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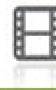
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Minnesota and the *UN Convention on the Rights of the Child:* A Comparison—SURVIVAL AND HEALTH RIGHTS

Introduction

The 2010 *Snapshots on Minnesota Youth* series deviates from the previous topic-specific format and explores how Minnesota fares with the rights and protections afforded all children under the *United Nation's Convention for the Rights of the Child.*[1]

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Introduction (Continued)

In 1989, world leaders convened in acknowledgement that youth under age 18 have rights and need special care and protection that adults do not. The Convention resulted in 54 Articles and two optional Protocols[2] that assert children everywhere have: the right to **survival**; to **develop** to the fullest; to **protection** from harmful influences, abuse and exploitation; and to **participate** fully in family, cultural and social life.

The 2010 *Snapshot* series will mirror the aforementioned survival, development, protection and participation priority areas, beginning with this issue dedicated to survival and health. Each *Snapshot* issue will explore:

- The key articles of the *UN Rights of the Child* that fall within that category;
- State-level data to illustrate the relevance of the issue to Minnesota youth; and
- How Minnesota law or policy guarantees or fails to provide each right or protection to children.

While the United States was an active participant in the drafting of the *UN Rights of the Child* and the Convention itself, we remain one of only two UN nations, the U.S. and Somalia, which have yet to ratify the treaty. Through ratification, nations commit themselves to protecting and ensuring children's rights and they agree to hold themselves accountable for this commitment before the international community. Parties to the Convention are obliged to develop and undertake all actions and policies in the light of the best interests of the child.

A Note About the Data

Due to the large number of rights drafted by the UN Convention's General Committee, only select articles will be chosen for exploration in this series. The full text for each of the 54 articles is available through the *Office of the United Nations High Commissioner of Human Rights.*[3] In addition, some articles contain subdivisions such that a portion of an article may be presented in one *Snapshot* issue and the remaining portion may appear in another.

It should be noted that each UN article is cited using specific UN language. Nations which have ratified the treaty are referred to in the articles as *States Parties*. This term is not referring to state subdivisions within a country, which is the common usage of the term in the United States.

The information in this *Snapshot* series is compiled from the most recently available publicly disseminated data at the state and federal level. Many topics covered in this issue relate to public health and social security programs, immigration and refugee data, and the application of state statute. Some of these topics are extremely complex such that only an overview can be provided in this format. The authors have aspired to accurately portray program services and requirements but acknowledge that nuances of program eligibility and application are not fully represented. Please contact the relevant state agency cited for further information.

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This first *Snapshot* issue focuses on children's rights to **Survival and Health**. Rights in this series include: children's right to an identity; to live and develop; to have quality health care; to have safe food, water and a safe living environment; to an adequate standard of living to meet physical and mental needs; and to government assistance if they are poor or in need. First, the UN Convention General Committee defines a child:

Definition of a Child

Article 1:

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Age: In Minnesota, the age of majority is set at 18 years, consistent with the *UN Rights of the Child*. Minnesota Statutes section 645.451 defines the terms *adult, majority, legal age*, and *full age* as 18 or older; terms for youth under the age of 18 include *infant, child, juvenile* or *minor*. While most US states have 18 as the age of majority, for a few the age is higher.[4] No states have an age of majority that is below 18. From an international perspective, the UN Convention General Committee supports every nation in raising their age of majority to 18. In this regard Minnesota, and the United States as a whole, is in compliance with Article 1.

Consent: As in other states and countries, the age of majority in Minnesota is *not* the same as the age of culpability or consent. Certain rights and responsibilities apply at younger ages including consenting to some medical care, sexual activity, being adopted, and being employed. Culpability for illegal acts in Minnesota can occur for children as young as 10. Some of these age distinctions will be explored further in additional *Snapshot* issues related to youth **protection, development** and **participation.**

Youth Non-Discrimination

A preeminent value of the UN Convention General Committee is that the rights and protections afforded under the *UN Rights of the Child* articles apply to all youth. Article 2 serves as the Committee's non-discrimination assertion:

Article 2:

States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Federal Protection: The United States has, in its federal Constitution, a *Bill of Rights* which prohibits Congress from establishing laws that establish a religion, prohibit the free exercise thereof, or abridge the freedom of speech, the press, or the right to peaceably assemble. In addition, the federal *Civil Rights Act of 1964* prohibits (in part) discrimination in public places, public accommodations, public education, in federally assisted programs, and in employment.[5] Discrimination is expressly prohibited on the basis of race, color, religion, sex or national origin. At the federal level, these rights have been extended to other arenas, such as housing,[6] and have been expanded to include other protected groups, such as persons with disabilities.[7]

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State Protection: The state of Minnesota has its own policy prohibiting discrimination. Minnesota Statutes section 363A.02 states that it is the public policy of the state to "secure for persons in the state freedom from discrimination." These protections apply in the following areas: employment, housing and real property, public accommodations, public services, and education. Generally, the policy prohibits discrimination based on race, color, creed, religion, national origin, sex, marital status, disability, status with regard to public assistance, sexual orientation and age. As it relates to children, under the federal Fair Housing Act of 1968, adults cannot be discriminated against for the "familial status" of being pregnant or having minor children for housing.[8]

Undocumented Youth: The UN Convention General Committee notes that nations often fail to recognize that Article 2 states that *all* youth in a State's jurisdiction are to be protected which includes citizens, visitors, refugees, children of migrant workers, *and those in State illegally*. While Minnesota's nondiscrimination statute broadly applies to "persons in the state," the policy does not expressly include protections for undocumented residents or their children.

A 2005 report to the Governor prepared by the Minnesota Department of Administration estimated that there were 80,000 to 85,000 undocumented immigrants in Minnesota and 14,000 children of undocumented immigrants in Minnesota schools.[9] The same report estimated that there were roughly 5,000 children in the Minnesota school system who were US born children of undocumented parents. If adopted in full, the protections of the *UN Rights of the Child* would apply to these youth.

While the federal government and the state of Minnesota offer many publically funded programs, most are *not* available to persons who are undocumented. Programs that *are* currently available, regardless of citizenship status, include: public K-12 education; emergency medical care under Emergency Medical Assistance (EMA), and pre- and postnatal care under the State Children's Health Insurance Program (SCHIP).[10] These programs, and others, will be described in greater detail in the coming sections dedicated to health and social insurance.

The Right to Life, Survival and Development

Having defined a child and emphasized that the rights of the Convention apply to all children, the UN Convention General Committee makes the following statement about a children's inherent right to life, survival and development:

Article 6:

States Parties recognize that every child has the inherent right to life. States Parties shall ensure to the maximum extent possible the survival and development of the child.

The UN Convention General Committee names the following issues as germane to this article: abortion, euthanasia, infanticide, early marriage, the death penalty, life threatening violence/injury, disappearance, and the investigation and registration of death.

Abortion: While the *Convention on the Rights of the Child* establishes age 18 as the end of childhood, it intentionally does not define the "minimum age" of life. The intention of those who drafted the article was to avoid taking a position on abortion, family planning, and other pre-birth issues which would have threatened the Convention's universal acceptance.

