

*First Nations, Métis and Inuit Health and the Law:
A Framework for the Future*

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Abstract

First Nations, Métis and Inuit Health and the Law: A Framework for the Future charts the development of ill health from a formerly healthy, disease-free Aboriginal society pre-contact. However, because of historical factors and events, Aboriginal health was shaped through many Canadian laws, legislation and policies that were detrimental to not only the social fibre of Aboriginal people but to their physical health. Today, there is a stark difference between the health of Aboriginal people and non-Aboriginal people in Canada with alarming rates of chronic diseases and socio-economic ills.

While health indicators, such as mortality and morbidity, are important – it is also equally important to look at economic measures that determine health outcomes as the basic needs of clean water, adequate and available housing, sewage, food security, environmental contaminants and access to basic health care services. These are services that the majority of Canadians take for granted. For these reasons, a study of Aboriginal health must reflect a holistic approach that considers the importance of key health determinants. In addition to the determinants that affect Aboriginal health it is important that other key factors are also examined for their particularly harmful effects on Aboriginal people (especially on Aboriginal women). These factors include (but are not limited to), historical epidemics and the intergenerational effects of poor nutrition and starvation, socioeconomic, geographical and environmental factors, colonization, residential schools, forced sterilization, drug experiments, the *Indian Act* and other laws that may not directly target Aboriginal people but the law's effect have proven devastating.

It is proposed that the health of Aboriginal people has been shaped through Canadian laws, legislation and policies beginning with the early Crown/Aboriginal relationship. Early agreements and negotiation terms are explored regarding their promises that form the basis for the establishment of the Crown/Aboriginal fiduciary relationship that includes legally

enforceable fiduciary obligations to provide access to quality health care. The assertion of Aboriginal rights and the signing of specific treaties, which deal with health care also reaffirmed this relationship. Unless the treaty expressly extinguished Aboriginal rights, anyone who possesses treaty rights also possesses Aboriginal rights (although not all people who possess Aboriginal rights also possess treaty rights). Aboriginal rights are inherent to all Aboriginal people in Canada and are passed down from generation to generation. They are derived from Aboriginal knowledge, heritage, and law. Traditional healing and health practices, medicines and medical applications for the prevention and promotion of good health are ways through which Aboriginal people manifest or express an inherent right to health. Aboriginal and treaty rights are entrenched in the *Constitution Act, 1982*. This thesis will examine why Aboriginal health is in crisis today while considering how the law can be used to bring the health status closer together – to help close the gap by discovering the reasons that there are gaps and to identify if any legal breaches are the cause. To achieve this, the rights that Aboriginal people possess are examined to highlight any breaches of the government’s constitutional obligations towards Aboriginal peoples that may have contributed to the poor health outcomes.

While concentrating on law, policy development and a review of other jurisdictions, *First Nations, Métis and Inuit Health and the Law: A Framework for the Future* explains how policies and laws can be reshaped into becoming useful tools for community and national development that will ultimately advance all realms of Aboriginal health and asserts that not only do Aboriginal people possess the same rights to health that all Canadians do, but also possess constitutionally entrenched Aboriginal and treaty rights to health. While accountability is important, so are solutions and recommendations for change. The aim of this work is to move the dialogue towards new ways to deal with old problems and offer hope for change and practical solutions that may provoke thought and real difference in the lives and generations of Aboriginal people to come.

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***First Nations, Métis and Inuit Health and the Law:
A Framework for the Future***

Abstract	ii
Acknowledgments	iv
Table of Contents	v

TABLE OF CONTENTS

Introduction	1
1. Demographics, Who are the Aboriginal People in Canada?	8
2. Health Determinants	15
2.1 Socioeconomic Factors	16
2.1.1 Poverty	19
2.1.2 Shelter and Housing, Overcrowding	21
2.1.3 Substandard Housing	23
2.1.4 Water Quality	26
2.2 Geographical Factors	29
2.2.1 Access to Quality Health Care	29
2.3 Environmental Factors	31
2.4 Colonialism as a Determinant of Health	34
2.5 Summary	40
3. Current State of Aboriginal Health	42
3.1 Aboriginal Health Statistics	42
3.2 Health of Aboriginal Women	47
3.3 Mental Health	49
3.4 Chronic Diseases	50
3.5 Cardiovascular Disease	53
3.6 Tuberculosis	54
3.7 HIV/AIDS and Hepatitis C	55
3.8 Summary	60
4. Aboriginal Society and Good Health	62
4.1 Aboriginal Women: Balance of Healing	62
4.1.1 Women as Healers	66
4.2 Health and Healing Practices	71
4.2.1 The Sweatlodge	76
4.2.2 Conjurors and Jugglers	79
4.2.3 Sucking Doctors	81
4.2.4 Botanical Cures	82
4.2.5 Other Remarkable Cures	85
4.2.6 Shaking Tent	87
4.2.7 Pau wau	88
4.3 The Medewiwin	89
4.4 Métis Healing	93
4.5 Inuit Healing	98
4.5.1 The Inuit Sled Dog and Healing	103

4.5.2	The Connection to Human Health	108
4.6	Summary	112
5.	Historical Health Influences	114
5.1	Historical Determinants of Health	114
5.1.1	Epidemics	114
	i) Tuberculosis in Residential Schools	119
	ii) Tuberculosis Treatment	123
5.1.2	Nutrition	130
	i) Hunger, Starvation, Disease and Death	132
	a) A Case Study of Scurvy	136
	ii) Residential School Hunger	137
5.1.3	Genetic Changes Due to Nutritional Deficiency	139
	i) The Dutch Hunger Winter Families Study	142
	ii) Aboriginal Diets – Dr. Jay Wortman	145
5.1.4	Summary	146
5.2	How Federal Government Policies Affect Aboriginal Health	148
5.2.1	Provision of Health Services	151
	i) National Organizations Related to Aboriginal Health	159
	ii) The National Aboriginal Organizations	163
	iii) Midwifery and Traditional and Western Medicine	165
	iv) Status of Midwifery in Canada for Aboriginal Women	166
5.2.2	Residential Schools	172
	i) History of the Residential School System	173
	ii) Life in the Residential School	176
	iii) Abuse in the Residential School System	178
5.2.3	Forced Sterilization	181
	i) Aboriginal People and Eugenics	186
	ii) Institutional Eugenics	188
	iii) Summary	196
5.2.4	Experiments	197
	i) Dorothy Proctor	198
5.2.5	Murdered and Missing Women	201
5.3	Summary	205
6.	The Law is a Determinant of Health	206
6.1	Why is the Constitution a Determinant of Health?	208
	6.1.1 Federal Powers Applicable to Aboriginal Health	216
	6.1.2 Provincial Powers Applicable to Aboriginal Health	219
	6.1.3 Jurisdiction Conflicts	222
	6.1.4 Does Aboriginal Health Have Charter Protections?	232
6.2	Legislation	236
	6.2.1 <i>The Indian Act</i>	236
	6.2.2 <i>The Criminal Code of Canada</i>	246
6.3	Legal Issues Affecting Traditional Practices	257
	6.3.1 Codex Alimentarius and Bill C-36	265
	6.3.2 Regulation of Health Professionals	268
6.4	Summary	270
7.	Aboriginal and Treaty Rights to Health	273

7.1	Aboriginal Rights to Health	273
	7.1.1 Aboriginal and Treaty Rights Tests as Applied to Aboriginal Health	288
7.2	Treaty Rights to Health and Healing	295
	7.2.1 Interpretive principles	302
	7.2.2 Protection and Non-interference	305
	7.2.3 Medicine and Medical Care	307
	7.2.4 Pestilence and Famine, Sickness and Disease	307
	7.2.5 Judicial Interpretations of the Treaty Right to Medicine and Health Care	309
	7.2.6 Interpretation of Treaties	313
	i) Canada, Health Canada	313
	ii) First Nation Organizations	315
7.3	Analysis Summary	319
8.	Fiduciary Law and Aboriginal Health	323
8.1	Introduction	323
8.2	What is Fiduciary Law?	325
8.3	Crown-Aboriginal Fiduciary Relationship	329
8.4	Sources of the Fiduciary Relationship	331
	8.4.1 Early Treaties	331
	8.4.2 <i>Royal Proclamation of 1763</i>	332
	8.4.3 Judicial Recognition of Fiduciary Obligations	337
	i) <i>Sui Generis</i> Fiduciary Obligations extend to the Constitution	342
8.5	Nature and Scope of the Crown/Aboriginal Fiduciary Duty in Relation to Aboriginal Health	344
8.6	Elements of Fiduciary Obligations	347
	8.6.1 Discretion is an Important Aspect of Fiduciary Obligations	347
	8.6.2 The Duty to Consult is an Element of Fiduciary Obligations	348
	8.6.3 Indian Affairs Response to the Duty to Consult and Accommodate	356
	8.6.4 Summary	358
8.7	Constitutional Supremacy, Equality Rights and the Fiduciary Obligation	360
	i) Section 35(4)	363
8.8	Summary	367
9.	Reconciliation of Aboriginal Health and Healing Practices and Canadian Law and Policy	371
9.1	Influencing Policy Development	372
9.2	Health Delivery Systems for Indigenous Populations: Canada, the United States, Australia and New Zealand	379
	i) Differences and Similarities in Health Status between Indigenous Populations	380
	ii) The Historical Contexts	382
	iii) Three Areas that Require Further Study	397
	a) The Rights Dialogue	398
	b) Treaty Rights	398
	c) Fiduciary Obligation	399
	iv) Summary	399
10.	Conclusions and Recommendations for Further Study	401
	Bibliography	428
	Appendix “A” - <i>United Nations Convention on the Rights of the Child</i> and the implementation of Aboriginal and treaty rights (Health Canada)	

Figures, Tables and Photographs

Figures

Chapter 2	Figure 1 - Aboriginal people live in every province and territory	29
Chapter 3	Figure 1 Reported AIDS cases and positive HIV test reports by exposure category: A comparison of Aboriginal and non-Aboriginal peoples	57
	Figure 2 Reported AIDS cases and positive HIV test reports by percentage of females	58
Chapter 7	Figure 1 First Nations and the Federal Government maintain their differences in how they view Treaties	317

Tables

Chapter 1	Table 1 Métis Locations	11
	Table 2 Inuit Locations	13
Chapter 2	Table 1 Comparisons of chronic disease prevalence in Aboriginal versus non-Aboriginal populations	22
Chapter 4	Table 1 Cree Medicine	84
	Table 2 Métis healing methods	95
Chapter 5.2	Table 1 Birth locations by province	169
	Table 3 Sex drive reduction - chemical castration treatment	189
Chapter 7	Aboriginal Rights	283-284
	<i>Van Der Peet</i> Test to Determine an Aboriginal Right to Health	

Photos

Chapter 4	Photo 1 The sacred Migiis shells (<i>cypraea moneta</i>) used by the Midewiwin	92
Chapter 4	Photo 2 Keenan rubs noses with her son Keepseeeyuk, near Padlei, NU, 1950 by Estate of Richard Harrington	98
Chapter 5.2	Photo 1 Shingwauk Indian Residential School Sault Ste. Marie, ON.	172

Introduction

Aboriginal people endure ill health, run-down and overcrowded housing, polluted water, inadequate schools, poverty and family breakdown at rates found more often in developing countries than in Canada. These conditions are inherently unjust. They also imperil the future of Aboriginal communities and nations. (Royal Commission on Aboriginal People, Gathering Strength, Vol. 3, Chapter 1 - New Directions in Social Policy – Indian and Northern Affairs Canada, 1996)

1.1 Contextual background

First Nations, Métis and Inuit Health and the Law: Framework for the Future charts the status of health of Aboriginal people living in Canada.¹ There is a significant gap between Aboriginal and non-Aboriginal life expectancy and chronic diseases. Evidence of a health crisis comes in many forms, including increasing rates of suicide (particularly amongst Aboriginal youth), diabetes, heart and circulatory disease, fetal alcohol syndrome, infant mortality, injury, pertussis, rubella, tuberculosis, shigellosis, respiratory diseases, STDs, mental health disorders, and lower rates of life expectancy and birth weights.²

A recent study compiled on risk factors and chronic conditions among Aboriginal and non-Aboriginal people showed that, compared with southern Canada, the health of Aboriginal people is clearly worsening. For example, obesity is more common among Aboriginal people,

¹ This paper uses the term “Aboriginal” where it is referred to the three groups of Aboriginal as per the *Constitution, Act, 1982*. There is ongoing debate among lawyers, scholars and academics on the correctness of this term, some preferring to use the term, First Peoples, North American Indian or Indigenous. This paper uses the term Aboriginal people as a collective name for the original people living in Canada. As noted, the term “aboriginal peoples of Canada” in the *Constitution Act* refers to the “Indian, Inuit and Métis. Correspondingly, the terms First Nation, Indian, Métis, Inuit, Indigenous and Aboriginal are used interchangeably depending upon the documentation of the historical and legal language used. It is also recognized that some Nations do not consider themselves as citizens of Canada and that there are Nations who straddle the Canadian/American border who are included in the term, Aboriginal or First Nations within the context of this paper.

² Canada, Health Canada, *First Nations, Inuit and Aboriginal Health* (Ottawa: Health Canada), online: <http://www.hc-sc.gc.ca/fniah-spnia/pubs/index-eng.php> (accessed November 4, 2009). See also, The University of Manitoba, *Aboriginal Health Collection*, online: <http://www.umanitoba.ca/libraries/units/health/aboriginal/aborighcoll.html> (accessed March 5, 2010); The University of Victoria, The Centre for Aboriginal Health Research (CAHR), online: <http://www.cahr.uvic.ca/> (accessed March 5, 2010); The National Aboriginal Health Organization, online www.naho.ca (accessed March 5, 2010).

and diabetes and cardiovascular disease are far higher in Aboriginal populations.³ While, health indicators such as mortality and morbidity are important – it is equally important to look at economic measures that determine health outcomes including water, housing, sewage and sewage in water systems, food security, environmental contaminants and access to basic health care services. These are services that the majority of Canadians take for granted that are sorely inadequate or missing in rural, urban and reserve Aboriginal communities. For these reasons, for Aboriginal people health must reflect a holistic approach which considers the importance of health determinants. In addition to the economic measures that affect Aboriginal health it is important that other key factors are also examined for their particularly harmful effects on Aboriginal people (especially on Aboriginal women). These factors include (but not limited to), historical epidemics and the intergenerational effects of poor nutrition and starvation, socioeconomic, geographical and environmental factors, colonization, residential schools, forced sterilization, drug experiments and societal apathy for large numbers of murdered and missing Aboriginal women. The effects of the *Indian Act* and other laws has proven devastating and has eroded the traditional way of life for many Aboriginal persons and affected the core and social fibre of their being. This erosion has left a destructive legacy on the health and well-being of individuals, families, and communities.

1.2 Relevance of the study

This work is motivated primarily by the recurring injustices seen in the current health, social and economic status of Aboriginal people in Canada. It is noted that federal policy and institutions created the crisis in Aboriginal health.⁴ The failure of Aboriginal health policies resides in the false assumptions that Aboriginal people were biologically predetermined to vanish, were inherently unhealthy and inferior, and that their culture caused them to pursue harmful lifestyles. This study reviews these policies and laws which embrace these false underlying assumptions and highlights some of the particularly poignant historical points in Aboriginal health that led to the creation of the current federal Aboriginal health policies.

³ Lisa Lix, Sharon Bruce, Joykrishna Sarker, T. Kue Young, “Risk factors and chronic conditions among Aboriginal and non-Aboriginal populations” in Statistics Canada, Catalogue no. 82-003 XPE – Health Reports, vol. 20, no. 4 December 2009 at 1.

⁴M. Lux, *Medicine That Walks: Disease, Medicine, and Canadian Plains Native Peoples: 1880-1940* (Toronto: University of Toronto Press, 2001); Canada, *Report of the Royal Commission on Aboriginal Peoples* (Ottawa: Supply and Services Canada, 1996).

1.3 Objective of the study

This thesis will examine why Aboriginal health is in crisis today while considering how the law can be used to bring the difference in health statistics closer together – to help close the gap by discovering the reasons that there are gaps and to identify if any legal breaches are the cause. To achieve this, the rights that Aboriginal people possess are examined to highlight any breaches of the government’s constitutional obligations towards Aboriginal peoples that may have contributed to the poor health outcomes.

