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April 14, 2018

Inter-American Commission on Human Rights
Organization of American States
1889 F Street NW
Washington, DC
20006

Via Email: CIDHMonitoreo@oas.org

Attention: Executive Secretary Paulo Abrão

RE: Responses to Questions Posed by the Honourable Commissioners at a Hearing on the Sexual and Reproductive Rights of Women and Girls in the Americas on February 27, 2018 in Bogotá, Columbia (our ref 434.01)

Dear Mr. Paulo Abrão:

I. PURPOSE

1. We remain very grateful for the recent opportunity to present at the IACHR's hearing on the sexual and reproductive rights of women and girls in the Americas on February 27, 2018 in Bogotá, Colombia. Further, we are grateful for the interest and thoughtful inquiries the Honourable Commissioners posed. This correspondence serves to provide responses to those questions to the extent possible at this time, a contextual overview where possible, and sets forth specific petitions relating to the forced sterilization of Indigenous women in Canada.

II. QUESTIONS FROM COMMISSIONERS ON FEBRUARY 27, 2018

A. COMMISSIONER FLAVIA PIOVESAN, RAPPORTEUR FOR CANADA

(1) In Canada, what policies are in place to prevent the forced sterilization of Indigenous women and what training policies are in place?

2. Presently, there are no government policies in Canada, at either the federal or the provincial level, that are geared toward ensuring that Indigenous women are not

forcibly sterilized. Tubal ligation policies in Canada are developed at the provincial and/or regional health authority level or by the medical profession under the guise of ethical standards.

3. Today in Saskatchewan, tubal ligation costs are typically covered by publically funded provincial health care. Other forms of birth control, such as inter-uterine devices (IUDs) and birth control pills, are paid by Canada under the non-insured health benefits program for registered status Indians and other Indigenous eligible beneficiaries. Prior to the integration of white and Indian hospitals in the 1970s, registered Indians received health care in federally operated and funded Indian hospitals.
4. Systemic financial incentives operate, on their face, to the benefit of surgeons performing tubal ligation procedures, who are paid per procedure. Systemic cost avoidance in the provision of alternative forms of birth control mentioned above, on its face, appears to benefit Canada.
5. In response to media reports in 2015 that several Aboriginal women were coerced into sterilization after the delivery of their babies, the Saskatoon Health Region (SHR) re-drafted its *Post Partum Tubal Ligation Policy*, which had been in place from 2005 – 2010 when many of these reports of coerced sterilization took place. Currently, any woman who wants a tubal ligation following delivery must have discussed it with her physician and have had that discussion documented prior to coming to hospital.
6. However, this policy has been criticized and no further systemic changes have been made. In their report after an external review of the SHR's tubal ligation practices with respect to the lived experiences of indigenous women, *External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women* dated July 22, 2017¹, authors Dr. Boyer (recently appointed to the Senate of Canada) and Dr. Bartlett² criticized the new policy. It was developed and adopted without consultation with the women affected by it. They have since determined that the policy needs further revision in consultation with Indigenous parties and women.
7. Specifically relating to the consent forms examined, the reviewers found that:

Some of the omissions from the earlier policies were addressed in the 2015 [policy] such as a definition section and an “overview” or preamble. Although consent is defined, it does not include the principles of free, prior and informed

¹ Dr. Yvonne Boyer & Dr. Judith Bartlett, *External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experiences of Aboriginal Women*, July 22, 2017, available online at: < https://www.saskatoonhealthregion.ca/DocumentsInternal/Tubal_Ligation_intheSaskatoonHealthRegion_the_Lived_Experience_of_Aboriginal_Women_BoyerandBartlett_July_22_2017.pdf> [External Review Report].

² Dr. Yvonne Boyer is a lawyer and Canada Research Chair in Aboriginal Health and Wellness at Brandon University. Dr. Judy Bartlett is a physician and former professor with the College of Medicine at the University of Manitoba. See also Senate of Canada, “Biography” online: <https://sencanada.ca/en/senators/boyer-yvonne/>

consent. Without the inclusion of understanding what these words mean and ensuring that the words free prior and informed are understood by all before implementing it is possible that a true consent may not be achieved. It would further be beneficial [for the SHR] to review the *United Nations Declaration on the Rights of Indigenous People* (UNDRIP); TRC Calls to Action; an Aboriginal and treaty rights analysis; a cultural review (applicable culture for the Saskatoon Health Region meaning Cree, Sauteaux, Dene, Dakota, Métis and Inuit) and a solid set of definitions that include the Aboriginal worldview, linguistics and thinking on consents and tubal ligation.³