Some Nations have elected to make declarations about when life begins to guide their interpretation of and compliance with the *UN Rights of the Child*. For example, Argentina has declared that the articles apply from the moment of conception to age 18, whereas the United Kingdom has expressly declared that the rights of the child apply only following a live birth.[11] The United States has not ratified the *UN Rights of the Child* and therefore has not had to define at what point the articles would apply. Abortion, within limits, is presently legal in the United States under *Roe v. Wade* (1973).

According to a report prepared by the Minnesota Department of Health for the Legislature,[12] 12,948 abortions were performed in Minnesota in 2008. Abortions have been declining since a peak in 1980 of over 19,000 documented procedures.

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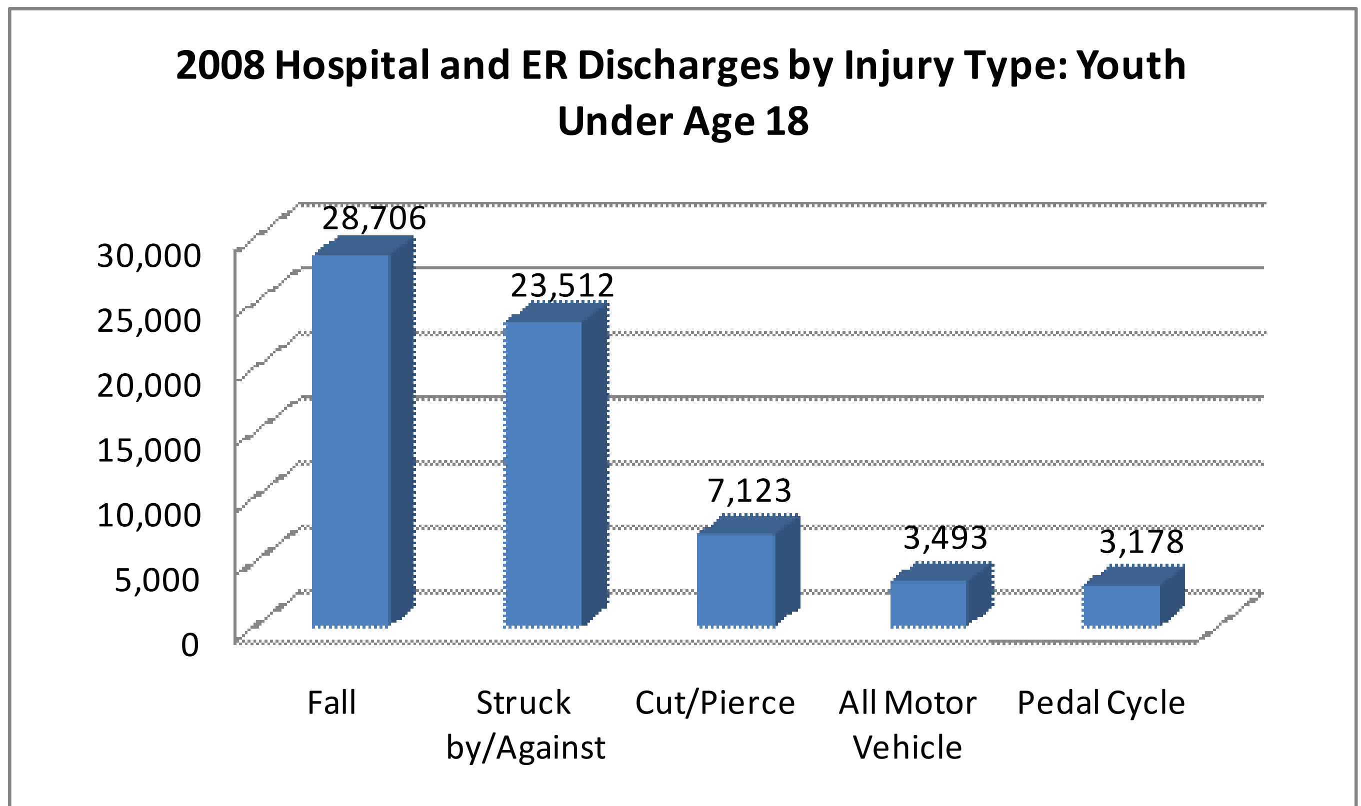
Euthanasia: The Merriam-Webster dictionary definition of euthanasia is "the act or practice of killing or permitting the death of hopelessly sick or injured individuals in a relatively painless way for reasons of mercy." Medical definitions of euthanasia are far more complicated and include "active" and "passive" euthanasia and "physician assisted suicide."

It is illegal in Minnesota to "intentionally advise, encourage or assist" one in taking his or her own life. Health care providers can manage pain so long as the medication does not hasten death, and medical providers may withhold or withdraw life saving procedures in accordance with reasonable medical practice.[13] This statute exists under the state's Criminal Code such that criminal penalties apply.

Infanticide: The UN Convention General Committee emphasizes that globally, infants and young children are most vulnerable for discrimination based on qualities at birth including being female, having physical disabilities, and having HIV/AIDS. Infants born out of wedlock, those of certain ethnic groups and of lower class/caste are at risk for discrimination and maltreatment. In some countries, the most severe form of discrimination in these population groups is infanticide or the intentional, selective killing of infants by murder or neglect.

In developed nations such as the United States, infanticide is rare. In Minnesota, during 2008, there was one death of an infant under age of one attributed to assault (homicide) and an additional 11 deaths of youth ages one to 14.[14] There is no evidence of a societal trend of selective harm to infants. The UN notes that a system of birth registration, death registration and death review are ways that States Parties protect child citizens from harm and ensure their survival.

Unintentional Injury: Reducing injuries experienced by youth and preventable deaths are of interest to the UN Convention General Committee. In Minnesota in 2008, there were over 86,800 emergency room discharges statewide for youth under age 18 who had been admitted for unintentional injuries.[15] There were also 2,717 hospital discharges of youth admitted for unintentional injuries; these injuries resulted in 43 fatalities. Unintentional injuries are the leading cause of death for children ages 5-14, and young people ages 15-24.



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The most common injury for youth under age 18 are falls, followed by being struck by or struck against something. Youth also went to the emergency room for cuts and piercings. All accidents involving a motor vehicle (whether as an occupant, cyclist, or pedestrian) are combined for the 4th most common injury type. All pedal cycling injuries not involving a motor vehicle combine for the 5th largest injury category. Different ages are at risk for different injuries. For youth ages birth to nine, falls are the most common type of injury; for youth ages 10 to 17, being struck by or against something is the most common injury. While protections against the most common forms of injuries are difficult, the state does have laws related to child safety in motor vehicles and on bicycles.

Violence and Abuse: Youth may also be injured by acts of violence. In 2008, there were 1,834 emergency room or hospital discharges for youth under age 18 where the manner of injury was the result of assaultive action. Of these injuries, 64 percent were male youth and over 60 percent were in the 15 to 17 age group for males and females combined.[16] These are only injuries that were severe enough to require emergency medical attention, which is a small subset of all assaults.

