GENDER-BASED VIOLENCE AGAINST INDIGENOUS WOMEN IN THE CANADIAN HEALTH CARE SYSTEM & THE DIVISION OF POWERS

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"I am not free while any woman is unfree, even when her shackles are very different from my own."

— Audre Lorde

Stupid as hell. Only good for sex. Better off dead. These are only some of the disparaging remarks made about Joyce Echaquan, a 37-year-old mother who was admitted to a Joliette, Quebec hospital on September 28, 2020 for stomach pain.[1] She died several hours later while under the care of the nursing staff. Echaquan was given morphine despite her insistence that she would have an adverse reaction to it. Apart from being ridiculed in French, a language she could not understand, she had also been tied down to her bed. The hospital staff, having shown a blatant disregard for their patient's quality of care and for her life, refused to listen to her concerns. Echaquan died from an allergic reaction to the morphine prescribed.[2] This was not Echaquan's first mistreatment in a healthcare setting; making her wary enough to film the encounter. The last hours of her life were recorded and uploaded to her Facebook account. How many other women have suffered a similar fate but did not have proof? This is not a first for many Indigenous women in Canada, nor will it be the last.

Gender-based violence against Indigenous women in Canada is not only a human rights violation, but a collective healthcare problem. The Canadian National Health Insurance Program, referred to more commonly as Medicare, is designed to ensure that all Canadians have equal access to hospitals and physicians. Instead of having one standard plan, there are 13 provincial and territorial health care insurance plans.[3] According to section 92 of the Constitution Act, healthcare falls under the responsibility of the provinces, and therefore allows provinces to administer their own healthcare plan. According to section 91 of the Constitution Act, however, Indigenous peoples fall under the responsibility of the federal government, making the proper care

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[1] "Criminal Investigation Needed Into Death of Joyce Echaquan, Say 2 Legal Experts" (1 October 2020), online: *CBC News* <www.cbc.ca/news/indigenous/joyce-echaquan-death-lawyers-investigations-1.5745587>.

[2] *Ibid.* Echaquan's family believes their mother died from an allergic reaction to the morphine prescribed.

[3] "Canada's Health Care System" (22 August 2016), online: *Government of Canada* <www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html>.

and treatment of Indigenous peoples a divided jurisdictional issue. Those who are impacted most by the decisions and consequences of these issues are women and children. There has long been jurisdictional debates over the rights of Indigenous peoples, but perhaps none so callous as arguing over who should pay for their healthcare treatment. Ultimately the dispute boils down to: who will foot the bill? The quarrel over funding and the lack of a standard procedure means that more energy is expended on finances than on the healthcare of Indigenous peoples. The goal of this paper is to demonstrate how this division of powers issue contributes to gender-based violence against Indigenous women, and in turn, further contributes to their oppression and inability to fully participate in their citizenship; a citizenship that was founded upon their land, no less.

Statistics show that Indigenous women face significantly higher levels of violence, both sexual and domestic, than non-Indigenous women.[4] Despite Indigenous women making up the largest part of women who are assaulted in Canada, they are the most likely to die or receive less than adequate treatment in healthcare.[5] This issue is circular: the more women who are assaulted, the more likely they are to require medical treatment, and the more likely they are to require medical treatment, the more likely they are to receive below adequate care and suffer exponentially for seeking it. This is not an isolated issue. Indigenous women are less likely to have access to reproductive healthcare, safe abortions, and overall, are less likely to receive compassion and care from healthcare providers. Some of the reasons why healthcare is so hard to access include lack of services in remote locations, cost of travel off-reserve, and racism in the healthcare system – which endangers both the proper course of treatment and access to these services. If women are unable to easily access healthcare services, especially where reproductive resources are concerned, they lose agency over their bodies and their choices, which has a negative impact on their self-worth. This leads to further instances of trauma, which results in issues within the family, such as intimate partner violence, child abuse, and addiction issues becoming more prevalent.

Violence against women and the treatment they receive in healthcare are correlated, and the government has historically perpetuated this cycle by not actively legislating to protect these women or by not intervening in some capacity. By turning a blind eye to the individual practices and systemic racism in the provinces, Indigenous women are more at risk for mistreatment – even though they are supposedly under the protection of the federal government, and have been promised as much. Racist practices, continued today, are expressly contrary to the inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG), the Truth and Reconciliation

[4] Nihaya Daoud et al, "The Contribution of Socio-economic Position to the Excesses of Violence and Intimate Partner Violence Among Aboriginal Versus Non-Aboriginal Women in Canada" (2013) 104:4 CJPH 278.

[5] "About Gender-Based Violence" (28 October 2020), online: *Government of Canada* <women-gender-equality.canada.ca/en/gender-based-violence-knowledge-centre/about-gender-based-violence.html>.

Commission's Calls to Action (TRC), and the United Nations Declaration on the Rights of the Indigenous Person (UNDRIP).

To a large extent, the degree of intimate partner violence and the abhorrent history of abuse in the reproductive healthcare system, has contributed to a legacy of distrust among Indigenous peoples. The remnants of these discriminatory practices continue to affect the level of care provided to Indigenous women today. This narrow issue is simply a microcosm of the larger issue of systemic racism in Canada. There are many contributing factors at the root of racist medical practices in a healthcare setting, including a general lack of awareness. Many healthcare professionals – from receptionists to doctors – charged with caring for Indigenous women, do not see systemic racism as a problem. Policy and governmental change are driven by social attitudes and perceptions. Until there is an unqualified demand for better quality services from society as a whole, the government will see no reason to invest in them. Research into these topics are underfunded, under-researched, and underrepresented, which contribute to a lack of visibility about Indigenous women's issues in these areas.