1.4 Research methodology

The methodology used consists of an interdisciplinary approach. The analysis and arguments provided in this paper are drawn from government sources, legal documents, archival research, documents from relevant organizations and literature from disciplines such as history, health, law, and social work. The legal analysis is informed by the knowledge produced in the field of public health, history, Aboriginal law, constitutional law, comparative law and human rights law. Also, particular attention has been paid to the blossoming sources of literature which have begun to make correlations between genetics, physical activity, obesity, nutrition and health. These sources of literature help inform this examination of Aboriginal health, as well as help provide a discussion on a possible framework for effective and appropriate lifestyles changes. Several requests under the *Access to Information Act* were initiated and provided information on experiments conducted by the federal government in the prison systems and mental institutions. Much information was gleaned on the Dorothy Proctor case as well as cases of forced sterilization and residential school claims.

This multidisciplinary collection of sources provide for a more nuanced understanding of the determinants to changing the health status of Aboriginal people in Canada. From this framework, normative arguments for policy reform have been made from both ethical and legal standpoints. At a basic level, post-colonial decolonization methodologies inform and provide

the general framework for the Aboriginal health analysis.⁵ The analysis benefits from critical race theory generally but the focus of the analysis is grounded within a Culturally Relevant Gender Based Analysis (CRGBA).⁶ The more in-depth analysis builds upon both post-colonial decolonization and in a specific analysis of gender, CRGBA more richly informs the analysis of Aboriginal health. Dovetailing with this are the arguments for change couched in a pragmatism that recognizes that both Aboriginal health and the laws and policies that impacts Aboriginal health that show the reliance on the need for policy changes that acknowledges the history and status of Aboriginal and treaty rights in Canada. It is only then that Aboriginal people will begin to enjoy the same health status that non-Aboriginal Canadians do.

1.5 Limitations of the study

There has been a paucity of information on Métis healing practices and health statistics. This also holds true for Inuit health statistics. The definitions of who is Métis and who is First Nations have also posed somewhat of a problem, particularly in light of membership reforms to the *Indian Act*.

In researching the methods of healing pre-contact, it is understood that there are limitations arising from the written recordings of the Jesuits priests and missionaries, the explorers, the whalers and the traders. These accounts show a bias towards the purposes and objectives of the healing activity as seen through the eyes of the foreigner. Where possible oral accounts have been used that incorporate the spiritual and holistic methods of healing. This also holds true for the treaty discussions, to arrive at a well rounded and culturally appropriate understanding of the treaties, it is important to understand the limitations inherent in the sources as well as the courts bias against Aboriginal oral evidence.

⁵Linda Tuhiwai Smith, *Decolonizing Methodologies: Research and Indigenous Peoples*, (University of Otago Press, New York, 1999); Norman K. Denzin, Yvonna S. Lincoln, Linda Tuhiwai Smith, *Handbook of critical and indigenous methodologies*, (Sage Publications: Thousand Oaks California, 2008).

⁶ Y.M. Boyer, Wanda D. McCaslin, “Culturally Relevant Gender Based Analysis: Principles In Health System Transitions” prepared for the Native Women’s Association of Canada, January 2011; Y.M. Boyer, *Culturally Relevant Gender Based Analysis*, prepared for the Native Women’s Association of Canada, 2009; Patricia Williams, *Inflecting Critical Race Theory* [Feminist Legal Studies](#), [Volume 7, Number 2](#), 111-132; Barbara A. Mann, *Iroquoian Women: The Gantowisas* (New York: Peter Lang 2000) at 60; Patricia Monture-Angus. *Thunder in my Soul: A Mohawk Woman Speaks*. Halifax: Fernwood Publishing, 1995.

1.6 Outline of Chapters

This study consists of ten chapters which are structured as follows:

In this Introduction the contextual background to the research is discussed and addresses the relevance, objective, methodology, limitations and outline of the study. Chapters 1 to 5 provide much background information that previously has not been collected in one source but lays an important base for the Aboriginal and treaty rights analysis to follow.

Chapter 1 presents the demographics of the Aboriginal people in Canada while Chapters 2 describes many various determinants that have contributed to the current poor health status and statistics that are noted in Chapter 3. Chapter 3 reviews diseases and chronic conditions that are prevalent in Aboriginal communities today and particularly reviews the specific health concerns that Aboriginal women face. Chapter 4 provides a historical backdrop for pre-contact health and health practices, separating First Nations, Métis and Inuit practices where possible. Chapter 4 details the health practices that are critical as the basis for understanding the Aboriginal rights analysis found in Chapter 7 as it concludes that these practices were in place and thrived before Europeans arrived.

Chapter 5 reviews historical and current health influences outside of the socioeconomic, geographical, environmental and colonialism determinants found in Chapter 2. Chapter 5 is important because not only does it provide a glimpse into some particularly deadly health conditions brought to North America by the Europeans but it also presents many of the federal government policies that had devastating effects on Aboriginal health, historically and currently. Chapter 6 briefly provides a discussion on various Canadian laws and legislation and their harmful impacts and determinants of Aboriginal health. The Constitution and the *Charter* protections are important here to show that although these protections are in place in the Canadian law, they have basically been ignored or misinterpreted in law. The harmful effects of jurisdictional squabbling are clear in the documented tragic cases of the death of Jordan River Anderson.⁷ The *Indian Act* is noted as a tool of assimilation with harmful effects on First Nations women and families.

⁷ See Jordan's Principle, *infra* Chapter 6.

The legal appraisal of the factual findings in chapters 1 through 5 is the most important basis for the conclusions drawn in chapters 7 and 8. Chapters 7 and 8 provide a legal analysis on the constitutional status of Aboriginal and treaty rights and examines if there are any breaches that may contribute or be the source of the current poor health status of Aboriginal people today. These chapters explore early agreements and negotiation terms as to their promises and legal agreements which form the basis for fiduciary obligations for health through the establishment of the Crown/Aboriginal fiduciary relationship. The sources of the Crown/Aboriginal relationship are explored and the ensuing fiduciary obligations are noted and reviewed for any possible breaches that would also contribute to the poor health status.

The assertion of Aboriginal rights and the signing of specific treaties, which deal with health care, also established this relationship. Chapter 7 deals with Aboriginal and treaty rights that review the oral and written clauses of the treaties that are closely aligned with medicine and medical care, the provision of services and access to those services. Although not all people who possess Aboriginal rights also possess treaty rights, the *Constitution Act, 1982* confirms that anyone who possesses treaty rights also possesses Aboriginal rights (if these rights were not extinguished or modified by treaties). While entrenched in the *Constitution Act, 1982*, Aboriginal rights are inherent to all Aboriginal people in Canada and are passed down from generation to generation. They are derived from Aboriginal knowledge, heritage, and law.⁸ Traditional healing and health practices, medicines and medical applications for the prevention and promotion of good health are ways through which Aboriginal people manifest or express an inherent right to health. In addition to defining the terms of “health” it is also helpful to define the application of western law in relation to those rights; jurisdiction over health and health matters for First Nations, Métis and Inuit may be seen as law making powers that affect Aboriginal health; the provision of medical care by the federal government (ties back to jurisdiction); the ability to practice and maintain traditional health care free from Canadian

⁸ Marie Battiste & James Youngblood Henderson, *Protecting Indigenous Knowledge and Heritage: A Global Challenge* (Saskatoon: Purich, 2000) at 205. See also *R. v. Van der Peet*, [1996] 2 S.C.R. 507, [1996] 4 C.N.L.R. 146; *Delgamuukw v. British Columbia*, [1997] 3 S.C.R. 1010, [1998] 1 C.N.L.R. 14, reversing in part (1993), 10 D.L.R. (4th) 470, [1993] 5 C.N.L.R. 1 (B.C.C.A.), varying in part [1991] 3 W.W.R. 97, [1991] 5 C.N.L.R. 1 (B.C.S.C.).

interferences (meaning legal sanctions); the ability to seek and maintain good health within all the realms noted here and in particular Chapter 6 – *The Law is a Determinant of Health*.

Chapters 9 and 10 provide a reconciliation of Canadian law and policy through a comparative analysis of commonwealth countries with health gaps found rather than through a comparison of similar Indigenous health status. A review of common legal structures is added to provide a direction for further study. An example of Health Canada's Aboriginal Head Start Program is used that has drawn a correlation between Aboriginal and treaty rights and children's health. Other government departments should take heed of the direction this program has taken and further develop the concept.

The study concludes with two types of recommendations for further action and further research. Concentrating on law and policy development, *First Nations, Métis and Inuit Health and the Law: A Framework for the Future* explains how policies and laws can be reshaped for the goal is to transform them into useful tools for community and national development that will ultimately advance all realms of Aboriginal health. While accountability is important, so are solutions and recommendations for change. The aim of this work is to move the dialogue towards new ways to deal with old problems and offers hope for change and practical solutions that may provoke thought and real difference in the lives and generations of Aboriginal people to come.

1. Demographics - Who are the Aboriginal People in Canada?

From the 2006 census, Statistics Canada reported that the total population of Canada is 31,241,030. The total Aboriginal population, however, is 1,172,785 or 4 percent of the total Canadian population.⁹ Since 1996, the Aboriginal population has grown by 45 percent which is six times faster than the non-Aboriginal population.¹⁰ The term “Aboriginal People” refers to the original inhabitants of Canada who are First Nations (Indian), Inuit, and Métis peoples. Although not defined by the legislation, Aboriginal people are recognized in section 35(2) of the *Constitution Act, 1982*:¹¹

S. 35 (2) In this Act, "aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada.

While the *Constitution Act, 1982* recognizes three groups of Aboriginal people, each group possesses distinct linguistic, spiritual, and cultural attributes. The federal government treats each group differently depending on their jurisdictional and legal responsibilities but does not provide a definition of the terms ‘Indian,’ ‘Métis,’ or ‘Inuit.’ However, it has created a complex and artificial system of different categories that defines Indians: “non-status,” “Status,” “Treaty Indians,” Métis, and Inuit.

The term “Indian” has been replaced with Native in some contexts and more recently with the term “First Nation” or “Original Peoples” in other contexts. A First Nation person may fit into one or more of these categories. Currently there are seventeen ways to define a First Nations person within the meaning of the *Indian Act*.¹² The federal government recognizes “status Indians” if they are entitled to benefits, limitations and rights under the *Indian Act*; they are

⁹ Canada, Statistics Canada. 2008, *Aboriginal identity population, 2006 counts, percentage distribution, percentage change for both sexes, for Canada, provinces and territories - 20% sample data* (table). *Aboriginal Peoples Highlight Tables*. 2006 Census. Statistics Canada Catalogue no. 97-558-XWE2006002. Ottawa. Released January 15, 2008, online: <http://www12.statcan.ca/english/census06/data/highlights/aboriginal/index.cfm?Lang=E> (accessed October 24, 2009).

¹⁰ CBC News, “Canada’s aboriginal population tops million mark: Stats Can” January 15, 2008, online: <http://www.cbc.ca/canada/story/2008/01/15/aboriginal-stats.html> (accessed November 4, 2009).

¹¹ *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c.3, reprinted in R.S.C. 1985, App. II, No. 5. The *British North America Act, 1867* (U.K.), 30 & 31 Vict., c.3 (*B.N.A. Act, 1867*) was the original name of the legislation that provided for the formation of the Dominion known as Canada. See s.92(16).

¹² O. Mercredi & M.E. Turpel, *In the Rapids: Navigating the Future of First Nations* (Toronto: Penguin Books, 1994) at 3.

also called “registered Indians.” The *Indian Act*¹³ is the legislation that defines who an Indian is for most federal government purposes and is the key operative body of legislation enacted pursuant to s. 91(24) of the *Constitution Act, 1867*, which states:

s. 91 ... Legislative Authority of the Parliament of Canada extends to all Matters coming within the Classes of Subjects next hereinafter enumerated; that is to say,

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

A non-status Indian is someone who may have never registered under the *Indian Act* or who may have been registered and become enfranchised according to the rules under the *Indian Act* and subsequently lost their status. For women, this has been devastating. Many Indian women lost their status (or had to transfer to their husband’s band) when they married outside of their band. Non-Indian women gained Indian status when they married a registered Indian man. In 1985, women who previously had lost their status through marriage regained their Indian status through the Bill C-31. These amendments to the *Indian Act* created a new set of problems that are discussed in Chapter 6. Treaty Indians may be registered under the *Indian Act* and are represented by Indian Chiefs and Headmen (council members or grandfathers) who signed treaties with the Crown. There are 11 numbered treaties in Canada from Ontario to Alberta and the Northwest Territories in the north. Canada also entered into numerous other historical and contemporary treaties with Indian Peoples.¹⁴

Indian and Northern Affairs Canada (INAC) reported 615 Bands in Canada and 2,964 reserves¹⁵ as of December 31, 2007 with a total population of 778,050.¹⁶ However, Statistics Canada reported a total First Nations population of 698,035 in 2006 (INAC reported 763,555 for 2006 for a discrepancy of 65,520).¹⁷

¹³ *Indian Act*, R.S.C. 1985, c.I-5.

¹⁴ See Chapter 7, *infra*.

¹⁵ A reserve is land designated by the federal government for the collective use and occupancy of a First Nations community.

¹⁶ Canada, Indian and Northern Affairs Canada, “Population by Sex and Residence 2007,” online: <http://www.ainc-inac.gc.ca/ai/rs/pubs/sts/ni/rip/rip07/rip07-eng.asp#Sum2> (accessed November 3, 2009).

¹⁷ Canada, Statistics Canada, “2006 Census: Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census: Findings,” online: <http://www12.statcan.ca/census-recensement/2006/as-sa/97-558/index-eng.cfm> (accessed November 3, 2009) (Stats Can 2006).

A statement by the Assembly of First Nations (AFN) indicates how the discrepancy in population numbers may well have occurred. Former National Chief of the Assembly of First Nations, Phil Fontaine explained longstanding problems with how Canada counts First Nations people:

However, Statistics Canada confuses a key issue to combining non-status with status Indians in the majority of its table to indicate that more First Nations people are living off reserve and in urban centres. That number is very misleading...and...In addition, the Government of Canada's Indian Registry indicates that more than 200-thousand status Indians are not included in the 2006 census. This discrepancy of more than 25 percent is potentially harmful and could have serious negative impacts on future policy and economic decisions if it is not properly taken into account.¹⁸

Statistics Canada claims that it is an independent agent of the federal government and that providing statistics is a federal responsibility. Statistics Canada is the central statistical agency. As such, it is legislated to serve this function for Canada and the Provinces and Territories.¹⁹ The Assembly of First Nations has requested an independent review of the 2006 Census of First Nations, Inuit and Métis by an external qualified party.²⁰

The Métis People are a distinct nation recognized in the *Constitution Act, 1982*. The word "Métis" is a French word, which means "mixed blood." In the Cree language, "Métis is translated to "Apêtowik'sian," meaning half person or half son. The Métis are the descendants of First Nations women and the early fur traders that emerged and developed its own specific culture, language, and traditions. According to the Métis National Council (the national political body):

The Métis people constitute a distinct Aboriginal nation largely based in western Canada. The Métis Nation grounds its assertion of Aboriginal nationhood on well-recognized international principles. It has a shared history, a common culture (song, dance, dress, national symbols, etc.), a unique language (Michif

¹⁸ Assembly of First Nations, "Briefing Note, 08-02-08 HS BN to CCOH Release of the Report Aboriginal Peoples in Canada in 2006". Presentation to the Chiefs Committee on Health.

¹⁹ Canada, Statistics Canada, "Mandate, Responsibilities and Objectives," (Ottawa: 2008), online: <http://www.statcan.gc.ca/about-apercu/mandate-mandat-eng.htm> (accessed November 3, 2009).

