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Chair

Mrs. Karen Vecchio

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● (1530)

[*English*]

The Chair (Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC)): Good afternoon.

Welcome to the 127th meeting of the Standing Committee on the Status of Women. This meeting is being televised.

Following the motion adopted by the committee on December 3, 2018, today officials from the Department of Indigenous Services Canada will provide the committee with a briefing on the government's efforts to immediately end the practice of forced and coerced sterilization of indigenous women.

For this, I am pleased to welcome Valerie Gideon, senior assistant deputy minister, first nations and Inuit health branch; and Katherine Cole, senior manager, first nations and Inuit health branch.

I am going to turn the floor over to you for opening statements. You have approximately 10 minutes.

Ms. Valerie Gideon (Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Indigenous Services Canada): Thank you for inviting me to appear before this committee on this critical issue of forced or coerced sterilization.

I'd like to begin by acknowledging that today we're meeting on the unceded traditional territory of the Algonquin people.

[*Translation*]

We are here today because we are all disturbed by reports of forced and coerced sterilization of indigenous women in this country. I want to acknowledge these women and recognize their bravery. I speak as a first nations woman, member of the Mik'maq Nation of Gespegagiag in the Quebec region, a mother of two young girls, and as someone who has dedicated her entire career to advocating for the health of indigenous peoples, both outside and inside the public service.

[*English*]

Forced or coerced sterilization is a serious violation of human rights and medical ethics. It is a form of gender-based violence. It is evidence of a broader need to eliminate racism and discriminatory practices, ensure cultural safety and humility, improve culturally competent informed consent, and remove barriers that indigenous women face when accessing health services in this country.

This issue is an indication of racism in the health care system, and addressing it is a matter of reconciliation, as cited by the Truth and Reconciliation Commission. All Canadians have a responsibility to ensure that these practices never happen again.

In the motion passed to request this appearance, the government's commitment to the United Nations Declaration on the Rights of Indigenous Peoples was raised. As you may know, in May 2016 the Minister of Indigenous and Northern Affairs announced that Canada is a full supporter, without qualification, of the declaration.

The declaration is a statement of the collective and individual rights that are necessary for the survival, dignity and well-being of indigenous peoples around the world. The government must take an active role in enabling these rights to be exercised. It will fulfill a commitment to implementing the declaration through the review of laws and policies, as well as other collaborative initiatives and actions, some of which I will outline today.

[*Translation*]

This committee has specifically raised article 7.2 of the declaration, which states that:

> Indigenous peoples have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group.

I would also like to point out that the principle of free, prior and informed consent is central to the declaration. In its July 2018 resolution on forced sterilization, the Assembly of First Nations stated that “the forced sterilization of indigenous women by medical professionals breaches the free, prior and informed consent standards contained in the UN declaration”.

[*English*]

Forced or coerced sterilization is not something that any one profession or order of government can address alone. Federal, provincial, territorial and indigenous governments and organizations all have a role to play. At the same time, coerced sterilization is a matter of the practice of medicine. Only surgical practitioners, such as obstetricians and gynecologists, can perform surgical procedures such as tubal ligation, so doctors and those who regulate the profession must be involved. Informed consent policies are administered at the local level, which means that hospital administrators and the health authorities they work within must also be part of measures to ensure free, prior and informed consent, and culturally informed and safe practices.

In keeping with its commitment to the recognition of rights, respect, co-operation and partnership, the federal government can play a leadership role in convening these bodies to facilitate dialogue and action in the spirit of the UN declaration and the principle of free, prior and informed consent.

[*Translation*]

The government will play this leadership role by reaching out to provincial and territorial ministers of Health, as well as medical associations, to seek ways to work collaboratively to ensure safety and respect for indigenous women in Canada's health care systems.

We will work with our Health Canada colleagues to bring together federal, provincial, and territorial officials to engage with indigenous groups and national provider organizations on measures to ensure cultural safety and humility in health systems.

● (1535)

[*English*]

Within Indigenous Services Canada, the department that I represent here today, we have been acting on this issue for several months. For the sake of time, I will outline some of our more recent actions.

Last week, we held a teleconference with indigenous organizations and national health organizations to discuss ways to advance collaboration and identify actions that will ensure free, prior and informed consent and culturally informed and safe services for indigenous women across Canada. The teleconference was part of our efforts towards a forum in early 2019. This is a milestone event that we had decided to undertake in June 2018 at our senior management committee, where the Assembly of First Nations and Inuit Tapiriit Kanatami are full members, and where we had invited the Native Women's Association of Canada and Pauktuutit, the national Inuit women's association, to attend as special invitees.

The forum will be an opportunity to convene indigenous and professional associations, to mobilize actions for indigenous women's reproductive health, and to discuss a recommendation received at the Inter-American Commission on Human Rights in Bogotá, Colombia to issue guidance regarding sterilization procedures.

[*Translation*]

Another recommendation made in Bogota was to produce an information brochure for health care providers and patients on proper and informed consent in the context of women's health services. We have been in discussions with national indigenous women's organizations to make this happen.

