Submission of the Assembly of First Nations to the Office of the United Nations High Commissioner for Human Rights

Study on Children's Right to Health

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INTRODUCTION

The Assembly of First Nations (AFN) is the national organization for First Nations peoples in Canada. This includes more than 800,000 citizens living in 633 First Nations communities, as well as rural and urban areas. The AFN is an advocacy organization for First Nations and our role is to advance First Nations priorities and objectives as mandated by First Nations and expressed through the Chiefs-in-Assembly. This includes providing an organizing and coordinating role, providing legal and policy analysis, communicating with governments and the general public, facilitating national and regional discussions and facilitating relationship building between the Crown and First Nations.

The AFN is submitting information to the Office of the United Nations High Commissioner for Human Rights (OHCHR) in preparation for a forthcoming report by to the Human Rights Council (March 2013) on children's right to health.

This document is organized with the following sub-sections:

1. HEALTH CHALLENGES FACED BY FIRST NATIONS CHILDREN

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Health Challenges Faced by First Nations Children

The health status gap that exists between First Nations children and their non-Aboriginal peers is well documented in a variety of studies. For example, in 2009, UNICEF released the "Aboriginal Children's Health: Leaving No Child Behind"[1] report which identified First Nations children and youth as faring significantly worse than non-Aboriginal children on a variety of health issues. The following are some statistics from different sources that present the landscape of First Nations children health:

- First Nations mothers and their children experience disproportionately high levels of poverty, household crowding, and multi-generational trauma, compared to mothers in the general Canadian population[2].
- In First Nations, poverty, lower levels of educational completion, household crowding, parent or grandparent Indian Residential School (IRS) attendance, and living in a remote or isolated community were all positively associated with a higher prevalence of maternal smoking. Similarly, maternal smoking during pregnancy was associated with poorer child general health and school failure.[3]
- First Nations communities have not experienced the same increases in breastfeeding initiation (at a rate of 60.2%) that have been documented over the past decade in the general Canadian population (at a rate of 90.3%)[4].
- One-third of First Nations children had been told by a health care professional that they had at least one health condition[5].
- Close to 50% of First Nations children with chronic condition(s) on reserve, have difficulty accessing health services due to lack of availability of services, facility or doctor/nurse within their area[6].
- In regards to mental health, 16.5% of First Nations youth contemplated suicide and 5.9% have attempted suicide[7].
- Lack of access to appropriate resources has made it challenging for First Nations children to have food security. Thus, unbalanced diets and the deterioration of traditional foods have fueled an obesity epidemic, as 62% of First Nations children living on reserve are either overweight or obese. Unhealthy weight is known to be a precursor for type 2 diabetes among children, and other chronic diseases once they reach adulthood[8].
- Another implication of lack of access to a nutritional diet and proper health care services is tooth decay. 91% of First Nations, Inuit and Metis (FN/I/M) children are affected by dental decay with children averaging 7.8 decayed teeth by the age of six[9].

[1] Aboriginal Children's Health: Leaving No Child Behind. UNICEF. 2009

[2] First Nations Regional Longitudinal Health Survey – Phase 2. First Nations Information Governance Centre. 2007/2008

[3] Ibid

[4] Ibid

[5] Ibid

[6] Ibid

[7] Ibid

[8] First Nations Regional Longitudinal Health Survey – Phase 2. First Nations Information Governance Centre. 2007/2008

[9] Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre. "Report: A Sense of Belonging: Supporting Healthy Child Development in Aboriginal Families." 2006. p. 23.