Firearms were involved in 217 injuries to children in 2008. Of these, 57 were determined to be inflicted with assaultive intent versus 149 unintentional shootings.[17] Males were also more likely to be the victims of firearm shootings, both intentional and unintentional.

Child maltreatment is among the most prevalent and far-reaching forms of violence in Minnesota. It includes physical, sexual and emotional maltreatment and physical and emotional neglect. It contributes to fatal and nonfatal injuries, disabilities and mental health disorders and is associated with a range of social and intergenerational issues, including substance abuse and youth violence. In Minnesota, the number and rate of determined cases of child maltreatment has decreased slightly from 2006 to 2007. Minnesota counties assessed 18,348 reports of child maltreatment in 2007, involving 26,561 children. Of those reports, 7,414 were traditionally investigated and maltreatment was determined to have occurred in 4,370 reports (with 6,584 victims). An additional 10,934 reports in 2007 received a Family Assessment, a strengths-based and family-focused method for working with families in the child protection system, where no determination of maltreatment is recorded.[18]

Death Penalty: In the United States, individual states are permitted to decide if they will have capital punishment. Minnesota has not had the death penalty since 1911.[19] At present, 37 states have the death penalty however, in 2005, the US Supreme Court ruled that persons convicted of a crime that occurred when they were under the age of 18 cannot be sentenced to death.[20] As such, all persons in the Unites States who committed their crime when under the age of 18 are exempt from capital punishment.

Armed Conflict: Under federal law, the minimum age of military service enlistment in the United States is 17 years of age. Youth under age 18 require parental permission to enlist. The same minimum age conditions apply for the National Guard. Males must register for the Selective Service at age 18 meaning they could be conscripted to serve in the armed forces; 17 year olds cannot be drafted.[21] In 2004, 17 year olds made up 5.6 percent of those newly enlisted to the Armed Forces from all states.[22] It is unknown how many Minnesota military personnel enlisted when age 17.

Child Marriage: In some countries, youth are permitted, expected or required to marry at a very young age. While child marriage affects both sexes, it disproportionately affects girls whose overall development is compromised and can result in limited or no education, skill or opportunity for employment. It can also have adverse health outcomes, particularly affecting reproductive health.

According to Demographic and Health Surveys (DHS), which provides much of the current country-level child marriage data, child marriage is most common in the world's poorest countries. A UNICEF study[23] found that nearly half of women between the ages of 15 and 24 were married before age 18 in South Asia; nearly 40 percent of women in Africa,[24] and more than 60 percent of women in some parts of East and West Africa.[25] In Latin America and the Caribbean, prevalence of marriage under age 18 is about 30 percent, though some individual countries have much higher rates.[26]

In Minnesota, every person of full age (18 years) is capable under law of contracting into marriage. A person of the age of 16 may marry with the notarized consent of their legal guardians or, under certain conditions, the court.[27] Youth under the age of 16 are not legally permitted to marry. In 2003, when marriage

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by age data was last publically available, out of over 31,500 marriages in Minnesota, a bride or groom under the age of 18 was involved in less than one half of one percent.[28]

Suicide: In 2008, the Minnesota Department of Health reported five deaths by suicide of children ages 10-14, and 25 deaths by suicide of adolescents ages 15-19 in Minnesota.[29] Suicides among young people 19 and under make up about five percent of the 593 total suicides in Minnesota. According to the 2007 Minnesota Student Survey, 17 percent of 9th graders and 15 percent of 12th graders report experiencing suicidal ideation in the past 12 months. A smaller percentage reported actually having a suicide attempt in the past year at four percent of 9th graders and three percent of 12th graders. Ninth grade girls reported the greatest frequency of suicidal ideation (22%).[30]

Death Certification and Review: The UN Convention's General Committee acknowledges the importance of adequate investigation of and reporting on the deaths of all children and the causes of death, as well as the registration of deaths and their causes. Establishing an obligation and a procedure in legislation for investigating all child deaths reduces the possibility of a cover-up of the real causes.

In 2008, 37,998 death records were created in Minnesota, 298 of which were for persons age 19 or younger. Minnesota Statutes section 144.221 states that a death record must be filed for each death that occurs in the state within five days of death and prior to final disposition. In addition, Minnesota Statute requires that "all sudden or unexpected deaths and all deaths that may be due entirely or in part to any factor other than natural disease processes must be promptly reported to the coroner or medical examiner for evaluation."[31] The Department of Health was charged in statute with developing uniform investigative guidelines and protocols for coroners and medical examiners conducting death investigations and autopsies of children under two years of age.[32]

Public Health and Safety Legislation/Initiatives: In the interest of preserving life and protecting children from common and preventable causes of death, illness and injury, Minnesota has enacted many laws and undertaken many public health initiatives. The following are just some of the ways that Minnesota acts in the spirit of Article 6:

Program or Law	Summary
Dangers of Shaking Infants and Young Children Education	Minnesota Statutes section 144.574 passed in 2005, requires that certain hospitals make available for viewing by the parents of each newborn baby delivered in the hospital a video presentation on the dangers associated with shaking infants and young children. This statute also requests that pediatric health care providers review the dangers of shaking children at all wellness visits up to age three.
Infant Sleep Safety Education	The Safe and Asleep Campaign began in 2007 and is an ongoing, multi-agency public health campaign that provides a range of materials about safe sleeping environments and Sudden Infant Death syndrome.
Postpartum Depression Education	Postpartum Depression Education legislation was passed during the 2005 Legislative Session. It requires hospitals to provide new parents and other family members written information about postpartum depression. It also requires providers of health care services to pregnant women to have available information on postpartum depression for pregnant women and their families.[33]
Suicide Prevention [34]	In 2001, the Minnesota Legislature began providing funds to the Minnesota Department of Health (MDH) for suicide prevention. This funding allows MDH to provide information to the public and grants to local communities for the implementation of proven effective prevention strategies.