We are also establishing a new Advisory Committee on Indigenous Women's Wellbeing to inform the department on current and emerging issues, including sexual and reproductive health. The inaugural meeting will be held in January 2019, and we are pleased to have several indigenous women's organizations already confirmed to participate as full members.

[*English*]

In addition to responding to recommendations made at the Inter-American Commission on Human Rights, Indigenous Services Canada endeavours to support indigenous women's reproductive health more broadly through its programs and policies. The maternal and child health program, which was introduced in 2005, offers community-based home visiting services by nurses and family visitors to over 8,100 pregnant women and families with young children in over 300 first nations communities. Through the program, expectant mothers receive case management, screening, assessment and referral services, as well as health promotion strategies to identify risks and improve maternal and child health.

Budget 2017 increased the existing program funding of approximately $25 million annually by $21.1 million over five years, which represents a 30% increase. With $7.5 million ongoing from year five, the total investment by 2022 will be $32.5 million annually.

[*Translation*]

In addition, budget 2017 invested $6 million over five years for indigenous midwifery—the first ever federal investment into this area. Midwifery care to indigenous communities has been identified as a pathway that improves health and well-being of women, their children and the entire community, and it signals a repatriation of birthing into communities, a longstanding traditional practice. Furthermore, informed choice is recognized as a central tenet of midwifery care in Canada.

[*English*]

While the budget 2017 investment in midwifery is historic for the federal government, it represents just a first step. Most indigenous families in Canada are still with very little or no access to midwifery care. There is some evidence that midwives not only support women in their reproductive health planning, which may prevent further cases of forced or coerced sterilization, but also provide support to women in preventing custodial loss of their children.

Senator Yvonne Boyer and Dr. Judith Bartlett have found that past custodial loss or the threat of custodial loss played a role in coerced sterilization in Saskatchewan. Further work is required in this area, and we are looking to indigenous midwives' leadership to better understand. We are very pleased that the National Aboriginal Council of Midwives has agreed to sit on the indigenous women's well-being advisory committee.

[*Translation*]

The presence of a support person in labour offers many benefits to a labouring woman, including assisting her with decision making and advocating for her wishes. Budget 2017 also included new investments to strengthen maternal supports by ensuring that all first nations and Inuit women are entitled to an escort when they leave their community for childbirth.

Indigenous Services Canada's Non-Insured Health Benefits Program now provides coverage of an escort to accompany expecting mothers regardless of their age or medical condition, recognizing that no woman should have to give birth alone.

● (1540)

[*English*]

The Government of Canada has committed to implementing the Truth and Reconciliation Commission's calls to action, including calls 22, 23 and 24, which pertain to using and recognizing the value of aboriginal healing practices, retaining and increasing the number of aboriginal health care professionals and providing cultural competency training, and providing anti-racism and cultural competency training for all medical and nursing students.

With the Royal College of Physicians and Surgeons of Canada and indigenous organizations, our department has been exploring project ideas for an online repository of cultural competency learning tools. Last year, the Royal College approved indigenous health and cultural safety as a mandatory component of post-graduate medical education and certification.

In 2013, all Indigenous Services Canada's health-related operations were transferred to the control of B.C. first nations under a newly established First Nations Health Authority, which we refer to as FNHA. The FNHA has done remarkable work with the province and its regional health authorities in finalizing a declaration on cultural safety and humility, and informing cultural safety and humility training across the provincial health system.

The FNHA is presently developing the first-ever cultural safety and humility standard, in partnership with the Health Standards Organization, which is affiliated with Accreditation Canada. We are funding this work.

We are hopeful that other provinces and territories will look to this work as a promising practice. It is a key item that we will bring forward to the newly formed federal-provincial-territorial working group I referenced earlier.

[*Translation*]

The Native Women's Association of Canada and Pauktuutit have been providing leadership on indigenous women's health, and as our relationship with these women's organizations grows and expands to include Les Femmes Michif Otipemsiwak, Women of the Métis Nation, we are encouraged by their good work and guidance. Their collaboration in addressing the issue is essential to getting this right.

[*English*]

It will take the efforts of many to ensure that structural racism and the effects of colonization do not interfere with the health of indigenous women. I want to assure you that we are taking this matter very seriously and working in the spirit of collaboration and partnership towards culturally informed and safe health services for indigenous women throughout Canada.

I will be pleased to answer any questions that you have.

The Chair: Excellent. Thank you very much.

For our first round of questions, each member will have seven minutes.

We will begin with Pam Damoff.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): Thank you very much, Chair.

Thank you, both, for being with us today.

I think everyone around this table can agree that women should have full control over their reproductive health, and that these coerced sterilizations are wrong and should not be happening. We're starting from the point where we're all agreeing and we want something to be done.

You mentioned that the minister is meeting with her provincial and territorial colleagues. In terms of meeting with the medical professional organizations, as well as involving indigenous leadership, how is she steering all of that together?