8. Moreover, no further action has been taken. The External Review laid out specific calls to action to change the practice of coercing Indigenous women into tubal ligations. According to the SHR website,

[t]he Health Region will be sharing the [External Review] report and discussing the calls to actions with government agencies and other partners with the hope that together we can begin to address the root causes of these inequalities and discrimination.⁴

9. The Health Region has also acknowledged that while the policy has since changed, there remains a need “to revisit these [changes] using a more collaborative approach involving those most impacted”, including the use of “a more robust Advisory Council with the voices of grandmothers, women and First Nations and Métis leaders” and actions

...to collaborate with our communities about First Nations and Métis health and wellness to support the creation of a service that allows women to feel a sense of belonging and support in the most difficult of circumstances, particularly through their pregnancy and following the birth of their child.⁵

10. Since this SHR press release on July 27, 2017 (shortly following the release of the External Review report), there have been no further public updates on the implementation of the recommended action plan by the SHR. On December 4, 2017 the health regions merged into the Saskatchewan Health Authority (SHA).⁶
11. No federal policy response in the form of concrete measures has manifested to date. Federal Minister of Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC), Carolyn Bennett, herself a former physician, stated that the

³ *External Review* at 34-35.

⁴ Saskatoon Health Region, “Reports and Publications: External Review of Tubal Ligation Procedures”, July 27, 2017, available online at: <https://www.saskatoonhealthregion.ca/news/media-centre/Pages/External-review-of-tubal-ligation-procedures.aspx>

⁵ Saskatchewan Health Authority, “Voices of First Nations and Métis women, As Well As Health Region Providers, Form Calls to Action,” July 27, 2017, available online at: <https://www.saskatoonhealthregion.ca/news/media-centre/news-releases/Lists/Posts/Post.aspx?ID=258>

⁶ Wendy Winiewski, “Saskatchewan Health Authority Launches, replacing 12 provincial health regions” Global News, December 5, 2017, available online at: <https://globalnews.ca/news/3896216/saskatchewan-health-authority-launches/>

External Review report was yet another indication of racism in a healthcare system that remains biased against Aboriginal women.⁷ In further support of this acknowledgement, the Minister pointed to a 2015 report entitled *First Peoples, Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada*.⁸ This report explores racism in the health-care system towards Indigenous patients and its ties to poor health outcomes. Further, it recommends improving the collection of Indigenous health data to prevent racism from causing disparities in care.

12. Minister Bennett called the External Review “completely troubling” and a sign that some doctors are still willing to project onto certain patients what they consider an “optimal family size”, which is “[a] very paternalistic” viewpoint and approach.⁹ Minister Bennett further stated that discrimination in health demands urgent attention, noting that it can be very difficult for patients to interact with health care providers who have an unconscious bias. Minister Bennett stated that she thinks “everybody is very aware that it is not just the social determinants of health that are responsible for the gaps in [Indigenous] health outcomes, but actually the quality of care they receive.”¹⁰ Yet, to date, nothing has been done.
13. The overlapping jurisdictional responsibilities between provincial and federal governments in relation to Indigenous peoples pose a challenge. Eugenic philosophies, physician discretion, sterilization legislation, and a lack of preventative measures are intact imprints of a sterilization legislative legacy in Canada’s health care system.¹¹ Historical imprints are actualized in the broad discretionary power of physicians, who are the main drivers resulting in the forced sterilization of Indigenous women. For more information on the gap in health care for Indigenous peoples in Canada, see Appendix “A”.
14. In addition to implementing the calls to action of the External Review on a nation-wide scale, we recommend criminalizing the forcible sterilization of individuals. The overly broad discretion of physicians in the delivery of health care services, in these circumstances, is what we say must be targeted to prevent the practice. We believe the most effective, immediate and enduring measure to

⁷ Kristy Kirkup, “Coerced sterilization of Indigenous women in Saskatoon ‘troubling,’ Minister says” *The Canadian Press*, August 4, 2017, available online at: <https://www.thestar.com/news/canada/2017/08/04/coerced-tubal-ligations-of-indigenous-women-in-saskatoon-troubling-minister-says.html>