- FN/I/M teen fertility is seven times higher than other Canadian youth, and early parenting compromises access to education, employment, and formal child care[10].
- Infant mortality rates (IMR) among FN/I/M and those living in Canada's northern communities are estimated to be higher than the general population. The infant mortality rate among First Nations people living on reserve is estimated at 7 deaths per 1,000 live births[11] (Canada's general population IMR is 5 deaths per 1000 live births)[12]. First Nations IMR may be an underestimate because of current limitations associated with data coverage and quality related to FN/I/M infant births and deaths in Canada[13].
- Sudden Infant Death Syndrome (SIDS) is the leading cause of death amongst FN/I/M babies in Canada at a rate 2.5 times higher than the national average[14].
- The prevalence of Fetal Alcohol Syndrome Disorder (FASD) in First Nations and Inuit communities may be as high as one in five children[15].
- FN/I/M immunization rates are 20 per cent below the general population, leading to high prevalence rates of preventable diseases[16].
- Rates of tuberculosis in northern FN/I/M communities are four times the national average and the number of infections is increasing. The spread of TB is being exacerbated by poor living conditions, poor nutrition, and poverty[17].
- The unintentional death rate in FN/I/M children and teens is estimated to be three to four times higher on average than the rate for other children in Canada. Higher rates however, are experienced in Manitoba, Saskatchewan and British Columbia with up to death rates 6.5 times higher than the general population, and some specific rates of injury in certain populations are as high as 22 times the Canadian average.[18][19][20]

Barriers in Implementing First Nations Children Right to Health

a) Access to Health Services: Jurisdictional Disputes

Canada has failed to effectively coordinate and monitor federal, provincial and territorial authorities, in the implementation of policies for the promotion and protection of First Nations children. Unfortunately, First Nations children, specifically those with complex needs, have difficulty accessing needed health and social services, due to jurisdictional disputes involving different levels and/or departments within the government. Specifically, Jordan's story represents the challenges that many First Nations children with complex needs encounter when attempting to access health services:

> *Jordan was a First Nations child born with complex medical needs. His family did not have access to the supports needed to care for him at their home on reserve; Jordan remained in hospital for the first two years of his life as his medical condition stabilized. Shortly after Jordan's second birthday, doctors said he could go to a family home. But the federal and provincial governments could not agree upon which department (and which level of government) would pay for Jordan's at-home care. The jurisdictional dispute would last over two years during which time Jordan remained unnecessarily in hospital. Shortly after Jordan's fourth birthday, the jurisdictional dispute was settled. However, Jordan passed away in 2007, before he could live in a family home[21].*

This tragic event inspired the child-first approach, otherwise known as **Jordan's Principle (JP)**. JP is a policy requiring that jurisdictional disputes between two levels of government involving payment for health care services for Status First Nations children, be dealt with after the child receives the care they need. This is a new standard that aims to replace the prevalent cost disputes that have caused harm to so

[10] Aboriginal Children's Health: Leaving No Child Behind. UNICEF. 2009
[11] Indian and Northern Affairs Canada. (2005). *Basic Department Data: 2004.* First Nations and Northern Statistics Sections.
[12] Statistics Canada. (2012). *Infant mortality rates, by province and territory.* Retrieved from http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health21a-eng.htm
[13] Smylie, J. & Anderson, M. (2006). Understanding the health of Indigenous peoples in Canada: key methodological and conceptual challenges. *Canadian Medical Association Journal*, 175(6), 602-605.
[14] Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre. "Report: A Sense of Belonging: Supporting Healthy Child Development in Aboriginal Families." 2006. p. 23. .
[15] Health Canada (2012). *Fetal Alcohol Syndrome.* Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/famil/preg-gros/intro-eng.php
[16] Aboriginal Children's Health: Leaving No Child Behind. UNICEF. 2009
[17] Leitch, K.K. (2007). Reaching for the Top: A Report by the Advisor on Healthy Children and Youth. Health Canada. Ottawa: Minister of Public Works and Government Services Canada.
[18] Health Canada, First Nations and Inuit Health Branch, 2001. Unintentional and intentional injury profile for Aboriginal people in Canada 1990-1999. www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_injury-bless/2001_trauma/index-eng.php
[19] Harrop, R., Brant, F., Ghali, A., & Macarthur, C. (2007). Injury mortality rates in Native and non-Native children: A population-based study. Public Health Rep;122(3):339-46.
[20] Canadian Red Cross Society, Canadian Surveillance System for Water-related Fatalities, 1998. An analysis of drownings and other water-related injury fatalities in Canada for 1996.
[21] Jordan's Principle. First Nations Family Caring Society. 2007. http://www.fncfcs.com/jordans-principle

many First Nations children, like Jordan, when seeking needed health services that would be undisputedly available to any other non-First Nations child.