Ultimately, why is it that Indigenous peoples experience some of the worst healthcare practices in Canada, despite its national healthcare coverage system? The following three sections will address how the division of powers contributes to the detriment of Indigenous women in the healthcare system. The first section will explore how colonial myths have contributed to the heightened levels of violence against Indigenous women in Canada. The second section will focus on the abusive and oppressive medical practices affecting agency and rights of Indigenous women. The last section will focus on weaving the previous two sections together by affirming that gender-based violence is a public healthcare problem which does not fully allow Indigenous women to engage in their citizenship, thereby constituting a blatant human rights violation, contrary to federal commitments, such as the TRC and MMIGW, and contrary to international human rights frameworks, such as UNDRIP. This section will focus on federalism issues that are at play in the healthcare system, specifically when it comes to equal access and funding. Successive government commitments to different human rights frameworks are lacking in the implementation stages concerning Indigenous peoples, making it both a deeply federal and provincial issue. The universal healthcare program exists to ensure everyone has equal access to medical services, regardless of socio-economic background or status. This public system ensures there is no price tag on health. It promises to treat everyone with dignity. Unfortunately, this concept is still illusionary for many Indigenous communities. The provinces look to the federal government for guidance, but their fluid policies are better known for what they do not say, rather than what they do say. Hospitals are meant to save lives; not take them.

Colonial Myths and their Contribution to Heightened Levels of Violence Against Indigenous Women in Canada

Indigenous women suffer from poorer healthcare and social outcomes compared to their male counterparts, and more blatantly, compared to non-Indigenous women. The reality of being an Indigenous woman in Canada today is not comforting. Indigenous women and girls are 12 times more likely to be murdered or go missing than any other woman in Canada, and 16 times more likely than Caucasian women.[6] They are also more likely to be assaulted, robbed, kidnapped, and in addition, make up the majority of people in Canada who are trafficked.[7] Due to these stressors and circumstances, it is therefore no surprise that Indigenous women suffer from higher rates of heart disease and stroke, higher rates of suicide, disproportionately live as single parents in poverty, and are more often criminalized.[8] The health and wellbeing of Indigenous people continues to lag behind that of the overall Canadian population in virtually every measure, and most research points to racism as a primary factor.

Gender-based administrative violence is a deeply colonial strategy and, for the most part, a wide range of medical practices "are the result of nonaccidental and systematic production of institutional violence that cannot be disentangled from the goals of ongoing settler occupation and dispossession of Indigenous lands."[9] These practices include forced sterilization, poor birth outcomes, and discrimination. There are wide disparities for maternal health care between Indigenous and non-Indigenous women: Indigenous women experience higher rates of adverse outcomes, including stillbirth and prenatal death, and, in some cases, low-birth-weight infants, prematurity and infant death.[10] Reasons for this include lack of access to health treatment within remote communities and the cost of travel to hospitals from reserves. Indigenous peoples living in rural areas are often subject to worse healthcare problems than those in urban areas because there may not be medical clinics or doctors nearby, and they may not have access to transportation to reach them. All this is compounded with their experience of racism within the system, which is a deterrent in itself. Difference between spiritual beliefs, which may prevent participation in Western medical healthcare, also contributes to lower health outcomes.[11]

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[6] National Inquiry into Missing and Murdered Indigenous Women and Girls, "Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls: Volume 1a" (2019), online: <www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf> [Missing and Murdered Indigenous Women].

[7] *Ibid.*

[8] *Ibid.* The incarceration rate of Indigenous women having risen by 90% in the last decade.

[9] Nora Berenstain & Elena Ruiz, "Gender-Based Administrative Violence as a Colonial Strategy" (2018) 46:2 Philosophical Topics 209 at 209.

[10] Fariba Kolahdooz et al, "Canadian Indigenous Women's Perspectives of Maternal Health and Health Care Services: A Systematic Review" (2016) 13:5 Diversity & Equality in Health & Care 334.

[11] Missing and Murdered Indigenous Women, *supra* note 6.

Another colonial strategy to subjugate women was creating false and harmful archetypes about the Indigenous race as a whole. Racialized and gendered eugenic practices were, and still are, informed by the myth that Indigenous women are hypersexual, hyper-fertile and not to be trusted with their own reproductive agency.[12] Research also points to Indigenous mothers being less likely to access healthcare for themselves when state apprehension of their children is being threatened.[13] These kinds of threats are used a basis for depriving Indigenous women of their rights and serves as a way of getting them to agree to unwanted medical procedures. This kind of systemic and systematic violence is particularly disturbing because "Indigenous women have historically held a respected, and even sacred status."[14] Women in Indigenous communities historically fought in battles, led wars, held leadership positions, traded and farmed, and were represented by sacred female deities.[15] In charge of their own tribal communities, female-centred leadership often reflected the cultural values and norms of unity and cooperation.[16] The role and status of women was deeply influenced by the arrival of settler Europeans. This female-centred leadership style was unfamiliar to them. They made quick work of upending the social structure and gender dynamic within Indigenous communities and substituting their own patriarchal ideas.

There is a large body of research which proposes that colonization has "undermined the traditional complementary and egalitarian gender roles that have been thought to naturally protect indigenous women" and as a result, Indigenous women now face the highest levels of violence, in all its forms, including intimate-partner violence (IPV) in Canada.[17] Traditionally, IPV was thought to be uncommon in matrilineal and female-centered Indigenous communities because their leadership style promoted values which were thought to naturally protect women. If a party transgressed these laws, the consequences would be grave. Aggressing parties would be banished or stripped of their status and respect.[18] The severity of these measures ranks IPV as one of the worst offences in Indigenous communities.

Through colonialism and the aggressive acts that accompanied it, both physically and legislatively, Indigenous women were stripped of their central roles. Being taken as sex slaves cemented the Western idea that women were objects of sexuality and were to be possessed by men. The failure to recognize women as equal

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[12] Berenstain & Ruiz, *supra* note 9 at 221.