Ms. Valerie Gideon: We started with some exploratory conversations with the indigenous women's organizations and the national indigenous organizations, to see if they would be interested in working with us on an ongoing basis with respect to these issues. Our minister and the Minister of Health are writing to provincial and territorial ministers in order to seek their collaboration as well, and their interest in participating in a federal-provincial-territorial working group to work through this issue, as well as to look at preventative measures such as cultural safety and humility.

We will also, of course, invite indigenous women's organizations to participate in that and to work with mainstream health organizations. I think the relationship between indigenous women's organizations and mainstream health organizations will be built over time as well. There have been many collaborative efforts that have been led by mainstream health organizations over the last number of years, but in some cases they haven't worked together before. They really need to get to know each other and build that relationship.

Ms. Pam Damoff: Is she working with the medical licensing bodies as well?

Ms. Valerie Gideon: The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada are also interested in collaboration. Also, through her outreach and our outreach to provinces and territories, we will need to engage with provincial and territorial licensing bodies as well.

● (1545)

Ms. Pam Damoff: Thank you.

Do we have any statistics on this? Is there any data? I know that there are women who are coming forward, but is there any data on how many women have been impacted by this practice?

Ms. Valerie Gideon: No, we don't have any of that information.

There has been some scoping work that has been done through Senator Boyer and Doctor Bartlett's work through the external review. That was specific to Saskatchewan. We don't have national data.

We have data on the number of hospitalization procedures that occur by province and that also involve sterilization, but that does not give you a sense of the consent, and it's not disaggregated by the population in terms of knowing how many of those women were indigenous.

Ms. Pam Damoff: Right. Okay.

Ms. Valerie Gideon: There would need to be quite a lot of research done to get some statistics of that nature. It will also depend on women coming forward. That needs to be a very culturally safe environment. You would design the research to ensure that indigenous women's organizations lead and are part of structuring that work, so that women feel safe to come forward.

Ms. Pam Damoff: In November of this year, Senator Murray Sinclair said that when he was documenting stories for the Truth and Reconciliation Commission's report on the legacy of residential schools, this issue came up in the hearings in Saskatchewan. He suggested there was a need for an evaluation of the child welfare system and its involvement in this horrific practice.

I wonder if you could give your thoughts—the department's thoughts—on the role that the child welfare system has played in women being coerced to be sterilized.

Ms. Valerie Gideon: In Senator Boyer's work and Dr. Bartlett's work, a direct connection was made between some of the women who came forward and told their story and their concern about the involvement of child and family services. That was raised as a pretty important factor in the external review work.

We have invited the individuals who are responsible for the child and family services reform and social programs overall, in our department, to be part of the indigenous women's well-being advisory committee, specifically because this is a cross-sectoral issue. It doesn't belong only to the health system. It will have linkages in other areas, including child and family services, of course. Because we don't have a lot of research or information about what's currently happening or what's happened in the most recent past, it's difficult for me to answer that question for you, except to say that so far the women who have come forward have established that link.

Ms. Pam Damoff: Thank you.

You also mentioned the calls to action from the truth and reconciliation report, the need for cultural competency training, and getting more indigenous people working in the health care field.

I serve on the public safety committee. We have heard repeatedly that it's really challenging to get indigenous people working in corrections. There have certainly been very positive steps taken.

What is the department doing to ensure that cultural competency training is being done for medical professionals? Is there a role for the federal government to play in that? Also, what kind of outreach is being done to encourage indigenous people to go into the medical profession?

Ms. Valerie Gideon: The department funds bursaries through Indspire that are specific to the area of health. We have also worked for years in the community to try to support health careers promotion. We did a lot of training of community-based workers as well, to try to identify laddering opportunities for them to move into paraprofessional or health professional training and education programs. We have funded some specific initiatives, such as aboriginal nursing entry programs in certain universities.

I think that's definitely an area that warrants further investment.

Ms. Pam Damoff: I don't have a lot of time left.

One of the things I've heard repeatedly, though, is that when people are not seeing role models in those fields, it's hard for them to think of themselves becoming a doctor or a nurse, or going into the medical profession. We've heard that...to try as much as possible to get those role models into communities where young men and women can aspire to follow in the footsteps of someone they see.

I don't know if you're doing anything along those lines.

Ms. Valerie Gideon: We used to have a role model program years ago. It's definitely something that the department can relook at. I think Indspire does quite a lot of work in terms of promoting some of its successful students whom it supported through the end into their careers as well.

● (1550)

The Chair: Excellent. Thank you very much.

We're now going to turn the floor over to Arnold Viersen. You have seven minutes.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Madam Chair.

Thank you to our guests for being here today.

I found it interesting that right off the top you talked about this being a human rights issue. What do you see as the role of your department in this human rights issue?

Ms. Valerie Gideon: I think our role is to support indigenous women's organizations to help inform what would be public awareness materials that would help to support a better understanding and an applicability of informed consent throughout the health system. We do have partnerships with indigenous organizations, both nationally and regionally, that we can leverage in that regard.

