

# Insights from a Jordan's Principle Child First Initiative in Alberta: Implications for Advancing Health Equity for First Nations Children

Alison J. Gerlach, University of Victoria  
Meghan Sangster, McGill University  
Vandna Sinha, University of Colorado, Boulder  
First Nations Health Consortium

In 2016, Canada was ordered to implement Jordan's Principle by the Canadian Human Rights Tribunal. In response to the order, Canada created the Child First Initiative to provide federal funding for provincial and territorial organizations supporting First Nations children's health, education, and social service needs, including service coordination. In the shifting national landscape of Child First Initiative funding, there is a lack of evidence on how pediatric healthcare services are addressing the serious health and healthcare inequities experienced by many First Nations children. This paper describes the implementation of a Child First Initiative by the First Nations Health Consortium in the Alberta region and research findings that provide insights into the complexity and challenges of advancing First Nations children's health and health equity within the current federal Child First Initiative mandate in this province. This paper highlights the need for transformative pediatric healthcare approaches that expand beyond an individual and demand-driven system and orient towards practices and policies that are socially-responsive. Also, this paper highlights that First Nations leaders and Jordan's Principle initiatives play a leading role in the design and delivery of all pediatric healthcare services with First Nations communities, families, and children across Canada.

**Keywords:** *Indigenous, First Nations Health Consortium, pediatric healthcare, early intervention, substantive equality, social determinants, structural inequities*

## Glossary

**AW:** Access Worker  
**CFI:** Child First Initiative  
**ESC:** Enhanced service coordination  
**FNHC:** First Nations Health Consortium  
**RSC:** Regional Service Coordinator

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## Introduction

Jordan's Principle is a legal requirement that Canada ensures all First Nations children have access to education, social, health services, supports, and products without denials, delays or disruptions (First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada, 2016). Jordan's Principle is named in honor of Jordan River Anderson, a little boy from Norway House Cree Nation in Manitoba who was born with a rare genetic disorder that required specialized care from birth. Jordan was denied the basic health supports necessary to leave the hospital and return home due to lengthy jurisdictional funding disputes between provincial and federal governments. Jordan spent his life in hospital until he passed away in 2005 at the age of five (First Nations Child & Family Caring Society, 2020). Jordan's Principle was created and championed by First Nations organizations and advocates. In 2007 Jordan's Principle was introduced as a motion in the House of Commons where it received unanimous support. However, meaningful steps towards the implementation of Jordan's Principle did not occur until a landmark 2016 ruling by the Canadian Human Rights Tribunal (CHRT) which ordered the federal government of Canada to immediately implement the full meaning and scope of Jordan's Principle (Caring Society v. Canada, 2016).

Following the CHRT ruling the federal government initiated a Jordan's Principle Child First Initiative (CFI) to provide federal funding for organizations supporting First Nations children's health, education, and social service needs. The CFI included funds for Enhanced Service Coordination (ESC) initiatives that were intended to help maximize First Nations children's access to existing health, social, and educational services. The CFI also

included funds for requests for individual children and group requests to address service gaps affecting large numbers of children. These funds were originally approved for three years and have recently been renewed for an additional three years (Sangster et al., 2019). In January 2017, a newly-formed First Nations Health Consortium (FNHC) in Alberta received CFI funding for all First Nations children living on- and off-reserve and initiated a research partnership with the Children's Services Policy Research Group at McGill University in order to document the organizational development of their ESC model.

This paper focuses on the implementation of a CFI initiative to implement Jordan's Principle and advance First Nations children's health and healthcare equity. The paper highlights the FNHC in the Alberta region as an exemplar of an ESC model and research findings that provide insights into the complexity and challenges of advancing First Nations children's health and health equity within the current federal CFI mandate. This paper also explores the implications of these findings for informing the transformation of pediatric healthcare services and systems in partnership with Jordan's Principle initiatives in Canada.