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Program or Law	Summary
Public Health Nurses and Family Home Visiting	Home visitation has been an effective strategy for the delivery of public health services to families for more than a century. Current research shows that Public Health Nurse (PHN) home visitation, especially for pregnant women and families with young children, is effective at helping families improve health status, achieve economic self-sufficiency, improve positive parenting, reduce child maltreatment, reduce juvenile delinquency, achieve maternal goals such as child spacing, education and employment, and establish links to community resources. Beginning in 2004, Family Home Visiting is one of the programs blocked together under Minnesota's Local Public Health (LPH) Act by the 2003 Minnesota Legislature, and PHN home visitation is included as one of the Essential Activities listed under the LPH Act. Three funding sources are included in the LPH Act: State general funds, Maternal and Child Health Block Grant funds, and Federal Temporary Assistance for Needy Families (TANF) funds.
Mandatory Reporting of Maltreatment of Minors[35]	It is the public policy of the state of Minnesota (Statute 626.556) to protect children whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse. In addition, the state requires the reporting of neglect, physical or sexual abuse of children in the home, school, and community settings. Mandatory reporters include medical personnel, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or employed as a member of the clergy.
Child Labor Laws	Generally, children under the age of 14 may not be employed unless they are over the age of 12 and are working in agricultural operations. The Minnesota Child Labor Standards Act restricts the age, days, hours and occupations of working minors in order to promote continued schooling and protect youth from certain hazardous machines or materials.
Child Passenger Restraint Law[36] and Primary Seat Belt Law[37]	To minimize injury and death for children when riding in a motor vehicle, Minnesota Statutes section 169.685 requires that children must use a safety seat or booster seat in combination with a seat belt until they are 8 years old or 4'9"; infants under one and under 20 pounds must be in a rear facing car seat.[38] All drivers and passengers must wear seatbelts in Minnesota (M.S. 169.686).
Motorized Vehicle Operations by Minors	A wide variety of laws relate to a minor's ability to operate motorized vehicles including for transportation, recreation and farming. A minor must be at least 16 to have a driver's license; cannot use cellular phones; restricts certain night driving; and restricts the number of passengers in the car.[39] Helmets are required for the use of snowmobiles, motorized scooters and motorcycles.
Age Specific Protections: Alcohol, Tobacco, Firearms	Youth under age 18 are prohibited from buying, possessing or using tobacco; youth under 21 are prohibited from buying, possessing or consuming alcoholic beverages; and youth under age 16 are generally prohibited from possessing a firearm unsupervised. Additional restrictions apply for youth under 18 possessing a pistol.[40]

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The Right to an Identity

The UN Convention General Committee addresses the importance of an identity for children as individuals; as a part of a family; and as a member of a nation. Articles seven and eight outline these rights. The sections that speak to a child's right to be cared for by his or her parents/family will be addressed in the second *Snapshot* devoted to development rights.

Article 7:

The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to be known and cared for by his or her parents.

States Parties shall ensure the implementation of these rights in accordance with their national law and obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8:

Children have a right to an identity—an official record of who they are. Governments should respect children's right to a name, a nationality and family ties.

The 14th Amendment of the US Constitution states that "all persons born or naturalized in the United States and subject to the jurisdiction thereof shall be citizens of the United States and of the State in which they reside." As such, children born in Minnesota are US citizens even though their parents may not be US citizens or may be undocumented residents.

Birth Registration: For children born in the United States, the birth certificate is the primary document of legal identity. A birth certificate is needed to receive a federal Social Security number, to acquire an international passport, and to obtain state issued identification cards. In Minnesota, statute requires that a birth record be submitted to the state registrar within five days after a live birth. [41] According to Administrative Rules promulgated regarding birth certificates, the certificate must include an infant's full name, sex, the parent(s)' full names, and their state/country of birth.[42] The contents of the Minnesota Birth certificate are consistent with that which is recommended by the UN Convention General Committee.

While birth and citizenship documentation are protections to which Minnesotans (and Americans) are long accustomed, the *UN Rights of the Child* must face the reality that in some nations, children are routinely sold or abducted into labour, marriage and sex industries; are victims of gendercide or infanticide, are abducted or recruited for political and military purposes from poor or disenfranchised families; and are systematically oppressed for their identity, nationality or lineage. Official documentation of identity is one way that youth are afforded protections against these abuses of children.

Rights of Refugee Youth

Refugees who must leave their country of origin because of war, armed conflict, political oppression or other reasons are especially vulnerable to rights abuses as they attempt to settle in a new nation. The UN Convention General Committee notes that these persons, especially children, need special protection and assistance.

Article 22:

States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive

appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

As of January 2009, 279,548 refugees and 69,228 asylum seekers resided in the United States.[43] In 2008, there were 60,108 refugee arrivals and 22,930 asylees, nationally.[44] Minnesota has a long history of providing safe-haven for immigrant and refugee communities. In 2008, the Minnesota Department of Health documented 1,205 arrivals of Primary Refugees (includes asylum) to Minnesota from 34 countries. The greatest number came from Burma, Somalia, Bhutan, Ethiopia and Iraq. Of these persons, 488 were ages 0 through 18.[45] As of 2007, the number of refugees in Minnesota was estimated at more than 70,500 people.[46]

Refugees, asylees and other persons legally in the United States for other conditional reasons are considered to be "qualified non-citizens" in Minnesota as it relates to accessing in Minnesota Family Investment Program (MFIP),[47] Medical Assistance,[48] student aid,[49] and cash assistance. In addition to these services, Minnesota Statutes section 256.484 specifically requires that the commissioner of human services establish a grant program to "provide social adjustment services to refugees residing in Minnesota who experience depression, emotional stress, and personal crises resulting from past trauma and refugee camp experiences."

Right to Health and Health Care

Beyond basic survival and identity documentation, the UN Convention General Committee establishes that nations have an obligation to ensure that children are born healthy, are raised in healthy environments, and have access to medical services.

Article 24:

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

States Parties shall pursue full implementation of this right, and particular, shall take appropriate measures:

(a) to diminish infant and child mortality

(b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health

(c) to combat disease and malnutrition, including within the framework of primary health care, …and through the provision of adequate nutritious foods and clean drinking water…

(d) to ensure appropriate pre-natal and post-natal health care for mothers

(e) To ensure that all segments of society are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventative health care, guidance for parents and family planning education and services

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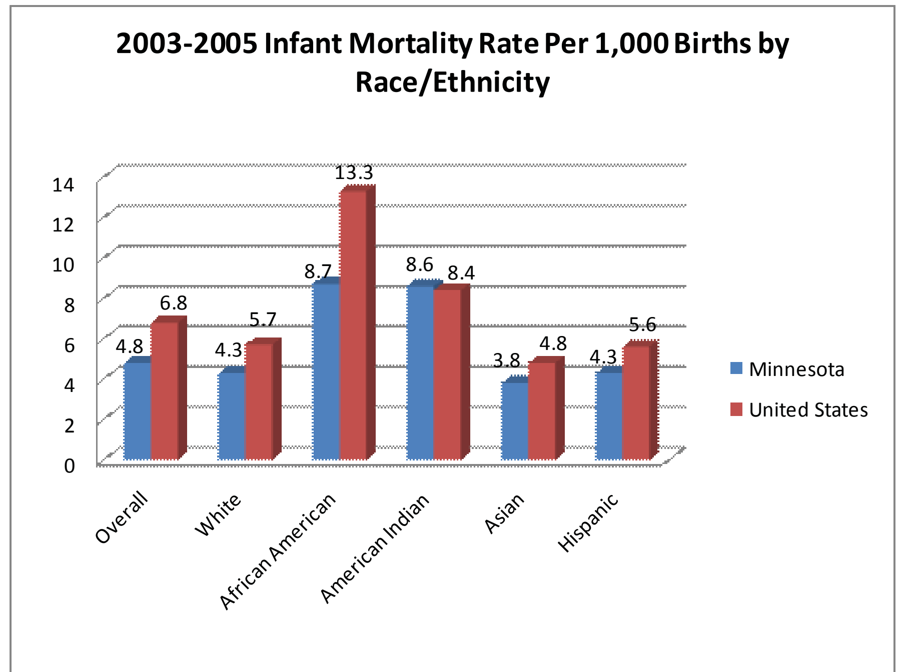
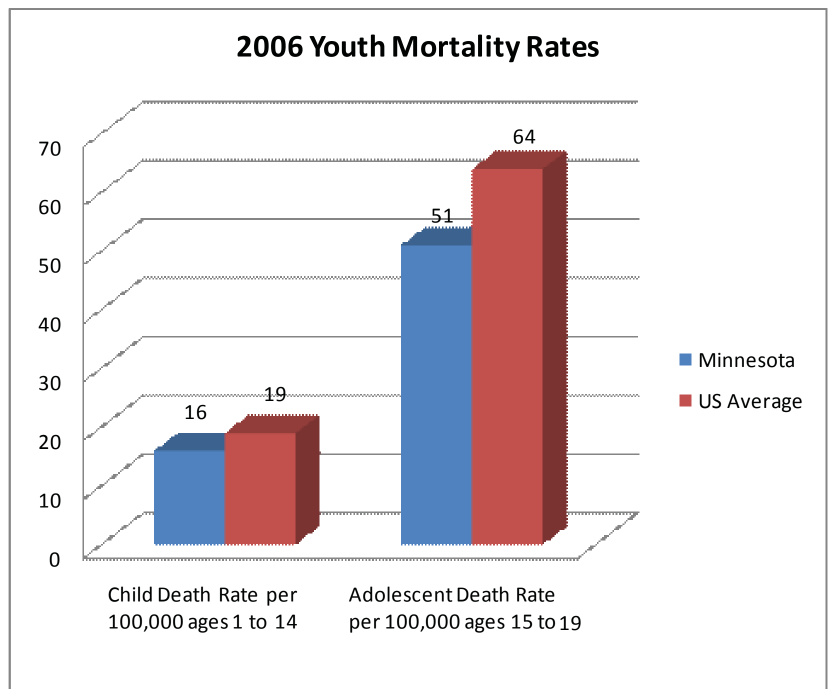
Minnesota Child Mortality