[13] Jacqueline Denison, Colleen Varceo & Annette Browne, "Aboriginal Women's Experiences of Accessing Health Care When State Apprehension of Children is Being Threatened" (2013) 70:5 Advanced Nursing 1105.

[14] Catherine Burnette, "Historical Oppression and Intimate Partner Violence Experienced by Aboriginal Women in the United States: Understanding Connections" (2015) 89:3 Soc Service 531 at 532.

[15] *Ibid* at 533.

[16] *Ibid* at 534.

[17] *Ibid.*

[18] *Ibid* at 533.

citizens is tied to the concept that to "be sexually penetrated means to be subordinate."[19] The history of subjugation of women is traced back to Ancient Rome, where rape was a property offense against husbands.[20] Canada is not shielded from this shameful history. Marital rape was not considered a crime until 1983.

The theory that colonization is the root of systemic racism is commonly advanced through several pathways, which have been identified to explain how colonialism has increased violence against Indigenous women.[21] The first pathway is through collective violence, which includes structural and systemic discrimination, racism and human rights violation. A second path speaks to the perception of gender roles subsequent to the "imposition of European and Christian patriarchal values that destroyed balanced power relations and communal relations between men and women in Aboriginal communities", which introduced new forms of violence to these groups. [22] Lastly, research points to the impact of colonial policies in Canada, including the residential school system and the Sixties Scoop, as leading causes of increased family violence.

Indigenous resistance to being assimilated by the settler state resulted in an increase of forceful government polices which sought to gain independent control of Indigenous peoples. Government use of unconscionable measures led to the heated climate of distrust experienced between Indigenous peoples and the government today. The residential school system, one of the government's most discriminatory policies, oversaw children being forcibly taken from their homes and separated from their families. These institutions, run by the church but funded by the government, had a shared goal of assimilation. In these schools, physical, cultural, mental and sexual abuse was rampant. The priests and nuns who served as educators often had no background or experience in teaching. The process of removing children from their families, not allowing visitation and barring them from speaking their language or talking about their culture, saw the residential school system develop adults who could not cope in a materialistic world, which depended upon initiative and financial stability to succeed. As a result of this trauma, those who survived resorted to coping mechanisms, such as alcohol, which in turn, saw family violence and abuse rates became more prevalent. [23] Because of these increased rates of violence and substance abuse, one of the most commonly developed misconceptions, which carries a heavy stigma in a healthcare setting, is that Indigenous women are unfit mothers. It is argued

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[19] Rashida Manjoo, "Violence Against Women as a Barrier to the Realisation of Human Rights and the Exercise of Citizenship" (2016) 112 Feminist Rev at 13.

[20] Burnette, s*upra* note 14 at 534.

[21] Daoud et al*, supra* note 4.

[22] *Ibid* at 278.

[23] It is estimated that over 6,000 children died while attending residential schools, see Chinta Puxley, "Up to 6,000 children died at Canada's residential schools, report finds" (31 May 2015), online: *Global News* <globalnews.ca/news/2027587/deaths-at-canadas-indian-residential-schools-need-more-study-commission/>.

that this "ideological assumption that Aboriginal mothers lack adequate parenting skills, [or] that a particular race is deemed 'incompetent' or 'incapable', stems back to the valuation and persistence of white-western patriarchy and assimilation."[24] Since many Indigenous women are single parents, subject to poverty, these stigmas affect them the most detrimentally.

By viewing women as equal and vital members of their community, by respecting and revering sexual fluidity, by respecting and preserving the land, and engaging in socially-conscious practices, Indigenous communities were, in many ways, more just than other communities. The great irony of colonization is the European effort to "civilize" the New World, which led to massive injustices and atrocities being committed against its native people. In respect to healthcare specifically, another point of irony is that Indigenous peoples helped settlers adjust to the harsh climate upon contact; had they not, the settler population may not have survived. The favor was not returned. Settlers brought with them a deadly contagion of diseases, which affected the vitality of whole Indigenous communities, and could not be cured through the natural and holistic healing measures they were accustomed to.

Historically, Indigenous women tend to be "associated with forms of involuntary movement; their mobility across imperial and colonial space is often equated with violence, coercion and abandonment."[25] Colonial practices took on different shapes and sizes of oppression, but perhaps none so demoralizing as turning a blind eye, or actively legislating abuse in the healthcare system. Stories of mistreatment within the healthcare system deterred, and continue to deter, Indigenous peoples from seeking medical attention. In an American study, 71% of women who experienced forced interventions during pregnancy were Indigenous.[26] In Canada, a proposed-class action lawsuit alleges the coerced sterilization of over 100 Indigenous women.[27] The class-action was proposed in 2018.

A History of Oppressive Medical Practices

The history of Indigenous peoples' access to healthcare is of great importance to the development, or lack thereof, in that area. During the period of oral treaty-making,

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[24] Randi Cull, "Aboriginal Mothering Under the State's Gaze" in Jeannette C Lavell & D Memee Lavell-Harvard, eds, *Until Our Hearts Are On the Ground*, (Toronto: Demeter Press, 2006) 146 at 146–151.

[25] Angela Wanhalla, "Indigenous Women, Marriage and Colonial Mobility" in Rachel Standfield, ed, *Indigenous mobilities: Across and Beyond the Antipodes* (Acton: Australian National University Press, 2018) 209 at 210.

[26] Karen Stote, "The Coercive Sterilization of Aboriginal Women in Canada" (2012) 36:3 American Indian Culture & Research J 117 at 121.

[27] "Indigenous women come forward with accounts of forced sterilization, says lawyer" (18 April 2019), online: *CBC News* <www.cbc.ca/news/canada/north/forced-sterilization-lawsuit-could-expand-1.5102981>.