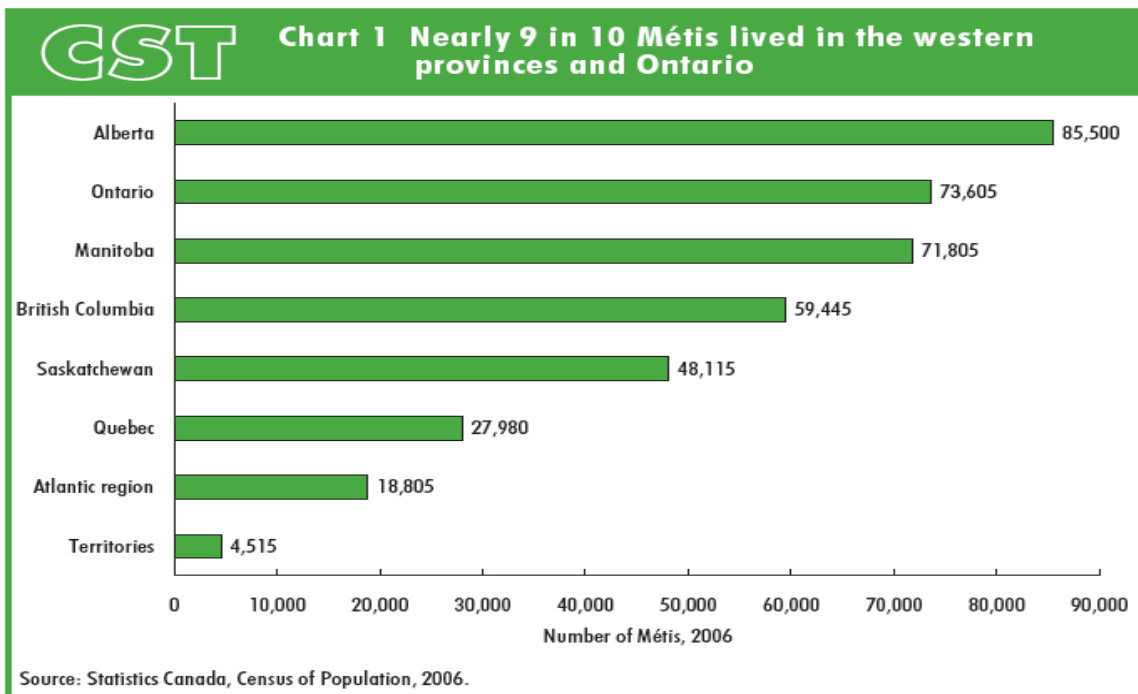
²⁰ Assembly of First Nations, Annual General Assembly, 2008 - Resolution no. 31/2008 "Support for First Nations Census," online: <http://www.afn.ca/uploads/files/aga-res-08.pdf> (accessed April 21, 2011).

with various regional dialects), extensive kinship connections from Ontario westward, a distinct way of life, a traditional territory and a collective consciousness.²¹

In 2006, the Métis population was 389,785.²² Thirty-one percent of the total Aboriginal population in Canada is Métis with the majority living in Ontario, Saskatchewan, Alberta, and Manitoba. Sixty-eight (68) percent of Métis live in the three Prairie Provinces. The highest Métis urban populations are located in Winnipeg (31,395), Edmonton (21,065), Vancouver (12,505), Calgary (10,575), and Saskatoon (8,305). One third of Métis live outside urban centres, and 40 percent of the total Aboriginal population living in urban centres are Métis. Less than 2 percent of Métis have a recognized exclusive land-base (6,000 on six Alberta Métis Settlements), while 3,580 Métis live in the North-West Territories and 535 in the Yukon.²³

Table 1 following shows where the Métis are located by percentages:

Table 1*



*(Statistics Canada, “Nearly 9 in 10 Métis lived in the western provinces and Ontario,” online: <http://www.statcan.gc.ca/pub/11-008-x/2009001/c-g/10769/c-g001-eng.htm> (accessed April 26, 2011).

²¹ Métis National Council “Who are the Métis?” (Ottawa: 2007), online: <http://www.metisnation.ca/who/index.html> (accessed October 23, 2009).

²² Stats Can, 2006, *supra* note 9.

²³ Canada, Statistics Canada, “Aboriginal Peoples Survey,” online: <http://www.statcan.gc.ca/aboriginal/aps/5801794-eng.htm> (accessed November 3, 2009).

A distinct Inuit-European population, who also call themselves Métis, lives in Labrador, but they are not recognized by the Métis National Council. The approximate 6000 Inuit-Métis who live in Labrador are descendants of the Inuit and Europeans who traveled to Labrador in the 1700-1800s.²⁴ In their own words:

The descendents of these two cultures can be seen within the communities that line the southern coastal and interior waterways of Labrador. The well-established community of Happy Valley-Goose Bay supports a large Inuit-Métis population, along with the smaller communities of Mud Lake, North West River, Cartwright, Paradise River, Black Tickle, Norman Bay, Charlottetown, Pinsent's Arm, Williams Harbour, Port Hope Simpson, St. Lewis, Mary's Harbour and Lodge Bay. The Inuit-Métis have lived, and continue to live, in other parts of Labrador, as well. ... We are more than 6,000 Inuit-Métis of Labrador.²⁵

According to the 2006 Census, the Métis population is young and mobile with a median age of 30 years (10 years younger than their non-Aboriginal counterparts). Of the total Métis population, 29 percent are Métis children under 14 years.²⁶

Inuit are the people of northern Canada who primarily live in the Arctic, most Inuit live throughout the Canadian Arctic in 53 communities, 51 which are located along the Arctic coastline. In 2006, the total Inuit population was 50,485.²⁷ At an average age of 22 years, the Inuit population is much younger than the non-Aboriginal population and other Aboriginal groups. Large percentages of Inuit are in the youngest age groups: 12 percent are age 4 and under; 11 percent are age 5 to 9 (compared with 6 percent of non-Aboriginal people); and 54 percent are age 24 and under (compared with 31 percent of non-Aboriginal people).²⁸

²⁴ Labrador Métis Nation, (2009), online: <http://www.labradormetis.ca/home/3> (accessed November 3, 2009) (LMN).

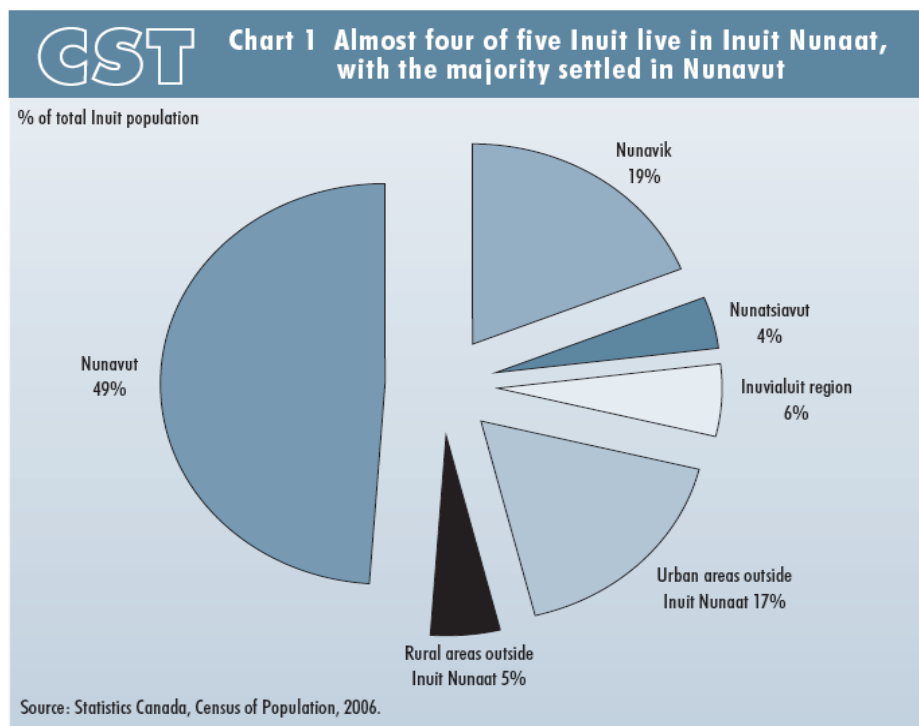
²⁵ LMN, *ibid*.

²⁶ Stats Can, 2006, *supra* note 9 at 33.

²⁷ Stats Can, 2006, *ibid* at 19. See also, Inuit Tapiriit Kanatami, Statistical Profile 2008, online: http://www.itk.ca/sites/default/files/InuitStatisticalProfile2008_0.pdf (accessed September 27, 2010).

²⁸ Stats Can, 2006, *ibid* at 9.

The Inuit primarily live in Northern Quebec, Nunavut, the Northwest Territories, and Labrador. “Inuit Nunaat” is the term used to describe the homeland of the Inuit and describes Nunatsiavut, Nunavik, Nunavut and the Nunakput region. Inuit Nunaat makes up approximately 40 percent of Canada’s land and contains about one half of Canada’s coastlines. It forms virtually all of one territory (Nunavut), significant portions of another territory (Northwest Territories) and two provinces (Quebec and Newfoundland and Labrador). Inuit means “the people” in Inuktitut.²⁹ The following Table shows in percentages where Inuit lived in 2006, the highest population being in Nunavut:



Source: Statistics Canada, “Almost four of five Inuit live in Inuit Nunaat, with the plurality settled in Nunavut,” online: <http://www.statcan.gc.ca/pub/11-008-x/2008002/c-g/10712/c-g001-eng.htm>.

Although the demographics of the Aboriginal people in Canada are as varied and expansive as their cultures, histories and traditional way, there are similarities in health patterns and the ways the government has treated Aboriginal people – historically and currently, through laws, legislations and policies. The following Chapter reviews determinants, social, economic and cultural that affect Aboriginal health.

²⁹ Inuit Tapiriit Kanatami, (2009), online: <http://www.itk.ca/> (accessed November 4, 2009).

2. Health Determinants

A human is not isolated like an island but is interconnected with families and communities. Certain factors inevitably have an impact on individuals, their communities, and their nations. These determinants also have an impact across generations. Their widespread effects force us to think about the indivisibility and interconnectedness of health and society. This chapter will review health determinants connected with socioeconomic status and the geography in which Aboriginal people live and how they impact the health of both the individual and their communities. Chronic diseases, for example, correlate with social, economic and environmental factors. The rise of chronic diseases in Aboriginal communities has jeopardized not only the health and life-span of Aboriginal people but also the core strength of Aboriginal communities and the endurance of Aboriginal languages and cultures.

Many factors determine a person's state of health. Aboriginal people in Canada take a holistic view of health. This includes environmental factors, connection to the land, culture and language, social/economic factors, mental/psychological factors, access to services, family/child/kinship relations, as well as the practice of self-determination and self-governance as a Nation and a people.¹ Health is central to the total well-being of Aboriginal Peoples. The Royal Commission on Aboriginal Peoples summarizes:

In the imagery common to many Aboriginal cultures, good health is a state of balance and harmony involving body, mind, emotions and spirit. It links each

¹ Author Kim Scott lists the following set of determinants of health for Aboriginal people in her 2003 report for the Canadian Population Health Initiative *Broadening the Lens Proceedings of a Roundtable on Aboriginal Peoples Health*:

Environment: Water, Housing, Air, Lands (harvesting);

Culture: Spirituality, Language, Lands (harvesting), Access to traditional healing;

Social/Economic: Wealth/Poverty, Employment, Education, Power/Politics, Family;

Mental/Psychological: Self Esteem, Coping/Stress/Resilience, Identity, Intellect;

Service: Access Medical Services, Traditional Healing, Service Range;

Family/Child: The Legacy of Residential Schools, Aboriginal Head Start, Ensuring healthy pregnancy and early childhood development;

Self-Determination/Governance: Legislative Changes, Lands Claims, Administrative Transfer, Restorative Justice.

(Kim Scott, *Broadening the Lens Proceedings of a Roundtable on Aboriginal Peoples Health* (Ottawa: National Conference and Health Information Fair of the National Aboriginal Health Organization, 2003), online: Canadian Population Health Initiative http://www.cihi.ca/cihiweb/en/downloads/CPHIBroadeningtheLens_e.pdf. (accessed November 4, 2009).

person to family, community and the earth in a circle of dependence and interdependence, described by some in the language of the Medicine Wheel. In non-Aboriginal terms, health has been seen primarily as an outcome of medical care. But we are quickly learning that any care system that reduces its definition of health to the absence of disease and disability is deeply flawed.²

As early as 1946, the World Health Organization (WHO) adopted a broad definition of health. It transformed the concept of health from an “absence of disease” model to an understanding that encompasses “[a] state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”³ The emergence of the WHO definition not only iterated an Aboriginal approach, they “defined an integrated approach linking together all the factors related to human well-being, including physical and social surroundings conducive to good health.”⁴

It also confirmed that the health and well-being of all people come from their living circumstances and their quality of life—social determinants. If people have control over their living circumstances and quality of life, then they are self-determining. They exercise voice and power over the social determinants of their health—as individuals, communities, and peoples.

Interestingly, the University of Southern Denmark has released a study that claims that more than half the babies born since 2000 to wealthy nations could live to 100 years old. In Canada, children born in 2007 could live to be as old as 104.⁵ Sadly, this is not true for Aboriginal children. Their life-expectancy remains five or more years shorter than the Canadian

² Canada, Royal Commission on Aboriginal Peoples, “Report of the Royal Commission on Aboriginal Peoples” Vol. 3, *Gathering Strength* (Ottawa: Supply and Services Canada, 1996) at 152 [RCAP].

³ Preamble of the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, at 100) and entered into force on 7 April 1948 [WHO]. The organization’s main objective is the “attainment by all peoples of the highest possible level of health.”

⁴ Enrique González, “Circle of Rights, Economic Social & Cultural Rights Activism: A Training Resource, Module 14 the Right to Health,” at para. 6, online: University of Minnesota Human Rights Resource Center <http://www1.umn.edu/humanrts/edumat/IHRIP/circle/modules/module14.htm> (accessed November 4, 2009).

⁵ Bradley Bouzane, Canwest News Service “Half of all wealthy nations’ newborns could reach 100th birthday: Study” October 1, 2009, online: <http://www.canada.com/Health/Half+wealthy+nations+newborns+could+reach+100th+birthday+Study/2058805/story.html> (accessed November 4, 2009).

population.⁶ The following section reviews some of the factors that contribute to a shorter life-span and ill health.

2.1 Socioeconomic Factors

Anthropologist, Harry B. Hawthorn authored a social science study in the 1960s that assessed the conditions of Indians in Canada noting a gap between Aboriginal and non-Aboriginal standards:

It has become increasingly evident in recent years...that the majority of the Indian population constitutes a group economically depressed in terms of the standards that have become widely accepted in Canada. They are not sharing equally with others in proportion to their numbers in the material and other gains, satisfactions and rewards that an affluent and rapidly growing national economy has to offer. True enough, their level of material welfare, as measured simply by average per capita real income from all sources, and their level of formal education, are probably higher than they have ever been, and a minority among them have had successful careers in various lines of work. Nonetheless, in comparison to the much larger gains in these and other respects that the majority of the non-Indian population has enjoyed in recent decades, there are indications that the gap between the two groups has been widening.⁷

Not only do socioeconomic factors continue to have a detrimental effect on Aboriginal health but racism and discrimination also have an adverse effect on health. Epidemiologist Dr. Vogli produced a study of 8,000 British civil servants over 11 years and found that those who felt they had been unjustly treated were 55 percent more likely to suffer from serious heart disease than those who did not feel unjustly treated.⁸ African Americans have a higher than normal hypertension rate which is thought to be due to the ongoing discrimination they face.⁹ A study of Aboriginal people in Canada may show the same results.

⁶ Canadian Institute for Health Information, "Health Care in Canada 2000: A First Annual Report" (Ottawa: Authors, 2000) at 6.

⁷ H.B. Hawthorn, ed., 1966. *A Survey of the Contemporary Indians of Canada: Economic, Political, Educational Needs and Policies*. Ottawa: Indian Affairs Branch at 1:21.

⁸ Roberto De Vogli, Jane E Ferrie, Tarani Chandola, Mika Kivimäki, Michael G. Marmot, Evidence based public health policy and practice "Unfairness and health: evidence from the Whitehall II Study" *J Epidemiol Community Health* 2007, online: <http://jech.bmj.com/content/61/6/513.full.pdf> (accessed August 11, 2010).

⁹ Vickie M. Mays, Susan D. Cochran, Namdi W. Barnes, "Race, Race-Based Discrimination, and Health Outcomes Among African Americans" *Annual Review of Psychology*, Vol. 58: 201-225 January 2007.

Aboriginal people throughout the world are burdened disproportionately not only with the social determinants of ill health but also with the conditions that result from these socioeconomic determinants, such as poverty, low household incomes, lack of adequate housing, lack of good nutrition, and homelessness. “Social inequality, whether measured at the population or individual level, is the single leading condition for poor health.”¹⁰ Social and economic disadvantages vastly increase the risk to the health and well-being of Aboriginal people. The negative impact of these socioeconomic factors extends further and damages the biological development of Aboriginal youth, reducing their immunity to disease. The consequences of weakened health accumulate across individual life spans as well as through succeeding generations. Colonization policies and tools of assimilation have had both a direct and indirect effect of the state of Aboriginal health¹¹ which is directly linked to “the corrosive effects of poverty and economic marginalization.”¹² It follows, then, that the damages caused by colonization are directly related and intertwined with the risks to health caused by socioeconomic disadvantage.¹³ Chapter 2.4 follows with a more detailed discussion on the harmful effects of colonization on Aboriginal peoples.