Infant Mortality: Currently about 70,000 babies are born and about 380 babies die each year in Minnesota. Infant mortality, the death of an infant in the first year of life, has a profound impact on families and communities, and is often used as a measure of the overall health of a community, state and country.



However, for infants the major causes of death in 2007 were congenital anomalies followed by perinatal conditions following child birth.[50] These include infections, asphyxia, and low birth weight. In 2007, 27 of 407 deaths of infants (6.6%) were attributed to *Sudden Infant Death Syndrome (SIDS)*.

Minnesota is consistently rated as one of the healthiest states in the nation. In several rankings including infant mortality, Minnesota often has the best rates. This is due to strong maternal and child health programs, higher insurance rates, healthier lifestyles, lower poverty rates and a number of other factors.



The overall infant mortality rate in Minnesota is one of the lowest in the nation, and infant mortality rates for African American, Asian, and Hispanic infants are significantly lower than the national average.[51] That being said, reducing overall rates of infant mortality and eliminating disparities in infant death rates among racial and ethnic groups are high priority public health goals. The *Eliminating Health Disparities Initiative* is one of the efforts targeting eliminating disparities in infant mortality with an initial goal of reducing infant mortality disparities by 50 percent.

Child and Adolescent Mortality: Youth mortality rates in Minnesota for 2006 were also below the national average.[52] In 2007, for children ages one to 14, the leading three causes of death were unintentional injury (27%), "other" (22%) and cancer (18%). For adolescents ages 13 to 19, death rates are over three times higher. The leading causes of death for this age group were unintentional injury (46%) and suicide (22%).

Childhood Mortality Review:[53] In 2008, there were 18 deaths of children determined to be a result of maltreatment and 46 victims of maltreatment who sustained life-threatening injuries.

Under Article 6, this *Snapshot* describes Minnesota's medical review requirement and procedure for recording child death. In addition, Minnesota Statutes section 256.01 established the state's Child Mortality Review.

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This 1989 law gave the commissioner of the Minnesota Department of Human Services responsibility for creating a process to review deaths and near fatalities of children and to require local mortality reviews.

The goal of Minnesota's child mortality review process is to reduce the number of children who die or are seriously injured as a result of maltreatment, or as a result of circumstances where maltreatment is a contributing cause. The local review process employs a multi-disciplinary team to study cases to discern as much as possible about the factors that contribute to deaths or near fatalities of children. Upon completion of a review, the local child mortality review team makes recommendations to improve the child protection system by identifying gaps in the provision of services and training, and by recommending modifications of practice, policy or the law.

Health Care Coverage

According to the 2007 National Survey of Children's Health, 87 percent of Minnesota's children ages 0 to 17 are insured for the entire year (85% - nationwide).[54] While this percentage shows that the majority of Minnesota's children have health insurance coverage, the remaining 13 percent represents 162,000 children in our state with no coverage or gaps in coverage. According to the Minnesota Department of Health, 6 percent of all Minnesota children ages 0-17 had no health insurance coverage in 2007 (five percent of white children but 13 percent of non-white children).[55] The following programs are available for Minnesota families and children.

Medical Assistance (MA): Medical Assistance is the largest of Minnesota's publicly funded health care programs and provides an average of more than 500,000 people per month with health insurance. More than half of these people are children. In 2007, an average of 262,057 Minnesota children were enrolled in this insurance program.[56]

Medical Assistance is available to families and children as long as they meet income and asset limit eligibility criteria and are documented citizens or non-citizens. These eligibility criteria vary depending on the number of people in the family. About two-thirds of people enrolled in MA receive all of their health care through health plans; the other one-third receive care on a fee-for-service basis under which providers bill the state directly for services provided.

MinnesotaCare: MinnesotaCare is another publicly subsidized program for Minnesota residents who do not have access to affordable health care coverage. People who are eligible for MinnesotaCare pay a monthly premium that is determined by a sliding-fee scale based on the family's size and income level. All health care services are provided through health care plans such that people on MinnesotaCare can choose which health plan they want from those being offered in their county. The program serves an average of more than 100,000 people each month. In 2007, the average monthly enrollment of children between 0 and 17 years old enrolled in MinnesotaCare was 36,843.[57] Again, program participants must be documented citizens or non-citizens.

Children's Health Insurance Program (CHIP): In 2009, President Obama reauthorized the Children's Health Insurance Program to expand coverage to an additional four million children and legal immigrants with no waiting period. The intent of CHIP is to provide coverage to children whose family income is modest, but too high to qualify for Medicaid. Minnesota has a State Children's Health Insurance Program (SCHIP), and children qualify whose family income is between 201% and 300% of the federal poverty level. Participation is allowed for undocumented residents for pre- and postnatal care only. In 2009, an estimated 5,621 Minnesota children were enrolled in SCHIP.[58]

Emergency Medical Assistance: Emergency Medical Assistance (EMA) is for people who are not eligible for medical coverage programs due to immigration or state residency status. With EMA they can still receive medical coverage in an emergency and for the duration of their medical emergency including child delivery.