We also have relationships with mainstream health organizations, and so does Health Canada. In working with them, we can also convene all of the individuals and all of the organizations that need to be at the table to, fundamentally, have a significant culture shift in the Canadian health system, promote anti-racism and prevent discriminatory practices.

Mr. Arnold Viersen: Have you been in contact at all with the justice department?

Ms. Valerie Gideon: We have, in the sense that there is pending litigation on this issue. Also, the Department of Justice has helped us to have an understanding of the historical significance of the issue over time. They are helping us with respect to research of documentation and also a better understanding of the historical nature of the issue.

Mr. Arnold Viersen: Do you know if the government is coming forward with a piece of legislation around forced sterilization?

Ms. Valerie Gideon: I'm not aware of that, no.

Mr. Arnold Viersen: Are there any international sanctions that are being placed on us because of this? I know the UN has a litany of condemnation for sterilization. Has there been anything international coming toward us because of this issue?

Ms. Valerie Gideon: The Inter-American Commission on Human Rights did table some recommendations, two of which are housed within our department, which are to improve access to public awareness materials on informed consent and on guidance on sterilization procedures.

Canada has also accepted the recommendation from Argentina, specifically, as part of the universal periodic review and Canada's report on that front. Last week, we received some concluding observations from the Committee Against Torture of the United Nations, as well. There are recommendations there for Canada to consider.

Mr. Arnold Viersen: If this were in a wartime situation, we might be accused of crimes against humanity. Would you agree with that?

Ms. Valerie Gideon: I'm not a Global Affairs representative. I regret to say that it's just not my area of expertise.

Mr. Arnold Viersen: Are you in contact with Global Affairs at all about this?

Ms. Valerie Gideon: I have not been in contact with Global Affairs directly, no.

Mr. Arnold Viersen: It's interesting. I read two articles from the news media recently. The caption on this one is “Morningstar Mercredi, pictured November 16, 2018, woke up from a surgery at 14 and discovered her developing baby was gone. What remained was an incision...cut without her permission.”

The other article, I think, is one that everyone has seen. It says, “When she was 17 years old, Liz was coerced by a Children’s Aid worker into having an abortion and being sterilized at a northwestern Ontario hospital, she says—an experience she’s carried for 40 years.” Reports from Alberta, Saskatchewan, Manitoba and Ontario suggest that this is still happening.

Forced sterilization is the topic that we're all talking about, but it obviously appears that other medical procedures are taking place without consent. Is this part of a broader effort on your part?

Ms. Valerie Gideon: Do you mean, to understand the issue?

Mr. Arnold Viersen: Yes. Forced sterilization seems to be just one part of this.

Ms. Valerie Gideon: Oh, I see. I'm sorry. Katherine is saying you're referring also to terminations and potentially other practices.

Mr. Arnold Viersen: Yes.

Ms. Valerie Gideon: I certainly agree that, in reviewing this issue, we do have to consider other impacts on indigenous women, impacts of racism or discriminatory practices that may be perpetuated in the Canadian health system in various ways, and to work with the medical professionals—and other health care practitioners, frankly—to ensure that we have a much more culturally safe environment for indigenous women across the country.

Mr. Arnold Viersen: I had a chat with the former head of the Indigenous Physicians Association, and I asked him about his thoughts on it. I'm wary of speaking for him in this forum, but I'd invite the committee to ask him to come in front of us, as well.

He said the underlying issue is that there is an idea that you can have too many children. Is that something the department has found as well, an underlying idea that you can have too many children and therefore we need to step in?

● (1555)

Ms. Valerie Gideon: Of the reports that have been written on this issue, I've seen that as a recurring theme. In our department, at this point, we have not fully reviewed or done direct research with respect to this issue. We've read through the reports that have been submitted, and I have heard that as a theme reported from women who have come forward.

Mr. Arnold Viersen: Is there something in the litany of things you are doing—I wrote it down—in or around that, to educate the health care system, saying that if these women choose to have this many children, there shouldn't be a problem with that?

Ms. Valerie Gideon: Absolutely. That would be part of cultural safety and humility training, which is also to not exercise judgements that are not based on any cultural understanding and actually listening to the voices of the women themselves.

Mr. Arnold Viersen: For sure.

I was interested that the first thing you mentioned off the top as an action that you're taking is a teleconference. Is that going to be a significant enough action to end it? This report—I don't know if it's legitimate or not—says that forced sterilization is still happening, and the government's solution is a teleconference.

Would we not want to engage the justice department on this?

Ms. Valerie Gideon: I was just going to say that this was an example of the most recent initiative where we've had dialogue with indigenous women's organizations and other partners.

We've actually been meeting and speaking with them separately for several months leading up to this point. We had a presentation back in June at our senior management committee, where we wanted to ensure that everybody was comfortable with the approach of setting up an ongoing advisory committee and hosting a specific forum with experts who could come forward and offer some advice and recommendations about what needs to be done.

Also, we will be looking at research in a way that indigenous women's organizations can provide a leadership role, to make sure that women feel safe coming forward.