⁸ B Allan & J Smylie, “First Peoples, Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada.” Wellesley Institute, 2015, available online at: <http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf>

⁹ The Canadian Press, “Tubal ligations of Indigenous women in Saskatoon ‘troubling’: Bennett” *The Globe and Mail*, August 4, 2017, available online at: <https://www.theglobeandmail.com/news/national/tubal-ligations-of-indigenous-women-in-saskatoon-troubling-bennett/article35881418/>

¹⁰ Kristy Kirkup, “Coerced sterilization of Indigenous women in Saskatoon ‘troubling,’ Minister says” *The Canadian Press*, August 4, 2017, available online at: <https://www.thestar.com/news/canada/2017/08/04/coerced-tubal-ligations-of-indigenous-women-in-saskatoon-troubling-minister-says.html>

¹¹ *External Review Report* at 6-8.

achieve prevention is the criminalization of forced sterilization in the federal Criminal Code of Canada. A constitutional analysis of the feasibility of that approach may lead to the conclusion that provinces must be involved in the discussion given overlapping jurisdictions as they pertain to implementation and prosecution. Time is of the essence - Indigenous women have been waiting for the law's protection for almost 100 years.

15. The criminalization of forced sterilization in Canada, which is not yet in the Criminal Code or proposed, would contribute significantly to the ability of Canada to prevent the practice, to provide criminal remedies, and to ensure informed consent prior to sterilization.
16. International bodies and courts support the criminalization of forced sterilization. In concluding observations following State reviews where the issue of forced sterilization was raised, the [Committee against Torture](#) and the [Committee on the Elimination of Racial Discrimination](#) have both recommended criminal penalties for forced sterilization. Additionally, in decisions on forced sterilization, the European Court of Human Rights in [V.C. v. Slovakia](#) and [N.B. v. Slovakia](#) distinguished between medical negligence and performing sterilizations with intent; when sterilization resulted due to medical negligence, the Court found civil remedies sufficient, but implied that in the latter case, criminal remedies are needed.
17. Criminalization would also be consistent with Canadian law. The Canadian government has shown a shift towards criminalizing individuals that exploit women. Further, Canada has recently announced an [“overhaul” of its criminal justice framework](#), that includes measures, Canada says, to protect women from violence and [targets sexual assault](#) by varying defenses available to exclude those associated with an accused's mistaken belief that the victim consented to sex. From our review of [Bill C-75](#), the criminalization of forced sterilization is not included.
18. Bodily autonomy and a physician's obligation to procure proper and informed consent must be at the center of legislative provisions affecting the reproductive health of women, including sterilization and abortion. This approach is particularly necessary for disadvantaged women in situations of added vulnerability, such as child birth. We submit that the Criminal Code must reflect the state of the law on consent and that such law is equally applicable to health professionals in the context of non-essential medical procedures affecting the reproductive rights of women.

B. COMMISSIONER MARGARET MAY MCCAULAY, FIRST VICE PRESIDENT, RAPPORTEUR ON THE RIGHTS OF WOMEN

(1) *What is the status of the amendment regarding rights of Indigenous women in Canada? Is the failure to amend the Indian Act a cause of continuing discrimination against them?*

19. Notwithstanding serious challenges associated with the federally-determined Indian status regime generally, and its perpetuation of racial and gender discrimination and ostensible violation of section 35 Aboriginal and Treaty constitutional rights, we do not think we are in the best position to advise on the impact of recent amendments to the *Indian Act* via Bill S-3 and its specific relation to forced sterilization of Indigenous women and continuing discrimination in the healthcare system towards Indigenous women.
20. That said, it is our position that federally-determined community belonging is a root cause, *inter alia*, of detrimental differential treatment. Layers of gender discrimination in the status provisions (section 6) of the *Indian Act* have resulted in complex and varying outcomes that one would need to study deeply in order to properly understand. A global view of the issue demands an examination of the socio-economic circumstances of Indigenous women and any improvements over time. We believe no amendment or incremental change to section 6 of the *Indian Act* over the years has resulted in a diminishment of the generalized incidence of violence and discrimination against Indigenous women. The legacy of colonial legislation and policy continue to impact Indigenous women. These impacts are unlikely to be reversed in the short-term by extending federally-determined Indian status to a larger group of individuals who descend from Aboriginal ancestors. Arguably, impacts may intensify with more State intrusion into Indigenous internal governance matters.
21. More broadly, we would like to point out the broader debilitating effects the *Indian Act* has wrought on Indigenous women. As noted in *First Peoples, Second Class Treatment*, research confirms that since its enactment in 1876, the *Indian Act* has played a key role in undermining the roles and responsibilities of women in previously matriarchal and/or matrilineal Indigenous societies by preventing women's involvement in governance and rooting "Indian" identity in male lineage.¹² These modes of social organization did not fit the views inherent in the eugenics and "family planning" philosophies that underpinned healthcare delivery for Indigenous women. Though not all Indigenous communities were traditionally matriarchal, colonial legislation such as the *Indian Act* among other policies and practices, continue to undermine the esteemed value, role and place of Indigenous women in their communities and in society. This imposed reality renders them vulnerable to exploitation and neglect, existing on a widespread institutional level in Canada:

¹² *External Review Report* at pp. 2 and 6.

With colonization, patriarchal laws, policies, legislation and regulations instituted attacks on Aboriginal women in their role as family anchors. The social fabric of the core of the family unit was attacked through the imposition of tools of assimilation. The loss of identity through colonizing actions such as the *Indian Act*, residential school policies, mental health laws, forced removal of children and the Sixties Scoop are some of the determinants that have contributed to erosion of women's role in Aboriginal cultures. Eroding the position of Aboriginal woman as caregivers, nurturers and equal members of the community inflamed the false colonial perception that Aboriginal women were somehow worthless and free to be exploited. Male-created and dominated values have shaped institutions, laws, legislations and policies that have implemented a long-lasting negative effect on the physical, mental and social health of Aboriginal women. Unfortunately, far too many institutions today claim to be value free but continue to reflect a colonial male dominated comprehension of reality. Along with a guardian and ward model, these realities continue to underpin the health policies in our medical institutions today and have real and harmful effects on the health of Aboriginal women.¹³

22. The *Indian Act* was designed to do away with Indigenous people altogether, either by assimilation or extermination through the imposition of conditions intended to destroy the tribal system. In 1887, Sir John A. MacDonal, former Prime Minister, said in a public statement:

The great aim of our legislation has been to do away with the tribal system and assimilate the Indian people in all respects with the other inhabitants of the Dominion as speedily as they are fit to change.¹⁴

23. Duncan Campbell Scott, Deputy Superintendent General of Indian Affairs from 1913 to 1932 seized Macdonald's repressive policies and advanced them, stating in 1920:

I want to get rid of the Indian problem...Our objective is to continue until there is not an Indian that has not been absorbed into the body politic, and there is no Indian question, and no Indian Department.

24. Due to the *Indian Act's* deeply flawed policy objectives and overall design, we submit that it cannot, despite amendments, be as inclusive and progressive as it needs to be to facilitate justice and reconciliation in Canada.

¹³ *External Review Report*, at p 5. See also Y.M. Boyer (2006), "First Nation, Métis and Inuit Women's Health – A Constitutional Analysis" Discussion Paper Series #4, National Aboriginal Health Organization and the Native Law Centre of Canada (March 2006) at 17; Global News, "What was the '60s Scoop'? Aboriginal children taken from homes a dark chapter in Canada's history" August 23, 2016, available online at: <http://globalnews.ca/news/2898190/what-was-the-60s-scoop-aboriginal-children-taken-from-homes-a-dark-chapter-in-canadas-history/>. See generally National Archives of Canada, RG 10, Reel 10 193c, Volume 3816, File 57,045 for a collection of newspapers detailing exploitation of Aboriginal women.

¹⁴ Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples: Looking Forward, Looking Back*, Vol 1 (1996) at 165.

25. For more information on the gap in health care for Indigenous peoples in Canada, please see Appendix “A”.

(2) *Has forced sterilization impacted suicide rates among Indigenous women and what data is available in that regard?*

26. Suicide rates within Canada are exceptionally high in Indigenous populations.¹⁵ Forced sterilization, and its correlated harms, are reported as primary contributors to death by suicide. In one particular instance, a woman from Winnipeg, Manitoba, reported that her daughter died by suicide after she was sterilized under the reported false promise that if she submitted to sterilization, her three children may be returned to her care.