Minnesota and the *UN Convention on the Rights of the Child:* A Comparison

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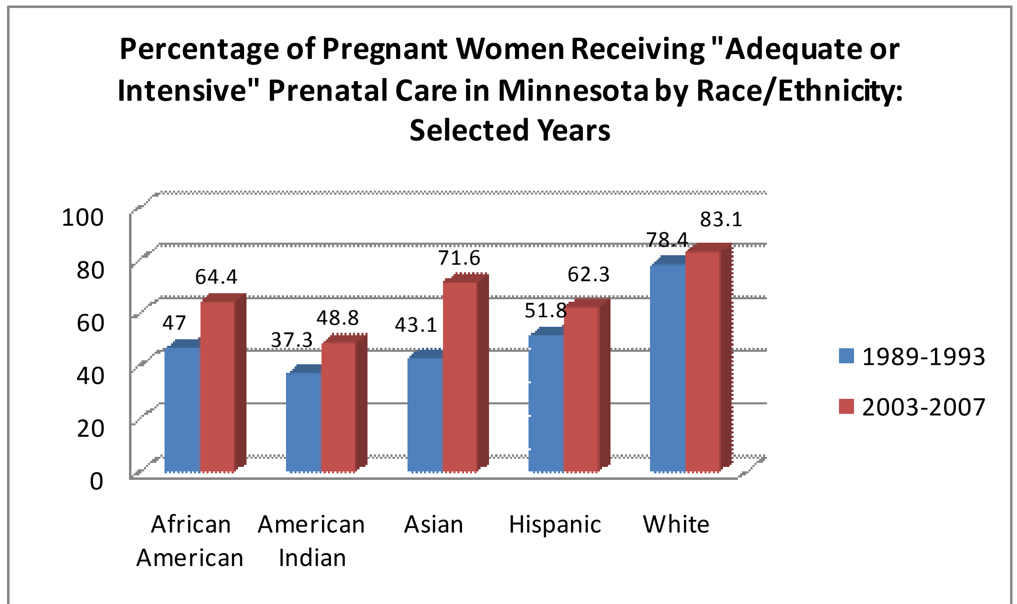
Preventative Health Care: Prevention of Disease and Disability

Prenatal Care: In 2008 in Minnesota, prenatal care had been initiated in the first trimester of pregnancy in 85.6 percent of births. Very few babies, a little more than three percent, were born to mothers who received late or inadequate prenatal care.[59] There have been decreases in the percent of women receiving inadequate and no prenatal care; for example, Asian women receiving inadequate and no prenatal care decreased from 20.6 percent in 1989-1993 to 5.6 percent in 2003-2007. For all race and ethnic groups, more women are seeking intensive and adequate prenatal care, yet large disparities continue to exist between White women and women from communities of color.



Immunizations: Between 2008 and 2009, Minnesota's immunization rate decreased from 84.7 percent to 77.4 percent of children ages 19 to 35 months receiving complete immunizations with the 4:3:1:3:3:1 shot series.[60] We are currently ranked 26th nationally.[61]

Supplemental Nutrition Program for Women, Infants, and Children (WIC):[62] WIC provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and to infants and children up to age five who are found to be at nutritional risk.[63] The benefit of breastfeeding for infants and mothers is a component of the WIC program.

The State agency's income standard for WIC eligibility is between 100 and 185 percent of the Federal poverty guidelines. However, certain applicants can be determined income-eligible for WIC based on their participation in certain programs, like the Minnesota Family Investment Program (see next section on Social Security) or Medicaid. In 2008, 36,246 pregnant, nursing or post-partum women in Minnesota utilized the WIC Program resulting in food assistance to themselves, 34,097 infants and 84,541 children.[64]

Title V of the Social Security Act:[65] In 1936, The Title V of the Social Security Act was enacted by Congress. The federal Maternal and Child Health Bureau (MCHB) provides funds through the Title V Maternal and Child Health (MCH) Services Block Grant to every state and territory to address the needs of children and adolescents; children and youth with special health care needs; and pregnant women, mothers, and infants. The purpose of Title V MCH Services Block Grant is to improve the health of all mothers and children consistent with national health objectives, enable each state to provide and assure access to quality maternal and child health services, reduce mortality, prevent diseases and disabling conditions, promote health, provide services to children and youth with disabilities, and promote family-centered, community-based, coordinated care.

Minnesota receives just over $9 million in federal funds through the block grant. Of this amount, two-thirds of the funding is distributed to Minnesota's local health departments.

Childhood Obesity: Minnesota does not have a statewide data monitoring system to track overall population trends in child and youth obesity. However, Minnesota-specific data from the Pediatric Nutrition Surveillance System shows that the prevalence of obesity in children aged 2 to 5 years enrolled in the

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Supplemental Nutrition Program for Women, Infants, and Children (WIC) increased 41 percent between 1995 and 2004, from 9.8 percent to 13.8 percent. According to the 2007 Minnesota Student Survey, 26 percent of 12th grade males and 17 percent of 12th grade females reported heights and weights that classified them as overweight or obese.[66]

The 2007 Minnesota Student Survey also found:

- Only 15–20% of 6th, 9th, and 12th grade students surveyed report eating five servings of fruits, fruit juices, and vegetables the previous day.
- Forty-seven percent of 12th grade girls and 65% of 12th grade boys report drinking at least one soda a day.
- 67 percent of 12th grade girls report not participating in moderate physical activity five or more days per week;
- 34 percent of 12th grade boys and 48 percent of 12th grade girls report not participating in vigorous physical activity at least three day per week.

Family Planning Programs

Ensuring that children are planned for and wanted is an important part to having a healthy start in life. Family planning information and services help women and men make informed choices about the timing and spacing of childbearing.[67]

Family Planning Special Projects (FPSP): Family Planning Special Projects is a grant program established by the Minnesota Legislature in 1978. FPSP funds are appropriated biennially by the Minnesota Legislature to fund family planning activities throughout Minnesota. The funds may be used for public information, outreach, and family planning method services and non-medical methods of family planning, counseling, and referral. FPSP funds are targeted to women and men who have difficulty accessing family planning services because of various barriers including poverty, lack of insurance, race, ethnicity, age or culture.[68] There are currently 33 grantees providing family planning services with the FPSP grant throughout the state. From July 2008 to June 2009, FPSP grantees provided education and outreach to 40,000 people, counseling to 28,728 people, and methods services (exams, prescriptions, etc.) to 24,096 people.

Title X: Title X of the Public Health Services Act is the only federal program dedicated solely to family planning related services.[69] In Minnesota in 2009, there were 35 clinics receiving Title X dollars, including rural, suburban, and urban parts of the state.

Minnesota Family Planning Program: The Minnesota Family Planning Program (1115 Medicaid Family Planning Waiver) was applied for and received from the Center for Medicare and Medicaid Services in 2002. The waiver program was designed to help reduce gaps in coverage and will increase the availability of pre-pregnancy family planning services.

Environmental Health

Having a living environment free of environmental hazards is also a key to health. Individual counties and cities may have their own ordinances related to molds, allergens, insect and animal infestations, garbage and hazardous chemicals, and fire dangers. At the state level, specific statutes are geared towards preserving health by regulating mercury use in schools, asbestos in buildings and remodeling, maintaining clean drinking water, and monitoring at risk persons for exposure to lead.