This paper uses the concept of health equity as meaning that "all people (individuals, groups, and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic, and environmental conditions" (National Collaborating Centre for Determinants of Health, 2015, p. 2). In Canada, health equity is enshrined in Canadian public health practices and policies (Pauly et al., 2013; Public Health Agency of Canada, 2014). Orienting pediatric healthcare towards equity in Canada and similar wealthy countries is starting to

emerge in response to concerns about widening social inequalities (Gerlach & Varcoe, 2020; Wood & Goldhagen, 2013), and increasing scientific evidence on the impacts of early childhood adversity on health and wellbeing across the life course (Boyce & Hertzman, 2018; Goldblatt et al., 2015). While the concept of health equity is used in public health discourses, policy discussions and legal rulings around services for First Nations children in Canada are increasingly using the term ‘substantive equality’ (Caring Society v. Canada, 2016). Despite being two distinct discourses, a primary indicator and intent of both of these concepts is equitable outcomes. Equitable outcomes cannot be measured in a single fiscal year as achieving equitable outcomes often requires examining and interrupting routine approaches and restructuring deeply rooted systems and practices so that they are inclusive of and responsive to individuals, groups, and communities’ social contexts and circumstances (Browne et al., 2018; Goldblatt et al., 2015). For example, the funding, organization and delivery of pediatric healthcare for a family and child living in a northern rural community may need to be very different from those provided in an urban centre.

### **The Structurally Determined Nature of First Nations Children’s Health**

First Nations children’s health is inextricably tied to past and present colonial violence. From the late 19th century until today, despite continued resistance from their families and communities, many First Nations children have been removed from their homes through state-sanctioned legislation and policies in the form of residential schools, the Sixties scoop, and the contemporary child welfare system (McKenzie et al., 2016; Truth and Reconciliation Commission of Canada, 2015). A legacy of this state-sanctioned

violence is that First Nations families can delay accessing child-related services because of deep-seated fears that it will result in their children being removed from their care (Gerlach, et al., 2017). Colonial violence and historically-rooted structural inequities continue to directly contribute towards First Nations children experiencing a greater risk of poor health outcomes compared to non-Indigenous children in Canada (Allan & Smylie, 2015; Greenwood & de Leeuw, 2012; Smylie et al., 2010). This structurally-rooted vulnerability is manifested in many First Nations children lacking access to basic determinants of health including family income, parental education and employment, safe drinking water, food security and safe housing (Smylie & Adomako, 2009). Importantly, health inequities are potentially avoidable or remediable (Marmot, 2007). However, in the Canadian context instead of creating policies that aim to remediate structural inequities, the federal government continues to enact policies that underfund or rely on short-term funding for needed services, while actively resisting legal requirements that would support improved outcomes for First Nations children (Sinha et al., 2018; The Canadian Bar Association, 2019).

### **An Enhanced Service Coordination Model for First Nations Children in Alberta**

In Alberta, there are an estimated 137,000 First Nations Peoples, with a young, fast growing population (Statistics Canada, 2017). There are 46 First Nations, encompassing 140 communities of varied sizes with distinct cultural traditions. The languages currently spoken include Blackfoot, Cree, Chipewyan, Dene, Sarcee, and Stoney (Indigenous and Northern Affairs Canada, 2010). Recognizing the enormous diversity within and between First Nations in the Alberta region, the FNHC

was formed with the goal of serving all First Nations families and children across this province. The FNHC is a collaboration between Bigstone Health Commission, Kee Tas Kee Now Health Commission, Maskwacis Health Services, and Siksika Health Services which are located in Treaty 6, 7, and 8.

In 2017, the FNHC initiated an ESC model based on their mandate to fulfill First Nations children's 'inherent rights to holistic services and supports' by connecting families and children to health, social, education services, supports, and products (First Nations Health Consortium, 2020). This ESC model operates within shifting federal and legal directives surrounding the eligibility, provision, and administration of Jordan's Principle, and with no clear directives on the long-term funding or implementation of Jordan's Principle, or the gap this funding is intended to fill (Sangster et al., 2019). The federal government's 'Standard Operating Procedures' for Jordan's Principle specifies that Jordan's Principle requires case reviewers to consider requests on a case-by-case basis, focusing on how the request will address the immediate need of the child, rather than long-term systemic change (Indigenous Services Canada, 2019). Group requests do provide a means for extending beyond a case-by-case approach. However, there is currently insufficient information or guidance around group requests for this to serve as a mechanism for systemic change (Sinha et al., 2018).