Indigenous peoples were promised equal rights to healthcare. However, this promise was not represented in the written reproduction of the treaty. This was not the first time the government promised something and did not deliver. When the Indian Act was passed in 1876, it purported to take care of Indigenous populations in Canada. Although amended since then, the content has remained largely unchanged. Originally, it allowed a band council to make bylaws for matters such as the healthcare of band members, which on the surface, would seem to grant self-governance. But, any bylaw or recommendation needed to be approved by the reserve's local "Indian Agent." Approval for funding or services was often rejected. The running joke was that Indigenous peoples could not get sick without the written permission of their "Indian Agent."[28]

In the early 1900s, the federal government began to assume responsibility for the delivery of health services on reserves and by the mid-1960s, most First Nations reserves had access to some level of public health and primary healthcare services delivered by federally employed nurses and interpreters.[29] Still, the allocation of medical care was at the discretion of local "Indian Agents," who often had no background or medical expertise. Each nation was typically given one first aid kit to share among its members, upon approval of the agent. These initial health practices demonstrated that the government did not value Indigenous peoples equally and believed they deserved less than other people, and as a result, the cost of such services should be lower. Government funding reflected that belief.

The myths discussed in the first section impacted the level of treatment Indigenous women receive in healthcare. The stigma of bad Indigenous mothering produces classic white supremacist tropes, like that of unfit motherhood, which is a "gendered and racialized controlling image that functions strategically to obscure the structural violence" that women of color experience through the denial of access to quality reproductive and medical care.[30] A common example is the image of the "drug-addicted baby born to the abusive mother who prioritizes her pleasure and addiction over her child." [31] These portrayals affect Indigenous women's rights to control their own bodies, especially in respect to reproductive healthcare. When women are viewed as unfit mothers, healthcare workers are less likely to defer to their personal choices and more likely to impose or substitute their own view of what they think is right. The attitude and biases of the staff caring for them affect the level and quality of treatment they are given. Whether knowingly or unknowingly, "Healthcare service providers' perception of Indigenous women as mothers influenced the women's experience of

[28] Harold Cardinal, *The Unjust Society* (Vancouver: Douglas & McIntyre, 1969) at 36.

[29] Brenda Gunn, "Ignored to Death: Systemic Racism in the Canadian Healthcare System" (undated) at 6, online (pdf): *Nourish Leadership* <www.nourishleadership.ca/resources-1/2021/4/9/ignored-to-death-systemic-racism-in-the-canadian-healthcare-system>.

[30] Berenstain & Ruiz*, supra* note 9 at 222.

[31] *Ibid.*

accessing care."[32] By removing the right to make decisions based on free will, healthcare workers are effectively subjugating Indigenous women and dehumanizing them, through the very channels they depend upon. As a result, racist attitudes pervade Canadian society, including the "consciousness of nurses, doctors, social workers, unit clerks, and receptionists."[33] Many people still fall victim to the myth that ill health, disease, injury and death are often the fault of Indigenous peoples themselves. This leads to many healthcare workers unconsciously treating these patients with a higher degree of blameworthiness, infused with personal moral judgment.

Healthcare workers themselves, whether admittedly or not, are subject to work in an environment deeply influenced by these biases. Initially, violence against women and the treatment they received in healthcare served as a weapon of colonization and oppression, but now it remains a stigma which affects the proper course of treatment. There is a notable and substantial power imbalance between non-Indigenous health care providers and Indigenous peoples, which "underpins their negative experiences in the health care system." [34] This problem is not well-understood, or even perceived, by many health professionals.[35] If healthcare professionals are unable to check their own biases, there is little hope for change. Despite the research which validates the experience of mistreated Indigenous peoples, some healthcare workers deny that racism in healthcare is a determinant to Indigenous peoples' health.[36] Refusal to acknowledge these biases, or to challenge them, is dangerous. The Canadian Minister of Health, Patty Hadju, acknowledges that non-accidental systemic racism played its part in the origin of healthcare. In response to the death of Joyce Echaquan, the same Minister said that the system is not broken, but rather, "was created this way" and therefore, the people in the system are incentivized to stay the same.[37]

This acknowledgement is in line with what many researchers have been saying for years. Karen Stote argues that the government is perhaps complicit in continuing the cycle of abuse and says that they may have actively played a role in ramping up the sterilization of Indigenous peoples in the North during the 1970s.[38] Before Stote's study, there had been no scholarship conducted in this area. The research revealed that:

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[32] Kolahdooz et al*, supra* note 10 at 337.

[33] Gunn, s*upra* note 29 at 3.

[34] Yvonne Boyer, "Indigenous people must become full partners in Canada's health system" (2018), online: *Macleans* < www.macleans.ca/opinion/indigenous-people-must-become-full-partners-in-canadas-health-system/>.

[35] *Ibid.*

[36] Gunn, s*upra* note 29 at 3.

[37] Peter Zimonjic, "Health care system was designed to subject Indigenous people to systemic racism: Hadju" (16 October 202), online: *CBC News* <www.cbc.ca/news/politics/health-indigenous-racism-miller-1.5764659>.

[38] Stote, s*upra* note 26.

> Though the federal government fell short of enacting legislation directly sanctioning the sterilization of Aboriginal peoples, through its refusal to condemn the practice, by its enactment of policies and legislation affecting other aspects of Aboriginal life making sterilization more likely, and through its financial support to provinces, it did allow for these sterilizations to be carried out more effectively, both in its own institutions and in those under provincial control.[39]

In the 1900s, the sexual sterilization of Indigenous women was viewed as a public health measure. Having been told for so long what to do by the government, with grave consequences attached, many Indigenous women did not realize they had a choice in the matter. Many were also led to believe the procedure was reversible. The threat of having their children apprehended was also a cruel incentive for Indigenous women to follow what they believed was standard procedure. By turning a blind eye to the different healthcare practices under the responsibility of the provinces, the federal government actively enabled the oppression of Indigenous women. Aside from passively allowing sterilization abuse to go unfettered in provincial legislation, certain instances prove the federal government actively enabled and expanded upon it.