The social conditions of many Aboriginal communities show the results of colonization in the form of addictive behaviors and violence. Alcohol and drug abuse are the most prevalent types of addictive behaviours in Aboriginal communities, and they are associated with a range of serious physical and mental health problems.¹⁴ Women face additional problems unique to their gender:

¹⁰ E. Geyorfi-Dyke, (2008), Poverty and Chronic Disease: Recommendations for Action. In Chronic Disease Prevention Alliance of Canada (Ed.): CDPAC in J. Reading, *The Crisis of Chronic Disease among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy* (University of Victoria Centre for Aboriginal Health Research: 2009), online: <http://www.cahr.uvic.ca/docs/ChronicDisease%20Final.pdf>, at 10, [Chronic], (accessed November 4, 2009) at 10.

¹¹ First Nations Centre (2005), First Nations Regional Longitudinal Health Survey (RHS) 2002/2003: Results for Adults, Youth and Children Living in First Nations Communities. Ottawa: First Nations Centre at the National Aboriginal Health Organization [RHS], D. King, (2006). A Brief Report of The Federal Government of Canada’s Residential School System for Inuit. Ottawa: Aboriginal Healing Foundation [King] in L. Kirmayer, G. Brass, & C. Tait, (2000), *The mental health of Aboriginal peoples: Transformations of identity and community*. Canadian Journal of Psychiatry, 45, 607-615 in Chronic, *supra* note 10.

¹²Chronic, *ibid* at 10.

¹³J. Beauchamp, M. Blaauwbroek, C. Brulé, J. Campbell, J. Lava, L. Malone, et al. (2004), Improving the Health of Canadians. Ottawa: Canadian Institute of Health Information et al in Chronic *ibid*.

¹⁴ Phil Lane, Jr., Michael Bopp, Judie Bopp and Julian Norris (2002). *Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities*. Ottawa, ON:

- Compared to men, women are affected more severely and in a shorter time by intensive substance abuse. Women reach higher peak blood alcohol levels from equal amounts per pound of body weight, and the average duration of excessive drinking before the first signs of liver disorders, hypertension, obesity, anemia, malnutrition, gastrointestinal hemorrhage and ulcers is much shorter for women.¹⁵
- Other dangers of addiction include the risk of HIV, osteoporosis, and coronary disease.¹⁶
- Substance abuse effects women’s reproductive functioning. It affects the menstrual cycle, early pregnancy, fetal development, childbirth, menopause, and sexual responsiveness.¹⁷
- Impacts on women’s mental health and functioning include depression, anxiety, suicidal ideation, reduced school/work performance, risky sexual practices, re-victimization, and violence.¹⁸
- Between the ages of 25 and 44, Aboriginal women are **five times more likely to die as a result of violence** than non-Aboriginal women.¹⁹ (Violence is discussed in more detail in Chapter 5.2.5, Murdered and Missing Women)

The impact on women’s health also affects the family. For instance, compared to one in 200 children in the general population, one in ten Aboriginal children is in foster care due to abuse and neglect. Aboriginal children and youth are also at a higher risk of substance-abuse behaviours:

- 1 in 5 Aboriginal youth reported having used solvents. Of these, 1 in 3 was under the age of 15. Over half began using solvents before the age of 11.²⁰

Aboriginal Corrections Policy Unit, Solicitor General Canada in Deborah Chansonneuve, (2007). *Addictive Behaviours Among Aboriginal People in Canada*. Ottawa, ON: Aboriginal Healing Foundation at 3.

¹⁵ Janet C. Currie, “Best Practices: Treatment and Rehabilitation for Women with Substance Abuse Problems,” Ottawa, ON: Minister of Public Works and Government Services Canada, 2001 [Currie] in Deborah Chansonneuve, *Final Report Of a Survey to Assess the Feasibility of a Residential Addictions Treatment Facility for Aboriginal Women and Their Children in the City of Ottawa* for Minwaashin Lodge/Aboriginal Women’s Support Centre, (Ottawa: 2008) at 3 [Chansonneuve, 2008].

¹⁶ Native Women’s Association of Canada, “Aboriginal Women and Health Care in Canada, a Submission on the Future of Health Care in Canada,” May 2002, online: <http://action.web.ca/home/narcc/attach/AboriginalWomenandHealthCareinCanada.pdf> (accessed September 8, 2010).

¹⁷ Currie, *supra* note 15.

¹⁸ Chansonneuve, 2008, *supra* note 15 at 3.

¹⁹ Chansonneuve, 2008, *ibid* at 3.

²⁰ Chansonneuve, 2008, *supra* note 15 at 3.

- Aboriginal youth are at two to six times greater risk for every alcohol-related problem than their non-Aboriginal counterparts.
- Aboriginal youth are more likely to use all types of illicit drugs than non-Aboriginal youth.
- Aboriginal youth begin using substances (tobacco, solvents, alcohol, and cannabis) at a much younger age than non-Aboriginal youth.²¹
- Alcohol and drugs are a major factor in the early sexual practices of Aboriginal youth, and the high rate of teen pregnancy.²²
- The rate of incarceration for Aboriginal youth in 2000 was 64.5 per 10,000 population compared to 8.2 per 10,000 population for non-Aboriginal youth.
Of these:
 - 1 in 6 were suspected or confirmed with Fetal Alcohol Spectrum Disorder; and
 - 8 in 10 had a substance abuse problem.²³

Children as young as nine years of age are involved in the sex trade and, in some communities, 90 percent of the sex trade is Aboriginal.²⁴

- In a Vancouver survey, almost 60 percent of the sex trade workers said they continued working in the trade to support a drug habit; in this same study, 30 percent of those surveyed were Aboriginal women.²⁵

The *Canadian National Coalition of Experiential Women* identified addiction as a key issue of concern for sex workers across Canada. Recommended remedies include removing the barriers to accessing treatment. A new approach provides a specialized addiction treatment model adapted to the unique needs of sex workers.²⁶

2.1.1 Poverty

One in four children in First Nations communities lives in poverty,²⁷ while 47.2 percent of the Ontario Aboriginal population receives less than \$10,000 per year.²⁸ Canada-wide statistics

²¹ Currie, *supra* note 15.

²² Kim Anderson, (2002), *Tenuous Connections: Urban Aboriginal Youth Sexual Health and Pregnancy*. Toronto, ON: Ontario Federation of Indian Friendship Centres in Chansonneuve, 2008, *supra* note 15 at 3.

²³ Chansonneuve, 2008, *supra* note 15 at 3.

²⁴ Chansonneuve, 2008, *supra* note 15 at 3.

²⁵ Amnesty International (2004). *Stolen Sisters: Discrimination and Violence against Indigenous women in Canada*. Ottawa, ON: Amnesty International.

²⁶ This model is currently being piloted in British Columbia through the Crossroads Treatment Centre in Kelowna and through PEERS in Victoria in Chansonneuve, 2008, *supra* note 15 at 3.

²⁷ Assembly of First Nations, "Make Poverty History for First Nations" 2006; First Nations Centre, National Aboriginal Health Organization. (2005) "First Nations Regional Longitudinal Health Survey 2002-2003." Ottawa: National Aboriginal Health Organization.

also show that Aboriginal people generally are economically disadvantaged: 73.4 percent of Aboriginal people earn less than \$20,000 per year, and the average income is \$15,699 versus \$25,414 in the rest of Canada.²⁹ Aboriginal people living in urban communities are twice as likely to live in poverty as non-Aboriginal people. Though they comprise only 1.5 percent of the urban population, Aboriginal people account for 3.4 percent of the poor population.³⁰ Former Assembly of First Nations National Chief Phil Fontaine connects poverty with child welfare:

... Indian and Northern Affairs reported a 70 per cent increase in child welfare cases from 1995–2003. The key reason for taking children into care is physical neglect due to poverty. ... Only through a comprehensive plan supported by real investments can First Nations finally and forever break free from the prison of poverty.³¹

Poverty increases an individual, family, and community's risk of developing chronic diseases that lead to death.³² Being deprived of the basic necessities of life, unhealthy living conditions, and poor access to health care services predispose people to developing chronic diseases and health-risk behaviours throughout the life course. Ill health is the inevitable result. WHO reports that "the poor and people with less education are more likely to use tobacco products and to consume energy-dense and high-fat food, be physically inactive, and be overweight or obese."³³

The Canadian Institute of Health Research has funded a study by Dr. Kim Raine that connects a lower ratio of fast food restaurants to supermarkets and fruit stands to lower odds of obesity in the people who live nearby. She states, "People at the lower socio-economic level are most

²⁸ Ontario Federation of Indian Friendship Centres (2004), Urban Aboriginal Child Poverty Background, online: <http://www.ofifc.org/ofifchome/page/notes.htm> (accessed July 21, 2008) in Chronic, *supra* note 10 at 12.

²⁹ Chronic, *supra* note 10 at 12.

³⁰ K. K. Lee, (2000). Urban Poverty in Canada: A Statistical Profile, online: <http://www.ccsd.ca/pubs/2000/up/> in Chronic, *supra* note 10 at 12.

³¹ Phil Fontaine, (Oct 30, 2006), "The Native Fiscal Imbalance", Globe and Mail. October 30, 2006, p. A19.

³² World Health Organization 2008c, "The urgent need for action. Chapter Two. Chronic Diseases and Poverty, Chronic Diseases and Health Promotion", online: http://www.who.int/chp/chronic_disease_report/part2_ch2/en/index5.html (accessed August 15, 2008)[WHO 2008c].

³³ WHO 2008c, *ibid*.

vulnerable (to environmental influences) and probably have the fewest resources to resist these external forces.”³⁴ Without doubt, these external factors lead to chronic disease.

2.1.2 Shelter, Housing and Overcrowding

Income directly affects shelter and housing, and housing disadvantages negatively impact health. The Métis National Council comments on Métis income and housing:

The ability to access adequate and suitable housing is as a consequence largely linked to income....

Low income levels translate into higher incidence of affordability problems: the lower the income the more likely is the individual or household, as the case may be, to have to spend more than 30% of gross income on shelter. This is compounded in many larger urban centres by the high cost of housing, both rental and homeownership, and by shelter costs rising faster than income. All of this dramatically affects the total wellness of families as there is no money left for other necessities of life such as medical or educational needs. It also translates in fewer Métis households becoming homeowners, particularly in urban areas, where housing costs are higher. Fewer can afford or can qualify for the down payment on a house – and more remain renters as a result. Métis low-income households are more likely to be tenants, despite the fact that in many areas of the country, it is now cheaper to own than to rent.³⁵

Although substandard housing is a grave concern, on the far end of the scale, the most detrimental impact of low income on housing is the lack of a home—homelessness.

In Toronto, 25% of Toronto’s homeless population is Aboriginal people, even though Aboriginal people make up only about 2% of Toronto’s total population. The disproportionate representation of Aboriginal people among Toronto’s homeless is evident.³⁶ Homelessness poses severe health risks: exposure to the elements, poor nutrition, lack of support, and poor access to health services. Clearly, these factors negatively impact the health and well-being of people living on the streets. Homeless people are more likely to have chronic and severe

³⁴ Canadian Institute of Health Research, Profile “Supersizing the Poor” (2009), online: <http://www/cihr-irsc.gc.ca/e/40310.html> (accessed November 4, 2009).

³⁵ Métis National Council, Canada-Aboriginal Peoples Roundtable: Housing Policy Paper (Ottawa: 2004), online: http://www.metisnation.ca/3in1/roundtable/policy_papers/MNCHousingPaper.pdf, (accessed November 4, 2009) [MNC housing].

³⁶ M. Wente, (2000), Urban Aboriginal Homelessness in Canada: Faculty of Social Work at the University of Toronto in Chronic *supra* note 10 at 12.

medical conditions than the general population.³⁷ The following statistics from a survey compare chronic disease prevalence in Aboriginal versus non-Aboriginal populations:

Table 1

<i>Disease</i>	<i>Homeless Aboriginal people</i>	<i>Non-Aboriginal General Population</i>
<i>Arthritis or Rheumatism</i>	43%	14%
<i>Heart disease</i>	35%	4%
<i>Chronic Obstructive Pulmonary Disease (COPD)</i>	24%	1%
<i>Asthma</i>	22%	6%
<i>Diabetes</i>	22%	4%

Source: Street Health, <http://www.streethhealth.ca/Downloads/SHReport2007.pdf>.

Aboriginal people who are homeless also suffer high levels of substance abuse. For example, the 2007 Street Health survey reported that 92% smoke cigarettes. Of those, 89% smoke daily. Among Aboriginal people living on the street, 77% used an illicit drug other than marijuana regularly in the past year; 26% had injected drugs in the past year; 29% had five or more drinks on one or more occasion at least once a week in the past year; and, 15% had consumed non-beverage alcohol in the past year.³⁸

Not only are chronic physical and mental diseases highly prevalent among Aboriginal homeless people, but also these diseases often remain undetected for years and may be poorly controlled. Both of these conditions can lead to premature mortality and excess morbidity.³⁹

For the Inuit, homelessness is particularly harsh. The Inuit Tuttarvingat Centre at the National Aboriginal Health Organization has identified three characteristics of Inuit homelessness:

1. Homelessness is hidden

It is very important to understand that the key characteristic of homelessness in Inuit regions is that it is hidden. Homelessness is hidden because Inuit cultural values are

³⁷ S. W. Hwang, (2001), "Homelessness and health" Canadian Medical Association Journal, 164(2), 229-233 in Chronic, *supra* note 10 at 18 [Hwang].

³⁸ Street Health, online: <http://www.streethhealth.ca/home.htm> (accessed August 11, 2010).

³⁹ Hwang, *supra* note 37; S. W. Hwang & A.L. Bugeja, (2000), "Barriers to appropriate diabetes management among homeless people in Toronto," Canadian Medical Association Journal, 163(2), 161-165 in Chronic, *supra* note 10 at 18.

making sure that those who have houses will share them with those who have no house.

2. Housing design is based on needs in southern Canada

It is equally important to realize that the houses that are being shared are prefabricated houses designed in sizes usually not larger than four bedrooms, a condition that easily leads to overcrowding, once family members extend the residential group beyond the southern model of the core family of three, four or five individuals.

3. The Arctic climate requires humans to have shelter

It is very obvious, albeit often overlooked, that the Arctic climate is a cold climate, implying that for most of the time in one calendar year, life for humans is possible only with shelter. This means that we do not see what has been called “absolute homelessness,” i.e. someone living on the street, because a person will freeze without protection against weather.⁴⁰

The Métis are also caught in a serious income/housing situation:

Low-income households are forced to pay high rents for what are often in fact sub-standard accommodations, because they continue to be considered high-risk by CMHC and mortgage lenders generally. For those most in need, the only recourse is slum housing or homelessness. It is not surprising therefore that over 1/3 of Metis tenant households are in core housing need.⁴¹

2.1.3 Substandard Housing

Poor housing conditions, overcrowding, and an inadequate housing supply are common in most Aboriginal communities. These factors create ill health.

The Inuit experience a severe housing crisis in both shortage and quality. A shortage of housing leads to overcrowding, deficient sanitation and ventilation, the spread of infectious diseases, psycho-social stresses, and violence. Housing problems have been associated with low achievement levels in schools, spousal abuse, respiratory tract infections among infants, depression, and substance abuse.⁴²

As for the Métis,

A disproportionately high percentage of Métis households live in “core housing need.” In the Métis Nation homeland, Métis households accounted in 2001 for

⁴⁰ National Aboriginal Health Organization, Report for Participants “Homelessness and Housing Realities for Inuit” (Ottawa: 2008), online: <http://www.naho.ca/inuit/e/documents/HomelessnessWorkshop.pdf>, (accessed November 4, 2009) [Inuit homeless].

⁴¹ MNC housing, *supra* note 35.

⁴² Inuit homeless, *supra* note 40.