The ESC model developed by the FNHC is typically accessed by families or service providers initiating contact with a Jordan's Principle Access Worker (AW) through a 1-800 number, who then conducts an initial interview in order to determine if a child's needs can be met by referrals to pre-existing services. When services are unavailable, a case file is opened, and the

AW connects the family and/or service provider(s) with a FNHC Regional Service Coordinator (RSC). RSCs gather the necessary and often extensive documentation for a Jordan's Principle request, which is then submitted to the Alberta based federal government focal point workers who determine whether the request is approved, denied, or forwarded to a national office in Ottawa for further review and outcome determination (Sangster et al., 2019). From Fall 2017 to Spring 2019, 739 First Nations children accessed the ESC, 57% of whom were children living on-reserve. During this time period, the FNHC opened cases for approximately 1 in every 85 First Nations children in the Alberta region. The FNHC also supported 21 Jordan's Principle group requests from organizations and First Nations across this region who successfully identified a gap in services for a group of children. Examples of approved group requests include early intervention therapy programs, diabetes care, and psychosocial assessments (Sangster et al., 2019).

### **Methods**

This research was initiated by the FNHC. Informed by a participatory research approach, the research team co-developed the study objectives, design, methods of data collection, and knowledge translation activities with the leadership and staff of the FNHC and their invited advisors from October 2017 to April 2019. A research agreement between the FNHC and the Children's Services Policy Research Group at McGill University was grounded in a framework based on OCAP® (ownership, control, access, and possession) principles (First Nations Information Governance Centre, 2007). Ethics was approved by McGill University. For a detailed summary of the methods see Sangster et al., 2019.

The findings in this paper are based on data generated through: (1) participant observation of weekly staff meetings, staff retreats and visioning sessions, and monthly meetings between the FNHC staff and federal government focal point workers, and (2) in-depth, semi-structured individual interviews with the FNHC Board (n=5) and staff (n=13) members following informed, written consent. During the study, the researchers had no access to identifying information about the children or families accessing ESC. All data were transcribed, coded, and analyzed by members of the research team and verified through an iterative member checking process with the FNHC staff and Board members over several months. Analysis was further informed by the literature and publicly available government and legal documents related to Jordan's Principle, First Nations of Alberta, and the Alberta health, education, and social service systems. The full findings from the study are summarized in a formative evaluation report (Sangster et al., 2019).

### Results

In this paper, the findings centre on data generated from interviews with FNHC staff and Board members, and two 'family stories' that were compiled from interviews and discussions with FNHC staff and researchers' fieldnotes. There are two inter-related themes that are pertinent to advancing health equity: (1) 'It's complex – it's the needs of the entire family' and (2) 'We have to find a better way'.

#### **'It's Complex - It's the Needs of the Entire Family'**

In their interviews, FNHC staff (RSCs and AWs) frequently talked about the time it took to fully understand the circumstances of a family's life, including their family history, geographical location,

housing situation, community infrastructure, and other factors impacting their child's unmet health, social, or educational needs. In connecting with families through the early intake and long-term case management process, staff described a relational and often emotional process that focused on developing trust with families who had been unable to access services for their children. As one RSC reflected:

*This [case] was complex because it was also emotional. You know, the mom cried, I cried. You know you're dealing with people's lives, and little children, and I'm a mom myself.... It wasn't just a medication - it was medical supplies, it was medical equipment, it was renovation of a house, it was a lack of transportation, it was the medical needs of the entire family.*

Staff described a process of 'walking with' families in gathering extensive amounts of information and documentation that were required to advance children's access to health-related supports, services, or products.

The following family story illustrates the complex nature of this work. Through her conversations with local public service providers, a RSC at the FNHC became aware of a family whose living situation was severely compromising their ability to continue caring for their child at home. The family consisted of two grandparents, a mother who used a wheelchair, and her three children. One of the children required a wheelchair and a feeding tube as a result of complications from a surgery when she was much younger. Following this surgery, the grandparents had been told that they would be unable to bring the child home because they did not have the supports necessary to meet her needs. Rejecting this, the grandparents sought the

training needed to care for their granddaughter while they were residing in the city where the surgery took place. After about a month, the family returned home.

The family home was approximately 900 square feet with poor ventilation, mold, and one wheelchair accessible exit. In an emergency, the mother and daughter would not be able to get out at the same time. The living room had sunken floors, making much of the house inaccessible to the mother and daughter in their wheelchairs. The isolated location of the home made it difficult for the family to arrange for purified water delivery, which they needed to clean the daughter's feeding tubes. Minor renovations on the house were supported by the family's Band, which had a housing budget of \$80,000 for the entire community. These renovations were not enough to adapt the home to the family's needs.