From 1933 to 1973, the provinces of Alberta and British Columbia had implemented sexual sterilization acts, which disproportionately targeted and affected Aboriginal women.[40] The federal government was aware that sterilizations were being performed without "following the proper legal channels, such as obtaining consent."[41] They did not however, undertake any formal action or inquiries into these practices. In addition, there are no factual statistics on how many women were sterilized during this period because the department of medical services, especially in Northern areas, were not properly keeping track of this data. To respond to this disparity, the Department of Indian Affairs suggested that consent be necessary before such procedures could occur. However, over 77% of Aboriginal women were considered "mentally defective" and thus the operations did not require consent.[42] The federal government not only failed to intervene, but actively undertook measures to legitimize these provincial sterilization acts. A 1951 amendment to the Indian Act saw the increased application of provincial laws to all Indigenous peoples, meaning that "a "mentally incompetent Indian" under the policy was to be defined according to the laws of the province in which they reside. In other words, "a mentally incompetent Indian was whatever a province deemed him or her to be."[43] The mental defect component would fall short of any kind of mental health threshold imposed today and was self-serving in carrying out the goals of assimilation. Forced sterilization and the

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[39] *Ibid* at 141.

[40] *Ibid* at 120.

[41] *Ibid* at 126.

[42] *Ibid* at 121.

[43] *Ibid.*

control of women's reproductive agency was not just politically motivated, but also economically motivated to reduce the financial burden of impoverished people to whom the government is responsible for assisting.[44] This is just one example of how public healthcare practices have affected the agency and rights of Indigenous women. Unfortunately, sterilization is only the "tip of the iceberg for the inhumane treatment of Indigenous people" in the health system.[45]

When news broke of Indigenous women coming forward with accounts of sterilization in 2018, the floodgates opened for complaints of a similar nature. It included the statement of one woman who sought medical care when she was six months pregnant and left the hospital with an unwanted abortion and having been partially sterilized.[46] She was given no explanation as to why the procedures were necessary. Numerous other accounts included racist assumptions by health practitioners that an Indigenous person "is drunk rather than suffering from low blood sugar as a diabetic; refusal and poor quality of care; denial of organ transplantation; and coerced sterilization and abortions."[47]

Even law enforcement, such as the police and the RCMP, have mistaken obvious signs of medical distress for classic racist tropes, such as automatically assuming a sick person is intoxicated. As a result, multiple people have died while being held in their custody. In 2008, a 43-year old First Nations man, Raymond Silverfox, died in the custody of an RCMP detachment in the Yukon.[48] The officers assumed he was simply drunk, when he was actually suffering from acute pneumonia. He had vomited 26 times within 13 hours and received no medical attention. He later died in a hospital. The officers charged with his care mocked and ridiculed him while he lay in a pool of his own vomit and feces. When he asked for a mat to sleep on, they laughed at him and told him to "sleep in your own shit."[49] There is not enough space in this paper to detail all the stories of abuse which have occurred at the hands of the police, but it serves as an example that a medical emergency may look very different when it is an Indigenous person presenting with symptoms.

As a result of these stories, Indigenous peoples are rightfully weary of institutions who purport to provide compassion and care. The system has historically punished them for seeking care. The stigma is even higher for those who are seeking care to cope with an addiction, an instance of abuse, sexual violence, or child neglect

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[44] *Ibid* at 125.

[45] Boyer, s*upra* note 34.

[46] *Ibid.*

[47] *Ibid.*

[48] "'We failed,' Yukon RCMP says of in-custody death" (27 April 2010), online: *CBC News* <www.cbc.ca/news/canada/north/we-failed-yukon-rcmp-says-of-in-custody-death-1.894466#:~:text=Yukon%20RCMP%20have%20expressed%20shock,hours%20in%20custody%20in%202008.>

[49] Boyer, s*upra* note 34.

– where the fear of criminalization and not being believed is a greater possible outcome, than with non-Indigenous people. Indigenous women consistently experience higher rates and more severe forms of physical assault, including sexual violence, which is a huge problem in all its forms. Indigenous women are sexually assaulted three times more often than non-Indigenous women.[50] Since women are more likely to be assaulted, violated, and abused, they are more likely than their male counterparts to seek necessary medical attention. This is an especially high cause of concern. Unlike men, if women become pregnant, they must typically accept the fact that the healthcare system will have a hand in their pregnancy. The basic right of reproductive freedom, already impeded by the fact that Indigenous women are the highest group of sexual assault survivors in Canada, offers a very different choice to Indigenous women. If they want to start a family, they must weigh the consequences of what seeking maternal healthcare will look like for them. Leading Indigenous scholar, Andrea Smith, argues that women of color are particularly threatening to the patriarchal society because they have the ability to reproduce the next generations of communities of color.[51] Smith's research focuses on how the elimination of women's reproductive rights were used a colonial weapon of controlling the population. In their, "Better Dead than Pregnant" chapter, Smith focuses on Indigenous women in particular, whose ability to reproduce continues to stand in the way of the continuing conquest of Native lands, endangering the continued success of colonization.[52]

Maternal health is also deeply influenced by the image of the "unfit Indigenous mother." Prenatal care is deemed to increase the chances of healthy birth, but Indigenous women on average, access this care less than non-Indigenous women. There are a variety of factors which affect their access to this care, such as the cost of recommended vitamins or medicines, clash of cultural values, access to doctors or hospitals, and the cost of travel and missed work opportunities. When Indigenous mothers are deemed as "unfit," for missing these appointments, it affects their perception of themselves and leads to more instances of depression. The prevalence of mental health issues are also disproportionately high among Indigenous women and girls and is directly tied to the disproportionate levels of violence they face, or will likely face, at some point in their lifetime.