38.6% of off-reserve Aboriginal households in core housing need, and the proportion was closer to 50% in the three Prairie Provinces. Based on CMHC data, over 20,000 Métis households are in core need in this region – about one in every five Métis households.⁴³

For the on-reserve population, First Nations housing is generally old. Houses need to be upgraded and better maintained. According to the 2002/03 Regional Health Survey, one-third (33.6%) of First Nation homes are in need of major repairs. Another third (31.7%) need minor repairs. While the presence of household incomes below the \$20,000/year cut-off were more likely to require repair and more regular maintenance, rates of houses needing repair varied with income brackets and were still high (26.4%) in more moderate income brackets (\$50,000 to 79,999/year).⁴⁴

These figures suggest systemic concerns about housing for Aboriginal people across all sectors of Aboriginal society. The shortage of housing raises additional concerns. In 2001, Indian and Northern Affairs Canada (INAC) reported a shortage of 8,500 units on reserves.⁴⁵ The Assembly of First Nations estimates, however, that there is a backlog of 80,000 units waiting to be built.⁴⁶

Substandard Aboriginal housing creates prime conditions for mould growth, poor indoor air quality, poor ventilation and a breeding ground for the transmission of contagious diseases. These factors contribute to environmental toxins, affect the respiratory system, and lead to chronic respiratory problems. Clearly, the impact on Aboriginal health is devastating:

Martin St. Pierre shines a flashlight in the crawl space under Stephen Tssessaze's house to illuminate a black wall so corroded by mould it's soft to the touch. The beam of light uncovers a patch of long, white mushrooms growing from a crack in the foundation. Thin strips of last year's withered, slimy mushrooms appear to drip down the putrid wall. St. Pierre does plumbing work for the band in Lac Brochet. He said he sees too many houses that should be condemned - including others just like this one on the west side of town. Here, St. Pierre said, houses are in a low-lying area where spring run-off drains into the crawl space where moisture gets trapped. The gag-inducing sight of patches of fungi and pervasive

⁴³ MNC housing, *supra* note 35.

⁴⁴ RHS, *supra* note 11.

⁴⁵ Government of Canada (2003), *Report of the Auditor General to the House of Commons*, online: http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_200304_6_e_12912.html (accessed August 18, 2008).

⁴⁶ RHS, *supra* note 11.

rot is overwhelming, even for St. Pierre. "When I come through a house like this and there's kids in there, you feel bad, you know?" St. Pierre said. Tsessaze lives with his two young boys and his girlfriend. The pungent stench of damp decay is unmistakable. It fills your nostrils when you walk through the front door. Tsessaze said his kids get sick a lot and he often has trouble breathing. He peers at the white fungi in the underbelly of his house, before a solemn look envelops his face.⁴⁷

Long Lake First Nation in Northern Ontario discovered deadly moulds growing in their homes in 2001. The community was evacuated and a state of emergency was declared. Band members state that in the late 1960s they were moved from a reserve north of Thunder Bay to a new location that was "swampy." By 2001 residents suffered from a spate of health problems such as skin rashes, respiratory infections, eye irritation, nose bleeds, headaches, fatigue and nausea. A Class Action law suit against the Government of Canada has been approved by the courts and Won Kim, the lawyer who is handling the case for Long Lake First Nation stated "This [mould] problem exists in each and every reserve across the country."⁴⁸

Overcrowding also leads to chronic diseases. A house is considered to be overcrowded if the density exceeds one person per room. The overall room density in Canada, as reported by the 2001 Census is 0.4 persons per room, whereas the First Nations Regional Longitudinal Health Survey (the RHS) reported an average density rate of 0.76.⁴⁹ This means that, on average, about 2.6 people live in a house in the non-First Nations population, whereas 4.8 people live in a single house on First Nations reserves. In some cases, overcrowding in First Nations communities is severe. The highest number of people per house reported by the RHS was 18. Clearly, homes in Aboriginal communities have more people per room than the Canadian population.⁵⁰ Research has also shown that the high rates of overcrowding impact both individual and community health and well-being. For instance, the 2002/03 RHS statistics indicate that 1 in 3 of all respondents once diagnosed with tuberculosis live in an overcrowded house. The fact that 24.6% of the homes with Aboriginal children that were surveyed for the

⁴⁷Jen Skerit, Winnipeg Free Press, "Tuberculosis rate skyrockets on northern reserves: Manitoba community has higher rate of infection than Bangladesh" October 31, 2009, online: <http://www.vancouversun.com/health/Tuberculosis+rate+skyrockets+northern+reserves/2168287/story.html#ixzz0wQVHxT2W> (accessed August 12, 2010).

⁴⁸ Tom Blackwell, National Post "Ottawa sued over mould: Class Action alleges First Nation reserve relocated to a swamp," December 21, 2009.

⁴⁹RHS, *supra* note 11.

⁵⁰RHS, *ibid.*

2002/03 RHS were overcrowded raises concerns about the long-term impacts of crowding on the health of new generations of Aboriginal people.⁵¹ The situation is desperate for Inuit:

As a group, Inuit suffer the worst overcrowding in Canada. It is estimated that 53 per cent of Inuit households are overcrowded, and it is not uncommon for seven or more people to inhabit a single household. Fifteen per cent of Nunavut's population is on waiting lists for public housing. In 2004, ITK estimated that 3,300 houses are needed to address the current housing shortage in Nunavut, and an additional 250 units per year would be required thereafter. A 2003 Housing Needs Survey in Newfoundland and Labrador found that 44 per cent of Inuit households were in "core need", meaning that they were overcrowded, in need of repair, or had rents exceeding 30 per cent of the household income.⁵²

Housing shortages and poor quality housing are an urgent public health priority for all Aboriginal people in Canada. Substandard housing creates a myriad of problems of overcrowding, deficient sanitation and ventilation, the spread of infectious diseases, psychosocial stresses, and an increase in violence.

2.1.4 Water Quality

Results from the First Nations Regional Longitudinal Health Survey (RHS) in 2003 confirmed serious concerns about community water quality and identified 21 communities that are at high risk. In 2005, Kashechewan First Nation faced a crisis of enormous proportions:

Kashechewan is located on the northern shore of the Albany River, ten kilometers upstream from James Bay. It is an isolated community and the nearest urban center, Timmins, is located approximately 300 miles south. Elijah Wesley, a life long resident, indicates the creek is "probably full" of E. coli. A nearby sewage lagoon is located less than 140 metres upstream from the reserve's now infamous water treatment plant. And the creek's shifting tides, he said, roll that bacteria up river and back. "Probably the majority of the people here have E. coli in their system from the drinking water," says Wesley, vice-principal of the local elementary school until it closed two weeks ago because its water was deemed unsafe. Trying to combat the E. coli by over-chlorinating the water only made matters worse as it resulted in people contracting burns and other skin lesions.⁵³

⁵¹RHS, *ibid.*

⁵² Ajunggingiq Centre, National Aboriginal Health Organization, "Homelessness and Housing Realities for Inuit: Background for Discussion" March 18, 2008, online: http://www.naho.ca/inuit/e/resources/documents/2008-03-18_HousingandHomelessness_BACKGROUNDFORDISCUSSION.pdf (accessed August 12, 2010).

⁵³ National Aboriginal Health Organization, "Backgrounder, First Nations Water Quality" (Ottawa: 2005), online: http://www.naho.ca/firstnations/english/documents/research/FNC_BackgrounderonFNWaterQuality.pdf (accessed November 4, 2009).

The Regional Health Survey 2002/03 report found that:

- About one-third (32.2%) of First Nations adults consider their household water unsafe to drink.
- Seven in ten adults (70.8%) resorted to alternative sources for drinking water.
- While most (63.2%) get water by pipe from a local source, about one in six get it from a well (16.5%) or delivered by truck (15.9%).
- Despite being their main supply, about one in thirty (3.4%) collect it themselves from rivers, lakes or ponds (0.9%), from the water plant (1.8%) or from a neighbour's house (0.7%).
- Among those who indicated their water was unsafe (32.2%), more than nine in ten (92.9%) resorted to alternative sources for drinking water.
- The most common alternate source of drinking water was bottled water, mentioned by 61.7% of all respondents. This compares with 35% of Canadians who report drinking bottled water at least once a week.
- Along with the high number of people that considered their water unsafe to drink (one-third), the above results also imply sub-standard water/sewage systems and a low level of trust with respect to general water safety.⁵⁴

Attawapiskat First Nation in northern Ontario has been on a boil-water advisory for over 20 years—since 1989.⁵⁵ This is just one of 116 of Aboriginal communities that are on boil-water advisories.⁵⁶ Worse yet, many communities have not been assessed by Health Canada and are drinking water and raising their children on water that may be unfit for human consumption.⁵⁷

On May 26, 2010 Bill S-11, the *Safe Drinking Water for First Nations Act* was introduced in Parliament. The Government of Canada also announced the two year extension of the First Nations Water and Wastewater Action Plan. The *Safe Drinking Water for First Nations Act* is intended to develop federal regulations in collaboration with First Nations that will provide a comparable level of protection for drinking water in First Nation communities. The Minister of Indian and Northern Affairs, Chuck Strahl stated:

⁵⁴ RHS, *supra* note 11.

⁵⁵ For a chilling video see, You Tube, Attawapiskat - where are the promises? online: http://www.youtube.com/watch?v=hXY8UUI_CAw&feature=channel_page (accessed August 12, 2010).

⁵⁶ Canada, Health Canada, First Nations, Inuit and Aboriginal Health, Drinking Water and Wastewater, online: http://www.hc-sc.gc.ca/fniah-spnia/promotion/public-publique/water-eau-eng.php#how_many (accessed September 9, 2010).

⁵⁷ Canada, Health Canada, First Nations, Inuit and Aboriginal Health Branch, "Backgrounder: Priority List of First Nation Communities With High Risk Water Systems and Drinking Water Advisories," online: <http://www.ainc-inac.gc.ca/ai/mr/nr/j-a2006/02757bk-eng.asp> (accessed September 8, 2010).

First Nations should expect, as do all Canadians, to have access to safe, clean drinking water. ... The introduction of legislation and the extension of the First Nations Water and Wastewater Action Plan will enable the Government of Canada to continue making tangible progress on its commitment to improving water conditions on-reserve.⁵⁸

The costs for the extension of the First Nations Water and Wastewater Action Plan are estimated at \$330 million over the next two years.⁵⁹ An additional *Assessment of First Nations Water and Wastewater Systems* is intended to provide a more accurate account of water and wastewater needs in First Nation communities.⁶⁰

INAC claims there has been vast improvements in improving water and wastewater conditions across the country and stated that in 2006 there were 193 high-risk drinking water systems and that number has now been reduced to 49 drinking water systems. Out of 21 communities identified as having both a high-risk drinking water system and a drinking water advisory, 18 communities have been removed from the list. In 2009, 92% of communities had access to portable test kits for on-site bacteriological analysis of drinking water, up from 56% in 2002.

Although it is unfortunate that so much damage has already been done to the health of Aboriginal people, the Government of Canada plans to invest over \$2.3 billion from 2006 to 2012 in First Nations water and wastewater infrastructure which includes:

- annual departmental investments of approximately \$200 million;
- \$270 million through the First Nations Water Management Strategy;
- \$60 million through the Plan of Action for Drinking Water;
- approximately \$660 million through the First Nations Water and Wastewater Action Plan; and
- \$183 million through Canada's Economic Action Plan.⁶¹

It is hoped that these initiatives will provide clean water and wastewater infrastructures at least to the standard that the majority of Canadians enjoy.

⁵⁸ Canada, Indian and Northern Affairs Canada, "Government of Canada Introduces Legislation to Improve Drinking Water Quality in First Nation Communities" May 2010, online: <http://www.ainc-inac.gc.ca/ai/mr/nr/m-a2010/23358-eng.asp> (accessed August 12, 2010).

⁵⁹ *Ibid.*

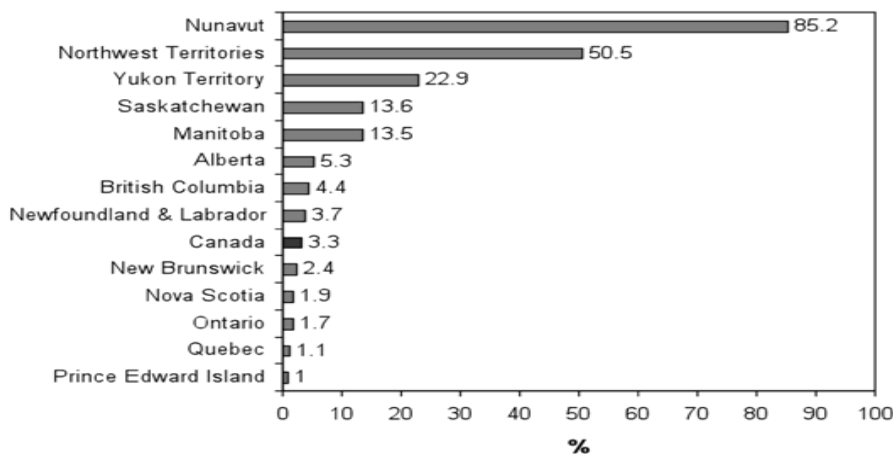
⁶⁰ *Ibid.*

⁶¹ *Ibid.*

2.2 Geographic Factors

In addition to the economic status and housing conditions of Aboriginal people, geographic location can negatively affect overall health and well-being by reducing access to facilities, supplies, and support services. The location of a community may correlate with the health of the community. The figure below shows that Aboriginal people live in every province and territory. They comprise the majority of the population in Nunavut and the Northwest Territories, and as noted in Figure 1 large portions of the population in the Prairie Provinces are Aboriginal as well.

Figure 1



Source: (Statistics Canada, 2001b Statistics Canada (2001b). Census 2001 Survey. from <http://www12.statcan.ca/english/census01/Products/Analytic/companion/abor/canada.cfm>.

Aboriginal peoples living in rural or remote regions of the country may not only lack access to healthy and affordable food but also may be exposed to health threats arising from their geographic location. In these areas, access to quality and appropriate health care is critical.

2.2.1 Access to Quality Health Care

In rural and remote areas, lack of local services, lack of access to a physician or other health provider, and the need to travel to a health facility in order to receive medical treatment form major barriers to adequate health care for Aboriginal people.⁶² Transportation, childcare, and the direct costs of some health services compound the challenges that Aboriginal people face. Cultural barriers, such as the lack of culturally appropriate or relevant care, and lack of traditional care are further issues.⁶³ A large and looming problem that seems to be unaddressed

⁶²RHS, *supra* note 11.

⁶³RHS, *ibid*.

is access to health care for people with disabilities. High rates of diabetes and the resulting effects of poor circulation, means that a high percentage of Aboriginal people may be either missing limbs or using prosthesis and be unable to access health services without aids such as wheelchairs, ramps, sidewalks or even doorways that are accessible. Further research is warranted into these issues.

Dr. Murray Trusler began working in remote communities 40 years ago. He has seen Aboriginal health decline steadily under the Federal government's "care." He notes that geographic location is critical. He sees people leaving hospital in wheelchairs after losing limbs to diabetes, yet they don't get far on the gravel roads common to most First Nations communities. He asks, "Where is the wheelchair accessibility on a reserve? You can't even get out of your front door in a wheelchair?" In 2005, Dr. Trusler was instrumental in focusing attention on the contaminated drinking water problems in Kashechewan First Nation. At that time, images circulated of sick people, which in turn prompted the Ontario government to evacuate the community (see *infra* 2.1.3, 2.1.4).⁶⁴ In the North, many Inuit communities are served by nursing stations. Doctors are available in larger centres, and specialized services are offered in southern centres. As a result, many Aboriginal patients must travel great distances to access these services. Aboriginal people must therefore cope with delays or even total lack of access to the following health services:

- disease detection;
- emergency services;
- follow-up;
- rehabilitation;
- palliative care;
- services that reflect Inuit culture and language; and,
- social supports for patients and their families.⁶⁵

⁶⁴ Margaret Munro, Canwest News Service, "Public Health Dire in First Nations Communities", October 14, 2009, Calgary Herald, online: <http://www.calgaryherald.com/health/story.html?id=2099189> (accessed November 4, 2009).

⁶⁵ National Aboriginal Health Organization, Ajunnginiq Centre, Health Sectoral Roundtable: Background Documents on Inuit Health Issues. Ottawa. 2004, online: http://www.naho.ca/english/documents/health_sectoral_AC.pdf (accessed March 5, 2010).

These and many other factors affecting Aboriginal health are tied to the geographic locations of many Aboriginal communities.

2.3 Environmental Factors

Environmental contaminants from hydroelectric, mining, energy, and forestry projects; chemical pollution; nuclear energy and weapons testing; toxic waste mismanagement; depletion of the ozone layer; and global warming: these are only a few critical environmental problems facing Aboriginal people. The far-reaching impacts of environmental damage and contamination confirm what has been long understood: human health is intertwined with and indivisible from the natural environment.

