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Equal Health, Equal Rights

Addressing Health Inequalities Among Indigenous Canadians Through a Human Rights Lens

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Table of contents

1 Introduction

Since the first settlers arrived on the land that would come to be called Canada, the Indigenous peoples who have occupied the lands since time immemorial have experienced great efforts to eliminate their culture. Over the course of hundreds of years, structures of discrimination and colonization by European settlers have attempted to erase Indigenous culture, but their resiliency has stood up to these attempts. and Indigenous culture has endured. As a result of the early colonial practices which made there way into the formulation of Canadian laws and policies, great discrepancies between Indigenous and non-Indigenous Canadians have developed in numerous socioeconomic outcomes, but especially in the area of health.

During this thesis, an examination of the structures which account for, and result from the colonial structures in Canadian society will be examined in relevant literature and legislation, before analyzing the efforts made by the federal and provincial governments to counter these structures. Despite the major ground being gained in the protection of civil and political rights for Indigenous peoples, their socioeconomic status is still lagging, particularly in the provision of services through structures like the healthcare system. Although Indigenous people in Canada are divided into 3 distinct groups−First Nations, Métis, and Inuit−this is really an oversimplification of the diversity among Indigenous Canadians. Despite this diversity, Indigenous people are entitled to particular rights which are aimed at providing unique protections related to their position in Canadian society. To address the socioeconomic discrepancies and discrimination faced by these communities, the Canadian and provincial governments must protect these unique rights through a meaningful and effective approach.

2 Context

2.1 Issues

In 2007, the United Nations General Assembly adopted the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) to protect Indigenous peoples' rights and encourage states to be accountable to their legal obligations under international instruments.[1] Crucial to the development of this historic document was the work done in the early 1980s by

[1] United Nations, “UNDRIP.”

the Special Rapporteur on national and international discrimination against Indigenous peoples, Martinez-Cobo, regarding the vast forms of discrimination that Indigenous peoples face in areas such as education, employment, housing and health.[2] Canada, like many nation-states rooted in colonization, has a long history of marginalization and systemic discrimination against Indigenous peoples, and the evidence of that discrimination is prevalent in Canadian society.[3] Despite its history of colonization and discrimination, Canada was one of 4 nations to vote against the adoption of UNDRIP in 2007, and would not incorporate the declaration into national law until June 2021,[4] shortly following the discovery of a number of mass graves at sites associated with Indian Residential Schools (IRS).[5]

Over the past number of years, the government has made efforts to improve the structures in which discrimination occurs, as will be discussed further, but when it comes to making meaningful changes in policies which address the root causes related to systemic discrimination, it is unclear how effective these actions are at responding to the problem at hand. Although there is regular discourse regarding various Indigenous issues in Canada, the statistics, particularly regarding health, paint a clear picture of the inequalities that Indigenous peoples face, and the limited improvement that has been made to manage these inequalities. Despite this stagnation, the government continues to employ similar tactics to address these issues, while boasting its efforts in the public sphere.

The stark reality of disparities in the health status of Indigenous Canadians compared to non-Indigenous Canadians becomes clear when we begin to look at the statistics. With regard to general physical health outcomes, Statistics Canada found that the life expectancy of First Nations Canadians was 8.9 and 9.6 years less than non-Indigenous males and females, respectively, 4.5 and 5 years less for Métis Canadians, and 11.4 and 11.2 years less for Inuit Canadians.[6] Further, the probability of living to age 75 for non-Indigenous Canadians was 76% for men and 84% for women, yet for First Nations Canadians it was 53% and 66%, for Metis

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[2] Martínez Cobo, "Study of the Problem of Discrimination Against Indigenous Populations."

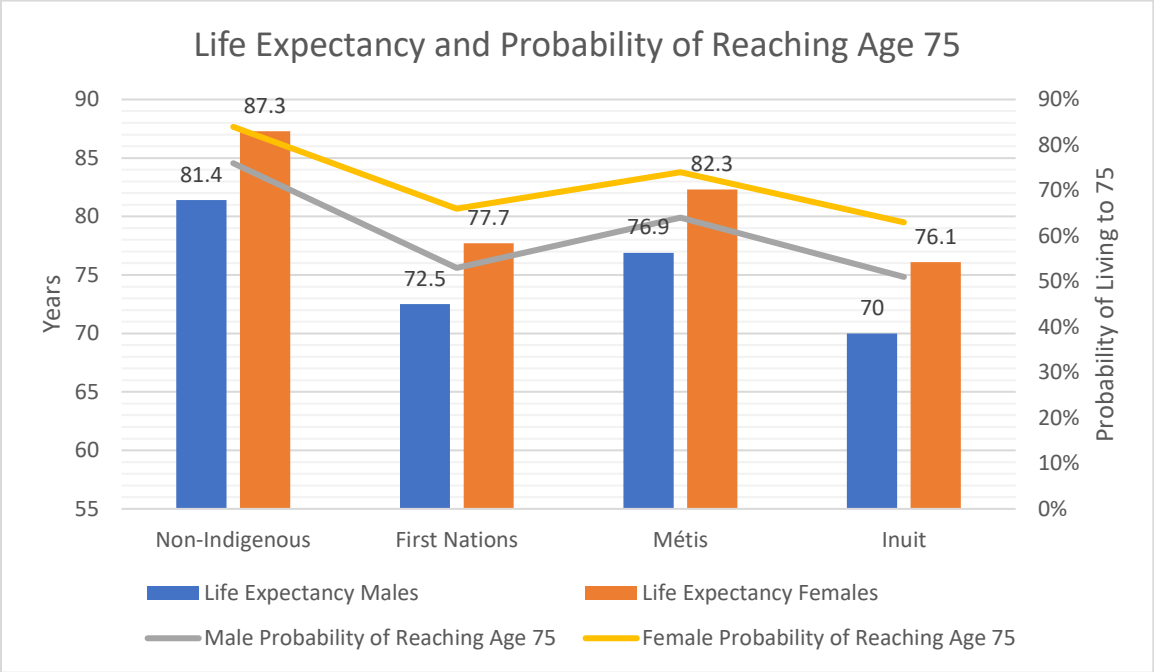
[3] See Turpel-Lafond, "In Plain Sight"; Centre For Equality Rights in Accommodation, National Right to Housing Network, and Social Rights Advocacy Centre, "Housing Discrimination & Spatial Segregation in Canada"; Currie et al., "Racial Discrimination Experienced by Aboriginal University Students in Canada"; Nangia and Arora, "Discrimination in the Workplace in Canada: An Intersectional Approach."

[4] Government of Canada, "Consolidated Federal Laws of Canada, United Nations Declaration on the Rights of Indigenous Peoples Act."

[5] Dickson, Watson, and CBC News, "Remains of 215 Children Found Buried at Former B.C. Residential School, First Nation Says | CBC News."

[6] Tjepkema, Bushnik, and Bougie, "Life Expectancy of First Nations, Métis and Inuit Household Populations in Canada."

Canadians it was 64% and 74%, and for Inuit Canadians, it was only 51% and 63%. [7] These statistics can be better visualized using the following table:



[8]

With regard to mental health, the Canadian Community Health Survey found that barely over half (53.2%) of Indigenous Canadians reported a positive mental state in 2020, in contrast to 65.8% of non-Indigenous Canadians.[9] Common among Indigenous populations are individuals who suffer from anxiety, depression, and post-traumatic stress.[10] These conditions further extrapolate other statistics, such as those found by a study conducted between 2011 and 2016 which concluded that per 100,000 people, there are 8 deaths by suicide for non-Indigenous people; this is contrasted by 24.3, 14.7, and 72.3 per 100,000 for First Nations, Métis, and Inuit people, respectively.[11] Further aggravating these conditions is the commonality of instances of physical and sexual abuse within Indigenous communities. One study from 2015 found that of the 358 participants, "34.1% (n = 117) reported being physically abused before the age of 18,

[7] Ibid.

[8] Ibid.

[9] Statistics Canada, "Self-Perceived Mental Health and Mental Health Care Needs during the COVID-19 Pandemic."

[10] Corrado and Cohen, *Mental Health Profiles for a Sample of British Columbia's Aboriginal Survivors of the Canadian Residential School System*.

[11] Government of Canada, "Suicide among First Nations People, Métis and Inuit (2011-2016)."

while 35.2% (n = 121) reported having been victims of sexual abuse."[12] The traumas of abuse and poor community mental health result in the prolonging of trauma throughout the surviving generations and family members: intergenerational trauma. As a coping method for dealing with this trauma, many people will turn to substances to numb their pain. Substance-use disorder, particularly relating to alcoholism is all too common. A study from 2008 discovered that 25% of Indigenous Canadians self-reported that they had a personal problem with alcohol use, and 27% of adults and 32% of youth use cannabis regularly.[13] However, more recent studies have found that "43.5% (n = 155) of participants had an alcohol problem, while 27.2% (n = 96) had a drug use problem."[14]

The primary reason for these high rates of mental health problems is the result of the discrimination, violence, and abuse inherent in colonial practices such as the IRS system which functioned from the 1880s until the late 1990s.[15] The purpose of these schools was to remove Indigenous children from their families and place them into boarding schools run mainly by the Catholic Church in order to assimilate them into Euro-Canadian society.[16] During the time spent at IRS, children were forbidden to speak their ancestral languages or maintain any of their cultural traditions at the risk of violent disciplinary action, and many survivors tell of cases of psychological and sexual abuse by the clergy who oversaw the schools.[17] In 2021, after the discovery of a number of unmarked mass graves at the sites of former residential schools, these traumas were thrust back into the public eye.[18] 3201 Indigenous children were reported to have died in IRS, however, estimates on the total number of deaths are assumed to be closer to 6000, as records relating to accidents and children's health were often destroyed due to a policy made by the federal government which allowed documents to be destroyed every 5-10 years.[19] Despite the closing of the last IRS in 1996, the effects of this colonial-era practice are still being felt among the Indigenous communities in Canada. As exemplified by the previously mentioned study from 2015, of the 358 Indigenous participants interviewed "28.5% (n = 102) had attended

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[12] Ross et al., "Impact of Residential Schooling and of Child Abuse on Substance Use Problem in Indigenous Peoples," 4.

[13] Khan, "Aboriginal Mental Health: The Statistical Reality."

[14] Ross et al., "Impact of Residential Schooling and of Child Abuse on Substance Use Problem in Indigenous Peoples," 4.

[15] Hanson, Gamez, and Manuel, "The Residential School System."

[16] Ibid.

[17] Ibid.

[18] Dickson, Watson, and CBC News, "Remains of 215 Children Found Buried at Former B.C. Residential School, First Nation Says | CBC News."

[19] Truth and Reconciliation Commission of Canada, "What We Have Learned," 60–61.

residential schools, 35.2% (n = 121) reported having experienced child sexual abuse, and 34.1% (n = 117) reported having experienced child physical abuse trauma."[20] The trauma that these individuals experienced, coupled with a long history of marginalization and systemic issues in government (and society more generally), have resulted in mental health issues including depression, anxiety, post-traumatic stress disorder, and substance abuse disorder.[21] There has been a transmission of these conditions down through generations so that even those individuals who did not experience residential schools firsthand are still feeling the effects of the traumas that were experienced there.[22]

The mental health problems that are associated with this intergenerational trauma are further exasperated by the limited and ineffective care that Indigenous Canadians receive in the healthcare system. When seeking medical care, many Indigenous Canadians are faced with stereotypes that are integrated into the healthcare system such as the presumption that they are intoxicated or seeking prescription drugs, that they are irresponsible and incapable of taking care of their own health, or that they are less worthy of care.[23] As a result of these stereotypes, many cases of improper care have been experienced by Indigenous Canadians such as cold or impersonal interactions, denial of services and lack of communication, rough physical treatment, misdiagnoses and improper treatment, and a disregard for culture.[24] As a result of these poor experiences, not only are people who are facing medical problems less likely to receive proper treatment, but they are also less likely to seek out treatment in future instances of medical distress.[25] In the year 2017, 14.7% of Indigenous Canadians had some sort of medical condition that they felt required medical care, but did not receive any, whether by choice or by the unavailability of services.[26] Nearly two-thirds of those individuals were female, showing the disproportionate way women are impacted by discrimination in the healthcare system.[27]

Another barrier to receiving medical care for Indigenous Canadians is a lack of access to services. 19.6% of Indigenous Canadians have no regular medical doctor, and 3.4% have no

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[20] Ross et al., "Impact of Residential Schooling and of Child Abuse on Substance Use Problem in Indigenous Peoples," 2.

[21] Bombay, Matheson, and Anisman, "Intergenerational Trauma."

[22] Ibid., 16.

[23] Turpel-Lafond, "In Plain Sight," 23.

[24] Turpel-Lafond, "In Plain Sight."

[25] Ibid.

[26] Statistics Canada, "Access to and Use of Health Care Services by Aboriginal Identity, Age Group and Sex."