That is a multitude of different actions. The teleconference is just an opportunity to say that we have very strong interest, and that a lot of organizations are interested in collaborating and working together to address the issue.

The Chair: Excellent. Thank you very much.

Now we'll move over to Charlie Angus, for seven minutes. You have the floor.

Mr. Charlie Angus (Timmins—James Bay, NDP): Thank you, Madam Chair. Thank you for having me at your committee.

Thank you for your witness testimony.

You said that you've been engaged in this issue for a bit of time. When did you officially begin to look into the issue of forced sterilization of indigenous women in Canada?

Ms. Valerie Gideon: I would say that we started really looking at it in a specific way last fall, in 2017. We had been looking at cultural safety and humility, at racism in the health care system, and at the TRC calls to action much prior to that.

Mr. Charlie Angus: Thank you.

I guess I would have been really shocked to find that women are being forced to be sterilized in hospitals in the north, in different communities—but, of course, if you have actually seen what happens, and the complete inequities faced by indigenous people, this kind of behaviour is actually not all that shocking. I think what's shocking is that it took a United Nations report on torture and a class action lawsuit to get this kind of issue brought to the fore.

The class action lawsuit, which named the federal government, was brought forward in October 2017, right around the time you said you started to deal with this. Were you not aware of this before the class action lawsuit, or was it not a priority? How did the class action lawsuit push your department into starting to address this and look at the cases?

Ms. Valerie Gideon: I think it was more the fact that the practice is being reported to still be occurring today. That was of significant concern to us. Within our department, we no longer run hospitals, outside of two hospitals in Manitoba, and in those hospitals we don't have surgical procedures. I think, for us, learning that this was still something ongoing in the health care system was of particular concern.

Mr. Charlie Angus: Right.

Measures to prevent births within national, ethnic, racial or religious groups are prohibited by the Convention on the Prevention and Punishment of the Crime of Genocide. The UN has brought forward very specific recommendations for Canada, including a call that the names of those who've been involved in this behaviour be turned over.

As a defendant in this lawsuit, would you know of the specific cases where women have been forcibly sterilized? Are you willing to comply with the UN call to turn over the names of people who have been engaged in this practice to criminal sanction?

Ms. Valerie Gideon: I really can't comment on pending litigation. Again, it's not my area of expertise, with respect to that piece of the litigation.

● (1600)

Mr. Charlie Angus: Have you taken any steps to hear directly from women who have been sterilized, so that you can have a better sense of the inequities and abuses happening within the system?

Ms. Valerie Gideon: We've been discussing with national indigenous organizations how to approach that, how to approach either research or outreach in a culturally safe way. At our first meeting of the advisory committee, planned for next month, this will be part of our agenda.

I've had some preliminary discussions with the organizations, but I do think it's important to reflect on what the best approach will be. Even in the external review conducted by Senator Boyer and Dr. Bartlett, they noted the difficulties in having women come forward, the fears women had, and the fact that they believed there were other women there but they were reluctant to do so.

I do think that the approach that is undertaken.... We do have to, if possible, have the support of indigenous women's organizations, so that they can play an important role in the outreach.

Mr. Charlie Angus: Has your department issued any statements to anybody involved in the first nations and Inuit health branch, or to any of the hospitals where women are being flown to receive treatment, to say that forced sterilization is a crime and that it meets the international conventions on torture and genocide? Have you issued any statements warning any of the hospitals where indigenous women who are under first nations health services are being treated? Have any warnings been sent out?

Ms. Valerie Gideon: We have not issued any specific statement. We have, however, discussed with indigenous women's organizations about providing funding to develop materials for women and for health care partners in order to raise awareness about that issue and also to provide culturally safe guidelines overall with respect to indigenous women's reproductive health.

Mr. Charlie Angus: I guess I'm concerned because the UN Committee Against Torture names Canada and demands immediate action. To me, that's a very shocking thing for our nation. We're not talking about good moms and healthy babies programs; we're talking about a crime that fits the convention on genocide.

After you were made aware of it roughly around the same time that a class action lawsuit was launched against the federal government, I would think there would be some clear steps in place. What are we going to see from the federal government? We know that the government has rejected the UN call to criminalize this behaviour. What concrete steps will you take to make sure this doesn't happen again? We've seen that this has happened in Manitoba, Saskatchewan, northern Ontario. If we keep looking, are we going to keep finding this practice?

What concrete steps will you take to ensure this will never happen again?

Ms. Valerie Gideon: I think our main role will be to convene federal, provincial and territorial partners, mainstream health organizations, licensing bodies of medical professions and medical associations in order to be able to collaborate on what will be essentially a series of preventative measures and also to redress racism and discriminatory practice in the health system where they exist.

I think having indigenous women's organizations play a leadership role in that is extremely important.

Mr. Charlie Angus: Last week, the first nations chiefs issued a resolution call on the federal government to change the Criminal Code to explicitly outlaw coerced sterilization, because we understand it's happened as late as 2017, maybe later; we don't know. Yet, you've issued no statements saying that this is a crime.