Industry releases contaminants into the air, water, and soil. Traditional foods and medicines are affected by industrial contamination, which wreaks untold damage on the habitats of wildlife as well. Traditional Aboriginal lifestyles depend on the purity of the land, the water, and all living things. The environmental impact of industrialization constitutes a brutal assault on Aboriginal ways of being and continues the harms of colonization. For many Aboriginal communities harmful pollutants include every day substances. The World Wildlife Fund reports that:

Persistent Organic Pollutants (POPs) include two major types: Organochlorines (OCs) as well as Polycyclic Aromatic Hydrocarbons (PAHs). These human-made chemical compounds are turned into pesticides, such as DDT and Chlordane, insecticides, such as Toxaphene and Mirex, as well as plastics, toothpaste, mouthwash, and solvents.⁶⁶

Polycyclic Aromatic Hydrocarbons (PAHs) are derived from the incomplete combustion of fossil fuels. They are used to produce asphalt, coal tar, and creosote, a wood preservative. However, their effects are devastating to the environment. PAHs contribute to ozone depletion, gradual global climatic warming, and acid rain. Heavy metals, such as lead, mercury, and cadmium are used extensively in industry, and they are highly toxic.⁶⁷ Dams used for hydroelectric power release methylmercury into the water, poisoning the water tables and

⁶⁶ World Wildlife Fund, "Contamination: The Result of WWF Biomonitoring Survey," online: <http://www.wwf.org.uk/filelibrary/pdf/biomonitoringresults.pdf> (accessed November 4, 2009) [WWF].

⁶⁷ WWF, *ibid.*

killing the fish and other life in the water. Lead is present in food, drinking water, air, soil dust, and various consumer products. Cadmium is a toxic heavy metal, and everyone is exposed to this poison in the water they drink and the food they eat. Smoking is a main source of cadmium exposure for smokers and those who breathe secondary smoke.⁶⁸

Nunavut has the highest smoking rate in Canada, with 54.2% of those over the age of 12 smoking either daily or occasionally as compared to the Canadian average of 21.4% in 2008. It is also suggested that more than 80 per cent of Inuit women in Nunavut smoke during pregnancy⁶⁹ In May 2010, Mary Simon, President of Inuit Tapiriit Kanatami, accepted \$350,000 in federal funding for smoking-cessation programs aimed at expectant mothers in four Inuit regions of Canada and commented:

We know that a lot of children have respiratory problems due to bad, poor air quality which could be related to smoking. In one study, more than 80% of Inuit women were shown to smoke during pregnancy. Another concluded that 85% of infants in Nunavut's capital, Iqaluit, were exposed to second-hand smoke in the womb.⁷⁰

Household moulds, poor sanitation systems, contaminated drinking water, and unsafe disposal of waste and refuse are also significant problems for crowded Aboriginal communities. Contaminated water spreads infectious disease, such as cryptosporidiosis and shigellosis. Pesticides and fertilizers sprayed on land around rivers or lakes carry contaminants that seep into the water.⁷¹

Indian and Northern Affairs Canada (INAC) are charged with protecting the First Nations environment. Yet, they have not been addressing the many landfill sites, sewage treatments, and other disposals on reserves that pollute. Many operate without required permits, according

⁶⁸ WWF, *ibid.*

⁶⁹ Canada, Nunavut, "Comparable Health Indicators for Nunavut and Canada," online: http://www.gov.nu.ca/health/PIRC_English.pdf (accessed August 12, 2010).

⁷⁰ Christina Spencer, Parliamentary Bureau, Toronto Sun, "Feds fund 'quit smoking' programs for Inuit" May 31, 2010, online: <http://www.torontosun.com/news/canada/2010/05/31/14200866.html> (accessed August 12, 2010).

⁷¹ WWF, *supra* note 66.

to Auditor General Sheila Fraser.⁷² Septic systems, water treatment facilities, wastewater discharges and hazardous waste, which are strictly controlled by provincial and municipal laws, are not subject to any regulations on reserves because of jurisdictional issues. In her report Auditor General Fraser commented that there are few federal regulations that apply to environmental protection on reserves, and the federal government has taken little action to change this. Fraser stated that the federal government is aware of the problems but does not or cannot monitor and enforce compliance of the few regulations that exist. Fraser's report also found that, while INAC wants to encourage First Nations to manage their own land, it will train only one person per community.⁷³ This lack of regulatory backup leaves Aboriginal communities vulnerable to duties being forgotten if that person dies or leaves the reserve. Indian and Northern Affairs Canada blamed a lack of funding for its failure to meet its obligations.⁷⁴

The Couchiching First Nation in Ontario is a sad example of what Attorney General Fraser is talking about. Their land, homes, and the lake where they fish for food are all contaminated:

The contamination is currently known to include concentrations of polychlorinated dibenzodioxins and polychlorinated dibenzofurans (dioxins and furans) at the former site of the J.A. Mathieu Sawmill, according to reports provided to the residents by DST Consulting Engineers. DST employees have done extensive testing inside and outside of homes in the area — groundwater testing, boreholes and soil samples, and dust sample collection inside the buildings — and have provided the results to Couchiching First Nation.⁷⁵

The sawmills and their pentachlorophenol (PCP) dipping pond are the likely sources of contamination. INAC leased the land to at least four sawmills on that location and was responsible for ensuring that the site underwent cleaning after each lease ended. They failed to do this.⁷⁶

⁷² Office of the Auditor General, 2009 Fall Report of the Auditor General of Canada, Chapter 6—Land Management and Environmental Protection on Reserves, online: http://www.oag-bvg.gc.ca/internet/docs/parl_oag_200911_06_e.pdf (accessed September 9, 2010).

⁷³ *Ibid.*, at 6.40.

⁷⁴ *Ibid.* See also, Althia Raj, Sun Media, "Feds turn blind eye to decaying reserves" November 4, 2009.

⁷⁵ Katie Kolt Hall, "Contaminants Investigated" the Daily Journal, October 14, 2009, online: <http://www.ifalldailyjournal.com/news/city-news-fort-frances/contaminants-investigated-katie-kolt-hall-staff-writer-110> (accessed November 4, 2009) [Couchiching First Nation].

⁷⁶ Couchiching First Nation, *ibid.*

Health Canada reported that:

[P]otential health effects of exposure to dioxins and furans include skin disorders such as chloracne; liver problems; impairment of the immune, endocrine and reproductive systems; effects on the developing nervous system and other developmental events; and certain types of cancer. The health department also noted that effects depend on many factors such as the way a person is exposed, the quantity of exposure, individual susceptibility, and whether a person is also exposed to other substances that may be associated with health effects.⁷⁷

Seventeen residents of Couchiching First Nation have provided blood samples to determine what toxins are in their blood. The results will be provided to Health Canada and not to the resident doctors. Once tests determine which toxins are contaminating the residents of Couchiching First Nation, Health Canada will direct INAC about how to proceed.⁷⁸

Ground water from the contaminated dipping pond site flows towards Rainy Lake—a traditional food source for Couchiching First Nation. The consultants hired by Couchiching First Nation state, “[t]he proximity of the contaminants to Rainy Lake presents a potentially wider ecological concern with respect to the aquatic environment.”⁷⁹

2.4 Colonialism as a Determinant of Health

Prime Minister Stephen Harper addressed the media at an international press conference in September 2009 and stated:

We also have no history of colonialism. So we have all of the things that many people admire about the great powers but none of the things that threaten or bother them.⁸⁰

In contrast to Mr. Harper’s views, the nucleus of the health problems Aboriginal people face can be traced to colonialism. Colonialism has caused acute trauma to the health of Aboriginal people and the social fibre of Aboriginal communities.

⁷⁷ Couchiching First Nation, *ibid.*

⁷⁸ Couchiching First Nation, *ibid.*

⁷⁹ Couchiching First Nation, *ibid.*

⁸⁰ [David Ljunggren](http://www.reuters.com/article/idUSTRE58P05Z20090926), Reuters, September 25, 2009 “Every G20 nation wants to be Canada, insists PM,” online: <http://www.reuters.com/article/idUSTRE58P05Z20090926> (accessed August 12, 2010).

The mechanisms of law, institutions, and public policies—the *Indian Act*, residential schools, and other assimilation projects—have been driving forces behind the colonization of Aboriginal people in Canada. Professor Sákéj Youngblood Henderson describes “Eurocentrism” as a “dominant intellectual and educational movement that postulates the superiority of Europeans over non-Europeans.” as the source of colonialism.⁸¹ The intent behind colonization has been to subjugate Aboriginal peoples and to take possession of Aboriginal lands. Aboriginal people were forced to assimilate through religious indoctrination and to adhere to Western society’s norms, rules, institutions, and ways of living and thinking.

Colonization came to North America with European settlement and subsequent industrialization. Colonization continues today which is evidenced by the marginalization of Aboriginal people in Canada. Professor Sharlene Razack explains that a “white settler society” is one that Europeans set up on non-European soil.⁸² The origins of this society lie in the Europeans’ multi-century campaign to dispossess and exterminate Indigenous populations.

As white settler societies have grown, they have continued to enforce a racial hierarchy. Their state mythologies outright claim, or tacitly assume, that European people have a superior intellect and create superior social structures. The Europeans imported hierarchical socio-economic structures, which have been forced onto Indigenous society. Aboriginal people were relegated to the role of secondary non-persons; the classification was considered temporary, because Europeans presumed that Aboriginal peoples were mostly dead, dying, or assimilated. European settlers thus established themselves as the privileged inhabitants and the ones most entitled to the fruits of the “new” lands. By imposing colonization in every facet of life, white settler societies claimed control over unimagined wealth, political power, human labor (slavery), and natural resources.⁸³

⁸¹ J. Sákéj Henderson, “Postcolonial Ghost Dancing: Diagnosing European Colonialism” in Marie Battiste, ed., *Reclaiming Indigenous Voice and Vision* (Vancouver: University of British Columbia Press, 2000) 57 at 58.

⁸² S.H. Razack, *Looking White People in the Eye: Gender, Race and Culture in Courtrooms and Classrooms* (Toronto: University of Toronto Press, 1998).

⁸³ See, on the Doctrine of Discovery, Robert A. Williams, *The American Indian in Western legal Thought: The Discourses of Conquest* (Oxford: Oxford University Press, 1990); Robert A. Williams, “Columbus’s Legacy: Law as an Instrument of Racial Discrimination against Indigenous peoples’ right to Self-Determination” (1991) *American Journal of international and comparative law*, Vol. 8 issue 2.

During the nineteenth century, a vocabulary of white racial superiority emerged to justify colonization's blatantly unjust criminal policies and practices. "Inferior" or "subject races," "subordinate peoples," "dependency," "expansion," "authority": such terminology became commonplace in law, public policy, and general parlance.⁸⁴ Professor Razack observes that,

A quintessential feature of white settler mythologies is, therefore, the disavowal of conquest, genocide, slavery,⁸⁵ and the exploitation of the labour of peoples of colour. In North America, it is still the case that European conquest and colonization are often denied; largely through the fantasy that North America was peacefully settled and not colonized.⁸⁶

The settlers were the people who invaded the land and had their identity, beliefs, standards and culture maintained and solidified in the institutions, laws and legislation of the lands that they invaded. This is the standard by which Aboriginal people are judged today, this is modern colonization.

Globally, the similarities are striking between the health issues of Aboriginal peoples in Canada and the health issues of Indigenous peoples throughout the world—Australian Aboriginal, Torres Strait Islander, Maori, Kanaka Maoli, American Indian, and Alaska Native peoples (and are discussed in Chapter 9). The International Network in Indigenous Health Knowledge and Development commented:

In each country the legacies of colonial dispossession, land alienation, forcible relocation, suppression of indigenous cultural practices, values and beliefs, loss of language, disruption of families, violations of indigenous inherent sovereignty and right to self-determination, treaties, international law and

⁸⁴ See James Muldoon *The Americas in the Spanish World Order, The Justification for Conquest in the Seventeenth Century* (Philadelphia: University of Pennsylvania Press, 1994); James Muldoon, *Popes, Lawyers, and Infidels: The Church and the Non-Christian World 1250–1550* (Philadelphia: University of Pennsylvania Press, 1979).

⁸⁵ E.W. Said, *Culture And Imperialism* (New York: Vintage Books, 1994) at 9.

⁸⁶ See also, Peter C. Newman, *Caesars of the Wilderness* (Markham: Viking, 1987) at 21, quoted in Jack Weatherford, *Native Roots: How the Indians Enriched America* (New York: Fawcett Columbine, 1991) at 274–275:

With the shortage of white women in the western and northern British colonies in Canada, men practiced a lively commerce in female Indian slaves. Although not recognized by the government, men bought and sold women, or even leased them for a certain number of years. They trafficked in Indian and mixed-blood women for cash, to repay gambling debts, and to trade for horses and rum.

indigenous cultural law, and other factors, have resulted in indigenous peoples experiencing a deplorable health status compared to non-indigenous settlers.⁸⁷

Taiaiake Alfred and Jeff Corntassel comment on how far-reaching colonization is:

There are approximately 350 million Indigenous peoples situated in some 70 countries around the world. All of these people confront the daily realities of having their lands, cultures, and governmental authorities simultaneously attacked, denied, and reconstructed by colonial societies and states. This has been the case for generations.

...

[In Canada] the results are measured in losses of cultural identity, marginalization and health status that fall well below that of mainstream Canadians.⁸⁸

Aboriginal people suffer from diseases that predictably follow certain social conditions. Poverty, poor housing, poor diet, lower education, racism and persistent fear and abuse: these conditions are known to cause damaging stress on individuals and families. The physical repercussions are disease. The body breaks down as stresses compound and intensify. Under these conditions, the options for sustaining healthy lifestyles and the ability to acquire help in health crises narrow. Illness and death are far more likely for those who are poor and marginalized. People who are not marginalized, who are not living in poverty, who enjoy adequate housing, who are educated, and whose cultural identity is not under constant attack have better states of health. In Canada, Aboriginal people pay the costs of colonization every day through the loss of their health as well as their lives.

For Aboriginal women, the realities are worse still. For instance, Canada's institutions claim to be value-free, yet they actually reflect a male construction of reality.⁸⁹ Male centered values

⁸⁷ International Network in Indigenous Health Knowledge and Development, *A Discussion Document: Knowledge Translation to improve the health of Indigenous Peoples* (Townsville: 2003), online: http://www.inihkd.org/INIHKD_Discussion_Document%20_March_2003.pdf (accessed September 9, 2010).

⁸⁸ Taiaiake Alfred & Jeff Corntassel, "Being Indigenous: Resurgences Against Contemporary Colonialism." Government and Opposition, 2005., online: http://www.wasase.org/pdfs/goop_166.pdf (accessed September 9, 2010).

⁸⁹ Professor Ann Scales notes that men have had the power to "to create the world from their own point of view, and then, by a truly remarkable philosophical conjure, were able to elevate that point of view into so-called 'objective reality.'" (Ann Scales, "Militarism, Male Dominance and Law: Feminist Jurisprudence as an Oxymoron?" (1989) 12 Harv. Women's L.J. 25 in Sherene Razack, "Speaking for Ourselves: Feminist Jurisprudence and Minority Women" (1990-1991) 4 Canadian Journal of Women and the Law, 440 at 441.

have shaped Canada's institutions, laws, legislation, and policies and set the standard for what is "normal."⁹⁰ These have had long-lasting negative effects on the health of Aboriginal people, particularly Aboriginal women. Colonial laws and policies have targeted the power of Aboriginal women as family anchors. The *Indian Act*, residential schools, involuntary sterilization, mental health laws, the forced removal of children, and forced enfranchisement (hence loss of Indian status) have been some of the major weapons used to attack the essence of Aboriginal woman as caregivers, nurturers, and equal members of their balanced society/community. These attacks have created a state of ill health for Aboriginal women: physically, mentally, spiritually, and emotionally.

Because of colonization's attacks on Aboriginal women and their traditional roles, "the cultural and social degradation of Aboriginal women has been devastating."⁹¹ Several generations of *Indian Act* rule in particular, combined with the discriminatory provisions regarding inter-marriage, have left many Aboriginal women voiceless (See Chapter 6 on the current status of the *Indian Act* and its membership provisions). In spite of this, they have attempted to use the equality provisions in the Canadian Bill of Rights, International instruments, and the *Charter*⁹² to access much needed services.

Although detailed in Chapter 6.4, some general colonial and historical aspects of the *Indian Act* warrant note here. For instance, broad definitions of the term "Indian" came into effect in 1850.⁹³ In 1876, section 3 specified the range of definition further: "[t]he term 'Indian' means

⁹⁰ For instance, it wasn't until 2006 that prosthetic knees were made for women. Women simply had to fit into a "man size" knee until someone took the plunge and decided that perhaps women shouldn't have to continue to suffer with an ill fitting knee:

Doctors have known for years that women's knees are different from men's. Women's knees are narrower, they attach at a slightly different angle, and they are more prone to injury. (Julie Kirkwood, November 6, 2006 "Fitting the female form: Do new prosthetic knees for women really make a difference?" online: <http://www.eagletribune.com/lifestyle/x1876288247/Fitting-the-female-form-Do-new-prosthetic-knees-for-women-really-make-a-difference?keyword=topstory> (accessed August 12, 2010).