The RSC joined with local service providers to advocate for a safe and wheelchair-accessible home for this family. At that time, the RSC was informed that because the CFI federal funding was due to end in March 2019, there was no funding available for services, renovations, or equipment beyond this date. Thus, funding could only be provided if a new home was built in less than a year. With this tight timeline in mind, the RSC gathered the documents required for the application to the focal point in Alberta for Indigenous Services Canada. The family's pediatrician wrote a letter explaining the granddaughter's health issues. The Chief wrote two letters: one confirming that land was available to the family for a new house and another detailing the community's insufficient housing budget. An occupational therapist met with contractors and reviewed plans for wheelchair accessibility. In addition, the RSC met with an environmentalist to inspect the home for mold and document the findings in a letter. The RSC also worked

with the Band administrator to gather three quotes to build a new home or purchase a prefabricated home that could be moved to the site.

This RSC submitted an initial request for house modifications for this family in March 2018 and communicated regularly with the focal point regarding the required documentation. In June 2018, the Alberta focal point informally confirmed that the federal government would fund major renovations to the family's existing home to make it wheelchair accessible but would not fund the building of a new home under Jordan's Principle. After a series of partial approvals, the necessary major renovations were denied. In December 2018, the FNHC filed an appeal on behalf of the family. In January 2019, the appeal was approved and renovations to the home finally began.

The findings in this theme highlight the extent of intersectoral coordination and collaboration between multiple health and social service stakeholders, including federal focal point workers, to advance a child's health and quality of life within families and communities that are impacted by discriminatory chronic federal underfunding. The social and often complex nature of 'needs' identified and addressed by the FNHC is also highlighted by the organization's statistics. Over an 18-month period from, October 2017 to April 2019, there were 447 requests categorized as 'outside of health' including 121 related to education, 78 for food and/or income, and multiple categories including transportation, housing and infrastructure, status or treaty, respite and social supports, and cultural supports and services. Of the families requesting services 558 had one need, 121 had two needs, 46 had three needs, and 14 families had four or more needs. During this same time period, the FNHC identified 551 requests for health needs including 169 for dental care, 107 for glasses and/or vision

needs, 62 for medication needs, and many others including but not limited to mental health, medical equipment and occupational therapy (Sangster et al., 2019).

### **‘We Have to Find a Better Way’**

The FNHC staff and Board members described how the current federal directive for Jordan’s Principle requests was predominately based on the premise that individual parents/caregivers or service providers will identify what service a child needs. Staff noted that caregivers were often hesitant to initiate a request due to their prior experiences of discriminatory or ineffective professional intervention, fears of racism or dismissal, and conflicting opinions within families about whether to ask for help. Moreover, some staff voiced their frustration about the individualistic framework established by the federal government, while broader systemic concerns were left unaddressed. This tension is reflected in the following family story.

The FNHC received a call from a social worker at the Stollery Children’s Hospital in Edmonton requesting service coordination for a family. The mother, accompanied by her own mother, had travelled from their home community to Edmonton with her severely malnourished infant. The family lived in an isolated northern community only accessible by plane or by ice road. Children under the age of two made up 10% of the community’s population. However, as in many northern communities, the cost of food created a significant burden for families. For example, in the spring 2018 a gallon of milk cost \$70. The price of baby formula was also exorbitant. Furthermore, a permanent boil water advisory made it difficult for parents to prepare powdered formula, which was the only formula officially approved through NIHB. Despite widespread and sometimes permanent boil water advisories in First Nations

communities throughout Alberta, NIHB did not cover bottled water. In the hospital, a social worker informed the Jordan’s Principle AW that the baby would be discharged in a few days, and would require liquid formula when returning home. Two days before the baby was to be discharged home, the Jordan’s Principle AW started gathering information about the family. She learned that the grandmother’s first language was Cree and that the hospital lacked a Cree translator, which created a barrier when communicating with hospital staff. The Jordan’s Principle AW then phoned a nurse in the family’s home community to gather information about the process of shipping supplies North. She was told that doctors completing rotations in the community often brought medications and prescriptions, but that access to these resources was weather-dependent, with up to three weeks between shipments.