Would you recommend to the minister that this be considered a crime at the federal level, that we have clear laws in place to make sure that this is going to stop, and that it be treated with the seriousness that the UN has called for?

Ms. Valerie Gideon: I think the Department of Justice has issued a statement on that issue that indicates they are taking a public health approach. We would definitely work with the Department of Justice in issuing our communications.

Mr. Charlie Angus: The public health approach is different from a criminal approach. You keep talking about it as a public health issue, and I keep talking about it in light of the UN and what the chiefs are calling it, which is a criminal action. Are we going to see it referred to as a criminal action and not just a public health issue, because forced sterilization meets the international convention rules on torture?

Ms. Valerie Gideon: Again, I'm not from the Department of Justice and I can't speak on their behalf. The Department of Justice has spoken about the criminal acts provisions in the existing legislation in Canada right now that will prevent forced sterilization and protect women.

However, I really cannot go farther. I'm just not a representative of the Department of Justice.

● (1605)

The Chair: Excellent. Thank you very much.

Thank you, Mr. Angus.

We're now going to move on to Marc Serré. You have the floor for seven minutes.

[*Translation*]

Mr. Marc Serré (Nickel Belt, Lib.): Thank you, Madam Chair.

[*English*]

I just want to go back to Mr. Angus's question. During question period today, our minister indicated that it is a crime. Is that your understanding, that where the laws are today, forced sterilization is a crime?

Ms. Valerie Gideon: My understanding from reading the Department of Justice notes is that existing legislation in Canada does protect women against forced sterilization.

Mr. Marc Serré: This is definitely an issue that we have to address. We talk about public health. We talk about education.

I just want to go back a bit to what you said earlier about the working group.

[*Translation*]

When will this working group begin its work? Who will the members be, and what will be its mandate? If I understand correctly, the idea is not just to hold a single meeting with no follow-up.

Ms. Valerie Gideon: That's right.

Mr. Marc Serré: Has the mandate of that working group been determined?

Ms. Valerie Gideon: It is up to the federal Minister of Health to write to the provincial and territorial ministers of Health to ask them to designate a representative. The Minister of Health Canada will coordinate the activities of the working group, in co-operation with her provincial and territorial colleagues. We will, of course, take part in that group and make sure that the national indigenous women's organizations are well supported to take part in the process.

When the provincial and territorial representatives have been designated, we will set a date for the first meeting. In the meantime, we will work on developing the mandate for the working group. There will be more than one meeting. We will have to work together to determine what structural obstacles exist in the health care system, in order to ensure that indigenous women receive the necessary services to protect their cultural security, among other things.

Mr. Marc Serré: You referred earlier to the Indspire program. I was present at the awards gala. That is an excellent initiative. Bursaries, for instance, are provided to encourage participation. It's a really good program.

You also mentioned some of the measures in Budget 2017 for midwifery. You mentioned an amount of $6 million.

Do you have any statistics about the impacts of that program? What impact has that investment had on the midwifery profession?

Ms. Valerie Gideon: This has just begun.

Mr. Marc Serré: I see.

Ms. Valerie Gideon: We went through a whole planning process in the past year to make sure that the demonstration sites work well.

We don't want to simply offer training or answer questions about process. We want the services to be provided in the communities. That is why the planning was somewhat long.

We will of course be able to report on the results of these investments in a few years.

Mr. Marc Serré: How can we find out a bit more? Our committee can make recommendations to the federal government, but it has to have statistics to base them on. And there are very few.

Ms. Valerie Gideon: Yes, that is true.

Mr. Marc Serré: If I understand correctly, this matter relates to hospitals, which are under provincial jurisdiction. However, I think the federal level should play a role, but which one? If we do not get statistics, it's difficult to do anything.

Did you make recommendations to Health Canada in order to obtain data, in co-operation with the provinces?

Ms. Valerie Gideon: There are already data on surgical procedures in this area that are performed in hospitals all over Canada.

The Canadian Institute for Health Information has already gathered such statistics from the provinces and territories. We could, therefore, work with that organization to see how we could obtain more specific information.

Mr. Marc Serré: You also spoke about public health, but from a different perspective than Mr. Angus; Mr. Angus was talking about health care in the correctional environment. I'd like to mention, for instance, the Northern Ontario School of Medicine, which has a mandate to teach medicine. It is the newest medical school created in the last 40 years, if I am not mistaken.

Regarding education—and I don't mean a public education program—do you have any recommendations to make about federal programs that would involve all of health care, from start to finish?

It's really a cultural issue. There is a real judicial issue. This committee has already discussed incarcerated indigenous women. Their situation is awful.

As for education in the health area, certain things can be done.

Should we consider a broader medical education program? Even if the provinces don't agree, we could do something at the federal level.

Ms. Valerie Gideon: Yes. I can tell you that in 2017, the Royal College of Physicians and Surgeons of Canada adopted a measure that included an obligatory cultural component in all medical programs. That was a big step forward.