27. It is challenging to ascertain the *cause* of suicide, as it is likely the convergence of many contributing circumstances and conditions. While we are unable, presently, to determine with accuracy the number of forced sterilizations directly resulting in suicide, logic suggests that coerced or forced sterilization is at least a contributing factor to a number of incidences of suicide plaguing Indigenous women in Canada.

III. PETITIONS/REQUESTS FROM THE INTER-AMERICAN COMMISSION ON HUMAN RIGHTS

28. We believe that concrete measures are immediately required to ensure that the forced sterilization of Indigenous women ceases. We propose the following:

- **Examine** the issue of, and engage in **ongoing monitoring** of, the forced sterilization of Indigenous women and girls in the context of violence against Indigenous women and girls and systemic discrimination and institutional racism against Indigenous collectives;
- **Engage** with the Canadian government on its implementation of measures requested herein to immediately cease the practice of the forced sterilization of Indigenous women and girls and to address the systemic discrimination and institutional racism Indigenous peoples face in Canada when receiving health care services, as well as in the judicial system when seeking redress;
- **Issue** timely press releases/statements on significant developments as they arise on the forced sterilization of Indigenous women and girls;

¹⁵ Truth and Reconciliation Commission of Canada, *Report of the Truth and Reconciliation Commission: The Legacy*, Vol II at 109; Laurence Kirkmayer et al., *Suicide Among Aboriginal People in Canada*, (Ottawa, ON: Aboriginal Healing Foundation, 2007); Statistics Canada, “Lifetime and past-year suicidal thoughts among off-reserve First Nations, Métis and Inuit adults, aged 18 years and over, Canada, 2012” October 13, 2016, available online at: http://www.statcan.gc.ca/eng/subjects/aboriginal_peoples/health_and_wellbeing?text=suicide&subject_levels=10003%2C10000&text-go=%3Cspan+class%3D%22wb-inv%22%3ESearch%3C%2Fspan%3E ; Michael Shulman and Jesse Tahirali, “Suicide among Canada’s First Nations: Key numbers” CTV News, April 11, 2016, available online at: <https://www.ctvnews.ca/health/suicide-among-canada-s-first-nations-key-numbers-1.2854899> .

- **Include** forced sterilization in the Commission's study of and language on the issue of violence against Indigenous women and girls in Canada, and in the rest of the Americas, in addition to the sexual and reproductive rights of women and girls in the Americas, generally;
- Follow up on Canada's efforts to **criminalize forced sterilization and forced abortion**;
- Follow up on Canada's efforts to **reinstate and operationalize the First Nations Statistical Institute**, which would result in reliable grassroots data from which patterns may be drawn to clearly identify the magnitude of the problem, its geographic, qualitative and quantitative dimensions, all of which ultimately leads to informed policy based on empirical data that factually illustrates preventable systemic failures; and
- Follow up on Canada's efforts to **build a new national framework for the delivery of health care services** to Indigenous women and peoples generally.

Sincerely,

MAURICE LAW, BARRISTERS & SOLICITORS



Alisa R. Lombard, B.S.Sc., LL.L., JD
Associate

cc: Clients; Native Women's Association of Canada

APPENDIX “A”

Brief Overview of the Health System in Canada and Indigenous Peoples

The delivery of health care to Indigenous peoples in Canada is complicated by the nexus of constitutional powers between the federal and provincial levels of government and the overlap between subsections 91(24) and 92(7) of the *Constitution Act*, 1982 which provide, respectively:

91. It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and House of Commons, to make Laws for the Peace, Order, and good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces; and for greater Certainty, but not so as to restrict the Generality of the foregoing Terms of this Section, it is hereby declared that (notwithstanding anything in this Act) **the exclusive Legislative Authority of the Parliament of Canada extends to all Matters coming within the Classes of Subjects next hereinafter enumerated; that is to say,**

...

(24) Indians, and Lands reserved for the Indians.

(92) In each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of Subjects next hereinafter enumerated; that is to say,

...

(7) The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.