⁹¹ Canada, Status of Women Canada, "Traditional Roles of First Nations Women," online: First Nations Women, Governance and the *Indian Act*: A Collection of Policy Research Reports, online: http://www.iidh.ed.cr/comunidades/diversidades/docs/div_enlinea/policy%20reports.htm (accessed September 9, 2010).

⁹² *Canadian Charter of Rights and Freedoms*, Pt. I of *Constitution Act, 1982*, being Schedule B to the Act, *Canada Act, 1982* (U.K.) 1982, c.11.

⁹³ See the term "Indian" as defined in *An Act for the Better Protection of the Lands and Property of the Indians in Lower Canada*, S.C. 1850, c. 42, s.5.

‘any male person of Indian blood reputed to belong to a particular band, ‘any child of such person,’ ‘any women who is or was lawfully married to such person.’⁹⁴ In 1906, the *Indian Act* was amended to define a “person” as an individual *other* than an Indian.⁹⁵ Not until 1951 were amendments passed that redefined the terms and the restrictions were lifted that affected women by defining them as legal “non-persons,” thereby denying their entry into many professions.⁹⁶ Lawyer Bill Henderson explains:

Status soon came to have other implications. Status Indians were denied the right to vote, they did not sit on juries, and they were exempt from conscription in time of war (although the percentage of volunteers was higher among Indians than any other group). The attitude that others were the better judges of Indian interests turned the statute into a grab-bag of social engineering over the years.⁹⁷

Education was also used as a tool of assimilation, and it played a large role in white settler society’s assimilation project. Although Indian residential schooling dates back to the 1600’s in Quebec, residential schools were a product of the *Indian Act* of 1876, and the Minister of Indian Affairs controlled education, and indeed life, for Indians through it. Historian John Milloy comments that the *Indian Act* of 1876 and 1880 and the *Indian Advancement Act of 1884* allowed the government to “mould, unilaterally, every aspect of life on the reserve and to create whatever infrastructure it deemed necessary to achieve the desired end—assimilation through enfranchisement and, as a consequence, the eventual disappearance of First Nations.”⁹⁸

Milloy adds:

While the acts related solely to Indian First Nations, the assumption behind them was the same for all Aboriginal people. Men, women, and children—Métis, “non-status and status” Indians, and Inuit—each in their own time and place, as their homeland was encompassed by the expanding Canadian nation, would be expected to abandon their cherished life ways, to become “civilized” and thus to lose themselves and their culture among the mass of Canadians. This would be an unchanging federal determination, justified in the minds of

⁹⁴ *Indian Act, 1876*, S.C. 1876, c.18.

⁹⁵ *Indian Act 1906*, S.C. c. 81, s. 2(c). For a general discussion of the effect of this section, see *Atkins v. Davis* [1917] 38 O.L.R. 548 (Ont. S.C.A.D.).

⁹⁶ See, for example, *R. v. Point*, [1957] 22 W.W.R. 527, in which the court held that “the accused, on the evidence, is an Indian within the meaning of the *Indian Act*, R.S.C. 1952, c.149, and being an Indian is a person (definition in the *Indian Act*, s.2(1)(g)) and being a person is subject to the application of sec. 44(2) of the *Income Tax Act*.”

⁹⁷ Bill Henderson, “Notes on the Indian Act,” online: <http://www.bloorstreet.com/200block/sindact.htm> (accessed September 9, 2010).

⁹⁸ J.S. Milloy, *A National Crime: The Canadian Government and the Residential School System 1879-1986*. Winnipeg: University of Manitoba Press, 1999 at 21.

Confederation policy makers and successive generations of politicians and Departmental officials by their sincere, Christian certainty that the nation's duty to the original people of the land was to prepare them "for a higher civilization by encouraging" them "to assume the privileges and responsibilities of full citizenship."⁹⁹

Of all the initiatives undertaken by colonialist forces in the first century of Confederation, none were more ambitious or central to the "civilizing" and assimilation strategies of the Department of Indian Affairs than the residential school system. The results of this system, coupled with the discriminatory marriage rules in the *Indian Act* and other tools of colonization, have left an indelible scar on the social fibre and health of Aboriginal people in Canada. This Chapter has explored the determinants of health for Aboriginal people from a modern perspective and how has colonization affected these determinants. Health and well-being correlate with a person's living circumstances and quality of life. The control one has over one's living conditions indicates the degree of health one is likely to have (self determination as a fundamental determinate of health). For Aboriginal people, colonization has meant the radical loss of this control, and this loss of control has had devastating effects on their health. The following chapter provides an examination of many of the health problems Aboriginal people are facing today.

2.5 Summary

The health statistics concerning Aboriginal people living in Canada provide abundant information about the challenges that Aboriginal people face and why. These statistics paint a grim picture, especially given all the factors that converge to endanger Aboriginal health. First Nations, Inuit, and Métis peoples each have a history that is distinct from each other. They have unique cultures and traditions with a myriad of cultural and linguistic differences within each group. Societal accountabilities and responsibilities are measured through human relationships, relationships with nature, and congruity with natural laws. These responsibilities, accountabilities, differences, distinctions, and similarities must form the context for addressing the current Aboriginal health crisis. The immense job of restoring Aboriginal health requires collaboration to generate an analysis that eventually will change and influence government policies in ways that will positively affect the health of Aboriginal people.

⁹⁹*Ibid.*

Restoring health for Indigenous people worldwide and in Canada involves a holistic approach that builds on balance and good harmony. Each person is linked to family, community, and the earth in a cycle of interdependence and indivisibility. It is clearly not “an absence of disease” model. The following chapter provides a backdrop on the current state of Aboriginal health.

3. Current State of Aboriginal Health

The overall health status of Aboriginal people falls well below that of other Canadians, and large inequities in health exist between Aboriginal people and the rest of the Canadian population. Health inequities for Aboriginal people take many forms and typically arise from social, political, cultural, and economic factors, which lie largely outside of the health realm. As noted throughout, but particularly in the preceding chapter *Health Determinants* - the many underlying determinants for Aboriginal people include poverty, homelessness, inadequate or substandard housing, unemployment, violence, lack of access to health services, lack of cultural awareness within the existing health system and lack of education.

These health-endangering conditions, in turn, have their origins in Canada's history of colonizing legislation and policies of assimilation. Canada's residential school system, its forced relocation programs, and its ongoing pressure on Aboriginal people to switch from Indigenous lifestyles to those of Canada's industrialized society have taken a heavy toll on Aboriginal health. The following chapter reviews current health statistics on some leading diseases that are affecting First Nations, Inuit and Métis. Because there is a paucity of health information for Métis whatever is available will be cited.

3.1 Aboriginal Health Statistics

Although statistics show that life expectancy of Aboriginal people has increased over the years, Aboriginal people continue to die at higher rates and younger ages than the general Canadian population. The Health Council of Canada reports:

- Life expectancy for First Nations and Inuit is lower compared to their Canadian counterparts at the national, provincial and territorial level.
- Based on national information, the incidence of infants with low birth weight is increasing in the First Nations population compared to the rest of Canada. The highest incidence is among the Inuit population.
- The crude mortality rate for First Nations is higher compared to the Canadian and available provincial rates. The four leading causes of death in the First Nations are: injury and poisoning, circulatory diseases, cancer and respiratory diseases.

- Lung cancer is the most common type of cancer for all Aboriginal peoples, followed by prostate and colorectal cancer for men and breast and colorectal cancer for women.
- Ischemic heart disease is the primary cause of death for First Nations people 45 years of age and older, according to national statistics, and is cited as the number one cause in British Columbia and Saskatchewan.
- Suicide is the leading cause of potential years of life lost in both the First Nations and Inuit populations.
- Sexually-transmitted infections, like genital chlamydia and HIV, are higher in the First Nations and Inuit populations as reported at the national and provincial/territorial levels.
- Diabetes is steadily rising in the First Nations and Inuit population but is much higher in the former group. The Métis diabetes rate is similar to the First Nations rate.
- Residents of the NWT tend to be more active than the rest of the Canadian population. The Inuit of Nunavut have an activity level that is similar to the rest of Canadians.
- Obesity rates in First Nations are twice as high in comparison to the rest of Canadians.
- Many older First Nations and Inuit adults do not receive needed home care services.¹

Additionally,

- First Nations' infant mortality rates are higher compared to national and provincial rates and are even higher for the Inuit in Nunavik, Nunavut and the Northwest Territories. In 2009 UNICEF reported that the infant mortality rate for First Nations on reserve is seven times higher than the national average.²
- The tuberculosis rate among some Inuit communities between 2002 and 2006 was 90 times higher than that for the non-Aboriginal population.³

¹ Health Council of Canada, The Health Status of Canada's First Nations, Métis and Inuit Peoples, 2005, online: <http://healthcouncilcanada.ca.c9.previewyoursite.com/docs/papers/2005/BkgrdHealthyCdnsENG.pdf> at 6 (accessed November 20, 2009).

²National Collaborating Centre for Aboriginal Health & UNICEF Canada, "Leaving no child behind - national spotlight on health gap for Aboriginal children in Canada" 2009, online: http://www.nccah-ccnsa.ca/s_140.asp (accessed November 20, 2009).

³ *Ibid.*

The 2003 *First Nations Longitudinal Regional Health Survey (RHS)* indicates that 28.4% of First Nations adults report that they have a disability. Compared with one in four Aboriginal men, nearly one in three First Nations women have disabilities. Disability becomes more common as people age. Half of First Nations people over 60 years of age have a disability, compared with 13.1% in the 18 to 29 age group. This increase of disability with age can be explained, in part, by increased exposure to factors that place people at risk of disability across a lifespan, such as accidents, exposure to environmental toxins, stress and anxiety, addictions, the aging process, illnesses and other chronic conditions (e.g., arthritis, heart conditions, progressive hearing loss).⁴

The Highlights of the Aboriginal People's Survey (APS) of 2006 collected the following health and social data for Métis people and communities:

- Nearly six in ten (58%) Métis adults rated their health as excellent or very good in 2006, the same as in 2001. The majority (84%) of Métis children 6 to 14 years of age were reported by their parents/guardians to be in excellent or very good health in 2006, similar to 2001.
- Young Métis aged 15 to 19 report better health than those in the total population of Canada. Self-rated health for Métis aged 20 to 34 is about the same as that of the total population in this age group. However, the trend reverses for Métis aged 35 and over. Métis in all older age groups are less likely than the total population of Canada in older age groups to report excellent or very good health.
- The most commonly reported chronic condition among Métis adults was arthritis and/or rheumatism (21%), higher than the 13% in the total population of Canada. High blood pressure was the second most common condition, reported by 16% of Métis compared with 12% of the total population.
- In most cases Métis have higher rates of chronic conditions than the total population of Canada. Almost double the percentage of Métis adults reported asthma (14%) and diabetes (7%) as compared with the total population (8% and 4% respectively).

⁴First Nations and Inuit Regional Health Survey National Steering Committee. *First Nations and Inuit Regional Health Survey, National Report*, Ottawa: NAHO, 2003 [RHS]. This issue is also very important as disabilities restrict access to health services. Michael Oliver in his book "The Politics of Disablement" discusses the theory of people with disabilities are marginalized, for Aboriginal people – this marginalization is doubled by being disabled and being Aboriginal. See, Michael Oliver, "The Politics of Disablement," MacMillan: London, 1990.

- A higher proportion of Métis women (57%) than men (50%) reported having a chronic health condition. Métis women were more likely than men to report arthritis and/or rheumatism (24% versus 18%), asthma (17% versus 11%), and bronchitis (8% versus 5%).
- The most commonly reported chronic condition of young Métis aged 15 to 19 was asthma (20%), almost double the percentage found among the same age group in the total population of Canada (11%).
- About 32% of Métis reported that traditional medicines or wellness practices were available in their community. Those living in urban areas (35%) were more likely than those in rural areas (25%) to report the availability of such practices.
- In both 2001 and 2006, about 7 in 10 Métis reported that there was something they could do to improve their health—most often identifying “increasing exercise.”⁵

The realities of health care in the North differ greatly from southern Canada. Geography, harsh climate, and smaller populations make access to services extremely difficult. The 2006 Aboriginal People’s Survey reports:

- Half of Inuit adults aged 15 and over (50%) stated that their health was excellent or very good, down from 56% in 2001.
- Inuit adults were less likely (56%) than those in the total Canadian population (79%) to have contact with a medical doctor, either a family doctor or specialist.
- The most commonly reported diagnosed chronic conditions among Inuit adults were arthritis/rheumatism (13%) and high blood pressure (12%). For Inuit children aged 6 to 14, they were ear infections (15%), allergies (10%), and asthma (7%).
- In 2006, the percentage of Inuit smoking daily (58%) was over three times that of all adults in Canada (17%).
- Just over six in 10 Inuit children aged 6 to 14 were reported to have received dental treatment in the previous year.
- Growing numbers of Inuit are moving on to post-secondary studies, but many do not finish elementary or high school. About one quarter of Inuit women said they did not

⁵Teresa Janz, Joyce Seto & Annie Turner, “Aboriginal Peoples Survey, 2006: An Overview of the Health of the Métis Population,” Social and Aboriginal Statistics Division, online: <http://www.metisnation.ca/PDF-May2009/press/APS%20M%C3%A9tis%20article%202006%20English.pdf> (accessed November 20, 2009).

finish because of pregnancy or looking after children. The main reasons given by Inuit men included wanting to work (18%), boredom (18%), and having to work (14%).

- Over half of Inuit children (aged 6 to 14) had attended an early childhood development program. Of these, 59% attended a program designed specifically for Aboriginal children.
- Three in 10 Inuit children aged 6 to 14 were reported by their parents to have experienced being hungry at some point in their lives because the family had run out of food or money to buy food.
- In Inuit Nunaat, the Inuit homeland, the majority of Inuit men and women of all ages had harvested country food—that is, food from the land and sea, such as seal, caribou, fish, whale, etc.
- Country food makes up a large percentage of the fish and meat eaten by many Inuit families across Inuit Nunaat and is widely shared with others in the community.⁶

A snapshot of current Inuit health also presents a grim picture:

- The average lifespan for Inuit women is 14 years less than that of the average Canadian woman.⁷
- Suicide rates in Nunavut are six times the national average.⁸
- The 2001 Aboriginal Peoples Survey found that 53 per cent of Inuit live in overcrowded housing. Furthermore, 33 percent of Inuit households are in need of core housing, almost double the Canadian rate of 18 percent.⁹
- In a 2003 study in Kugaaruk, Nunavut, on food security, five out of six Inuit households were classified as food insecure. This issue affects many Inuit communities. Over half of the households studied had experienced hunger in the last year.¹⁰

⁶ Heather Tait, “Aboriginal Peoples Survey, 2006: Inuit Health and Social Conditions”, online: http://dsp-psd.pwgsc.gc.ca/collection_2008/statcan/89-637-X/89-637-x2008001-eng.pdf (accessed November 20, 2009).

⁷ Statistics Canada, The Daily Monday, September 27, 2004, “Ajunnginiq Centre” at the National Aboriginal Health Organization, 2004.

⁸ National Aboriginal Health Organization, “Overview of Inuit Health,” online: <http://www.naho.ca/inuit/e/overview/> (accessed March 8, 2011) [NAHO].

⁹ *Ibid.*

¹⁰ Food Mail Pilot Project, Department of Indian Affairs and Northern Development, in “Hunger in the Arctic: Food (In) Security Issues in Inuit Communities,” prepared for the Ajunnginiq Centre at the National Aboriginal Health Organization. 2004.

- Educational attainment among Inuit is lower than that of southern mainstream Canada. Whereas 33 per cent of non-Aboriginal Canadians do not hold any level of post-secondary education, for Inuit the rate is double at 66 per cent.¹¹
- The unemployment rate among Inuit—22 percent—is more than three times the Canadian average of seven per cent.¹²
- Environmental concerns, such as contaminants and climate change, are having a disproportionately high impact on Inuit.¹³
- On most indicators where there is health data available for Inuit, Inuit fare far worse than not only their non-Aboriginal Canadian counterparts, but their First Nations and Métis counterparts as well.¹⁴

On the recent H1N1 pandemic, the Native Women's Association of Canada reported:

Aboriginal peoples across Canada have already been disproportionately impacted by the spread of the H1N1 virus. As of July 2009, First Nations communities in Manitoba and northern Ontario made up one-third of the 685 swine flu cases in the region, despite being only 10 per cent of the population. Other communities, whether on reserve, in rural and remote areas and in urban centres are trying to prepare for the worst; however, complex issues related to population health outcomes for the Aboriginal population include many factors related to access to care, as well as risk of infectious disease.¹⁵

The new viral influenza viruses have the potential to devastate the Aboriginal population in Canada. Basic health determinants such as overcrowded housing, reduced immunity, complex health needs, lack of access to health services, and higher sensitivity to infectious disease: these factors converge to increase Aboriginal people's vulnerability to any new viral infections.