[27] Ibid.

access to medical services due to no doctors being available to them.[28] There are a number of reasons for these statistics, but a primary reason is a lack of available medical infrastructure, particularly for those Indigenous peoples who live in communities which are in remote areas such as the northern parts of the country.[29] Despite northern communities recording the highest health expenditure per capita, basic health outcomes for this region such as life expectancy are significantly lower than the rest of the country.[30] Another reason for these outcomes is the incompatibility of the healthcare programs for addressing Indigenous-specific health problems. Many of the health services available to Indigenous Canadians are constructed in a Western diagnosis–based structure, which is ineffective at dealing with the health problems that Indigenous peoples face, and incompatible with the philosophies surrounding healing which have existed for thousands of years.[31] Indigenous cultural traditions have yet to be properly integrated into provincial healthcare, and as a result, it is ineffective at dealing with Indigenous-specific mental health issues. Due to these incompatibilities, coupled with the discrimination that Indigenous Canadians face in the healthcare system, many people choose not to seek medical attention when it is required. Further, information about medical care is not made easily accessible to Indigenous Canadians, specifically when they are looking for Indigenous-specific care.[32] The onus then falls on the individual facing a medical crisis to make inquiries to find a medical professional who specializes in dealing with Indigenous-specific issues in a culturally respectful way.

Since the adoption of UNDRIP in 2007, the Canadian government has made some steps toward meaningful change. As stated above, the principles of UNDRIP were incorporated into national legislation in 2021, but some steps were taken even earlier. In response to the high number of disappearances of Indigenous women along Canada's Highway 16 in Northern BC, coined The Highway of Tears, the government established a National Inquiry Into Missing and Murdered Indigenous Women following a damning report by the Royal Canadian Mounted Police in 2011.[33] In 2008, the government established the Truth and Reconciliation Commission (TRC) with the objectives of highlighting the need to respect Indigenous rights, close the gaps

[28] Ibid.

[29] Oosterveer and Young, "Primary Health Care Accessibility Challenges in Remote Indigenous Communities in Canada's North."

[30] Young and Chatwood, "Health Care in the North."

[31] Dell et al., "From Benzos to Berries."

[32] Participant 1, Interview with Elder.

[33] National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place*.

in social, health, and economic outcomes, bring attention to the pain and suffering which students experienced in the IRS system, as well as the generation that followed, and educate the general population about the realities of residential schools.[34] The TRC outlined the steps needed to be made by the government in order for real reconciliation to be reached in its 2015 Final Report, which included 94 Calls to Action.[35] This report prompted the BC government to adopt UNDRIP into its provincial legislation in 2019, 2 years before the federal government.[36] While this result is a step in the right direction, in the 7 years since the release of the TRC's Final Report, the federal government claims that they have met 17 of the 94 Calls to Action, however, Indigenous rights organizations say it's closer to 7.[37] Despite the creation of these mandates, which make worthy headlines, their effectiveness at improving the issues they claim to address remains to be seen.

2.2 Research Questions

With the contextual setting established, the overall research question examined in this thesis will be:

> *How is the Canadian government failing to meet its obligations under international, national, and provincial law to provide effective access to mental health care for Indigenous peoples?*

Based upon the review of the relevant literature, an analysis of legal obligations and implementation, and qualitative data resulting from interviews, the following sub-question will then be addressed:

> *What is the best approach for addressing discrepancies in healthcare provision between Indigenous and non-Indigenous Canadians?*

[34] Truth and Reconciliation Commission of Canada, "What We Have Learned."

[35] Truth and Reconciliation Commission of Canada, "Calls to Action," 2015.

[36] Government of British Columbia, "Declaration Act."

[37] Indigenous Watchdog, "How Many of the TRC Calls to Action Are Complete?," April 26, 2022.

2.3 Literature Review

2.3.1 Structural Discrimination and Trauma for Indigenous Canadians

Although a contextual framework has been established, in order to understand the academic discourse surrounding Indigenous discrimination and health, an examination of the literature relating to IRS and Indigenous mental health will serve to ground these concepts in the Canadian setting. To fully grasp the statistical impact of intergenerational trauma in Indigenous populations, Ross and colleagues examined relationships between IRS attendance, drug or alcohol problems, and childhood experiences of abuse in their 2015 study.[38] The authors began by reviewing previous studies on this topic, then applied their own findings from a survey they conducted with 358 participants in the province of Quebec. One of the studies they compared found that, of residential school survivors, 64.2% experienced PTSD, 26.3% had problems with psychoactive substances, and 21.2% experienced major depression.[39] Further, the authors noted another study which purposed that "being a victim of sexual abuse seemed to be associated with […] more self-mutilation, suicide attempts, sex work, HIV status, injection drug use, drug overdoses, and sexually transmitted infections."[40]

The survey conducted by the authors sought to bring understanding to their research hypothesis: "[Child] abuse (sexual and physical abuse) is associated with a greater probability of having an alcohol or drug use problem in adulthood" and "residential school attendance is associated with an increased probability of presenting an alcohol or drug use problem, regardless of whether sexual or physical traumas were experienced."[41] Their survey consisted of a questionnaire relating to socio-demographic information, residential school attendance, alcohol abuse, drug abuse, and traumas. The results of the survey found that 43.5% of participants had problems with alcohol, 27.2% had problems with drugs, 34.1% reported experiencing childhood physical abuse, and 35.2% reported childhood sexual abuse.[42] Further, the findings showed that the prevalence of abuse in childhood presented the participants with a 3.1 times more likelihood of developing issues with drugs.[43] Of the 358 participants, 102 had

[38] Ross et al., "Impact of Residential Schooling and of Child Abuse on Substance Use Problem in Indigenous Peoples."

[39] Ibid., 7.

[40] Ibid., 8.

[41] Ibid., 9.

[42] Ibid., 14.

[43] Ibid., 16.

attended a residential school, which made them "more than three times at risk of having an alcohol problem" than non-attendees.[44] The result of the authors' survey seemed to support their hypotheses: "Having lived through traumatic experiences in childhood – sexual abuse, physical abuse, or attending a residential school – increased the risk of experiencing alcohol and drug problems."[45] In light of these findings, the authors stress the importance of having trauma-informed care be an integral part of mental health care for Indigenous Peoples.[46]

One of the ways in which traumas such as these are exacerbated is by the structures of systemic racism prevalent throughout Canadian society, as exemplified by an examination of the healthcare system in the case study conducted by Brenda Gunn titled *Ignored to Death: Systemic Racism in the Canadian Healthcare System*.[47] The study is grounded in the case of Brian Sinclair, an Indigenous man who died from complications relating to a treatable condition after being ignored by medical staff in an emergency room for 34 hours. Despite nurses' claims that they did not see him, evidence contrary to this shows how "[he] was simultaneously 'invisible' and 'overly visible' as staff only saw stereotypes and assumptions."[48]

Structural racism is rooted in the policies and practices of the government which are based on the ideas that were prevalent in colonial times. The policies regarding social, educational, and health services, which were "set up to 'manage' Indigenous people,"[49] contain implicit and explicit "goals of segregating, assimilating, or eliminating Indigenous peoples."[50] These ideas are represented in national legislation such as The Indian Act, but also in the minds of non-Indigenous Canadians due to a lack of understanding of the history of colonization and the socioeconomic inequities which resulted from it.[51] As a result, discrimination occurs intentionally, through the law, and unintentionally, outside the law, through marginalization and a narrative of Indigenous peoples being less deserving of care.

Such a narrative perpetuates structural racism in several ways. Due to government policies of marginalization aimed at maintaining control over Indigenous peoples, socioeconomic gaps deepen through a lack of access to already limited and ineffective medical

[44] Ibid., 15.

[45] Ibid., 17–18.

[46] Ibid., 22.

[47] Gunn, "Ignored to Death: Systemic Racism in the Canadian Healthcare System."

[48] Ibid., 2.

[49] Ibid., 4.

[50] Ibid., 3.

[51] Ibid.

services.[52] This is exacerbated by a failure to implement effective strategies to combat racism, as was the case with the inquest into Brian Sinclair's death which included "no analysis of systemic racism, […] social exclusion, […] or the evident racist stereotyping"[53] which played a role in his death. Such inaction on the part of authorities reinforces the biased social lens within the minds of Canadians, and in turn reproduces cases of discrimination such as Brian's.

Gunn notes that structural racism results in negative health impacts for Indigenous Canadians through the stress following discriminatory interactions, the limited access to effective services, the internalization of stigma, and the courage that is required when seeking out services.[54] Through the biased social lens, and preconceived notions present in the minds of healthcare workers, Indigenous peoples become viewed "as drains on the system; whose care in never quite as urgent" and often they are "blamed for their ailments and medical needs."[55] Subsequently, Indigenous people receive less rapid and quality care, despite the disproportional need represented in the previous article. These hindrances created by dismissive socioeconomic policies, coupled with the systemic racism inherent in the minds of many Canadians have a "synergistically negative effect on the health of Indigenous people."[56]

2.3.2 Racial Discrimination in the Canadian Healthcare System

With such blatant issues facing Indigenous Canadians, an effective healthcare system is crucial to addressing these Indigenous-specific problems, however, the healthcare system in Canada has proven to fall short. In 2020, after being appointed by the BC Minister of Health, Mary Ellen Turpel-Lafond conducted a review of cases of Indigenous-specific racism in the provincial healthcare system titled *In Plain Sight*.[57] The review collected data through a wide variety of sources, such as a survey, interviews, a website for submissions, and discussions with Indigenous leaders and health advocates.[58] In total, researchers spoke to almost 9000 people[59] and divided their results into two categories: findings relating to Indigenous-specific racism in BC health care, and findings related to the current 'solutions' in practice.

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[52] Ibid., 4.

[53] Ibid., 2.

[54] Ibid., 1.

[55] Ibid., 4.

[56] Ibid., 5.

[57] Turpel-Lafond, "In Plain Sight."

[58] Ibid., 8.

[59] Ibid., 15.

Finding 1 was that widespread Indigenous-specific stereotyping, racism and discrimination exist in the BC healthcare system. The study found that only 16% of survey respondents reported no discrimination when receiving health care and that 35% of healthcare workers reported witnessing instances of discrimination.[60] This discrimination included assumptions that patients were drunk, or seeking drug prescriptions, less "worthy" of care, incapable of caring for themselves, and more.[61] The study found that this stereotyping resulted in harm, poorer quality of care, and mistrust or avoidance of the healthcare system by Indigenous Canadians.[62] Finding 2 was that racism limits access to medical treatment and negatively affects the health and wellness of Indigenous peoples in BC. The report states that inequitable access to services and a disproportionate reliance on emergency and hospital services contribute to poorer health outcomes for Indigenous peoples.[63] Finding 3 was that Indigenous women and girls are disproportionately impacted by Indigenous-specific racism, resulting in further misogynistic stereotyping and barriers to access.[64] Further, the author found that accountability and initiatives to support women's access to health services were lacking, despite commitments made by the government "such as the National Inquiry into Missing and Murdered Indigenous Women and Girls – that call for specific actions."[65] Finding 4 was that current health emergencies magnify racism and vulnerabilities, and disproportionately impact Indigenous peoples. The study found that Indigenous Canadians were more likely to contract the COVID-19 virus or die from an overdose than non-Indigenous peoples and that their health and well-being are disproportionately affected during this time.[66] Finding 5 was that Indigenous healthcare workers face racism and discrimination in their work environments. 52% of the Indigenous healthcare respondents reported experiencing racism at the workplace which limited their careers and created an unsafe working environment.[67] Further, the results of the study showed that there were insufficient numbers of Indigenous healthcare workers in the province and that efforts to bolster these numbers were limited.[68]

[60] Ibid., 20.

[61] Ibid., 21.

[62] Ibid., 22–23.

[63] Ibid., 25–26.

[64] Ibid., 28–29.

[65] Ibid., 29.

[66] Ibid., 30–32.

[67] Ibid., 34–35.

[68] Ibid., 36.

The examination of the current efforts to quell Indigenous-specific racism in the provincial health services shows that these efforts are proving to be ineffective. Finding 6 was that the current education and training programs are inadequate to address Indigenous-specific racism in healthcare. The training programs which currently exist, such as the San'yas ICS program are not regulated, and there exist no universally agreed-upon approaches to building an understanding of culturally-safe practices for healthcare workers.[69] Finding 7 was that the complaints processes in the healthcare system do not work well for Indigenous peoples. The study found that there are a relatively low number of complaints, due to inaccessibility, and that most complaints are not meaningfully addressed.[70] Finding 8 was that Indigenous health practices and knowledge are not integrated into the health care system in a meaningful and consistent way. Despite this integration being an integral part of UNDRIP, as well as federal and provincial law, and the desire of healthcare workers to see this incorporation, meaningful efforts in this field were not found.[71] Finding 9 was that there is insufficient hard-wiring of Indigenous cultural safety throughout the BC health care system, despite many calls for this in international and national legislation.[72] Finding 10 was that Indigenous roles in health leadership and decision-making need to be strengthened. Despite minimal progress being made, such as the formulation of the First Nations Health Authority, gaps still remain, such as the inclusion of Métis Canadians, or the lack of Indigenous people in senior roles within the healthcare system.[73] Finally, Finding 11 was that there is no accountability for eliminating racism in the healthcare system, including complaints, system-wide data, quality improvement and assurances, and monitoring of progress. The study found that information is not sufficiently collected relating to racism in the healthcare system and that Indigenous data governance rights must be implemented in a timely manner so as to highlight performance failures for Indigenous peoples.[74] The study concludes with a list of recommendations for changes in systems, behaviours, and beliefs which the author calls upon the government to implement in accordance with its obligations to UNDRIP, as well as to Indigenous peoples.[75]

[69] Ibid., 42–43.