In the 1930s, the Judicial Committee of the Privy Council in Great Britain (then the highest court of appeal available to Canada) decided that the administration and delivery of healthcare was a provincial concern under subsection 92(7), but that the federal government also had the responsibility of protecting the health and well-being of the population (under the section 91 catch-all “Peace, Order, and good Government” clause). As such, today, provincial and territorial governments are responsible for the management, organization and delivery of health care services for their residents, while the federal government is considered responsible for:

- setting and administering national standards for the health care system through the *Canada Health Act*;
- providing funding support for provincial and territorial health care services;
- providing other health-related functions; and
- supporting the delivery for health care services to specific groups (First Nations people living on-reserve and the Inuit).¹⁶

According to Canada’s *Indian Health Policy* of 1979, “the most significant federal roles in this interdependent [Canadian health] system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment.” According to this policy, health policy for federal programs “for

¹⁶ Government of Canada, “Canada’s health care system”, available online at: <<https://www.canada.ca/en/health-canada/services/canada-health-care-system.html#a21>>.

registered Indians flows from constitutional and statutory provisions, treaties and customary practice.”¹⁷

Many of the treaties signed by the Crown and Indigenous peoples as Canada was formed provide the Indigenous parties will be provided with health care. For example, Treaty 6, which covers a large part of Alberta and Saskatchewan, provides for the modern equivalent of a right to health care in its “relief in times of famine and pestilence” and “medicine chest” clauses.¹⁸ In the rights recognition era,¹⁹ these Treaty principles should properly form the basis of policy. However, the federal government has not recognized that it has responsibility for the health care under treaty.

Rather, Canada occupies the Indigenous health field only to the extent that it provides some health care primary services and health/mental health promotion programs targeted to on-reserve First Nation populations and the Inuit exclusively. Health care practitioners with cultural sensitivity and targeted training (mainly nurses and home care workers) are also retained through Health Canada to work in First Nation and Inuit communities.²⁰ Thirdly, Canada provides some non-insured health benefits (drugs, dental, vision care, etc.) to status Indians registered under the *Indian Act*, irrespective of residency (for the most part), though, these benefits have been reduced over time and have been subject to much criticism for other reasons as well.²¹ As summarized on their website, Indigenous Services Canada (ISC), First Nations and Inuit Health Branch (FNIHB), “works with numerous partners to carry out many program-type activities aimed at First Nations on-reserve and Inuit health and wellness promotion and prevention efforts.” FNIHB funds or delivers:

- Community-based health promotion and disease prevention programs;
- Primary, home and community care services;
- Programs to control communicable diseases and address environmental health issues; and
- Non-insured health benefits to supplement those provided by provinces, territories and private insurer.”²²

¹⁷ Government of Canada, “Indian Health Policy 1979” Online: <https://www.canada.ca/en/health-canada/corporate/about-health-canada/branches-agencies/first-nations-inuit-health-branch/indian-health-policy-1979.html>.

¹⁸ Treaty 6, available online at: < <http://www.aadnc-aandc.gc.ca/eng/1100100028710/1100100028783>.

¹⁹ Prime Minister’s Office, “Government of Canada to Create Recognition and Implementation of Rights Framework” February 14, 2018, available online at: < <https://pm.gc.ca/eng/news/2018/02/14/government-canada-create-recognition-and-implementation-rights-framework>.

²⁰ As such, Health Canada's First Nations and Inuit Health Branch (FNIHB) has developed *Clinical Practice Guidelines for Nurses in Primary Care* for use by community health nurses employed by Health Canada providing primary care in isolated, semi-isolated, and remote First Nations communities. These guidelines have been developed in consultation with health care professionals and efforts have been made to ensure that they accurately reflect current best practice standards for culturally acceptable delivery of primary health care by community health nurses.

²¹ For example, see *Wellesley Report* criticism of non-insured health benefits on page 2.

²² Government of Canada, “First Nations and Inuit Health”, available online at: <https://www.canada.ca/en/health-canada/services/first-nations-inuit-health.html>.

Despite Canada's jurisdiction over "Indians, and Lands reserved for Indians" under section 91(24) of the *Constitution Act* and treaty obligations, Canada has only acted on its jurisdiction over "Indians" (as that term is defined under the *Indian Act*) resident off-reserve to the extent that they are entitled to access the non-insured health benefits program. Canada also does not provide secondary health care services targeted to any Indigenous peoples off-reserve. Métis and non-status Indians also continue to be excluded from FNIHB services and programs altogether, though this should change following a recent Supreme Court of Canada decision in 2016 finding that the federal government does indeed have jurisdiction over them as well, as Métis and non-status Indians are "Indians" within the legislative authority of the Federal Crown under section 91(24) of the *Constitution Act*, 1982.²³ It is not surprising that the Truth and Reconciliation Commission (TRC) Calls to Action recommends that Canada accept and acknowledge its wider jurisdictional responsibilities over Indigenous peoples in the provision of health care services and programming, including "Métis, Inuit, and off-reserve Aboriginal peoples":