The Indigenous Physicians Association of Canada is preparing a series of cultural components in connection with that requirement, which will become a part of the medical schools' curriculum. The association is also assessing approaches that take trauma into account.

We have to go even further. We don't just have to show cultural sensitivity, we also need to understand the specific issues of indigenous populations, such as the intergenerational effects of colonization, residential schools and so on, as well as issues in the Canadian medical system.

● (1610)

Mr. Marc Serré: Is there a federally funded program that indigenous women and organizations could use in order to obtain the necessary tools to themselves do awareness-raising work in colleges, universities, provinces and territories, as well as in organizations?

The point would be to use federal funds to allow them to raise awareness on these topics. This would allow organizations like the Native Women's Association to get the message across.

Ms. Valerie Gideon: I think that is a really excellent idea.

The Native Women's Association of Canada has a cultural competency training program, but it is general in nature. Although the program is not aimed at health professionals, I am sure it could be adapted.

We will certainly present that idea to the association through our committee.

Mr. Marc Serré: Thank you.

[*English*]

The Chair: Thanks very much.

We're now going to move on to our second round. Those are all five minutes.

We'll start off with Cathay Wagantall.

Cathay, you have the floor.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you, Chair.

I have a question with regard to the indigenous issues around sterilization globally. UNDRIP talks specifically about indigenous rights to freedoms, not forceably moving children, all of these things.

Have you worked with Global Affairs and the Department of Justice in looking at Canada in relation to other countries in the world, such as in Africa, where there's a real movement internationally with the Marie Stopes foundation and others, and our government, putting funding toward basically controlling populations through sterilization and removal of the fetus?

Ms. Valerie Gideon: I have not specifically.... We've certainly worked with them in terms of preparing materials for the studies the UN has conducted and the committee presentations and for responses for specific questions that they've had, but we have not had a discussion with them.

Katherine, am I missing something? Okay, I just wanted to make sure.

We have not had a specific discussion with them to actually put that into that global context. I think it's an excellent suggestion and we definitely should do that.

Mrs. Cathay Wagantall: I would really encourage that, because it seems like we are doing one thing here and another over there.

Ms. Valerie Gideon: Absolutely.

Mrs. Cathay Wagantall: Also, you were talking about health services barriers to our first nations communities. The goal I'm hearing is to give them freedom and autonomy in taking care of their own community's health care delivery. Is that the goal?

Ms. Valerie Gideon: Absolutely.

Mrs. Cathay Wagantall: Okay. With that autonomy, then, they have the opportunity to determine what that should look like.

Ms. Valerie Gideon: Yes, absolutely.

Mrs. Cathay Wagantall: I actually have a first nation community that has met with me and with the community they live beside, which was building and adding on a hospital. They wanted to contribute to that facility, because they use it extensively, but they weren't allowed to because the funding they receive has to stay within certain pillars. Basically, their health dollars have to stay on their first nation's community reserve.

Does that make sense to you?

Ms. Valerie Gideon: It is actually part of the conditions of our health infrastructure program that we fund health infrastructure on reserve. But I do think that we're looking at different options with respect to innovation by enabling communities, for instance, to have access to grants or to have access to more flexible agreements, which this government is very committed to under the new fiscal relationship. Communities will have more flexibility in terms of how they access—

Mrs. Cathay Wagantall: Is that flexibility there as long as they do it only on their own land? Like, I—

Ms. Valerie Gideon: The terms and conditions of our program are that we fund health facilities, but in the first nations communities on reserve.

Mrs. Cathay Wagantall: So even if that first nation community says that this is what they want to do.... I can't think of a better way to build reconciliation than to be working and living together. If they find that it is the best way they want to have those services provided, that wouldn't be an option for them as far as self-determination of how those funds would be spent.

● (1615)

Ms. Valerie Gideon: It would be an option for them if they had other sources of revenue, but if it was.... I would need to know a little more about the specifics of the situation you're referencing. If they have received health infrastructure funding from our department, it is to build facilities on reserve specifically.

Mrs. Cathay Wagantall: Okay.

I have one other question. You mentioned the opportunity to have an escort come with them when they deliver, which I think is wonderful. Would there be a priority, first of all, for the father to be that escort, in light of trying to encourage family cohesion? There's nothing quite like a dad watching a birth to build that sense of responsibility. Would that be something you would build in there, that first and foremost that individual would have the opportunity to be that escort?

Ms. Valerie Gideon: We don't place restrictions on the escort, in the sense that it is the woman's choice, but we do have a responsibility to ensure that the escort is able to support the woman throughout labour, and of course we would say a close family member is obviously best placed in most circumstances to be able to do that.

The Chair: You have one minute.

Mrs. Cathay Wagantall: Okay.

Is the maternal and child health program you were speaking of specifically a first nations program?

Ms. Valerie Gideon: We also fund territorial governments to provide some support in Inuit communities, so it's a first nations and Inuit program.

Mrs. Cathay Wagantall: Okay. Can you give me a little more detail on what the priorities of that program are?