Regrettably, the intended spirit and adequate implementation of JP has faced a variety of challenges, including Canada's adoption of a startlingly narrow definition of JP, which continues to fail First Nations children[22]. The current definition of the policy limits the application of JP to Status First Nations children who reside on-reserve, have multiple special needs diagnosed by medical professionals, and require the services of multiple health providers. While this policy attempts to address the prevalent vacuum of care for First Nations children, various critical concerns remain. It is not clear whether Canada's narrow interpretation and application of JP will allow children to obtain a proper initial diagnosis, whether children with only one complex need will be able to access care, or whether children residing off-reserve with acute complex needs will be able to access care. Finally, the discriminatory principle of limiting access to needed health services based on a set of conditions that other Canadian children are not required to fulfill in order to access care, will be addressed. Consequently, families are many times left with the predicament of considering placing their children into the welfare system in order to access services[23] - a quandary not faced nor fathomed by non-First Nations families. To ensure the removal of prevalent discrimination against First Nations children in accessing health care, Canada must address these issues and adopt a definition and application of JP that will ensure that same standard of care for all Canadian children, regardless of residency.

Considering Canada's actions regarding JP, and considering Canada's awareness of First Nations poor health status (significantly below the national average), it is arguable that Canada is in violation of article 24 of the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities (Articles 2; 3(b), (e), (f), (h); 4(1c), (2), (3), (5); 5; 7; 9; 10; 19; 20; 23 (3-5); 25 and 26) as well as articles 2, 18, 19, 21, 22 and 24 of the United Nations *Declaration on the Rights of Indigenous Peoples*. Such violation is a result of the discrimination that First Nations children face based solely on the basis of being First Nations.

b) Inferior Social Determinants of Health and Poor Government Investment

Unfortunately, as a result of colonization, First Nations peoples have a long history of compromised social determinants of health which continues to negatively affect today's children, youth and their families. First Nations children inherit a colonial legacy that continues to impact their health through social conditions, such as the loss of culture, changes to diet and nutritional patterns, and living conditions[24]. This deplorable history, combined with apathy in action to meaningfully invest in First Nations wellbeing has resulted in health inequity that has become the norm for First Nations children and youth.[25]

The statistics above provide evidence that the government of Canada's investment in the health of First Nations children has been insufficient to protect their rights. Specifically, in the budget released by the Canadian government in the present year, organizations that work to ensure that proper and effective policies and programs are in place, have faced major cuts including: the Native Women's Association of Canada (NWAC), National Centre for First Nations Governance (NCFNG), Aboriginal Healing Foundation (AHF), First Nations Statistical Institute (FNSI), National Aboriginal Health Organization (NAHO), Inuit Tapiriit Kanatami (ITK) and the Assembly of First Nations among others.

Similarly, there are other areas that affect First Nations children health in which they are receiving significantly inferior funding than their non-First Nations peers. For example, funding for the First Nation and Inuit Child Care Initiative (FNICCI) has not been increased in the last 14 years and is based on outdated statistics from 1996 which do not reflect current needs[26]. Funding for on-reserve First Nations children is capped at $6000.00 per child, while Manitoba provides for children off-reserve at a base amount of $15,376 per child[27].

Another example of limited funding and lack of coordinated continuum occurs in mental health initiatives. Health Canada's funding over the past several years has largely focused on specific mental health and addictions issues (i.e. youth suicide prevention, addictions treatment, IRS supports). Federal mental health services focus upstream on general prevention and promotion activities targeting the community; downstream on crisis response, primary prevention and issues specific programming, but lack services that cover a full continuum of care. Often times programs are funded based on a single fiscal year and do not allow communities the flexibility needed to respond to emerging issues.

Best Practices

[22] *Pictou Landing Band Council and Beadle v. Canada (2011)*

[23] Lavallee, T. (2005). Honouring Jordan: Putting First Nations children first and funding fights second. 10 Paediatrics and Child Health 527 at 527–529.