[70] Ibid., 44–45.

[71] Ibid., 47–48.

[72] Ibid., 50–51.

[73] Ibid., 54–55.

[74] Ibid., 57.

[75] Ibid., 61–65.

Given the recent nature of the report relative to the commitments made by the federal and provincial governments to address Indigenous-specific racism, it is clear their efforts are ineffectively addressing these issues. Despite the Calls to Action included in the TRC report, the objective of UNDRIP, and the legal obligation to engage in bilateral partnerships with Indigenous communities, it seems that the efforts being made are superficial and the result of unrest rather than a desire to make the structural changes needed to best address discrepancies. It is clear that although there are promises to make improvements, rights violations are being perpetuated, and as a result, an approach which focuses on rights is best suited to promote meaningful change. Such an approach would need to be specifically respectful of Indigenous culture and have a distinct understanding of Indigenous-specific issues.

2.3.3 The Right to Health, and Human Rights-Based Approaches to Health

Given the fact that much of the academia surrounding the scope, implementation and limitations relating to the right to health is disputed by many scholars, a review of the relevant literature seems necessary to ground an examination of its insufficiency for Indigenous Canadians. As has been shown, the structures of systemic discrimination and racism throughout the healthcare sectors, and society more generally, provide disproportionate barriers for Indigenous health, and perhaps a new approach is required to address these barriers. Before examining such an approach, a general understanding of the right to health is essential. While many comprehensive examinations have been completed regarding the development and structure of the right to health, perhaps one of the most thorough was done by Brigit Toebes in 2001.[76] Toebes begins by explaining some of the reasons for the confusion regarding the right to health's functionality and its place in the body of international law. The right to health is not the same thing as the right to be healthy, but the codification of the right in international human rights declarations and covenants means that, while states are not directly responsible for individuals' health, they are "the entities best suited to create certain basic conditions under which the health of the individual is protected and possibly even enhanced."[77] This responsibility, as explained by Toebes, entails a number of preconditions such as basic sanitation, safe drinking water, and environmental health, and further, the right to health is interconnected with a number of other rights such as the right to life, the right to education, or

[76] Toebes, "The Right to Health."

[77] Ibid., 169.

the right to work.[78] The interplay of the right to health with other rights indicates that, while it is generally thought of as a 2nd generation right (economic, social, and cultural rights), it also contains norms that overlap with 1st generation rights (civil and political rights), such as the right to life.[79] This interplay between these two categories of rights draws into question how concrete the divide is between 1st and 2nd generations rights, and highlights their interdependency.

Toebes continues by explaining the elements which make up the core content of the right to health. According to the author, the right to health can be divided into 2 categories: elements relating to health care itself, and elements relating to the development of preconditions for living a healthy life.[80] Utilizing the Committee on Economic, Social and Cultural Rights' General Comment No.14 (GC No.14) as a guide, Toebes outlines the principles which she feels inform the content of these categories: (1) *availability* of health services; (2) financial, geographic, and cultural *accessibility* of health services; (3) *quality* of health services; and (4) *equity* in access to available health services.[81] The elements outlined by GC No.14 differ, in that they include *equity* within the scope of *accessibility*, and include a comment on the *acceptability* of health services,[82] an important factor which will be further discussed in following sections. Given the right to health's status as a 2nd generation right, while some of its elements can be progressively realized, the aspects relating to the core content of the right, such as proper care and the provision of essential drugs, should be immediately realized by states.[83] These obligations, both the immediate and the progressive, can be examined through the scope of the tripartite typology of state obligations; the obligation to respect, protect, and fulfill the right to health. As Toebes notes, the right to health's status as a right that circumvents the 1st generation-2nd generation divide means that states have the *positive* obligation to provide health-related services, but also the *negative* obligation to respect individuals' inherent right to health.[84] Generally, 1st generation rights are thought to be associated with negative obligations for states, and 2nd generation rights with positive obligations. The right to health's status as an

[78] Ibid., 170, 175.

[79] Ibid., 175.

[80] Ibid., 174.

[81] Ibid., 177–78.

[82] Committee on Economic Social and Cultural Rights, "General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)," para. 12.

[83] Toebes, "The Right to Health," 176.

[84] Ibid., 179.

intermediary between the two highlights the interdependence and interrelated nature of rights generally.

Expanding on the evolution of the right to health in international law was the work done by Paul Hunt regarding the right to health and the human rights-based approach to health.[85] While Toebes was concerned with the principles and content relating to the right to health, Hunt was interested in examining the relatively recent push for "its 'real-life' implementation[…] and a movement from short, general, abstract, legal treaty provisions toward specific, practical human rights guidance."[86] As Hunt explains, of the few scholarly works on the topic of the right to health prior to the early 1990s, most of them were concerned solely with the individual right to health, and state obligations in this regard. Then, in the mid-90s, new ideas developed regarding a more holistic human rights-based approach to health issues, which rarely mentioned health itself, but instead focused on the fulfillment of rights aggregately, which would, in turn, protect the right to health. Finally, since 2000, the scholarship has evolved into a blending of the two: human rights-based approaches to health, with the right to health at its core.[87] During his examination, Hunt points out that addressing issues relating to health purely with a human rights-based approach runs the risk of requiring a number of trade-offs or compromises which in turn limits the right to health and the approach itself.[88] Although a human rights-based approach attempts to bridge the gaps between legal treaty provisions and actual implementation, the author argues that such methods are not specific or practical enough to meet this objective.[89] Any rights-based approach regarding implementation must include guidance which references the legal backing which gives it its strength. Further, Hunt cites the work of Yamin and Cantor, who point out that these approaches may lead to "an erroneous conception of human rights that is limited to a narrow sphere of civil and political rights."[90]

Hunt purposes that the solution to these issues is a framework of human rights-based approaches to health with the right to health at its core. In doing so, these approaches gain a number of features. Key to assessing a rights-based approach, according to Hunt, is the framework proposed by Gruskin et al., which includes availability, accessibility, acceptability and quality (AAAQ), as well as participation, non-discrimination, transparency, and

[85] Hunt, "Interpreting the International Right to Health in a Human Rights-Based Approach to Health."

[86] Ibid., 110.

[87] Ibid., 114.

[88] Ibid., 111.

[89] Ibid., 115.

[90] Yamin & Cantor in, ibid., 111.

accountability.[91] As noted by the author, these are just minimal procedural requirements of the approach, though, and as with any socioeconomic right, an analysis of progressive realization, the use of maximum available resources, and international assistance and cooperation with regard to the right to health can ensure the fulfilment of the right over time. [92] Hunt proposes though, that this does not hinder the efficacy of the right to health, rather it ensures that it "has the conceptual and operational potential to make a sustained contribution to the implementation of complex and costly health interventions."[93] By ensuring that the right to health has centre stage in rights-based approaches to health, these approaches can ensure the proper implementation of health policies and programs both in the medium and long term.[94] In giving the right to health a primary role in right-based approaches, Hunt notes however that certain stipulations must be met: (1) a distinction between rights which are and are not subject to progressive realization; (2) an acceptance that high-income countries have a greater responsibility to meet obligations than low-income countries with regard to progressive realization; (3) ensuring that those countries with the capability to assistance and cooperation in health do so; (4) highlight the accountability that states must demonstrate to their right to health obligations; and (5) acknowledge that monitoring, while important, is not the same thing as accountability.[95]

With a greater understanding of the structures of the right to health, and its role within a rights-based approach to health examined, it would be useful to now examine the practical implication example described by Alicia Yamin in her case study from Peru. Yamin suggests that discrepancies in health outcomes within certain populations of a state are a direct reflection of the social relationship that those populations have within their broader societies. She explains that a lack of power held by marginal groups means that they have less capability in participating in the development of programs and policies which directly affects their wellbeing.[96] As discussed in the article by Gunn, these structures of discrimination and marginalization are built into the foundations of societies, which allows them to be unaffected by efforts to counter them.[97] To develop effective healthcare structures, which give power to

[91] Gruskin et al. in, ibid., 115.

[92] Ibid.

[93] Ibid., 117.

[94] Ibid., 122.

[95] Ibid., 122–23.

[96] Yamin, "Challenges and Possibilities for Innovative Praxis in Health and Human Rights."

[97] Gunn, "Ignored to Death: Systemic Racism in the Canadian Healthcare System."

these marginalized groups, Yamin suggests that a number of features must be included, such as minimum core content (as discussed by Hunt), adequate progress, non-discrimination, authentic popular participation, accountability, access to effective remedies, and multisectoral approaches to health. With these holistic themes in mind, approaches to health service delivery can shift away from the conventional individualistic public health approaches toward an approach which is centred on human rights, particularly the right to health.

The main challenge in this process is in its implementation, both for those working in the medical profession, as well as those advocating for the right to health. As Yamin notes, traditionally, advocates for human rights have taken on an adversarial role when it comes to working with governments. As governments are often the primary funders of healthcare, academia relating to health, and even some of the advocacy groups themselves, Yamin suggests that this adversarial position results in creating further hurdles for rights advocates to navigate. For medical professionals, as "the fiduciary of the patient's well-being, having the power and responsibility to protect and promote that well-being" there exists a burden of responsibility to protect the rights associated with the well-being of those under their care. These relationships are exemplified in what Yamin describes as a 'democratization of the entire health sector.' In this system, the communities in which the healthcare system is supposed to serve are given the voices needed in the planning and policy development of those healthcare programs, ensuring that the problems faced by those communities can be effectively addressed. This means that the effective popular participation that Yamin describes is crucial for this process of democratization.

Applying these principles to the case study of Peru, Yamin notes that discrimination, according to the Maastricht Guidelines on the Violations of Economic, Social and Cultural Rights, does not necessarily need to be intentional nor *de jure*, but merely have the effect of "nullifying or impairing the equal enjoyment or exercise" of the right to health, as is the case for many Indigenous Peruvians living in more rural parts of the country. One example of the ways in which healthcare was democratized in Peru is the work that the NGO Partners in Health conducted in the slums of Lima in addressing cases of tuberculosis in poorer populations. Partners in Health lobbied both the government, as well as the World Health Organization in order to see the value of treating tuberculosis in poor communities not through highlighting the long-term cost-effectiveness of treatment, but by advocating for the rights of those communities, arguing that medical treatment "should be available on a nondiscriminatory basis

to all people, regardless of their economic status or ability to pay."[98] By working with the government, as well as representing the communities that needed care most, the rights-based approach adopted by Partners in Health proved effective at providing treatment for these marginalized peoples, but also in changing the philosophies behind service delivery and public health in Peru more broadly. Such bilateral partnerships can work to address the root causes of structural violence, which are rooted in discrimination, and balance the power dynamics between states and marginalized groups. These relationships need to be structured in a way that they endure over the long-term and outside of cost-effective structures.

2.3.4 Power Dynamics, Self-Governance, and Effective Policy

In order to determine innovative strategies for developing and implementing effective healthcare practices in Canada, it seems clear that major structural changes are required. Paul Farmer's *Pathologies of Power* thoroughly discusses the necessary elements for such a framework. In his seminal work, Farmer discusses the right to health, social and economic rights more broadly, and strategies moving forward in the context of his personal experiences dealing with 3 particular cases of marginalized groups facing health crises: HIV/AIDS patients in poor slum regions in Haiti, populations of Russian prisoners being exposed to Multi-Drug Resistant Tuberculosis, and the poor involved with, or under the influence of the Zapatista rebels in Chiapas, the southernmost state in Mexico.[99] While it is not necessary for the purposes of this discussion to examine the intricacies of each of these cases, we can draw some conclusions from Farmer's examinations which would prove useful in developing new strategies for health and human rights for Indigenous Canadians.

In the final chapter of the book, titled *Rethinking Health and Human Rights: Time for a Paradigm Shift*, Farmer begins by examining the ways in which human rights violations have been perpetuated in an era of novel rights legislation. Beginning with the development of the Universal Declaration of Human Rights in 1948, remarkable gains have been made in the guarantee of civil and political rights across the world, however, "little progress in the efforts to secure social and economic rights" has been seen.[100] Farmer argues that addressing health rights violations in the context of social and economic rights opens the door for aid from public

[98] Yamin, "Challenges and Possibilities for Innovative Praxis in Health and Human Rights," 44.

[99] Farmer, *Pathologies of Power*.

[100] Ibid., 213.

health and broader international health communities.[101] He notes that previous efforts to address the types of deep-seated violations discussed in this chapter have stemmed from a narrow legal approach to health and human rights which can "obscure the nature of violations, enfeebling our best responses to them."[102] Legal approaches serve only to flesh out the issues which were previously veiled, however, Farmer claims that the normative nature of the law can be left powerless if it is ignored by states who have ratified such laws. He quotes Rosalyn Higgins saying:

> "No one doubts that there exists a norm prohibiting torture […] But it is equally clear […] that the *great majority* of states systematically engage in torture. If one takes the view that non-compliance is relevant to the retention of normative quality, are we to conclude that there is not really any prohibition of torture under customary international law?"[103]

Farmer purports that the driving force behind rights violations of this sort are power inequalities within societies and that if we can understand these issues through a sociological lens, we can address and redress these inequalities.[104] In doing so, a distinction can be made in the academic work between *analysis* and *strategy*. Analysis of rights violations can be used as a means of discovering the truth. While strategy "asks a different question: What is to be done?"[105]

The strategy that Farmer imposes is what he describes as *pragmatic solidarity*: "the rapid deployment of our tools and resources to improve the health and well-being of those who suffer this violence."[106] A key factor to pragmatic solidarity is a demand for preferential treatment to those who are at the greatest risk, rather than equally good levels of treatment within societies.[107] Such an approach can have the secondary effect of bolstering other human rights agendas within the most vulnerable communities such as education and housing. To develop such a strategy within the field of health and human rights, Farmer suggests 6 crucial elements.