Ms. Valerie Gideon: It's an ability for communities to have support services for women prior to birth and after birth, and also to support those early years with respect to families.

Mrs. Cathay Wagantall: Is that right in their communities?

Ms. Valerie Gideon: It's in their communities, in their homes. There will be home visitors who will go.... It's similar to what provinces have. You'll have a home assessment, and a nurse or a family visitor will come and speak with you about how you're doing, and your baby, and everything else. They'll follow up on immunizations. They, of course, have a great support role for breastfeeding. Some communities have chosen to hire doulas or to support doulas in the community to exercise that role, or in some cases even midwives will exercise that role.

The Chair: Excellent.

We're now going to move on to our final line of questioning with Eva Nassif.

Eva, you have five minutes.

[*Translation*]

Mrs. Eva Nassif (Vimy, Lib.): Thank you, Madam Chair.

Thank you, Ms. Gideon.

Ms. Gideon, I have a question for you. With regard to the class action suit filed in October 2017, we realized at that time that these practices—women being subjected to tubal ligation without their consent—had existed for 10 or 15 years, and no one noticed.

Could you explain what happened? Why did it take so long, 10 or 15 years, before the department realized what was being done?

Ms. Valerie Gideon: Our department does not manage direct services that involve surgical procedures. We continue to fund two hospitals and their operations, but they are small. No operations are performed there.

Our department delivers primary care or nursing care in some remote communities. In Canada, it is really the provincial and territorial health care systems that deliver these procedures and medical services. Our department provides complementary funding for the communities, but not for specialized, maternal or reproductive care.

Mrs. Eva Nassif: However, I still don't understand why it took between 10 and 15 years for these procedures—with regard to contraception and tubal ligation performed without consent—to become public. Why do you think it took so long?

Ms. Valerie Gideon: I have not been with the branch for 10 or 15 years.

Mrs. Eva Nassif: I apologize, but it says here that there was a class action suit filed in October 2017. The point was that people wanted an admission that these things had been done for 10 or 15 years.

Ms. Valerie Gideon: Yes.

Mrs. Eva Nassif: What I am talking about was happening in Saskatoon.

Ms. Valerie Gideon: Yes, I understand, but we are not directly connected to the Saskatchewan health authority. We don't have responsibility for health care services in that field. However, we do provide funding to Saskatchewan's first nations communities. Some programs are provided in the communities. That said, these are not specialized care programs that would involve surgery. If complaints were made, we do not have access to that information at our department.

● (1620)

Mrs. Eva Nassif: In that case, are the provinces or territories responsible for the lack of information?

Ms. Valerie Gideon: It is the provincial or territorial system that would have a more direct link with their regional health agencies, as well as with the patients, communities and the women who access their services. This issue was not submitted to us by first nations or Inuit leaders who participate in our processes. That does not mean, however, that nothing was going on. It simply means that we were not working with them on these matters.

There are several other matters we do study with them, such as cultural competency in the health care system and discriminatory practices. Those points are submitted to our upper management committee in the course of our work, as well as to our regional and national first nations partners. That practice, however, did not come up specifically. At least it was not raised since my arrival at the branch.

Mrs. Eva Nassif: Still on the topic of what was being done in Saskatoon, in their study, Dr. Judith Bartlett and Senator Yvonne Boyer said that this was not just about tubal ligation without consent, but that there were no other means of contraception.

How is it that your department and you, as assistant deputy minister, were funding these organizations?

Ms. Valerie Gideon: We fund contraception programs.

Mrs. Eva Nassif: How is it that other choices are not provided to indigenous women?

Ms. Valerie Gideon: A range of contraception methods are offered in Canada under the Non-Insured Health Benefits Program for first nations and Inuit. We offer coverage for a range of medications and they are available to indigenous women. This is, in fact, a very important point which we are going to emphasize in the documents we will be preparing with these people in order to improve access to information and direct communication with indigenous women in the communities.

Mrs. Eva Nassif: So, there were other means of contraception.

Ms. Valerie Gideon: Yes.

Mrs. Eva Nassif: I know that this is a provincial rather than a federal issue.

Ms. Valerie Gideon: Yes.

Mrs. Eva Nassif: This falls under provincial jurisdiction, but the federal government can certainly look into the issue of informed consent. However, what else can we do?

Ms. Valerie Gideon: We could work on that. We do have the Non-Insured Health Benefits Program. We have also been working on a joint review with the first nations since 2014. In that context, we are trying to see how direct access to information could be improved even more, so that the people concerned will know what coverage we can provide for medication. It is a very important point.

[*English*]

The Chair: That's excellent. Thank you very much.

On behalf of the committee, I'd like to thank Katherine Cole and Valerie Gideon for coming forward and bringing forward this information for our brief.

I want to remind the committee that our next meeting will be on Tuesday, January 29. We will continue our consideration of the draft report on barriers facing women in politics. There will also be a first draft regarding our shelter and transition houses study coming out to everybody by January 25.

To everybody, have a wonderful holiday, merry Christmas and a happy new year. See you in 2019.

The meeting is adjourned.