Often times, as mentioned above, if women seek medical treatment in response to sexual trauma or pregnancy, they may undergo non-consensual procedures which could result in an unwanted abortion or forced sterilization. It could also lead to the intervention of child protective services, which intentionally or not, is assimilatory in nature. Despite Indigenous children only making up less than 6% of the population in their age group, over half of all children in healthcare belong to that

[50] Missing and Murdered Indigenous Women, s*upra* note 6.

[51] See generally Andrea Smith, *Conquest: Sexual Violence and American Indian Genocide* (Cambridge: South End Press, 2005).

[52] *Ibid.*

group.[53] It also serves as a major deterrent to mothers, who live with the fear of having their children apprehended by social services. Indigenous scholar and mother, Chelsea Vowel states that "The possibility of having my child taken by the state is something I take very seriously because, as an Indigenous woman, I have to."[54] Vowel argues that the "…long and enduring history of Indigenous child apprehension in this country, from generations of kids being taken in the residential school system to the current crisis of child removal" makes this fear a bitter reality.[55] In Vowel's home province of Manitoba, on average one Indigenous newborn is seized everyday by social services – which exceed the rates during the height of the residential school era.[56] This fear, along with the fear of not being properly understood by healthcare professionals is a live issue. By deterring and punishing women for seeking healthcare, the impacts become more severe and long-lasting, especially in the realm of mental health.

Jurisdictional Issues in the Context of Reconciliation

Issues of jurisdiction have always been controversial when it comes to Indigenous rights. At the time of original negotiations, Indigenous peoples did not know they were signing away their sacred treaty rights. They thought the transfer of land was superficial and did not extend to exclusion or displacement from their land. In Indigenous culture, the land is inalienable, meaning that it cannot be owned, transferred, or given away. Taking advantage of cultural and language barriers, Indigenous peoples were "swindled" out of their land rights, which accompanied a host of other rights.[57] Since then, Indigenous peoples have fought to regain status and to have their sacred treaty rights affirmed. Self-governance is often the ultimate goal in these current negotiations and one of the main solutions proposed to combat systemic racism in healthcare is self-determination of health programs.[58]

When the Constitution Act came into play, the divide between Indigenous peoples and health care only became wider. In 1867, the Act designated that "First Nations peoples and the lands reserved for them" were the responsibility of the federal government, with the Indian Act being the primary piece of legislation of governance for First Nations peoples. The Indian Act was deeply divisive and drafted on the basis of racist underpinnings and assumptions about Indigenous peoples, with the ultimate goal of assimilation in mind. The Act also listed other responsibilities to be divided between the federal government and the provincial governments. These

[53] Missing and Murdered Indigenous Women, *supra* note 6 at 283.

[54] Chelsea Vowel, "As A Métis Woman, I Always Think About the Possibility of My Children Being Taken Away" (23 November 2017) online: *Chatelaine* <www.chatelaine.com/opinion/indigenous-children-families/>.

[55] *Ibid.*

[56] *Ibid.*

[57] Cardinal, *supra* note 28 at 33.

[58] Missing and Murdered Indigenous Women, *supra* note 6.

responsibilities are laid out in sections 91 and 92 of the Constitution Act. Section 91 granted the sole responsibility of Indigenous peoples to the federal government, however, under section 92, the provincial governments were allotted responsibilities which affected the day-to-day lives of Indigenous peoples, such as healthcare, education, housing and more. Some of the more contentious areas, such as natural resources, are divided between federal and provincial governments. This has created a number of conflicts over the profit and funding of land rights and resources. No single level of government is prepared to take full financial responsibility for Indigenous peoples, and that is inextricably linked to why they suffer from poorer health and social outcomes. Each successive government tries to slough off its responsibilities to the other level of government, and effectively, passes the buck on their promise of reconciliation. This cyclical way of managing responsibilities has prompted distrust, mistreatment, and has allowed for too many Indigenous peoples to fall through the cracks. The federalism issue is well articulated in the following passage:

> While the federal government and many First Nations argue that the provinces retain an obligation to provide equitable access to all health services to all provincial residents, including First Nations, perceptions remain among some service providers and provincial governments that First Nations are a federal responsibility for all services, with possibly the exception of family physicians, specialist care and hospital-based care.[59]

This lack of transparency and commitment can cause delays, erect unnecessary barriers, and result in the denial of care, "associated with the belief that care should be sought on-reserve."[60] Typically, the province is in charge of delivering health-care off-reserve, and the federal government is responsible for funding it on-reserve.[61] This has created arguments overfunding in complicated cases, which came to a head in 1999 between the province of Manitoba and the federal government. Jordan River Anderson, from Norway House Cree Nation, was born with severe disabilities. Since the federal and provincial governments could not agree on who would pay for his at-home care, Jordan spent over two years in a hospital.[62] Where governments cannot agree on whose responsibility it is to pay for services to First Nations children on reserves, the service is not typically provided until the issue of payment is sorted out. Unfortunately, Jordan died at the age of five before he could experience living in a loving home. After his death, *Jordan's Principle*, a child-first principle ensuring First Nations children get the services they need when they need them, was enacted. No such programs exists for women, or other groups of Indigenous peoples. Arguably, there should not be a need for specialized programs to exist to

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[59] Gunn, s*upra* note 29 at 6.

[60] *Ibid.*

[61] Cindy Blackstock, "Jordan's Principle: Canada's broken promise to First Nations children?" (2012) 17:7 Paediatrics & Child Health 368 at 369 [Blackstock].

[62] First Nations Child & Family Caring Society, "Jordan's Principle", online: *Jordan's Principle* <fncaringsociety.com/jordans-principle>.

serve the purpose of ensuring that fair treatment and equal care is given to everyone. After all, that is the premise of the universal healthcare system. But practically, the demand for individualized and specialized programs to ensure Indigenous peoples do not die or suffer from the treatment they received in the public health system is necessary.