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[101] Ibid., 217.

[102] Ibid.

[103] Rosalyn Higgins in ibid., 221.

[104] Ibid., 219.

[105] Ibid., 230.

[106] Ibid., 220.

[107] Ibid., 227.

First, we must make health and healing the symbolic core of this new agenda. Ensuring that the end goal of any health and human rights program is the alleviation of suffering, rather than cost-efficient servicing, we can "throw the full weight of the medical and scientific communities behind a noble cause."[108] *Second*, the provision of services must be central to the agenda. In order to remediate inequalities in access to services, Farmer calls for a collaborative effort between human rights groups and states: "[It] is important to respect the sovereignty of states, for experience shows that states, not "Western" human rights groups, are best placed to protect the basic social and economic rights of populations."[109] *Third*, we must establish new research agendas, an area which Farmer notes is full of pitfalls: "[None] of the victims of these events or processes are asking us to conduct research."[110] Instead, although documentation is a crucial element in the process of understanding rights violations, we must ensure that we are doing so in such a way that attention and resources are not diverted from addressing the problem. *Fourth*, Farmer highlights the need to assume a broader educational framework. Central to any meaningful societal change, education must engage with not only students interested in health and human rights, but all students, faculty members, and then to societies more generally.[111] *Fifth*, health and human rights must achieve independence from powerful governments and bureaucracies. "A central irony of human rights law is that it consists largely of appeals to the perpetrators."[112] Powerful states and international organizations, even those which fund human rights work, are often perpetrators of major human rights violations.[113] Farmer notes that "only a failure of imagination has led us to ignore the potential of collaboration with community-based organizations."[114] *Finally*, we must secure more resources for health and human rights. By calling for the realization of social and economic rights, then states, as well as international institutions, may be swayed "to prioritize human rights endeavours that reflect the paradigm shift advocated here."[115]

The 6 elements described by Farmer seem well-suited to address the barriers faced by Indigenous Canadians. While the circumstances of Indigenous peoples are well-understood,

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[108] Ibid., 239.

[109] Ibid., 240.

[110] Ibid., 241.

[111] Ibid., 242.

[112] Ibid., 424.

[113] Ibid., 242–43.

[114] Ibid., 243.

[115] Ibid., 244.

effective strategies for remediating inequalities remain lacking. Not only are the provision of services ineffective for these communities, but they are also based on strategies that are incompatible with Indigenous views surrounding health and healing. Despite this, much of the power remains in the hands of the government when designing and implementing these services. A collaborative approach would help to alleviate bureaucratic hurdles arising from limited self-governance policies and give Indigenous communities the power to build effective strategies. By applying Farmer's concept of pragmatic solidarity, we can provide those at the greatest risk with the resources and power to have a say in the ways in which they receive help.

2.3.5 Indigenous Canadians, Health, and Human Rights

Despite the health inequities faced by Indigenous Canadians, health and human rights strategies, such as those described in the previous article, can be found in some cases. One article which examines these cases is *Indigenous-led Health Care Partnerships in Canada*, by Lindsay Allen and colleagues. In their analysis, the authors examine the work that many Indigenous communities are doing to strengthen cultural healing practices and the ways that Indigenous Canadians benefit from this regained knowledge.[116] While a small number of Indigenous-led health partnerships do exist, both the medical professionals in Canada and Indigenous Peoples agree that they would like more access to and training in Indigenous traditional healing practices and integration into the Canadian healthcare system.[117] A key component of this integration however is that they are "grounded in traditional knowledge" and "bring in or are supported by biomedical knowledge and expertise as desired."[118] Indigenous-led health partnerships structured in this way can have dramatic effects on several health indicators, as one study from the Indigenous communities in Alaska has shown. Over a 10-year period, the partnership "reduced emergency department use by 42%, reduced hospital days by 36%, reduced staff turnover by 75%, increased childhood vaccinations by 25%, and increased patient and client reports of satisfaction by 94%."[119]

Several short-term studies from Canada have shown similar success, but the authors highlight some of the reasons that these partnerships have been slow to develop. Many within the Indigenous communities are skeptical of the "[assertion] that Indigenous medicine can be

[116] Allen et al., "Indigenous-Led Health Care Partnerships in Canada."

[117] Ibid., E209.

[118] Ibid.

[119] Ibid.

appropriately integrated into biomedical practices because of the cultural frameworks and limitations of biomedicine."[120] Because of traditional healing's emphasis on not only physical and mental health but also emotional and spiritual health, many feel that the healthcare system is incapable of integrating these practices. Further, the authors argue that Indigenous-led health partnerships require us to challenge the ways in which we measure the success of health programs.[121] The requirement of providing statistical evidence of positive outcomes can be problematic as it supposes that the data has "to 'prove' traditional Indigenous knowledge in terms of the dominant Western research paradigm and culture," and such an approach "assumes the superiority of one cultural worldview, knowledge system, or paradigm over another."[122] One final hurdle includes the misuse of traditional Indigenous knowledge and the commercialization and loss of autonomy that come with it.[123] Many elders who have experienced such misuse "are sometimes reluctant to build partnerships with physicians out of concern about the potential overharvesting of plant medicines, disrespectful treatment, [and] cultural appropriation."[124] Further, the authors reference a survey which "reported that 92% of the Indigenous respondents who use traditional medicine feared disclosing this information to health professionals."[125]

Despite these hurdles, the authors highlight the importance of Indigenous-led health partnerships in addressing health inequity for Indigenous Canadians. This work can only be done through the support of the broader medical community, a "deeper understanding of the diversity within and across First Nations, Inuit, and Métis communities, as well as how different models of Indigenous-led health partnerships can respond to context-specific service needs."[126] An understanding of these distinctions can lead to more effective approaches for removing the structures of bias and discrimination in the healthcare system. We must continue to evaluate and learn from the successes, in a culturally sensitive way, in order to ensure the availability of culturally accessible and acceptable health practices in the Canadian healthcare system.

Critical to the development of programs such as those previously discussed is the concept of self-governance, something discussed in the Canadian context thoroughly by Lavoie

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[120] Ibid.

[121] Ibid.

[122] Ibid., E209–10.

[123] Ibid., E215.

[124] Ibid.

[125] Ibid.

[126] Ibid.

and colleagues in *Missing Pathways to Self-Governance: Aboriginal Health Policy in BC*. As the article shows, while there has been success in achieving steps toward self-governance in health policy in one Canadian Province, Ontario, as well as further development internationally in New Zealand, BC is still lagging behind in discussions on self-governance.[127] The authors highlight the importance of the Transformative Change Accord (TCA), which was signed in 2005 by the federal government, BC government, and BC First Nations Leadership Council, and sought to form a new relationship between Indigenous communities and the government.[128] One result of this new relationship was that First Nations communities would be allowed to take over much of the responsibilities previously held by the government regarding health and other sectors.[129] This initiative prompted further progress, such as the development of the First Nations Health Plan in 2006, and the First Nations Health Authority in 2010.

While these steps are of course helping to bridge the gaps in health policy, the authors note one major flaw in these initiatives: the health programs which were developed as a result of policy changes were restricted to "registered Indians" living on the reserve.[130] As highlighted, only 56.3% of Indigenous people in BC are registered under the Indian Act, 59.7% live in urban areas, and only 26% live on the reserve.[131] With these statistics in mind, it is questionable how effective self-governance policies are being implemented, if nearly three-quarters of the population have no mechanisms to achieve these results.

The authors, therefore, call for a greater number of urban indigenous health centres, which can not only provide culturally appropriate service delivery for Indigenous populations living in an urban setting but can also provide a community leadership structure for those who do not belong to one particular. A similar approach was taken in New Zealand, where the government recognized, and developed relationships with 2 distinct peoples: Manawhenua (those belonging to local nations), and Mataawaka (those found predominantly in urban settings).[132] In the province of Ontario, a different approach was taken, where, as a result of agreements similar to that of the TCA, nearly 30 Indigenous-led health centres, all focused on a variety of fields, opened around the province.[133] These centres were operated under the

[127] Lavoie et al., "Missing Pathways to Self-Governance."

[128] Ibid., 1.

[129] Ibid., 2.

[130] Ibid.

[131] Ibid., 5.

[132] Ibid., 11.

[133] Ibid., 10.

management of a committee made up of key Indigenous political bodies who were dedicated to "representing the interests of urban, rural, and remote First Nations, Métis, and Inuit."[134] Over time, as the oversight of the committee proved to curtail some of the autonomy of community-based programming, the government adjusted to give management of health centres in the province to Local Health Integration Networks. These organizations, which are informed by the Aboriginal Health Council, allow for flexibility and a regional approach to health agendas.[135] In order for BC, and indeed Canada as a whole, to meet their obligations in providing all Indigenous Canadians with true self-governance, lessons need to be learned from these 2 holistic approaches.

3 Methodology & Limitations

3.1 Theoretical Approach and Methodology

For clarity in understanding the reasoning behind the methodological approach in this thesis, a reminder of the main research question is required:

> *How is the Canadian government failing to meet its obligations under international, national, and provincial law to provide effective access to mental health care for Indigenous peoples?*

With this scope in mind, a multidisciplinary socio-legal approach will be used to examine the law, and its effects on the socioeconomic outcomes for Indigenous peoples. First, a legal policy analysis will be used to outline the obligations on the Canadian and BC governments regarding its binding commitments to Indigenous Canadians. The grounding of these issues in the law allows for Indigenous peoples to hold the government accountable for its actions, and importantly, its inactions regarding health policy and bilateral cooperative agreements. Importantly, however, an analysis of the law in a socioeconomic context such as this can result in difficulties bridging the gaps between the law and its actual implementation.[136] With this in mind, a qualitative methodology is required to give context to the sub question of this thesis:

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[134] Ibid., 11.

[135] Ibid.

[136] Creutzfeldt, Mason, and McConnachie, *Routledge Handbook of Socio-Legal Theory and Methods*, 98.

What is the best approach for addressing discrepancies in healthcare provision between Indigenous and non-Indigenous Canadians?

By utilising a qualitative thematic analysis to identify the underlying causes for the gaps in the enjoyment of rights for Indigenous peoples, we can begin to understand the best methods for addressing these discrepancies. Further, such an approach bridges the gaps between the law and its actual implementation in a particular context.

3.2 Methods

The first method used in this thesis regarding the legal policy analysis will be an implementation assessment. First, a summary of the Canadian and BC government's obligations under international, national, and provincial law will be summarized before examining some of the more central efforts made by the governments to meet these standards. Using state reports to key human rights bodies, as well as required self-reporting measures relating to different legal documents, the successes and failure of these efforts will be summarized. Metrics such as progressive realization and accountability efforts will then be used to identify the ways that the governments fall short in meeting these binding commitments.

To identify the relevant themes regarding these issues, the second method used in this project was interviews with relevant stakeholders. A total of 6 interviews were conducted, with individuals from a variety of fields relating to this topic: academics, provincial government representatives, chiefs, elders, and First Nations support workers. These semi-structured interviews included guiding questions, but the participants were allowed to steer the conversation as they saw fit. The interviews were recorded, transcribed, then made anonymous to protect the identity of the participants. The selection process was done through several means including personal connections within the community, reaching out to organizations, and recommendations from previous participants. Individuals were required to give their consent to participate in the project and told that they could withdraw this consent at any time.

3.3 Limitations and Ethical Considerations

Given the traumatic nature of some of the topics discussed in the interview process, extra effort was made in this project to be respectful and to ensure that none of the conversations

were triggers for reliving those traumas. The effects of colonialization, residential schools, abuse, marginalization, systemic racism, and discrimination are still very real in the lives of many Indigenous Canadians today. Further, given that some of the participants included in interviews are representatives from the government, their participation in this project has the potential to negatively impact their careers. While a vague reference to the participant's positions may be made during the analysis section of this thesis, no names or identifying information will be included, and all transcriptions were encrypted and then destroyed upon the completion of this project.

The anonymity required for such a project creates limitations relating to the reliability and validity of the themes identified in the interviews. Despite the greatest efforts to accurately portray the opinions expressed by the participants, there is no way of confirming that accuracy without sacrificing anonymity. Another limitation is created by the jurisdictional divide between the federal and provincial governments. While the federal government is responsible for Indigenous affairs, the provision of health services is the responsibility of each of the provincial governments. As a result, the participants in the interviews, as well as the majority of the literature, are all relative to BC. Further exacerbating this limitation is the sociodemographic representation of Indigenous populations in BC. While the First Nations and Métis populations in the province are relatively high, there is little representation of Inuit Canadians in the region. Despite these limitations, some useful conclusions from this thesis can still be drawn and applied to the rest of the provinces and territories in Canada.

