you.
>
> Dr Seuss.

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