Drinking Water: Starting in 1974, the U.S. Environmental Protection Agency began regulating the nation's water supply under the federal Safe Drinking Water Act. Like most states, Minnesota assumed primary responsibility for monitoring drinking water at the state level in 1976. Minnesota has approximately 7,286 public supply water systems, mostly drawn from groundwater from underground sources. However, 23 systems use surface water drawn from lakes or rivers.[70] In Minnesota, ensuring clean and safe drinking water is maintained through preventing contamination, treating drinking water so it is safe to drink and monitoring our state's water sources for potential contaminants, through the Minnesota Department of Health's Drinking Water Protection Program.[71]

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Lead Exposure: Many of Minnesota's older homes still expose children to lead paint. Lead poisoning is the most common environmental health threats to children, even though its toxicity has been known for thousands of years. Children less than six years old, and especially ages one to three years, are most vulnerable to lead's toxicity due to their growing bodies, nutritional needs, mouthing behavior and spending time on the floor. Pregnant women and the developing fetus are also at risk because lead easily passes through the placenta to the fetus, and the changing nutritional needs of the mother cause release of lead stored in bone. The Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH) consider children and pregnant women to have elevated blood lead levels (EBLLs) if their blood test results are greater than or equal to 10 micrograms of lead per deciliter whole blood (μg/dL). In 2008 there were over 1,000 (1,115) Minnesota children with elevated blood lead levels.[72]

Right to Social Security

Social security programs are government operated financial protections against socially recognized conditions, including poverty, old age, disability, or unemployment. The UN Convention General Committee holds that children, as well as adults, have the right to social security.

Article 26:

States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve full realization of this right in accordance with their national law.

In the United States, social security isn't limited to the Federal government's payment program for retired employees. Other well-known social welfare and social insurance programs in the United States include Temporary Assistance for Needy Families (TANF), Medicare, Medicaid, the Children's Health Insurance Program (included in the prior health care section under Article 24) and Supplemental Security Income (SSI) for persons with physical and mental disabilities. Benefits received by these programs are often based on one's income and their relationship to the federal poverty guidelines.

Poverty Guidelines: Presently, the federal poverty guideline for an individual is an annual income of $10,830 or less[73] (or just over $900 per month). For each additional individual in the household, the poverty guideline increases by $3,740 annually. As such, a family of four has a poverty guideline of $22,050.

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	$10,830
2	$14,570
3	$18,310
4	$22,050
5	$25,790
6	$29,530
7	$33,270
8	$37,010
For families with more than 8 persons, add $3,740 for each additional person.	

Between 2002 and 2007, the percentage of people living in poverty in Minnesota increased gradually from 7.5 percent to 9.5 percent. The percent of youth ages 0 to 17 in poverty, however, has grown from 8.8 to 11.9 percent in that same time.[74] In 2009, 15.6 percent of Minnesota's children were in poverty.[75]

In Minnesota, 67 percent of children who live in low-income housing have families spending more than 30 percent of their income on housing costs.[76]

Minnesota Family Investment Program (MFIP): The Minnesota Family Investment Program is Minnesota's equivalent of the federal Temporary Assistance to Needy Families program. MFIP is Minnesota's primary program for helping low-income families with children move out of poverty through work. MFIP employment services are mandatory for all participants, parents must follow their employment plans or they will face financial sanctions. Assistance for most families is limited to 60 months. Families who participate in MFIP

receive child care help and almost all qualify for Medical Assistance and other health programs.

In 2008 about 36,000 families used MFIP during an average month and there were an additional 10,000 families that had child-only cases. The number of families receiving welfare has decreased more than 30 percent since 1994. More than two-thirds (67%) of MFIP cases are in the 11-county Twin Cities metropolitan area and the average family size is three people-typically one adult and two children.

Diversionary Work Program (DWP): The Diversionary Work Program is a four-month program that provides services and supports to eligible families to help them move immediately to work rather than go on welfare. The four months of DWP does not count towards the 60-month lifetime limit for MFIP. DWP is for families with children or pregnant women. Families must meet the income eligibility guidelines and cannot have more than $2,000 in assets. All parents are expected to work and develop an employment plan with a job counselor. Families may receive cash benefits to meet critical needs and/or services to move them quickly to work.[77]

Supplemental Security Income (SSI): Supplemental Security Income is federal financial aid to persons with disabilities. Eligibility for SSI does not require that a recipient ever have worked, but it does require US citizenship status and a Social Security number. In December 2008 there were 12,297 youth under age 18 receiving SSI in Minnesota. The average monthly SSI payment was $537.04.[78] Of all youth receiving SII nationally, 65.7 percent receive benefits due to mental disorders, 8.1 percent for diseases of the nervous system and sense organs, and 5.2 percent for congenital anomalies.[79]

Right to an Adequate Standard of Living

Beyond personal health and a safe living environment, the UN Convention General Committee expresses the importance of children having access to nutritious food, clothing, housing, and material assistance to maintain an adequate standard of living where basic needs are met.

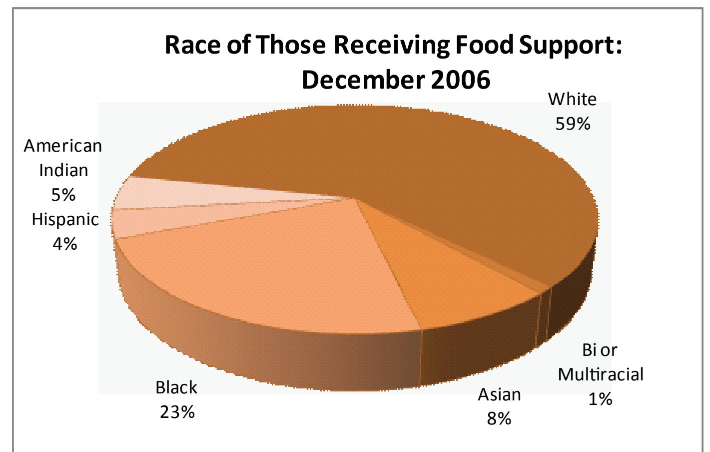
Article 27:

1. **States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.**

3. **States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programs, particularly with regard to nutrition, clothing and housing.**

Food Assistance

Food Support: Food Support is Minnesota's name for the federal Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps). The Food Support program is a county-run, federal program that helps Minnesotans with low incomes to receive the food they need for sound nutrition and well-balanced meals. Participation in the Food Support program has been slowly increasing over the past decade but in the last year the growth increased dramatically:



- The number of households on Food Support increased between two and six percent each year between December 2003 and December 2007. However, between December 2007 and December 2008 it increased by nine percent. In December 2008 there were 94,621 children in Minnesota using Food Support.
- As of April, 2009, the average number of households receiving Food Support was 161,500. Of these households, 127,000 received stand-alone Food Support and 34,500 received Food Support as a portion of their MFIP grant.[80]
- Thirteen percent of all family households on Food Support have no income.
- Sixty percent of family households on Food Support were White, 22 percent were Black.[81]

Additionally, the Women, Infants and Children Program (WIC) discussed under Article 24 is largely geared towards health outcomes for young children and new mothers and includes a food assistance component.