4 Findings

4.1 Brief Legal Analysis of Canada's Obligations and Efforts

4.1.1 Canada's Obligations According to the Law

For a broader understanding of Canada's legal obligations toward providing health services to Indigenous peoples, a brief overview of the relevant legislature will help to ground these obligations before an examination has begun. In international law, a variety of declarations and covenants speak to the relevant rights which are at issue in this case. Many of these are binding documents upon states, and therefore impose an obligation to meet particular standards regarding the rights that they describe. To begin with, Article 25 of the Universal Declaration of Human Rights affirms that "Everyone has the right to a standard of living

adequate for the health […] and medical care and necessary social services."[137] The International Covenant on Civil and Political Rights (ICCPR), which is binding, speaks to the same obligations for states to give access to services in Article 25(c): "Every citizen shall have the right and the opportunity […] To have access, on general terms of equality, to public service in his country."[138] Similarly, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) ensures "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" which includes "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" and "The creation of conditions which would assure to all medical service and medical attention in the event of sickness."[139] Importantly, all of these documents set forth that every person is entitled to these rights without any form of discrimination based on race.[140]

Of the UN's core international human rights instruments, another which can be applied in this case is the International Covenant on the Elimination of All Forms of Racial Discrimination (CERD). CERD defines discrimination as:

> "[Any] distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life."[141]

Article 2 lists the obligations of states to not engage in discrimination, ensure that public institutions do not engage in any form of racial discrimination, review policies on a national and local level which might perpetuate discrimination, eliminate barriers between races by encouraging multiculturalism, and take adequate steps toward the development and protection of marginalized racial groups whose fundamental rights may be being infringed upon.[142] CERD also reaffirms "The right to public health, medical care, social security and social services,"[143] and dictates that states are obligated to make necessary amendments to "the fields of teaching,

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[137] United Nations, "Universal Declaration of Human Rights."

[138] United Nations, "ICCPR."

[139] United Nations, "ICESCR."

[140] United Nations, "Universal Declaration of Human Rights," art. 2; United Nations, "ICCPR," art. 2.1; United Nations, "ICESCR," art. 2.2.

[141] United Nations, "CERD," art. 1.

[142] Ibid., art. 2.

[143] Ibid., art. 5.e.iv.

education, culture and information, with a view to combating prejudices which lead to racial discrimination and to promoting understanding, tolerance and friendship."[144]

The last of the international legal instruments which is important in this case is UNDRIP. Although it is a form of soft law, and therefore a non-binding instrument, UNDRIP was designed to be made binding through its implementation into national legislation by states. UNDRIP contains provisions like the ones discussed above, such as those relating to non-discrimination[145] and physical and mental health.[146] Perhaps it is more important to focus here on the more operational articles which provide more substantive guidance, such as those relating to self-governance, participation, the improvement of social conditions, and access to traditional medicines, knowledge and health services. Article 9 stipulates that all Indigenous individuals have the right "to belong to an Indigenous community or nation"[147] and Article 18 states that, in matters which affect their rights, Indigenous peoples must be allowed "the right to participate in decision-making […], through representatives chosen by themselves in accordance with their own procedures."[148] Article 21 affirms Indigenous peoples' right "to the improvement of their economic and social conditions, including […] health and social security"[149] and importantly, the development and improvement of these conditions must be done so with the active participation of the Indigenous communities to which these improvements are meant to affect.[150] Article 23 goes on to instruct that, as far as possible, Indigenous communities must be allowed to have distinct institutions which can administer such programs.[151] This condition is in line with the sentiment put forth in Article 4, which calls attention to "the right to autonomy or self-government in matters relating to their internal and local affairs."[152] Finally, Articles 24 and 31 insist that Indigenous peoples have the right to access all medical services while at the same time maintaining their traditional health practices and knowledge in order to achieve the highest attainable standard of physical and mental health.[153] States are responsible for taking appropriate measures, "in consultation and

[144] Ibid., art. 7.

[145] United Nations, "UNDRIP," art. 2.

[146] Ibid., art. 7.

[147] United Nations, "UNDRIP."

[148] Ibid., art. 18.

[149] United Nations, "UNDRIP."

[150] Ibid., art. 23.

[151] Ibid.

[152] United Nations, "UNDRIP."

[153] Ibid., art. 24,31.

cooperation with indigenous peoples"[154] so that all of the rights set forth in UNDRIP are protected.

Nationally, UNDRIP entered into Canadian national legislation in 2021 with the adoption of the United Nations Declaration on the Rights of Indigenous Peoples Act (The Declaration).[155] The Declaration made the principles of UNDRIP a part of national legislation, and also required the government, in cooperation with Indigenous peoples, to submit an annual report regarding the measures taken to implement the principles of the declaration.[156] Additionally, the Constitution Act of Canada contains the Canadian Charter of Rights and Freedoms as well as a section titled Rights of the Aboriginal Peoples of Canada.[157] Within the Constitution Act are similar references to non-discrimination[158] as well as affirmations of the "existing aboriginal and treaty rights of the aboriginal peoples of Canada."[159] Those treaty rights were set forth in the Indian Act of 1985.[160] The Indian Act contains, among other things, provisions relating to the registry of Indigenous Canadians[161], the definition and development of Indian bands[162], the management of Indigenous funding[163], and the election of Indigenous leadership.[164] While some of the structures and terminology contained within the Indian Act are dated, it remains a crucial legal instrument for Indigenous rights in Canada.

Prior to the adoption of UNDRIP into the national legislature, the BC government actually incorporated it into provincial law with the Declaration on the Rights of Indigenous Peoples Act (DRIPA) in 2019.[165] The purpose of DRIPA, as presented by the BC government, was fourfold: "to bring provincial laws into alignment with the UN Declaration,"; "to develop and implement an action plan, in consultation and cooperation with Indigenous Peoples, to meet the objectives of the UN Declaration"; "to monitor progress on the alignment of laws and implementation of the action plan, including tabling annual reports"; and "allow for flexibility

[154] Ibid., art. 38.

[155] Government of Canada, "United Nations Declaration on the Rights of Indigenous Peoples Act."

[156] Ibid., sec. 7(1).

[157] Government of Canada, "Constitution Act."

[158] Ibid., sec. 15(1).

[159] Ibid., sec. 35(1).

[160] Government of Canada, "Indian Act."

[161] Ibid., secs. 5–7.

[162] Ibid., secs. 8–13.

[163] Ibid., secs. 61–69.

[164] Ibid., secs. 74–80.

[165] Government of British Columbia, "Declaration Act."

for the Province to enter into agreements with a broader range of Indigenous governments and to exercise statutory decision-making authority together."[166] 8 years prior to DRIPA, the BC government, in cooperation with First Nations peoples signed the BC Tripartite Framework Agreement on First Nations Health Governance (Framework Agreement).[167] The Framework Agreement sets out the goal "of improving the health and well-being of First Nations individuals and communities in BC […] by ensuring that BC First Nations are fully involved in health program and service delivery and decision-making regarding the health of their people."[168] As a result of the Framework Agreement, the government passed the responsibility of "design, management, and delivery of First Nations health programming" to the First Nations Health Authority in October of 2013.[169]

4.1.2 An Evaluation of Canada's Efforts to Meet These Obligations

As a result of these legal obligations, several efforts have been made on the part of the Canadian and BC governments to combat the gaps present in providing effective health policies and programmes for Indigenous Canadians. On the national level, one of the most important initiatives, which has been discussed in previous sections, has been the establishment of the TRC in 2008. Over the course of 5 years, the TRC worked to compile stories and statistics regarding IRS attendance, as well as the intergenerational effects that followed. The results of these efforts were published in a series of reports which were released in 2015. The goal of the TRC was not only to document the history of the IRS system, but also to ensure that the Canadian public was well-informed about this history and participated in the processes of reconciliation,[170] which were outlined in these reports. The Calls to Action were a list of 94 actions to be taken by the government in order for meaningful reconciliation to be reached. Calls to Action 18-24 relate to health and include demands for increased funding, the braiding of Indigenous traditions into the health care system, better training of medical professionals in dealing with Indigenous health issues, an increase in the hiring of Indigenous healthcare

[166] Ibid.

[167] Government of Canada and Indigenous Services Canada, "British Columbia Tripartite Framework Agreement on First Nations Health Governance."

[168] Ibid.

[169] Ibid.

[170] Truth and Reconciliation Commission of Canada, "Honouring the Truth, Reconciling for the Future," 32.

workers, and an acknowledgment by all levels of government that the current state of Indigenous health is a result of the historical treatment of Indigenous populations.[171]

Another important step taken recently by the federal government was the cooperative development of several agreements on shared priorities between First Nations,[172] Inuit,[173] and Métis Nations.[174] These agreements, all signed in 2017, set out the common agreement between the Government of Canada and the Indigenous communities to develop relationships of bilateral governance on a set of shared priorities. These priorities include the improvement of socioeconomic conditions for Indigenous Canadians, the full acknowledgement and implementation of Indigenous peoples' rights, the decolonization of the law, the development of a nation-to-nation or government-to-government relationship, and a commitment to the minimum of an annual dialogue between the parties regarding the evolution of priorities.[175] These agreements, while they are not binding on the parties, are an important first step in the implementation of self-governance policies for Indigenous Canadians, and a commitment to cooperative relationships between the government and Indigenous peoples.

Provincially, the BC government has also taken some steps to improve the health disparities for Indigenous Canadians and meets its legal obligations. As a result of the BC Tripartite Framework Agreement on First Nations Health Governance, the FNHA established as the mechanism through which policy and programming can be planned, developed and implemented in cooperation with the provincial government.[176] The FNHA also works as an intermediary between the Provincial government and the First Nations communities in BC, in order for local communities to have their particular health needs expressed, and for the government to be able to have a holistic picture of health priorities in local communities. Another result of the Tripartite Framework Agreement was the development of a Memorandum of Understanding between the First Nations Health Council, the Province of BC, the Government of Canada, and the First Nations Health Authority in 2018.[177] This partnership

[171] Truth and Reconciliation Commission of Canada, "Calls to Action," October 29, 2015, 2–3.

[172] Assembly of First Nations and Government of Canada, "Assembly of First Nations-Canada Memorandum of Understanding on Joint Priorities."

[173] Government of Canada et al., "Inuit Nunangat Declaration on Inuit-Crown Partnership."

[174] Government of Canada and The Métis Nation, "Canada-Métis Nation Accord."

[175] Assembly of First Nations and Government of Canada, "Assembly of First Nations-Canada Memorandum of Understanding on Joint Priorities," 4; Government of Canada and The Métis Nation, "Canada-Métis Nation Accord," sec. 1; Government of Canada et al., "Inuit Nunangat Declaration on Inuit-Crown Partnership."

[176] First Nations Health Authority, "FNHA Overview."

[177] First Nations Health Council et al., "Memorandum of Understanding."

highlights an understanding, by all parties, of the holistic nature of health and wellness for Indigenous Canadians and acknowledges the importance of incorporating these understandings into the health system. In order to shift from a reactionary model of healthcare to one that focuses on preventative methods, the Memorandum set out 4 commitments to be cooperatively developed by the parties over the course of the following 2 years: "Community-Driven and Nation-Based Planning and Partnerships"; "Flexible, Predictable and Sustainable Funding for Mental Health and Wellness"; "Mental Health and Wellness Reporting Framework"; and "Mental Health and Wellness Infrastructure Funding."[178] Documents such as these highlight the importance of cooperative and bilateral development of health policies and programs between the Federal, Provincial, and Indigenous governing bodies, however, it is still too early to gauge their effectiveness in combatting health discrepancies.

Another important recent step in BC was the development of an Action Plan in 2022, as a requirement included in DRIPA. The Action Plan includes four main themes: self-determination and inherent right of self-government; title and rights of indigenous peoples; ending indigenous-specific racism and discrimination; social, cultural and economic well-being.[179] The 89 goals included in the Action Plan include objectives relating to the fostering of long-term agreements relating to nation and governance-rebuilding,[180] "[Co-developing] strategic-level policies, programs and initiatives",[181] "[introducing] anti-racism legislation that addresses Indigenous-specific racism", and the creation of effective funding models which "supports First Nations to plan, design and deliver mental health and wellness services."[182] The Provincial government is expected to progressively meet particular standards of these themes and report on the ways it has worked to ensure that provincial law is in accordance with UNDRIP annually, as a requirement included in Section 5 of DRIPA.[183]

[178] Ibid., 3–4.

[179] Government of British Columbia, Ministry of Indigenous, and Relations and Reconciliation, "Declaration Act Action Plan."

[180] Ibid., sec. 1.1-1.2.

[181] Ibid., sec. 2.6.

[182] Ibid., sec. 4.7.

[183] Government of British Columbia, "Declaration Act."