After gathering this information, the AW started the process of securing liquid formula for the family. She asked the hospital nurse to have the attending doctor write a prescription for the liquid formula and take it to the pharmacy immediately. The pharmacy tried to charge NIHB for the prescription but received an immediate denial. The doctor completed a form explaining why the medical team requested a formula prescription and faxed this documentation to NIHB. At this point, the Jordan’s Principle AW was advised it could take 24 to 48 hours for an answer from NIHB; time the family did not have, because the baby was soon to be discharged. The AW anticipated, based on past experience, that the liquid formula prescription would be denied by NIHB. She developed a contingency plan with the focal point - if the family did not receive NIHB approval by Friday, they would apply to fund the formula under Jordan’s Principle. The family received a second denial for liquid

formula coverage from NIHB, after which the focal point approved funding.

In the interim, the doctors decided to keep the child in hospital over the weekend. During this observation period, doctors prescribed a different liquid formula in order to better meet the child's medical and developmental needs. The AW was told by a focal point that this change in prescription meant she had to again complete the process of documentation gathering and NIHB denial. The secondary submission process required taking the new prescription to the pharmacy and getting another immediate denial from NIHB, after which the doctor wrote another letter to explain why the prescription was changed. This was followed by a fourth submission to NIHB, which received another denial. At this point, the AW submitted a second Jordan's Principle application, which was deemed complete by the focal point.

The mother, baby, and grandmother returned home with a prescription for a year's worth of liquid formula. The family later contacted the AW to confirm the compensation process for purchase of additional formula. The AW contacted the focal point and learned that, after four NIHB denials and two Jordan's Principle applications, NIHB had agreed to fund the medically necessary liquid formula for the family. The community and AW were concerned by the family's experience and submitted a successful group request so that all parents in the community could have access to liquid formula for their infants under the age of two. According to the RSC, this cost more than \$700,000. The entire group application process took about 2½ months. The community continues to have no access to safe drinking water. This family story highlights the increased vulnerability of First Nations infants for health inequities as a result of a lack of access to a basic determinant of health – safe

drinking water. As of February 2020, there are 60 long-term drinking water advisories in First Nations across Canada (Government of Canada, 2020). Efforts towards adequate funding, infrastructure and human resources to resolve drinking water advisories remain inadequate despite significant commitments from provincial and federal governments (Lukawiecki, 2018).

Several FNHC Board members also expressed concerns about a system based primarily on responding to individual children's needs, including the following in relation to speech therapy:

*A major issue is the lack of speech language therapy. So, we have to change [the] regulation so speech language therapy is an automatic approval process. Then you don't have to go through a Jordan's Principle system. We used to have allied health services as part of NIHB that include occupational therapy, physio, speech language therapy and chiropractic. We have to be able to, through our data, we have to tell people... that there is a better way of delivering services.*

The findings in this second theme highlight the challenges and limitations of a predominately individual identification and request driven system that operates within the status quo of underlying structural inequities and a fragmented pediatric healthcare system.

### **Limitations**

A limitation of this study is that it did not include interviews with First Nations families, children, or youth or First Nations community-based healthcare providers or Elders. Their experiences and perspectives would have further enhanced our understanding of the lived realities of

navigating Jordan's Principle and the ESC model delivered by the FNHC in Alberta.

### **Discussion**

Currently there is a lack of evidence on how pediatric healthcare systems, organizations and professionals are addressing the serious health and healthcare inequities experienced by many First Nations children in the midst of shifting federal responses to the CHRT rulings on Jordan's Principle (Assembly of First Nations, 2018; Sinha & Wong, 2015). In the following section, we explore how the findings in this paper can inform greater dialogue on transforming pediatric healthcare in partnership with Jordan's Principle initiatives in Canada.

### **Expanding Beyond Individual and Demand-Driven Systems**

The findings in this paper provide insights into an individualistic and demand-driven system for Jordan's Principle funding in the Alberta region. This system requires that caregivers or professionals in a child's life can identify an unmet need and recognize which specialized supports, services, or products exist to resolve the unmet need. This responsibility is compounded by unclear and shifting federal procedures for the approval of services that exceed normative provincial standards in order to advance equitable health outcomes for First Nations children. For example, the current federal guidelines for assessing whether a Jordan's Principle funding request is approved for a pediatric healthcare service rely heavily on the capacity of caregivers and FNHC staff to describe the social disadvantages that are impacting a child's health. A reliance on individual caregivers or service providers making a request and being approved for Jordan's Principle funding risks that an unknown number of First Nations children continue to

experience unmet needs (Sangster et al., 2019). The lack of systemic federal and provincial reform of funding for, and provision of pediatric healthcare services for First Nations children, and the federal government's failure to address the deficits in on-reserve resources and services, severely limits the capacity of the current CFI funding to ensure that all First Nations children can achieve health outcomes equitable to other children in Canada.