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.²⁴

Aboriginal and treaty rights to health and healthcare is specifically identified in the TRC Calls to Action as follows:

18. ... to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.²⁵

While the federal government is expected and called upon to support the increase of the availability of appropriate healthcare services targeted to Indigenous peoples irrespective of residency, and otherwise work with Indigenous peoples to close the gap

²³ *Daniels v Canada (Indian Affairs and Northern Development)*, 2016 SCC 12. The Métis Nation (as represented by the Métis National Council and its Governing Members: the Métis Nation of Ontario, Manitoba Metis Federation, Métis Nation-Saskatchewan, Métis Nation of Alberta and Métis Nation British Columbia) recently signed an accord with Canada, dated April 13, 2017, whereby one stated objective going forward is to "[i]mprove socio-economic conditions of Métis and their access to social and economic programs and services that address their needs." The political accord is available online: <https://pm.gc.ca/eng/canada-metis-nation-accord>

²⁴ Truth and Reconciliation Commission of Canada, *Calls to Action* (Winnipeg, 2012), available online at: http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf

²⁵ *Ibid.*, Calls to Action.

in health outcomes, according to Canada, the trend is to work closer with local providers to deliver appropriate health services:

Direct federal delivery of services to First Nations people and Inuit includes primary care and emergency services on remote and isolated reserves where no provincial or territorial services are readily available; community-based health programs both on reserves and in Inuit communities; and a non-insured health benefits program (drug, dental and ancillary health services) for First Nations people and Inuit no matter where they live in Canada. In general, these services are provided at nursing stations, health centres, in-patient treatment centres, and through community health promotion programs. Increasingly, both orders of government and Aboriginal organizations are working together to integrate the delivery of these services with the provincial and territorial systems.²⁶

Despite the ongoing provision of health programs and services as described above, Canada admits on its website, that “[i]n recent years, First Nations and Inuit health has improved; however, gaps remain in the overall health status of First Nation and Inuit when compared to other Canadians.”²⁷ Given Canada has largely failed in its mandate, there is a trend towards control over programming and services for First Nations being transferred to First Nation governance.

In British Columbia in 2013, the First Nations-managed First Nations Health Authority – the first of its kind in the country – assumed control over programs, services, and responsibilities (including funding) formerly handled by the Pacific Region of FNIHB. The FNHA however “does not replace the role or services of the Ministry of Health and Regional Health Authorities. The First Nations Health Authority will collaborate, coordinate, and integrate our respective health programs and services to achieve better health outcomes for BC First Nations.”²⁸ Their mandate is described as follows, and relates largely to “health promotion and disease prevention” programs as was the case for FNIHB:²⁹

The FNHA is responsible for planning, management, service delivery and funding of health programs, in partnership with First Nations communities in BC. Guided by the vision of embedding cultural safety and humility into health service delivery, the FNHA works to reform the way health care is delivered to BC First Nations through direct services, provincial partnership collaboration, and health systems innovation.³⁰

²⁶ Government of Canada, “Canada’s Health Care System”, available online at: <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html#a5>.

²⁷ Government of Canada, “First Nations and Inuit Health”, available online at: <https://www.canada.ca/en/health-canada/services/first-nations-inuit-health.html>.

²⁸ The programs they oversee include: Primary Health Care, Children, Youth and Maternal Health, Mental Health and Wellness, Communicable Disease Control, Environmental Health and Research, First Nations Health Benefits, eHealth and Telehealth, Health and Wellness Planning, Health Infrastructure and Human Resources, Nursing services and Traditional healing.

²⁹ First Nations Health Authority, “About the FNHA”, available online at: <http://www.fnha.ca/about/fnha-overview> [About the FNHA].

³⁰ *Ibid.*, About the FNHA.

For a more detailed review of various attempts in Canada to increase Indigenous access to health care and to mitigate the impact of racism on Indigenous peoples at the health care service and delivery level, please see the section under “Health care and service delivery responses” at pp.10-11 of *First Peoples, Second Class Treatment*.