4.1.3 An Assessment of Implementation Measures

To assess the effectiveness of Canada's efforts to meet the standards set forth in international laws, it would be useful to begin by examining the country reports and concluding observations from UN human rights bodies such as The Committee on the Elimination of Racial Discrimination (CERD Committee), or The Committee on Economic, Social and Cultural Rights (CESCR). Although Canada has not submitted their reports to either of these committees which were due in 2021, some useful information can be drawn from the Concluding Observations from the most recent reports. In 2016, CESCR submitted their Concluding Observations regarding Canada's latest state report and highlighted several relevant factors. First, CESCR stated their concern regarding the decreases in funding going to on and off-reserve Indigenous peoples, as well as the growing disparities in socioeconomic factors.[184] Further, they noted the discriminatory effects for minorities which were inherent in the National Anti-Drug Policy of 2007.[185] In the latest Concluding Observations regarding Canada's latest report to the CERD Committee, it applauded the work that was accomplished by the TRC[186] but noted the lack of implementation with regard to the 94 Calls to Action.[187] The CERD Committee also drew attention to the fact that Canada's national action plan against racism had expired in 2010, and the government has yet to create a new strategy.[188] It should be noted here that efforts have been made by the government since the release of these assessments, however, due to the absence of reporting to these committees on behalf of the Canadian government, it is difficult to assess these efforts, particularly those relating to self-governance, on the international stage. Further, many of these issues remain present on the list of issues prior to the submission of Canada's next CESCR report.[189]

An important area for evaluation on the national level would be the effectiveness of the TRC's Calls to Action, and the ways in which they are being implemented. The federal government, in an annual report regarding Indigenous-Crown relations, made the claim that progress is being made in 80% of the areas highlighted by the Calls to Action and that 17 have

[184] Committee on Economic, Social and Cultural Rights, "E/C.12/CAN/CO/6," para. 19.

[185] Ibid., para. 49.

[186] Committee on the Elimination of Racial Discrimination, "CERD/C/CAN/CO/21-23," para. 3(c).

[187] Ibid., para. 17.

[188] Ibid., para. 9.

[189] Committee on Economic, Social and Cultural Rights, "E/C.12/CAN/QPR/7."

already been fully implemented.[190] Importantly, none of these 17 are related to the health inequalities experience by Indigenous peoples. Indigenous Watchdog, an Indigenous-led reconciliation monitoring organization disputes this claim though, suggesting that the government has actually only fully implemented 7 of the Calls to Action.[191] Further, with regard to the sections specifically related to health, Indigenous Watchdog notes that 3 of the 7 Calls to Action have completely stalled due to issues such as "ongoing systemic racism in health delivery."[192] Of course, all of the Calls to Action are important in the process of reconciliation, however, the 7 which Indigenous Watchdog suggests have been implemented arguably require less action on behalf of the government and make limited meaningful changes with regard to reconciliation and the systemic issues within government and society. Included in the 7 changes are the establishment of a National Day for Truth and Reconciliation, increased funding for the Canadian Broadcasting Company to support reconciliation, and the modification of the Oath of Citizenship to include a reference to Aboriginal and Treaty rights of Indigenous peoples.[193]

Another important mechanism for measuring the effectiveness of national policy changes related to the principles of UNDRIP is the reporting requirement included in the Declaration Act. In the latest Annual Progress Report, the government included a list of guiding principles regarding the co-development of implementation efforts, touted its efforts regarding consultation and cooperation with Indigenous peoples, proposed the creation of an action plan in order to achieve the objectives of UNDRIP, then divided and assessed each of the articles from UNDRIP into 10 broad thematic categories.[194] Through each of these thematic groups, the report outlines the key characteristics of each article and details their interrelated nature, before presenting any progress that may have been made in these areas. For example, in the section titled *Economic & social rights, including health*, which covers UNDRIP Articles 20-24, the report highlights that progress has been made in closing health gaps, particularly through the shift toward trauma-informed and culturally respectful approaches to mental health care, efforts to reduce food, water, and housing insecurities, and economic developments for Indigenous organizations and communities.[195] These signs of progress seem like important first steps,

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[190] Crown-Indigenous Relations and Northern Affairs Canada, "Second Annual (2021) Statutory Report Pursuant to Section 10 of the Department of Crown-Indigenous Relations and Northern Affairs Act," sec. 1.

[191] Indigenous Watchdog, "How Many of the TRC Calls to Action Are Complete?," April 26, 2022.

[192] "Call to Action # 18."

[193] Indigenous Watchdog, "How Many of the TRC Calls to Action Are Complete?," April 26, 2022.

[194] Department of Justice Canada, "Annual Progress Report on Implementation of the United Nations Declaration on the Rights of Indigenous Peoples Act."

[195] Ibid., 41.

however, even the report notes that the socioeconomic gaps between Indigenous and non-Indigenous Canadians remain just as wide and that much more work needs to be done by both the government, and the Indigenous communities.[196] Another important thing to note is the stress that UNDRIP, and as a result, the Declaration Act, places on the importance of these annual reports being done "in consultation and cooperation with Indigenous peoples."[197] Despite this, only a few paragraphs in the report discuss the topic of cooperation, no Indigenous representatives are included as authors, and the report itself admits that "we are still learning and working together on developing appropriate mechanisms for consultation and cooperation."[198]

Finally, an assessment of the BC government's efforts to meet its legal obligations can be done through an evaluation of similar annual reports which are a requirement of Section 5 of DRIPA.[199] The reports cover the Provincial Government's efforts relating to the 4 themes of DRIPA which were previously discussed. The 2021-2022 report, with regard to self-determination and self-governance, highlights funding spent on education in Indigenous communities, shared priority frameworks, and regional agreements with a particular Indigenous community regarding consent and decision-making power in environmental projects.[200] On the theme of ending Indigenous-specific racism and discrimination, the report lists a number of different monies that will be dedicated to topics such as Missing and Murdered Indigenous Women and Girls, sexual violence and survivor support workers within communities.[201] This section also recognizes that "[resiliency] and self-determination are strengths among existing challenges with poorer health outcomes," and praises the work done in other reports conducted by organizations such as the Métis Nation of BC.[202] Finally, in the section titled Social, Cultural, and Economic Wellbeing, the report notes efforts made by the government on things such as funding for a cultural heritage fund, a First Nations wellbeing fund, and a strategy to combat a toxic drug crisis in the province.[203]

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[196] Ibid.

[197] Government of Canada, "United Nations Declaration on the Rights of Indigenous Peoples Act," sec. 7(1).

[198] Department of Justice Canada, "Annual Progress Report on Implementation of the United Nations Declaration on the Rights of Indigenous Peoples Act," 22.

[199] Government of British Columbia, "Declaration Act."

[200] Government of British Columbia, "Declaration on the Rights of Indigenous Peoples Act 2021-2022 Annual Report," 20–23.

[201] Ibid., 25.

[202] Ibid., 26.

[203] Ibid., 28–33.

While the requirement for the Federal and Provincial governments to provide annual reports such as these is of course crucial to the process of monitoring, it is unclear how much actual success is being reported. Funding is a large part of fostering change, however, increases in funding do not necessarily mean that the structures which are utilizing those funds are effectively meeting their objectives, and the reports do not seem to be reporting on successes which resulted from those funds. Many of the achievements highlighted in these reports are either referring to the amount of tax dollars spent,[204] the work that other organizations, often Indigenous organizations, have done,[205] or the creation of cooperative partnership agreements with Indigenous organizations, without any real evidence of that cooperative work being conducted.[206] Much like the Federal report, the Provincial report does not cite any Indigenous organization as an author and only discusses how Indigenous "feedback and guidance were used to inform the development"[207] of the report. Both the federal and provincial law imposes the obligation for the governments to prepare reports "in consultation and cooperation with the Indigenous peoples".[208] While feedback and guidance are forms of *consultation*, meaningful *cooperation* should require the participation of Indigenous organizations in the actual reporting process, rather than the government just reporting on and monitoring themselves based on the feedback of communities.

Based on the limited success shown in the national and provincial reports, it seems as though Canada's approach to meeting their right to health obligations fall into the gaps highlighted by Hunt between legal treaty provisions and actual implementation. Further, international accountability cannot be achieved if Canada does not submit reports to the relevant human rights bodies on the progress that is being made. As highlighted above, Canada's latest submitted reports to the CERD Committee were in 2016[209] and to CESCR in 2012[210] despite updated reports being due in 2021. The perpetuation of issues such as a lack of meaningful structural changes and limited reporting and accountability efforts are due to the structures of discrimination and marginalization which built into the socioeconomic system. So long as the governments meet the bare minimum legal obligations, there seems to be little effort remaining

[204] Ibid., 30.

[205] Ibid., 26.

[206] Ibid., 21.

[207] Ibid., 5.

[208] Government of British Columbia, "Declaration Act," sec. 5.

[209] Government of Canada, "Twenty-First to Twenty-Third Periodic Reports of States Parties Due in 2015."

[210] Government of Canada, "Sixth Periodic Reports of States Parties Due in 2010 Canada."

for actual implementation. Therefore, to understand the best ways of addressing these socioeconomic structures, a qualitative socioeconomic approach is required to inform effective policy and structural reforms.

4.2 Qualitative Thematic Analysis

During the process of conducting interviews with the 6 participants, a number of common themes began to appear in the discourse. These themes appeared in discussions between a wide variety of participants and came up without them being prompted to do so. As mentioned in the Methodology and Limitations section of this paper, due to the sensitive nature of this topic, and confidentiality agreements with the participants, their names will be emitted and replaced with Participants 1-6. Again, the positions that the participants held ranged between academics, provincial government representatives, First Nations chiefs, elders, and support workers.

4.2.1 Loss of Identity

The first theme which became clear while discussing the mental health crisis and IRS was a loss of identity, both for individuals and whole communities. The IRS mandate of eliminating Indigenous culture had worked to such a degree that when many IRS survivors returned home, they could not speak their own languages or understand their own cultural practices, and struggled to reintegrate back into their own communities.[211] As a result of these feelings, many Indigenous people grew up with a negative perception of themselves, buying into the notions fed to them by settlers that if you are Indigenous, there must be something wrong with you.[212] This loss of identity was also felt by Indigenous communities collectively with a loss of their knowledge, traditions, ceremonies, and practices.[213] An early inclusion into the Indian Act was the Potlatch Ban, which outlawed the potlatch ceremony, and other ceremonies which were crucial to the holistic well-being of communities.[214] This ban would

[211] Participant 1, Interview with Elder.

[212] Ibid.

[213] Participant 6, Interview with Academic.

[214] Ibid.; Cole and Chaikin, *An Iron Hand Upon the People*.

remain in place for 66 years until 1951, at which point, generations had missed the opportunity to take part in these important ceremonies.

Due to this collective loss of identity, coupled with the traumas which were experienced in the IRS system, the structures of well-being in Indigenous communities were torn down. Individuals turned to drugs and alcohol as a means of coping with strains on their mental well-being.[215] Addiction became a way of surviving these negative feelings; a side effect of a more substantial condition. As a result of these problems, traumas which were rooted in colonization and IRS attendance are then passed down to further generations, creating a perpetuating mental health crisis within these communities.[216] This intergenerational problem relating to trauma is ineffectively being addressed in the current governments and therefore will continue to be passed along to the next generation. To begin the processes of healing and reconciliation, not only do Indigenous peoples have the enormous task of facing their trauma in a system which is not designed to support them, but it is also necessary for cultural identity to be relearned and embraced both individually and collectively.[217]

4.2.2 Inadequate and Incompatible Health Care System

One of the most prevalent themes that came up in all the interviews was an incompatibility of the Provincial healthcare system with addressing Indigenous well-being. This incompatibility stems primarily from differing views of health and well-being between Indigenous and non-Indigenous Canadians. While the provincial healthcare system is set up in a diagnostic way of addressing biomedical wellbeing, Indigenous ideas surrounding wellbeing are much more holistic, including elements from land, language, culture, and ceremony.[218] These elements combine into a system of preventative medicine, which keeps individuals healthy in all four areas: physical, mental, spiritual, and emotional.[219] The Provincial healthcare system is set up so that it is reactionary to individuals who are already sick,[220] and as a result, people are expected to navigate a system which is not in line with their beliefs, while they are

[215] Participant 1, Interview with Elder.

[216] Ibid.

[217] Participant 6, Interview with Academic.

[218] Ibid.

[219] Participant 1, Interview with Elder.

[220] Participant 2, Interview with Chief.

already struggling.[221] Doctors and nurses are also not given training to provide holistic treatment; they look at one problem at a time and are unable to accept things which are outside the realm of biomedical science.[222] One interviewee described how they were treated after requesting to use the traditional healing practice of smudging while being treated in a provincial health facility. As soon as the participant brought this up, the way that the health professionals treated her began changed from positive to negative.[223] Aggravating this situation are all the well-documented cases of discrimination that Indigenous peoples face when trying to access services, the result of which has been mistrust and fear of the conventional healthcare systems.[224] Further, these deep-seated discriminatory biases result in less quality of care for Indigenous peoples.

Admittedly, there have been some efforts to incorporate culturally-respectful practices into the healthcare system and the provincial government generally.[225] Within certain parts of the Ministry of Mental Health and Addictions, cultural competency courses are required for incoming staff,[226] and health professionals are given the opportunity to receive similar training, although this is not mandatory.[227] Further, many hospitals have reserved positions for elders to be support workers, able to be called upon in the event of an individual requesting their guidance.[228] While these steps are important, and the work done by reports such as In Plain Sight brings the issue of discrimination in the healthcare system to the forefront of Canadians' minds, one further problem remains. As highlighted in many of the interviews, not all Indigenous peoples are the same, and hence, not all Indigenous cultures are the same.[229] As mentioned, there are over 204 First Nations communities in BC alone, all with different traditions and cultural practices, not just one 'Indigenous culture'.[230] As a result, for real integration of culturally respectful practices to be introduced to the mainstream healthcare

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[221] Participant 6, Interview with Academic.