Thus, pediatric healthcare providers working with First Nations can find themselves in a landscape that continues to be characterized by fragmented healthcare funding, inadequate responses, and individual remedies. This landscape aligns with the constant pull of healthcare funding and delivery towards neoliberal and biomedical individualism that often fails to attend to how broader social and structural factors can profoundly shape children's health, development and life trajectory (Gerlach, Teachman, et al., 2017). This approach to children's health is in sharp contrast to the work of the FNHC frontline staff as described in this paper. A common thread in this work is the frequency with which staff are having to respond to, and navigate through colonial structural inequities that result in communities and/or families' lacking access to basic determinants of health such as safe drinking water and housing (Vives & Sinha, 2019; Woodgate, 2013).

### **Orienting towards Socially-Responsive Pediatric Healthcare**

The findings in this paper point to the importance of broadening the scope of pediatric healthcare beyond a focus on an individual child's health and development to services and practices that are socially-inclusive and responsive. This transformation requires a shift in focus towards building authentic relationships

with each First Nation community and family in order to learn *from* them about their everyday lives, social circumstances, resources and priorities. Allocating the time to build genuine relationships is central to avoiding the imposition of interventions and approaches that are informed by non-First Nations' perspectives and settings. This relational approach also broadens the scope of routine practices to be inclusive of, responsive to, and directed by communities and families' realities and self-identified priorities surrounding their children's health and wellbeing (Gerlach et al., 2018; Gerlach & Elliott, 2017). Unfortunately, at an organizational and system level, the reductionist tendencies of how pediatric healthcare services are structured and evaluated means that spending time building relationships to learn from a community or family about their social history, resources and circumstances are not typically prioritized or legitimized. Doing this form of relational work can also be compromised by the short-term or limited nature of current Jordan's Principle funding that does not allow healthcare professionals the time to work with communities and families in a trusted and meaningful way.

Healthcare professionals who are collaborating with First Nations on the implementation of Jordan's Principle may also experience uncertainty or moral distress as they question their agency and responsibility in orienting their care to be socially-inclusive and responsive. Central to this approach is the expectation that healthcare providers engage in a process of ongoing reflexivity and dialogue with First Nations community members and leaders (Canadian Pediatric Society, 2016; Sinha & Wong, 2015). This process can include questioning - *'What am I/we doing to build authentic relationships?'* *'Is my/our service relevant and useful?'* *'How have I/we sought to understand the social and historical*

*context of this community or family?'* *'How have I/we created space and mechanisms for engaging with community members and First Nations colleagues so that they can direct the work I am/we are doing?'*

Ultimately, orienting towards socially-responsive pediatric healthcare requires a fundamental structural change, in which First Nations lead, design, and deliver services. In this context, respectful, responsive and effective programs and services are predicated on close and equitable relationships between pediatric organizations and First Nations organizations in order to ensure that pediatricians, family physicians, and allied pediatric healthcare professionals are fully informed about and collaborating effectively on Jordan's Principle initiatives (Canadian Pediatric Society, 2016; Sinha & Wong, 2015). Central to this endeavor is the need for a greater investment in human resources to support the full implementation of Jordan's Principle.

### **Conclusion**

Historically-rooted inequitable power relations, that are the hallmark of colonization, continue to endanger First Nations children's health and wellbeing with potentially lifelong consequences. This paper contributes further evidence on the need for the federal government to address the chronic underfunding of services, resources and infrastructure in First Nations communities in order to advance health equity for all First Nations children (Sangster et al., 2019). Federal reforms are also necessary to create long-term funding that adequately provides for the sustained implementation of Jordan's Principle and allow healthcare programs and services to mature and be effectively implemented. A federal and provincial response that shifts the provision of pediatric healthcare beyond a demand driven approach focused on the

needs of individual children to policies that create long-term, equitable funding for First Nations communities is necessary in order to advance First Nations children's equity in health and healthcare. Finally, it is imperative that First Nations leaders and Jordan's Principle initiatives play a leading role in the design and delivery of all pediatric healthcare services with First Nations communities, families, and children in Canada.

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