[24] Greenwood, M. (2005). *Children as citizens of First Nations: Linking Indigenous health to early childhood development*. Paediatric Child Health **10**(9): 553-555.

[25] Assembly of First Nations. (2007). *First Nations Wholistic Policy and Planning Model: Discussion Paper for the World Health Organization Commission on Social Determinants of Health*. Ottawa, ON: Assembly of First Nations.

[26] Assembly of First Nations. (2010). Resolution 21- Call for Increase in Day Care Funding. *Annual General Assembly.* Winnipeg, MB.

[27] Ibid

a) Aboriginal Head Start on Reserve (AHSOR) Program

The AHSOR funds activities that support early intervention strategies to address the learning and developmental needs of young children living in First Nations communities. AHSOR is centered around six components: education; health promotion; culture and language; nutrition; social support; and parental/family involvement. It also helps parents and other caregivers learn and improve skills that contribute to healthy child development. It also works with families to help strengthen family relationships.

Health Canada conducted a Cluster Evaluation[28],[29] of Children and Youth programs in 2009 (Funding Years 2005-06 to 2007-08). AHSOR was found to effectively address those identified community health needs of young First Nations children and their families. For example, AHSOR has contributed to increased Indigenous language revitalization as reported by the First Nations Regional Longitudinal Health Survey (RHS). RHS 2002/03 reported that 19.3% of children age 3-11 years old could speak one or more First Nations languages; RHS Phase 2 – 2008/10 Preliminary Results[30] note this same age group increased to 22.4% - a modest but critical growth of 3.1%.

In addition, Dr. K. Kellie Leitch, former federal government's Advisor on Healthy Children and Youth, acknowledged in her report "Reach for the Top" (2007) that "Aboriginal Head Start is an excellent example of a program that is having a meaningful impact on early childhood development". She further highlights its positive impact in management of chronic disease, promotion of healthy lifestyles and reduction of injury prevention for First Nations and Inuit children and youth.

Unfortunately, due to funding constraints, this program reaches approximately only half of the First Nations communities in Canada, and does not provide enough 'centre-based' programs.

b) Maternal Child Health (MCH) Program

Pregnancy and childbirth were traditionally monumental moments in the lives of First Nations families and communities which were honoured and respected. One of the "most profound changes in the childbirth process during the 20th century was to isolate labouring women from her social supportive network"[31]. For First Nations families, this impact has been amplified, especially in remote regions where women are required to leave their home communities to give birth[32]. Increased efforts are required to allow First Nations women to once again experience birthing closer to home.

The MCH program included in upstream investments, was announced at a September 13, 2004 Special Meeting of First Ministers and national Aboriginal leaders. Specifically, the goal of the MCH program is to support pregnant First Nations women and families with infants and young children, who live on reserve, to reach their fullest developmental and lifetime potential. Program clients include: all pregnant women and new parents, with long term support for those families who require additional services[33].

The MCH program builds on other community programs which are important to pregnant women and families with infants and young children such as the Canada Prenatal Nutrition Program (CPNP), the FASD program, Nursing Services, Oral Health, and the AHSOR program. Specifically, this program includes home visiting by Nurses and Family Visitors (experienced mothers in the community) as well as coordinating access to services for children with special needs. It supports information and linkages to other services for pregnant women and families with infants and young children allowing them to care for themselves.

Home visiting by nurses and family visitors, has been linked with improved parenting skills and quality of home environment, improved cognitive development of infants and young children, and the decreased incidence of unintentional injury. These visits have also improved detection and management of postpartum depression, improved rates of breast-feeding, and enhanced quality of social supports to mothers[34].

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[28] Health Canada. (March 31, 2010). *Children and Youth Programs: Cluster Evaluation.* Finance, Evaluation and Accountability (SMB-FEA).

[29] FNIHB's CY Evaluation Framework (2008) states that the scope of the cluster evaluation is: (i) to capture commonalities among programs; and, (ii) to enable reporting of high level results. **7** The Framework also states that this evaluation *is not* intended to evaluate or measure the results of the four individual programs in the CY cluster, but rather to examine the contribution of the services and supports as a group (p.2).