[222] Ibid.

[223] Participant 1, Interview with Elder.

[224] Ibid.; Participant 3, Interview with Representative of the Ministry of Child and Family Services.

[225] Participant 3, Interview with Representative of the Ministry of Child and Family Services; Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

[226] Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

[227] Participant 4, Interview with First Nations Support Worker.

[228] Participant 1, Interview with Elder; Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

[229] Participant 1, Interview with Elder; Participant 6, Interview with Academic; Participant 4, Interview with First Nations Support Worker.

[230] Participant 6, Interview with Academic.

system, these practices need to be distinctions-based and recognize the differences in Indigenous cultures within specific regions.

4.2.3 Lack of Resources

As no surprise, many of the conversations during the interviews revolved around the topic of resources. What did come as a surprise, however, relating to the topic of actual funding, there was almost a full consensus that there was enough money being allocated by the government and ministries.[231] This seems to be a confirmation of the achievements regarding the allocation of funds highlighted in the reports by the federal and provincial governments regarding the integration of UNDRIP principles. The problems lay with the way that those funds were being distributed and spent and whether they actually reach their desired outcome. In one case, a large amount of funds was allocated to renovate a space into an Indigenous-specific addictions treatment centre. However, when the government changed hands following an election, the incumbent provincial government withdrew the funds halfway through the project, leaving the community with a massive deficit in the work which had been completed.[232] In another case in the same community, 1 million dollars per year were allocated to a specific mental health program, yet when the First Nations leadership audited the program, they discovered that the program was spending about 400,000 dollars, with the surplus disappearing into thin air.[233] These examples show that it is not necessarily a problem of the government promising certain amounts of dollars to combat these issues, it's the bureaucracies and politicized nature of these promises which hinder the effective use of these funds. Further, there is the underlying assumption within the government that more funding is equivalent to better strategies for addressing issues. However, if the strategies themselves are lacking, more resources supporting such an approach are wasted.

One resource which is lacking is a sufficient number of Indigenous-specific facilities for mental health and addictions. Despite some promise of growth regarding accessibility recently, BC only has 2 treatment centres specifically for Indigenous individuals facing addictions, and the waiting list to get into these facilities can be months long, which is a problem

[231] Participant 1, Interview with Elder; Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions; Participant 3, Interview with Representative of the Ministry of Child and Family Services; Participant 4, Interview with First Nations Support Worker.

[232] Participant 2, Interview with Chief.

[233] Ibid.

in the non-Indigenous-specific centres too.[234] With regard to mental health care, some First Nations communities do have some designated medical offices, however, it can be difficult to maintain a regular number of doctors and psychologists at these facilities, especially in remote regions of the province, and often the staff are not trained in culturally-respectful practices.[235] Further, these offices are more commonly found in the communities with the resources to operate these health centres, and despite receiving some funds from the government, they are often subsidized by the community.[236] This is especially true when off-reserve or urban Indigenous people seek help from these medical centres, as the communities responsible for providing these services only receive funding to serve on-reserve members of their communities.[237] Despite this, as Participant 4 put it in the interview, these medical centres have a policy that 'every door is the right door', and they try to provide anyone who is seeking help with the proper guidance and care needed, whether they receive funding for doing so, or not.[238]

Finally, it is important to address the lack of information resources available to Indigenous Canadians. It has not been made clear to Indigenous people, especially urban Indigenous people what resources are available to them, and what resources they are entitled to. One anecdote discussed in an interview detailed the difficulty of an individual struggling with mental health issues to find a culturally-respectful and trauma-informed health practitioner who could help them through a major mental health crisis.[239] After visiting a hospital, the individual requested that they be able to see a therapist who would be culturally aware and respectful. The onus fell on the extended family to make calls and do research to find a therapist who could provide appropriate assistance, because information detailing those kinds of services was not accessible to the family.[240] Without the informational resources available to Indigenous people, even if effective health strategies are developed, they are underused due to a lack of knowledge of their existence, or the ways of accessing them.

[234] Participant 1, Interview with Elder; Participant 2, Interview with Chief.

[235] Participant 2, Interview with Chief; Participant 6, Interview with Academic.

[236] Participant 2, Interview with Chief.

[237] Ibid.

[238] Participant 4, Interview with First Nations Support Worker.

[239] Participant 1, Interview with Elder.

[240] Ibid.

4.2.4 Challenges of Governance

One of the most interesting themes discovered through the interviews was the problems that are created at all levels of government because of bureaucracy, the absence of cooperative partnerships, and a lack of understanding of what is desired by Indigenous organizations, communities, and front-line workers themselves.

From a national standpoint, the federal government has made commitments to international conventions and national treaties to participate in government-to-government or nation-to-nation relations with each Indigenous community, as equals, yet there is evidence to suggest that this is happening in a superficial way through accords and agreements such as the ones discussed in the previous chapter. These non-binding documents claim to have been developed in consultation and cooperation with Indigenous communities but lack evidence of that cooperation.[241]

Another complication is that the issues in this discussion are broad and span a wide range of governmental sectors. In BC for example, the Ministry of Health, the Ministry of Mental Health and Addictions, the Ministry of Indigenous Relations and Reconciliation, and the Ministry of Child and Family Development would all have a stake in combatting the issues discussed here.[242] This creates bureaucratic problems, as a result of different ministries addressing common problems in different ways, and while there does seem to be some discourse between Ministries regarding these common approaches,[243] most within the Indigenous communities feel that there is not enough.[244] As a result of this lack of communication, funds are allocated from the different ministries, with the objective of solving the same issues, all with different tactics on how to do so.[245] This 'siloing' of efforts results in limited progress being made by any ministry, when there could potentially be real solutions available if a discourse between the ministries and Indigenous groups could work cooperatively on a unified approach.

Finally, the problems associated with bureaucracy are not limited to the Federal and Provincial governments. Some feel like the leadership within Indigenous communities is not

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[241] Participant 6, Interview with Academic.

[242] Participant 2, Interview with Chief.

[243] Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions; Participant 3, Interview with Representative of the Ministry of Child and Family Services.

[244] Participant 2, Interview with Chief; Participant 4, Interview with First Nations Support Worker.

[245] Participant 2, Interview with Chief; Participant 4, Interview with First Nations Support Worker.

effectively addressing the issues of mental health and addiction.[246] While the gaps in mental health continue to grow, some feel like the leaders are ignoring the issue in order to pursue funding and support for other concerns.[247] This may not be purposeful, however, and one individual, in particular, felt that this oversight was due to a lack of connectivity to the issue.[248] Indigenous leadership is often more involved in policy making, and far removed from the people on the front lines who are actually seeing people and helping them who know what the needs of the community are, and those people are not always given a voice.[249]

4.2.5 Progress Requires Time and Flexibility

Despite some of these bleak outlooks, it became clear through the interviews that some meaningful steps have been taken, and that the genesis of progress has begun. Despite its slow implementation, the governments of Canada and BC are now bound by law to engage in partnership relationships on a nation-to-nation basis with all Indigenous communities, including Métis and Inuit Canadians.[250] These partnerships, which have begun a transfer of powers to Indigenous leadership, will form the basis for self-governance which is a crucial component in achieving reconciliation. These relationships are complicated and require time and mutual respect to develop, and despite some cases of the government dragging its feet, they are developing.[251] These relationships are developing bilaterally, between the colonial and Indigenous governments, but also there has been an effort to include Indigenous participation within the structures of the Federal and Provincial governments, as well as society more generally. The past 10 years have seen liaison positions included in Ministry teams dealing with Indigenous issues, a concerted effort to hire Indigenous medical professionals and as well as government employees generally,[252] have Indigenous elders available in health facilities,[253] and the histories of colonialism and the IRS system in education.[254]

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[246] Participant 1, Interview with Elder.

[247] Ibid.

[248] Participant 4, Interview with First Nations Support Worker.

[249] Ibid.

[250] Participant 6, Interview with Academic.

[251] Participant 3, Interview with Representative of the Ministry of Child and Family Services; Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

[252] Participant 3, Interview with Representative of the Ministry of Child and Family Services; Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

[253] Participant 4, Interview with First Nations Support Worker; Participant 1, Interview with Elder.

[254] Participant 2, Interview with Chief.

Key to the maintenance of this progress is flexibility on both sides of the aisle. In their search for funding, Indigenous-led health programs must piece together funding from a variety of sources such as the FNHA, different ministries, and even school districts.[255] Indigenous organizations must then allocate those funds to a wide variety of services, as well as a broad range of individuals; one Indigenous health centre even specifies that they serve non-Indigenous Canadians.[256] Communities also have to remember that any government process is a slow-moving process, and to be patient but vigilant. The transfer of power and development of long-term bilateral partnerships will take time, and they have especially been hampered by the events of the previous decade (COVID-19, the toxic drug crisis, extreme weather events, and the discovery of mass graves).[257] Such flexibility is needed to keep a steady progression over time.

The Federal and Provincial governments, along with their ministries and services must remain flexible in a number of ways. First, there is a consensus that ideas surrounding healing and health differ between Indigenous and non-Indigenous peoples, and therefore health structures and desired outcomes will differ.[258] These differences will manifest themselves as unique to the First Nations community of which they are a part, and no two Indigenous health policies will, or should, look the same.[259] This means an acceptance of a shift in health practices which are general and overarching, to more unique and specific practices.

In one anecdotal case, an individual struggling with mental health problems, who had tried Western biomedical methods that did not work, asked their doctor to write them a note to receive time off to work on carving a canoe.[260] Rather than taking another pill, this individual spent time outside with knowledge-keepers who inspired in them a sense of brotherhood and were able to discuss culture and beliefs to stimulate this person's identity in order to discover the underlying reasons for illness. This in turn benefitted the entire community by enhancing the level of community identity and prevent future crises for the individual.[261] These methods provide a form of preventative medicine which is not found in the contemporary health care system.[262]

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[255] Participant 4, Interview with First Nations Support Worker.

[256] Ibid.

[257] Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

[258] Participant 1, Interview with Elder; Participant 6, Interview with Academic.

[259] Participant 6, Interview with Academic.

[260] Ibid.

[261] Ibid.

[262] Participant 1, Interview with Elder; Participant 2, Interview with Chief.

It is not only the prescriptions that must be flexible to change but also the ways in which we measure the success of Indigenous-led practices. Often, cases of success are not easily quantifiable statistics,[263] but rather stories of success like some of the ones shared here. Storied and community based-research such as holistic forms of cultural evidence, spirituality, and community health, combined with quantifiable metrics such as the number of individuals served, provides new methods of measuring success in cases of Indigenous health a programming.[264]

5 Discussion

5.1 An Indigenous Rights-Based Approach to Health

Despite the best efforts from the federal and provincial governments, as well as the Indigenous communities, the disparities found in health outcomes for Indigenous Canadians have remained the same. One of the primary reasons for this, mentioned by all but one of the participants in interviews, was a lack of accessibility regarding health services.[265] The participants were read the 4 elements of AAAQ, and they selected accessibility as the biggest barrier for Indigenous peoples, with the last participant saying that it was a holistic issue, and that all of the elements were lacking in combination.[266] This inaccessibility relating to health services stems from a number of factors, including the geographical challenges of remote communities[267] and the services not being culturally safe.[268] Despite these established barriers, structures of bureaucracy, politics, and systemic violence impede any meaningful efforts to address them. The current approach taken by the government is focused on analysis and procedure, while lacking in meaningful strategy and implementation.

For different results to be achieved, a different approach is required. By merging the work done by Farmer and Hunt mentioned in this paper's Literature Review, I propose that the best way to approach discrepancies in healthcare provision between Indigenous and non-

[263] Participant 4, Interview with First Nations Support Worker.

[264] Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

[265] Participant 2, Interview with Chief; Participant 3, Interview with Representative of the Ministry of Child and Family Services; Participant 4, Interview with First Nations Support Worker; Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions; Participant 6, Interview with Academic.

[266] Participant 1, Interview with Elder.

[267] Participant 3, Interview with Representative of the Ministry of Child and Family Services.

[268] Participant 2, Interview with Chief.

Indigenous Canadians is an Indigenous rights-based approach to health. We can begin to examine what such a framework would look like by utilizing Farmer's 6 elements of an effective strategy toward health and human rights, then discuss how these can be more effectively targeted toward addressing Indigenous-specific issues:

1. Health and healing are the symbolic core.
2. Provision of services is central.
3. Develop new research agendas.
4. Assume a broader educational framework.
5. Independence from bureaucracies
6. More resources for health and human rights.[269]

A rights-based approach is being developed within bilateral agreements between the Indigenous, Federal, and Provincial governments.[270] However, these approaches are falling into the pitfalls described by Hunt where such an approach results in the weakening of individual rights, and a number of trade-offs or compromises being made on both sides, such as governments giving up margins of control, while Indigenous peoples receive limited efforts of collaboration.[271] Further, such an approach is not specific enough to provide guidance on how to bridge the gaps between legal provisions and actual implementation.[272]

To avoid these problems, we can utilize Farmer's concept of pragmatic solidarity to supplement an Indigenous rights-based approach to health. Pragmatic solidarity requires preferential treatment rather than equal treatment to protect those who are at the greatest risk.[273] An Indigenous rights-based approach differs from a human rights-based approach because rather than addressing these issues, which are Indigenous-specific, with a general human rights approach, we can focus our efforts on an approach that has a more holistic understanding of Indigenous rights. In doing so, we put Indigenous peoples at the forefront and avoid wasting any effort on solutions to problems that are outside of the realm of Indigenous health and well-being.