Indigenous peoples are unique in the healthcare setting, given that they are the only group in Canada which consistently faces these complex issues of funding. Each level of government tries to shirk its fiscal responsibility in an attempt to avoid financial strain. As a basic matter of policy, the federal government should take responsibility in the event of a disagreement, because the federal purse is larger than the provincial one – and Indigenous peoples have treaties with the Crown, not the provinces. The provincial borders were arbitrarily enacted long after the treaties were signed promising Indigenous peoples equal rights. The continuing, and very public, debate over who should foot the bill informs the myth that Indigenous peoples are a burden on the Crown.

In another unique attempt to assimilate Indigenous peoples, the government took aim at the subjugation of women specifically. The government legislated the loss of status for women who married non-Indigenous persons. However, if an Indigenous man married a non-Indigenous person, that person and any subsequent children gained status. Marriage, a foreign legal concept to Indigenous peoples prior to contact, functioned as a vehicle for disenfranchisement. Women who wanted to marry non-Indigenous persons had to forfeit their claim to be a "registered Indian," and the treaty rights that accompanied this title. This loss of status impacted their identity and self-worth. Today, the Indian Act still discriminates against Indigenous women and their descendants in the transmission of Indian status and membership in First Nations.[63] In response to the backlash, Bill C-31 was introduced in 1985 to be consistent with section 15 of the Canadian Charter of Rights and Freedoms, which guaranteed equal rights between men and women. It provided a process for women to apply for the reinstatement of their lost status, but the process was extremely difficult to execute, and thus looked better on paper than it did in reality.[64] Although government intentions may have been noble, practically, the process was largely inaccessible.

Canada has long prided itself on being a diverse, pluralistic nation, but it has yet to recognize the Aboriginal right of self-government universally. Therefore, in order for all members to fit cohesively into a single Canadian society, that society must be accepting of Indigenous peoples in a positive way, before there can be "an identification of common purpose" and before "true citizenship can develop."[65] Along with many other consequences, violence against women in general "impairs and nullifies women's realisation of all human rights; prevents women from participating

[63] Missing and Murdered Indigenous Women, s*upra* note 6.

[64] *Ibid.*

[65] Cardinal*, supra* note 28 at 23.

in their community as full, equal citizens; reinforces male dominance and control; supports discriminatory gender norms; and also maintains systemic inequalities between women and men."[66] These factors, among others, preserve and perpetuate the conditions that facilitate the continuation of gender-based violence. There is a direct correlation between gender-based violence against Indigenous women and their inability to fully participate in their citizenship. Their true citizenship, rooted in Indigeneity, has already been taken from them, making it twice as difficult to reclaim their culture. Indigenous women are twice displaced from their culture, having lost it initially through colonial influence and policies, such as the upending of gender dynamics, residential schools and the sixties scoop, and legislatively – through the loss of their status. Therefore, believing and participating in a citizenship that has time and time been a source of oppression, is extremely difficult.

The failure to implement the recommendations of frameworks which would grant Indigenous communities self-governance continues to oppress communities and as a result, their most vulnerable members. Individual members within the government have recognized that "the current state of Indigenous health is a direct result of government policies in our collective past," but no formal government inquiry has been launched.[67] After Joyce Echaquan died in the hospital, Indigenous Services Minister Marc Miller acknowledged that the federal government had a role to play in addressing systemic racism in society but also noted that jurisdiction was a major barrier in fixing the system.[68] Miller, who met with the Echaquan family, said that one of her children got down on their knees and begged for him to deliver justice. Taken aback by this gesture, Miller says that his team should have gotten down on their knees and begged them for forgiveness for a system that failed them. The impact of this case is widespread. There is a real concern that reports like these will deter Indigenous peoples from seeking basic health services. Miller says the implications of medical mistreatment will have a severe impact on flattening the COVID-19 curve and that Indigenous communities are now seeing an increase in the second wave of COVID cases.[69] Not surprisingly, the uptake for the flu vaccine is lower for Indigenous peoples than it is for non-Indigenous peoples. Miller acknowledges that he would not seek a flu shot either if he were going to be treated "like garbage."[70]

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[66] Manjoo, s*upra* note 19 at 12.

[67] Zimonjic*, supra* note 37.

[68] Peter Zimonjic & Olivia Stefanovich, "Federal ministers, Indigenous leaders plan to discuss systemic racism in health system" (9 October 2020) online: *CBC News* <www.cbc.ca/news/politics/marc-miller-joyce-echaquan-1.5755912 >.

[69] *Ibid.*

[70] *Ibid.*

Recommendations: Stuck on Paper

Despite the acknowledgments that reform is needed, desperately and urgently, little progress has been made. Numerous bodies have researched, consulted and suggested a host of recommendations and suggestions to ameliorate healthcare and basic human rights for Indigenous peoples in Canada. Although international human rights frameworks, such as UNDRIP, may influence policy and law-making, they do not impose any binding legal requirements. Still, their suggestions are sound. In line with the healthcare component in the UNDRIP, the United-Nations recommends that:

> United Nations agencies and actors coordinate in the development and implementation of an international research project on the sexual and reproductive health of indigenous peoples, ensuring an active partnership with indigenous peoples and organizations in all stages of the project.[71]

The TRC's calls to action, in the health section, similarly call upon the federal, provincial, territorial and Aboriginal governments to:

> Acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.[72]

They also call upon all levels of government to implement a 3-step, minimal effort program which would:

i. Increase the number of Aboriginal professionals working in the health-care field.
ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
iii. Provide cultural competency training for all healthcare professionals.[73]

However, since its release in 2015, none of the recommendations in the health section of the TRC have been completed. At the recommendation of the federal government, "the TRC wasn't set up merely to investigate the past; it was to provide concrete ways to address the legacy of residential schools and to advance reconciliation between Canada's Indigenous and non-Indigenous peoples."[74] The time has come to implement those suggestions and recommendations.

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[71] United, Nations Department of Economic and Social Affairs, *Permanent Forum on Indigenous Issues Report on the thirteenth session* (New York: United Nations, 2014) at 8.