[30] First Nations Regional Longitudinal Health Survey. RHS Phase 2 (2008/10) Preliminary Results, p. 90. www.fnigc.ca

[31] Maimbolwa, M. C. (2004). Maternity Care in Zambia with special reference to social support. Stockholm, Sweden: Karolinska Institute

[32] National Aboriginal Health Organization. 2008. Celebrating Birth - Exploring the Role of Social Support in Labour and Delivery for First Nations Women and Families. Ottawa: National Aboriginal Health Organization.

[33] Health Canada. (2008). First Nations and Inuit Health- Funded Health Programs and Services. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/finance/agree-accord/prog/index-eng.php

[34] AFN. (2010). Maternal Child Health- Frequently Asked Questions. Retrieved from http://64.26.129.156/article.asp?id=2270

Interventions like MCH, that focus on improved reproductive health, prenatal and postpartum services, and early childhood development, present an opportunity to break the cycle of persistent gaps in life chances between Aboriginal and non-Aboriginal children. These kinds of approaches are referred to as making strategic 'upstream' investments early in a child's life[35].

c) Tripartite First Nations Health Plan: British Columbia- A Promising Development

British Columbia is responsible for the provision of health services to all citizens of the province through its regional health authorities. Health Canada supports First Nations through a range of public health programs and benefits intended to improve population health and ensure effective access to the health care system[36]. On November 27, 2006, the British Columbia (B.C) First Nations Leadership Council (FNLC) and the Province of British Columbia negotiated the ten-year Transformative Change Accord: First Nations Health Plan (TCA:FNHP), which identifies twenty-nine actions intended to close the gaps in health status between First Nations people and other British Columbians. As a result, the Framework Agreement was established between the federal government, the Province of British Columbia and B.C. First Nations, when all parties signed the "First Nations Health Plan: Memorandum of Understanding".

The purpose of the Framework Agreement is to support better health for B.C. First Nations through a new governance structure and a new relationship among the three parties. The new governance structure includes[37]:

- First Nations Health Authority, to take on responsibility for the planning, management, delivery and funding of health programs presently provided for First Nations in B.C. through Health Canada.
- Tripartite Committee on First Nations Health, to coordinate and align planning and service delivery between the First Nations Health Authority, the B.C. health authorities, and the B.C. Ministry of Health.
- First Nations Health Directors Association, to represent health directors and managers working in B.C. First Nations communities and to be an advisory body in research, policy and program planning.
- First Nations Health Council, to support health priorities and objectives of B.C. First Nations and provide leadership for implementation of tripartite commitments.

The TCA: FNHP identifies some specific projects and activities intended to close jurisdictional and health gaps and optimize funding opportunities for innovations that will make a greater difference in First Nations communities. A multi-jurisdictional health planning framework is in progress to provide service delivery linkages between goals and activities described in First Nations' community health plans with those of regional health authority service plans. Service delivery planning is scheduled to commence on July 1st, 2013[38].

Given that First Nations governance and control are key components to this Framework Agreement, the TCA: FNHP is expected to be a promising practice to spearhead similar strategies to close the health inequity gap that First Nations children face in comparison to their non-Aboriginal peers across Canada.

[35] Ibid

[36] The First Nations Leadership Council, First Nations Summit, Union of British Columbia Indian Chiefs, Government of Canada & Government of British Columbia (2010). Tripartite First Nations Health Plan. Retrieved from http://fnbc.info/sites/default/files/documents/tripartite_plan.pdf

[37] Health Canada. (2011). B.C Tripartite Framework Agreement on First Nation Health Governance. Retrieved from http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2011/2011-133bk-eng.php

[38] The First Nations Leadership Council, First Nations Summit, Union of British Columbia Indian Chiefs, Government of Canada & Government of British Columbia (2010). Tripartite First Nations Health Plan. Retrieved from http://fnbc.info/sites/default/files/documents/tripartite_plan.pdf