The ideas set forth in points 1-3 of Farmer's 6 elements are of crucial importance in the development of such an approach. As we have seen in the analysis of the Canadian context, the

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[269] Farmer, *Pathologies of Power*, 239–44.

[270] Department of Justice Canada, "Annual Progress Report on Implementation of the United Nations Declaration on the Rights of Indigenous Peoples Act."

[271] Hunt, "Interpreting the International Right to Health in a Human Rights-Based Approach to Health," 111.

[272] Ibid., 115.

[273] Farmer, *Pathologies of Power*, 227.

accessibility of health services for Indigenous Canadians is extremely limited, and of the services available, many of them are not appropriately equipped to address Indigenous-specific issues. Centring the efforts of an approach on the Indigenous understanding of health, wellness, and healing can lead to a better understanding of how programming and policy should be shaped. Further, a better understanding of holistic healing can allow for the development of new ways of researching and evaluating these health programs. As discovered in the qualitative analysis, the ways in which we measure success in the contemporary biomedical healthcare system do not fully reflect the ways in which we measure success in Indigenous-led health programs. A greater emphasis is placed on metrics which are not as easily quantifiable such as spirituality, community health, and storied and community-engaged research.[274] Any successful approach must re-examine the ways in which we evaluate these issues and the policies and programs which are meant to address them.

Next, element 4 from Farmer is of particular importance in an Indigenous rights-based approach to health. Broader education in relation to Indigenous health has several required parties, including healthcare professionals, government personnel, Indigenous communities, and society more generally. Government and healthcare employees need to be educated on Indigenous health practices and beliefs around well-being to identify the best methods for healing. These processes have begun,[275] however, they have not yet reached their full potential or implementation throughout government and healthcare systems, as they are not a fundamental part of training, and remain supplementary. Education within Indigenous communities is also critical. Following the damage done to Indigenous culture by the IRS system, efforts to relearn Indigenous traditions, ceremonies, medicines, and culture, generally, are crucial to the healing of individual identities as well as community identities. Finally, as set forth by the Truth and Reconciliation Commission, the education of all Canadians on the topic of IRS and reconciliation must be made a priority so that underlying biases can be removed, and the entire population can take part in the processes of reconciliation. Through a broader education on topics like colonization, IRS, and discrimination for the entire population of Canada, the colonial structures which reproduce discrimination and the biased social lens within the minds of Canadians can begin to be torn down.

[274] Participant 6, Interview with Academic.

[275] Participant 1, Interview with Elder; Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

Finally, elements 5 and 6 from Farmer would remove the barriers for Indigenous communities that stem from poor politics and bureaucracy and help to develop and maintain self-governance on a wide range of topics, not just limited to health. As discovered in the interviews, there is a substantial amount of funds being dedicated to the closing of health disparities between Indigenous and non-Indigenous Canadians,[276] however, those funds are being hampered and mismanaged due to the siloed nature of the government, and the many steps of bureaucracy that they must go through before reaching their intended objective. Health policies aimed at addressing Indigenous-specific issues must be removed from the politicized world, and the control of allocated funds must be transferred to the people that they are meant to aid. Without such an approach, true policies of self-governance for Indigenous peoples, which are a legal obligation for the Canadian and BC governments to develop, will continue to be superficial. Further, an effective self-governance policy and the redress of health inequalities would have a secondary benefit to other categories of rights such as education, environment, housing, and employment due to the normative overlap that the right to health has with other rights.[277] By supporting an Indigenous rights-based approach to health, progress can be made in areas such as the right to safe drinking water, which one-quarter of reserves do not have access to.[278] Further, due to the right to health's intermediary position between a multitude of 1st and 2nd generations of rights, as discussed by Toebes, supporting it in a holistic way can also improve the right to life, education, and work more generally.[279]

An approach such as this can help to address disparities in health outcomes in several different ways. While a human rights-based approach makes use of human rights, an Indigenous rights-based approach would be able to use human rights as well as Indigenous rights set out in Canadian legislature to support arguments surrounding self-governance, reconciliation, and land rights. In doing so, self-governance policies can be fully developed and control over Indigenous health can return to Indigenous communities where healing practices which are centred on land, language, culture, and ceremony can begin to restructure what health and wellness practices and programs should look like for Indigenous Canadians.

Further, an Indigenous rights-based approach would highlight the importance of the broader issues in Canadian society, allowing for more comprehensive responses to take place

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[276] Participant 1, Interview with Elder; Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions; Participant 2, Interview with Chief.

[277] Toebes, "The Right to Health," 175.

[278] Participant 6, Interview with Academic.

[279] Toebes, "The Right to Health," 175.

in several sectors. Much like Farmer's concept of pragmatic solidarity, a disproportionate amount of effort and resources need to be allocated to protect those whose socioeconomic status is most at risk. This means doing away with the cost-effective requirements in health programs, as discussed by Farmer,[280] but also housing projects, investments in Indigenous industry, and expanding educational programs. By recognizing the stark disparities found in these areas, and focusing on the alleviation of suffering, we can utilize every resource available, rather than just those that are determined by the government to be worthwhile. Such an approach mitigates the problems stemming from limited and bureaucratic government efforts, which result in little to no meaningful change in socioeconomic status, despite the tremendous effort.

The success of such an approach to health is dependent on several conditions which were detailed in the article by Hunt: AAAQ, participation, non-discrimination, transparency, and accountability.[281] With the current steps taken by the Canadian and Provincial governments, it can be argued that all these areas need to be improved. The availability and accessibility of health services for Indigenous Canadians are clearly lacking, and of the services available, many of them are not acceptable regarding their cultural appropriateness. Further, the discrimination which was outlined in the In Plain Sight report makes it even more difficult for Indigenous Canadians to seek medical aid, and the lack of transparency and participation makes accountability a challenge.

5.2 Reconstructing Governance, Healing, and Indigenous Identity

To meet these requirements, an Indigenous rights-based approach to health will lead to the fulfillment of these elements through the means of transferring powers of governance back to Indigenous communities. The current approach by the federal and provincial governments is failing to meet their legal obligations regarding the right to health in almost all the parameters described by Hunt. Rather than making operational changes, the current approach to addressing socioeconomic disparities has remained largely procedural, and hence unable to bridge the gaps between legal policy and implementation. This can be attributed to the need for decolonization within the government,[282] and the requirement to address the ways in which structures of discrimination within society inform policy decisions. As per the obligations set out in Article

[280] Farmer, *Pathologies of Power*, 239.

[281] Gruskin et al. in, Hunt, "Interpreting the International Right to Health in a Human Rights-Based Approach to Health," 115.

[282] Participant 5, Interview with Representative of the Ministry of Mental Health and Addictions.

2 of CERD, it can be argued that Canada falls short in all the domains of opposing discrimination built into the structures of Canadian society. This is exemplified by limited efforts to implement the right to self-governance, and the ineffective approach for addressing socioeconomic disparities for Indigenous Canadians.

While there have been recent efforts made by the Federal and Provincial governments toward this transfer of powers, their actual meaningful operationalization remains to be seen. Despite the legal obligation imposed on the federal and provincial governments, true cooperative partnerships have yet to emerge. If true self-governance were achieved, the requirements of included in AAAQ would be met, due to the distinctive nature of health programming. If each community was allocated the resources and control to develop unique health programming, appropriate programming would be made available to them which is distinct top their particular beliefs and needs. Moreover, they would be culturally accessible and acceptable because they would be distinctions-based and unique to each community. Once the foundation of programming is grounded in local traditional knowledge and practices, it can then be supplemented by contemporary biomedical approaches, to provide a complete medical service which begins with culturally relevant practices. Because of the unique nature of these programs, their quality would also be improved compared to the currently available programs, as exemplified by the case described by Allen where dramatic effects were observed in the 10 years of implementing such practices in Alaskan Indigenous communities.[283]

The participation and non-discrimination components of such programs would be easily managed, as the development and maintenance of such programs would be completely run by individual communities, whose sole objective would be to serve their populations. Further, as shown in the interviews, some of the already existing Indigenous-led health programs go beyond this requirement and serve non-members who are both Indigenous and non-Indigenous.[284] Regarding transparency and accountability, functional long-term bilateral partnerships between Indigenous governments and colonial governments ensure accountability to one another: the Indigenous community provides effective services and requests assistance as required, and the colonial government provides the funding and support, as well as respecting the inherent rights of Indigenous communities. As discussed previously, the contemporary methods for assessing the success of medical programs fall short when applied to Indigenous-

[283] Allen et al., "Indigenous-Led Health Care Partnerships in Canada," E209.

[284] Participant 4, Interview with First Nations Support Worker.

specific programming,[285] and more holistic elements need to be included in these assessments such as stories, spirituality, and community health. Of course, quantifiable statistics can still be important and can show success over the long term, but these need to be included as supplementary metrics in such assessments.

As noted in the article by Hunt, progressive realization, maximal use of available resources, and international cooperation play a crucial role in these types of approaches.[286] These mechanisms ensure the continued improvement in the delivery of services for at-risk groups such as the Indigenous in Canada. Bearing in mind that the bilateral structures are still being developed, accountability using storied and community-based research can speak to the continued progression of the realization of the right to health for Indigenous communities. Further, as Canada has a legal obligation for participating in these bilateral nation-to-nation relationships, as well as the provision of most funding, there also needs to be accountability regarding the provision of the maximum available resources and international cooperation between the Canadian and Indigenous governments. An examination of the current efforts to combat health inequalities has shown that not only are gaps in health outcomes not closing, but resources are not being effectively utilized, and cooperation between Indigenous and Canadian governments has not occurred.

A fostering of genuine self-governance can lead to a more successful approach to combatting these inequalities. By utilizing an Indigenous rights-based approach, the Canadian and BC governments can be held to the standards set out in the law and establish a meaningful bilateral partnership with Indigenous governments. Each individual Indigenous community is best equipped to determine what forms of programming and policies are needed to address the issues within those communities, and the resources required to meet those objectives. This particularity is particularly important, due to the unique nature of each Indigenous community. As stressed, there is no such thing as one 'Indigenous culture' and therefore unique structures and modalities must be built in each community. Further, urban community leadership structures need to be developed, like that described by Lavoie et al., so that unregistered and off-reserve Indigenous Canadians can seek the same level of support as the 26% living on their home reserve land.[287] With such a high proportion of Indigenous Canadians living in urban settings, the establishment of these community institutions is also crucial to the full

[285] Ibid.; Participant 6, Interview with Academic; Farmer, *Pathologies of Power*, 241.

[286] Gruskin et al. in, Hunt, "Interpreting the International Right to Health in a Human Rights-Based Approach to Health," 115.

[287] Lavoie et al., "Missing Pathways to Self-Governance."

implementation of self-governance policies. By doing away with cost-effective models, and focusing on health and wellness, the maximum available resources can be properly utilized to address inequalities which have remained stagnant for decades.

Using an Indigenous rights-based approach to establish legally enshrined self-governance institutions can also have dramatic secondary effects beyond health improvement. The cultural identity of Indigenous peoples and their practices have been critically torn apart by centuries of colonialization, assimilation, and legal policy. Despite generations of marginalization and abuse, these communities have remained resilient and ensured the survival of their culture, despite the great efforts to eradicate it. By re-establishing Indigenous governance, the process of reconstructing that identity can reach its full potential through a connection to land, language, culture, and ceremony.[288] Through the transfer of governmental powers back to Indigenous communities and urban community leadership centres regarding their own matters, cultural identities can be re-established and Indigenous representation within Canadian society can no longer be ignored. For too long, Indigenous peoples have been marginalized and discriminated against, but through the acknowledgement of their rights and nationhood within the country, the process of regaining equal positions within society can be jumpstarted. The establishment of meaningful self-governance policies, and the closing of gaps in the health, education, work, and housing sectors can put them on equal footing within society, and work to eliminate the structures of marginalization and discrimination that are built into the colonial system.

6 Conclusion

Through an Indigenous rights-based approach, the specific issues which face Indigenous communities can be addressed in an effective and distinction-based manner. Such distinctions among communities are particularly important in a holistic approach which is tailored toward the communities they are intended to benefit. The current approach taken by the Canadian and BC governments falls short in its efforts to implement effective policies which address the structural discrimination which has seeped into the fundamental parts of governance, and the social lens through which many Canadians view Indigenous peoples. Despite the legal obligations imposed on the federal and provincial governments through international, national, and provincial law, years continue to pass without any gains being made in the protection of

[288] Participant 6, Interview with Academic.

Indigenous peoples' rights. It is not only an analysis and understanding of these issues that is needed, but effective strategies and implementation as well.

The federal and provincial governments must make good on their commitments to Indigenous communities regarding self-governance and long-term cooperative partnerships. With a meaningful embrace of Indigenous self-governance, processes of rebuilding cultural identity and healing practices can begin, and gaps between Indigenous and non-Indigenous people can begin to close, finally putting them on equal footing within society. With the control afforded to these communities through self-governance and nation-to-nation relationships with federal and provincial governments, the unique issues facing Indigenous communities can be approached in the most effective ways. It is only through great cooperative efforts that the scars created from centuries of colonization and be healed.

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