[72] Truth and Reconciliation Commission of Canada*, Truth and Reconciliation Commission of Canada: Calls to Action* (Manitoba: Truth and Reconciliation Commission of Canada, 2015) at 2.

[73] *Ibid.*

[74] Chelsea Vowel, "Are We Serious About Truth and Reconciliation?" (1 December 2016), online: *AlbertaViews* <albertaviews.ca/coming-together/>.

These frameworks all share common ground in the implementation stages, by arguing that they should be carried out with the greatest level of consultation and cooperation with Indigenous peoples. They also propose that healthcare staff be trained and sensitised to the background and culture of Indigenous people. The care of Indigenous women specifically, needs to be treated with the utmost respect and deference to a cultural context. Women must be able to regain their agency over their bodies and their reproductive rights in order to fully fulfill participate in society. This means concrete steps to elimination tropes and myths about unfit motherhood. Violence, in all its forms, whether in the private or public spheres, impedes women's right to equality within the family, the community and the workplace.[75] In conclusion, violence against Indigenous women in Canada is a barrier to the realisation of their human rights, resulting in negative implications for the exercise of their citizenship.[76] More specifically, in a healthcare context, Indigenous women are being treated more poorly than any other Canadian citizen, without legitimate reason.

Conclusion: Where to Next?

For far too long, harm and pain have been tied to the experience of Indigenous women with the medical healthcare system in Canada. Social programs have repeatedly failed them. In a climate that systematically abuses Indigenous women and girls, their healing process must be protected. They should be able to find solace, dignity, and respect in the same healthcare system that prides itself on providing universal and dignified care to everyone.

The public health system initially functioned incidentally to assimilation, but it failed in total erasure of the Indigenous person and the Indigenous culture. It did succeed, however, in gradually erecting more barriers and delays for Indigenous women in accessing equitable healthcare. Colonial influence and myths have been a cornerstone of healthcare since its inception. It is a well documented crisis. The government has promised, and pledged itself to mending relations with Indigenous peoples, but little has come to pass in that respect. This is not for a lack of in-depth research, meaningful conversation, reports, inquiries and recommendations provided by multiple independent and expert bodies.

This is a total failure of the concept of federalism. The provincial and federal governments have proven that they can work together in creating programs of assimilation, but they are unable to exhibit any cooperation when it comes to protecting these same populations. It is a failure on the part of the government of Canada, on an international human rights stage, and a failure on the part of the nation to secure equal rights and access for their most vulnerable populations.

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[75] *Ibid.*

[76] Manjoo, s*upra* note 19.

A change in this horrifying reality requires steady guidance from the federal government – with whom the Indigenous peoples have affirmed treaties. The provincial governments and the federal government need to work together to develop a healthcare plan which addresses Indigenous issues in the system. In order to make up for the disparities, proper funding and programs which ensure equal access and care for Indigenous peoples, must be implemented immediately. There is no excuse for poor health outcomes based on racial status. If the Liberal government can pledge two billion dollars to implementing a nation-wide internet access service, they also have the funds to end the boiling water advisories on over sixty reserves, which represents a known healthcare issue.[77]

Jurisdictional issues are grounded in the much larger context of reconciliation. Since healthcare is the responsibility of the provinces, the government is happy to stay in its lane. But when it comes to natural resources, such as oil, the government is all too happy to assert its authority. Likewise, the provincial governments are all too happy to argue that the responsibility of Indigenous peoples is up to the federal government. New Brunswick's own Blaine Higgs declined requests for a public inquiry into racism on the basis that it was a federal jurisdiction issue, and thus up to them to handle the request.

Although there are a host of discriminatory problems apparent in the healthcare system, there is also a large body of research dedicated to offering solutions for these disparities. A major solution, offered by many Indigenous scholars, is self-governance; especially in respect to medical treatment. Any attempts to improve Indigenous peoples' health outcomes must include Indigenous knowledge and worldviews such as measures that target all levels of well-being – including spiritual, emotional, physical and social.[78] Research suggests that positive experiences with healthcare providers were due to respect and understanding of cultural and historical context.[79]

In order for healthcare workers to treat Indigenous women properly, they should be sensitized to the cultural beliefs of an Indigenous background. Only when Indigenous women feel understood and safe will they openly seek medical attention without fear of repercussion. Since women are the primary caregivers, this security would also extend to their children. Improving healthcare for Indigenous women is rooted in educating healthcare employees about the impacts of colonization. This requires, in the grand scheme of things, very little work and funding to achieve. In order for employees to take proper care of their patients, the entire atmosphere of the hospital setting must be changed to incentivize cultural sensitivity, instead of racism. Often, there is little dispute about the expertise or credentials of the staff, but problems

[77] Kristine Ligo, "61 Indigenous Communities in Canada Still Face Water Crisis" (30 September 2020), online: *Global Citizen* <www.globalcitizen.org/en/content/canada-indigenous-drinking-water-dangers/>.

[78] Blackstock, *supra* note 61 at 7.

[79] Kolahdooz et al, *supra* note 10 at 338.

lie in the manner in which certain procedures are chosen or carried out for Indigenous patients. A step towards reconciliation is a step towards eliminating systemic racism and discrimination in the healthcare setting. When Indigenous women and their families are treated with empathy, dignity and respect, they will be better suited to achieving full participation in their citizenship. Twelve-year old girls should be going to school and having sleepovers, not committing suicide.[80] Aboriginal mothers should be attending prenatal appointments and discussing baby names, not leaving the hospital without their child. What is owed to Indigenous women and girls everywhere is exactly what they have always been promised.

[80] Jody Parker & John Paul Tasker, "Wapekeka First Nation asked for suicide-prevention funds months before deaths of 2 girls" (19 January 2017) online: *CBC News* <www.cbc.ca/news/canada/thunder-bay/wapekeka-suicides-health-canada-1.3941439>.