Free or Reduced Price Lunch: The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or free lunches to children each school day. The program was established under the National School Lunch Act in 1946.[82] Children qualify for free lunch if their family income is below 130 percent of poverty and reduced-price school lunch if their family income is between 130 percent and 185 percent of poverty.[83] Thirty-three percent of all Minnesota K-12 students (270,247) qualified for free and reduced-price school lunch in 2007, a percentage that has been increasing steadily since 2000.[84]

Housing Assistance

In the state of Minnesota there is a continuum of shelter and housing services for low-income people and/or people experiencing homelessness. This continuum includes emergency shelter, transitional housing and transitional living programs, permanent supportive housing and rental subsidy programs such as the Section 8 program. The continuum is funded through a combination of federal, state and private funding sources.

Emergency & Youth Emergency Shelter: Emergency lodging is provided on a short–term basis (usually less than three months) with the purpose of providing a homeless youth, individual or family with a clean, safe place to stay. Shelter providers offer residents access to supportive services, but residents may or may not be required to participate in a service plan. Youth emergency shelters can provide specific services for young people including family reunification services; recreational activities; individual, family, and group counseling; advocacy and referral services; assistance obtaining clothing; Independent Living Skills training; access to medical and dental care and mental health counseling; education and employment services; transportation; and aftercare and follow-up services.

Additional information on the prevalence of youth homelessness will be presented on the second *Snapshot* issue related to youth **development**.

Transitional Housing: Transitional housing programs assist families and individuals through the provision of housing and supportive services for up to 24 months.[85] Transitional housing residents pay at least 25 percent of their income for rent, are required to work with program staff to accomplish goals set forth in a housing independence plan, and are eligible for up to six months of follow-up services.

Youth Transitional Living Program/Supportive Housing: Youth transitional living programs must help homeless youth and youth at risk of homelessness to find and maintain safe, dignified housing. The program also provides rental assistance and a wide array of related supportive services (such as parenting, budgeting, violence prevention and independent living skills), or refer youth to other organizations or agencies that provide such services.

During the 2009 state fiscal year, the transitional

housing program served 3,966 individual people. Of these, 2,121 were children under the age of 18. Over half of participants (54%) self-identified as Black/African American or American Indian. Over 90 percent of the people staying in transitional housing programs moved on into stable housing when they left the program.

Permanent Housing: In Minnesota, there are three major housing programs designed to subsidize rent for low to moderate income earners. These four programs include: Section 8, public housing, and project-based section 8. The following is a brief description of each program:

- *Public housing* is rental units that are owned publically for low-income households. Renters pay 30 percent of their income toward their rent, while some units have a fixed low rent amount. In public housing, the subsidy stays with the unit and if a renter leaves the housing, he or she no longer receives rental assistance.
- *Section 8 vouchers* are used to help renters pay the rent on private, market rate rental units, with the local housing authority paying a portion of the rent directly to the property owner. Unlike public housing, if you move, the voucher moves with you.
- *Project Based Section 8* also places low income earners into subsidized housing, but in this program, the subsidy stays with the privately owned and managed rental unit, not the renter. Therefore, if the renter moves out, he or she is no longer receiving rental assistance.

For all of these programs, renters pay approximately 30 percent of their income toward their rent. Renters must meet the income eligibility requirements and may also be screened for eligibility through credit, rental and criminal history checks.

The capacity of the shelter and housing support continuum in Minnesota is not large enough to meet the need and there are large waiting lists across the state for housing support. For all three of the public housing programs, the wait list may be extremely long or even closed. As an example, Minneapolis Public Housing Authority (the largest PHA in the state) has a waiting list of almost 17,000 people needing public housing or Section 8 vouchers.[86]

Heat: Because of the severity of winters, Minnesota Statutes section 216B.097 prevents low-income households from having their heat disconnected between October 15 and April 15 if the disconnection affects the primary heat source for the residential unit. There are several eligibility requirements, one of which is that the household income is one-half the median state household income (currently $55,000).

Conclusion

As is relates to survival and health, the *UN Convention on the Rights of the Child* expressly states that nations have an obligation to ensure that children are born healthy; are free from discrimination; are protected from injury, abuse and exploitation; have a safe living environment; and have adequate food and clean water. It is also the responsibility of the government to ensure that children have access to medical care and social security if they are ill, injured or are experiencing poverty.

It is important to reiterate that the United States has not ratified the *UN Convention on the Rights of the Child* and is therefore not accountable to the international community when it comes to upholding these rights. Despite this, both federal law and Minnesota Statutes recognize that children are in need of unique protections. While we cannot compare how well Minnesota is working to address the rights outlined in the Convention to other states, this *Snapshot* reveals that the State does indeed strive to ensure that the rights of children are protected and, when needed, their rights are met through state intervention.

This assessment shows that the United States and Minnesota have particularly prioritized the welfare and health of infants and young children, recognizing the need for care during these very vulnerable and formative early years of life. Educational programs to keep very young children safe, laws to promote safety in motor vehicles, and food support programs for women and young children strive to maximize the survival and development of Minnesota's children. Both state and federal programming is in place to provide health care coverage to children whose parents are unable to provide insurance. Nevertheless, while most children in our state do have some type of health care, over

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100,000 children each year have gaps in coverage or no coverage at all.

At times, it may seem like this *Snapshot* addresses basic issues that we may take for granted. Birth and death records, official identity and citizenship, and exclusion from military service are protections afforded the children in our country that we have come to expect. Unfortunately, these very basic protections are not always available to children in other countries and put children at extreme risk for exploitation and abuse.

Ratification and implementation of international treaties has historically been a slow process for the United States. That being said, the *UN Rights of the Child* also faces targeted opposition. Those opposed to the treaty feel it would threaten US sovereignty, dictate domestic policy, and impinge upon states-rights. In addition, some oppose the articles based on a belief that they would undermine parental authority over children. Indeed, ratification of the Convention at the national or state level could initiate difficult discussions on charged topics over which citizens and politicians are divided. These include formal national and state positions on abortion, poverty, access to health care and undocumented non-citizens. While many protections are in place today for children, they can be amended or eliminated due to changing social and economic environments, or political will.

Furthermore, the presence of programs and protections in Minnesota does not mean that they are equitably distributed or applied across the state. Disparities attributable to income level, race and ethnicity, geographical location, and citizenship status exist in state level data related to health disparities, program participation, housing access and medical care coverage. Minnesota must continue to work to ensure that all youth have equitable opportunities for health and success in order to act within the spirit (and by the letter) of the *UN Rights of the Child*.

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In Our Next Issue

In the next *Snapshot*s on Minnesota Youth issue, articles of the *UN Convention on the Rights of the Child* will be explored that pertain to child development. These articles include the rights of children to a free primary education; to relax and play; to practice one's own culture; to be raised by one's parents; and to certain protections if raised by persons other than one's parents. Please watch for the next *Snapshot* publication in the summer of 2010.

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