3.2 Health of Aboriginal Women

Because the health of Aboriginal women is worse than that of Aboriginal men and starkly

¹¹ Canadian Institute for Health Information, "Improving the Health of Canadians" 2004 in Ajunginiq Centre at the National Aboriginal Health Organization, 2004 [Improving].

¹² Improving, *ibid.*

¹³ National Aboriginal Health Organization, "Access and Integration," online: http://www.naho.ca/documents/naho/english/health_sectoral_AC.pdf (accessed April 21, 2011).

¹⁴ Inuit Tuttarvingat, National Aboriginal Health Organization, "Overview: Inuit Health," 2009, online: <http://www.naho.ca/inuit/e/overview/> (accessed November 20, 2009).

¹⁵ Native Women's Association of Canada, "H1N1 Pandemic and Aboriginal Women in Canada: Backgrounder" 2009, online: <http://www.nwac-hq.org/en/documents/Backgrounder-H1N1.pdf> (accessed November 20, 2009).

worse than the health of non-Aboriginal Canadians, the overall health status of Aboriginal women will be assessed and analyzed separately wherever possible. Drawing from the 2006 Statistics Canada census data,¹⁶ the Native Women's Association of Canada compiled some important but basic health statistics on Aboriginal women:

- Aboriginal women can expect to live 76.8 years on average, versus 82 for non-Aboriginal women.
- Among female youth, the rate of suicide deaths among registered Indians was nearly 8 times that of other Canadian youth.
- The rate of suicide for Aboriginal women is three times the national average for non-Aboriginal women.
- Aboriginal women are almost three times more likely to contract AIDS than non-Aboriginal women (23.1% versus 8.2%).
- Chronic conditions like arthritis, rheumatism, asthma, high blood pressure, gastrointestinal disorders, and cardiac conditions begin to affect Aboriginal women at 45 years of age.
- Seven percent (7%) of Aboriginal women over the age of 15 have been diagnosed with diabetes compared to 3% for the rest of the female population of this same age category.
- The demand for institutional and related continuing care needs for Aboriginal communities will continue to grow over the next few decades due to increases in the number of First Nation members aged 55 and over and growing incidences of chronic disease.¹⁷

In addition:

- The rate of diabetes increases with age. Twenty-four (24%) of Aboriginal women over the age of 65 have diabetes compared to 11% for the rest of the senior female population in Canada.¹⁸
- 67% of Aboriginal women are overweight versus 55% of non-Aboriginal women.¹⁹

Aboriginal women are critical in determining the health of a community. They are often the center of the household. They are the primary caregivers of children, families, and the elderly, and they most often deliver health care services to family and community members.

¹⁶ Native Women's Association of Canada, "Aboriginal women: Statistics and Demographics," (Ottawa: 2009).

¹⁷ *Ibid.*

¹⁸ Canada, Statistics Canada, Women in Canada, Fifth Edition. Statistics Canada, 2006.

¹⁹ S. Narine, *Report shows 67 per cent of Aboriginal women overweight*, [Alberta Sweetgrass](#); Feb2008, Vol. 15 Issue 3, 2-7 at 2.

3.3 Mental Health

The mental health problems of Aboriginal people arise from a long history of colonization.²⁰ This history includes tools of oppression, such as residential schools, racial discrimination and violence, and loss of land, language, and livelihood. Entire families are deeply affected by the government's residential school policy. First Nations, Inuit, and Métis children were forcibly taken from their homes and sent to residential schools. Many, if not most, experienced violence and abuse. Many lost their languages and their deep connections not only to their families but also to their traditions, cultures, and communities.

Mental health problems, such as depression and substance abuse, are the direct result of Canada's colonizing assaults on Aboriginal people. Mental health problems are significantly higher in many Aboriginal communities than in the general population and are directly attributed to the residential school system and its legacy.²¹ The rate of suicide among Aboriginal people, for example, is 2.1 times greater than the average rate of suicide among the general Canadian population.²²

- Suicide and self-injury were the leading causes of death for Aboriginal youths. In 2000, suicide accounted for 22 percent of all deaths among Aboriginal youth (aged 10 to 19 years) and 16 percent of all deaths among Aboriginal people aged 20 to 44 years.²³
- Suicide rates of registered Indian youths (aged 15 to 24) are eight times higher than the national rate for females and five times higher than the national rate for males.²⁴
- In 2005, Nishnawbe Aski Nation territory witnessed 24 completed suicides—one of the highest rates in Canada.²⁵

²⁰Canadian Mental Health Association, Aboriginal/First Nations, online: http://www.ontario.cmha.ca/about_mental_health.asp?cID=23053 (accessed September 23, 2010) [CMHA]; See also, Jeff Reading, Centre for Aboriginal Health Research, *The Crisis of Chronic Disease among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy*, 2009, online: <http://www.cahr.uvic.ca/docs/ChronicDisease%20Final.pdf> (accessed November 20, 2009) at Chapter 7 and 8 [Reading].

²¹ See, the Aboriginal Healing Foundation, online: www.ahf.ca (accessed November 20, 2009).

²² Health Canada, (2002), [A Statistical Profile on the Health of First Nations in Canada](#), Ottawa: Health Canada (Stats 2002).

²³ Stats 2002, *ibid.*

²⁴ CMHA, *supra* note 20.

- In 2000–2001, approximately 13.2 percent of the Aboriginal population living off-reserve had experienced a major depressive episode in the past year. This is 1.8 times higher than the non-Aboriginal population.²⁶

Noted mental health expert, Lawrence Kirmayer reports that suicide does not have one single cause. However, he states that the most important factor is the mental health of the individual. Kirmayer observes that “many studies concur that the majority of people who die by suicide suffered from a psychiatric disorder that contributed to their death.”²⁷ The *Regional Longitudinal Health Survey* notes that both depression and drug and alcohol abuse are strongly correlated with both suicide and suicide attempts. “[I]ndividuals who had experienced feeling sad or depressed for at least two weeks in a row in the previous year were more than twice as likely as others to report suicidal ideation or a suicide attempt.”²⁸

3.4 Chronic Diseases

Among Aboriginal people, Health Canada reported in 2009 that chronic disease occurs in epidemic proportions:

- Type 2 diabetes is 3 to 5 times higher among First Nations people, and rates are increasing among the Inuit.
- Heart disease is 1.5 times higher.
- Tuberculosis infection rates are 8 to 10 times higher.²⁹

The following two sections deal specifically with these diseases.

²⁵ Catherine Cheechoo, Serene Spence and members of the Nishnawbe Aski Nation Decade Youth Council, Thunder Bay. (2006). “[The Seventh Generation Helping to Heal: Nishnawbe Aski Youth and the Suicide Epidemic](#)” Toronto: Voices for Children.

²⁶ Ottawa: Statistics Canada, “The Health of the Off-Reserve Aboriginal Population” (2002), Catalogue 82-003.

²⁷ Laurence J. Kirmayer, Gregory M. Brass & Tara Holton, “Suicide Among Aboriginal People in Canada” Aboriginal Healing Foundation, 2007, online: <http://www.ahf.ca/publications/research-series> (accessed September 23, 2010).

²⁸ RHS, *supra* note 4.

²⁹ Canada, Health Canada, First Nations Inuit and Aboriginal Health, Diseases and Health Conditions, online: <http://www.hc-sc.gc.ca/fnih-spnia/diseases-maladies/index-eng.php> (accessed November 20, 2009).

Diabetes (type 2) causes the body to become resistant to insulin for various reasons. Many of the complications that follow become separate but associated conditions. Diabetes affects blood vessels and nerves, which increases the risk for chronic eye, heart, blood vessel, nerve, and kidney disease. Insulin is a hormone that helps the body control the level of glucose in the blood. In Type 2 Diabetes, the pancreas does not produce enough insulin, or the body does not properly use the insulin it makes. The body needs insulin to turn glucose into cells that it uses for energy. Without the transport of glucose into cells, it cannot be used properly and so builds up in the blood instead. Excess glucose damages the body and, over time, can cause permanent damage.³⁰ Type 2 Diabetes develops in adulthood, although increasing numbers of children in high-risk populations are being diagnosed with type 2 diabetes as well. Aboriginal people are considered a high-risk population.³¹

Type 1 Diabetes affects ten percent of the people who have diabetes and is usually diagnosed in children and adolescents. Type 1 occurs when the pancreas is unable to produce insulin. Ninety percent of those who have diabetes have Type 2 Diabetes. Again, this means that the pancreas does not produce enough insulin or the body does not effectively use the insulin that is produced.³²

Compared to people without the disease, Canadians with diabetes are hospitalized at much higher rates. Diabetes patients are hospitalized:

- 23 times more often with lower limb amputation (2,657 diabetics were hospitalized for limb amputations in 2005–2006);
- 7 times more often with chronic kidney disease (26,120 diabetes were hospitalized with chronic kidney disease in 2005–2006); and
- 3 times more often with a stroke, heart attack, or hypertension (131,102 diabetics were hospitalized for stroke, heart attack, or hypertension in 2005–2006).³³

In addition:

³⁰ Canadian Diabetes Association, Type 2 diabetes, online: <http://www.diabetes.ca/about-diabetes/living/just-diagnosed/type2/> (accessed November 20, 2009) [CDA].

³¹ CDA, *ibid.*

³² CDA, *ibid.*

³³ Canada, Health Canada, National Diabetes Surveillance System: Diabetes in Canada, 2008, Public Health Agency of Canada [Surveillance].

- 10 to 20 per cent of people with diabetes die of kidney failure; and
- First Nations people end up in hospital with complications from diabetes at seven times the rate seen in the general Canadian population with diabetes.³⁴

Only in the past 50 years has Type 2 Diabetes been detected in Aboriginal populations in Canada.³⁵ The steady increase of Type 2 Diabetes in Aboriginal communities is the root cause of serious health complications. These affect the circulatory system, eyes, kidneys, periodontal and nervous systems. These complications can result in premature death, disability, and a compromised quality of life.³⁶ A recent study showed that among the Métis, diabetes is not uniformly distributed across the population. It more frequently affects women, the elderly, the obese, and the less educated. The disease has a serious negative impact on quality of life and is associated with premature death.³⁷

Clearly, Aboriginal people face an epidemic of Type 2 Diabetes.³⁸ The prevalence of diabetes among the Métis is comparable to the rates in First Nations in most age and sex groups.³⁹ In Canada, the rate of diabetes among Aboriginal people is 3 to 5 times higher than in the general population.⁴⁰ They also suffer high rates of complications and a younger average age of onset.⁴¹

Type 2 Diabetes among the Aboriginal population occurs for a multitude of reasons. Sources include genetic factors—Aboriginal ancestry and family history—coupled with

³⁴ Surveillance, *ibid.*

³⁵ Health Canada (2000b), *Diabetes among Aboriginal People in Canada The evidence*, online: http://www.hc-sc.gc.ca/fnih-spni/pubs/diabete/2001_evidence_faits/index_e.html (accessed November 20, 2009).

³⁶ *Ibid.*

³⁷ Sharon G. Bruce, Erich V. Kliewer, T. Kue Young et al, “Diabetes Among the Métis of Canada: Defining the Population, Estimating the Disease” *Canadian Journal of Diabetes*, 2003; 27(4):442-448 [Bruce].

³⁸ T.K. Young, J. Reading, B. Elias et al. “Type 2 diabetes mellitus in Canada’s First Nations: status of an epidemic in progress,” *CMAJ*. 2000; 163:561-566.

³⁹ Bruce, *supra* note 37.

⁴⁰ E. Bobet, *Diabetes Among First Nations People: Information From the Statistics Canada 1991 Aboriginal Peoples Survey*, Ottawa, ON: Minister of Public Works and Government Services Canada: 1998. Publication H34-88/1998E; *First Nations and Inuit Regional Health Survey: National Report 1999*, St. Regis, QC: First Nations and Inuit Regional Health Survey National Steering Committee: 1999; S.B. Harris, J. Gittelsohn, A. Hanley, et al. “The prevalence of NIDDM and associated risk factors in Native Canadians”, *Diabetes Care*, 1997; 20:185-187.

⁴¹ H.J. Dean, R.L. Mundy, M. Moffatt, “Non-insulin-dependent diabetes mellitus in Indian children in Manitoba,” *CMAJ*. 1992;147:52-57; S.B. Harris, B.A. Perkins, E. Whalen-Brough, “Non-insulindependent diabetes mellitus among First Nations children: New entity among First Nations people of northwestern Ontario,” *Can Fam Physician*. 1996; 42: 869-876.

detrimental lifestyles.⁴² Diabetes correlates with the harsh socio-cultural changes that Aboriginal peoples have experienced.⁴³ It also reflects harsh social conditions, such as poverty, lack of education, stress, and depression, all of which can lead to obesity (a predisposing factor for diabetes and heart disease). Under these circumstances, the genetic susceptibility for diabetes interacts with the environmental stressors of changing nutrition and a sedentary lifestyle. These, in turn, lead to increased chances of obesity and related chronic conditions.⁴⁴

In James Bay, Dr. Murray Trusler says that “amputations are so common that one in 500 people in the area have lost a limb, most because of life-threatening foot and leg lesions associated with diabetes ... many more have lost toes.”⁴⁵ In Saskatchewan, a 1999 study on 601 adults from the Battleford Tribal Council reserves found twenty-two percent had diabetes, and many exhibited signs of kidney disease. Over 60 percent smoked, and 73 percent were obese.⁴⁶

3.5 Cardiovascular Disease

Cardiovascular disease (CVD) is the leading cause of death in most Western countries.⁴⁷ CVD refers to a general class of diseases that involve the heart and/or circulatory system. The most common type of CVD is ischemic heart disease (IHD), also referred to as coronary heart disease or coronary artery disease. Fatty deposits accumulate in the cells along the walls of the coronary arteries (which provide the heart’s main blood supply), until

⁴² P. Zimmet, “The pathogenesis and prevention of diabetes in adults. Genes, autoimmunity, and demography.” *Diabetes Care*, 1995;18:1050-1064; J.V. Neel, A.B. Weder, S. Julius, “Type II diabetes, essential hypertension, and obesity as “syndromes of impaired genetic homeostasis”: the “thrifty genotype” hypothesis enters the 21st century.” *Perspect Biol Med*. 1998; 42:44-74.

⁴³ T.K. Young, *The Health of Native Americans: Toward a Biocultural Epidemiology*, New York, NY: Oxford University Press, 1994; M. Daniel, K. O’Dea, K.G. Rowley, et al. “Social environmental stress in indigenous populations: potential biopsychosocial mechanisms,” *Ann NY Acad Sci*. 1999, 896:420-423.

⁴⁴ Ann C. Macaulay et al, “Primary Prevention of Type 2 Diabetes: Experiences of 2 Aboriginal Communities in Canada, online: <http://www.diabetes.ca/Files/T2DMPreventionMacaulayDec03.pdf> (accessed November 20, 2009).

⁴⁵ Margaret Munro, Ottawa Citizen October 19, 2009 “Another Doctor fighting the aboriginal diabetes dilemma,” online: http://www.ottawacitizen.com/story_print.html?id=2108497&sponsor= (accessed November 20, 2009).

⁴⁶ Margaret Munro, Ottawa Citizen October 14, 2009 “Confronting diabetes head-on on Saskatchewan reserves,” online: http://www.ottawacitizen.com/story_print.html?id=2082607&sponsor (accessed November 20, 2009).

⁴⁷ T. Dorner & A. Rieder, (2004), “Risk management of coronary heart disease-prevention,” *Wien Med Wochenschr*, 154(11-12), 257.

the arteries become clogged and narrow from atherosclerosis. Ischemia (decreased blood supply to the heart) will develop and may cause permanent heart damage.⁴⁸

In a recent study, 301 Aboriginal people were randomly recruited from the Six Nations Reserve and 326 people of European origin were recruited from Hamilton, Toronto, and Edmonton. The presence and degree of CVD was determined by personal and family history and/or by electrocardiographic tests. Atherosclerosis (build up of waxy deposits called plaque) was measured by ultrasound. The study found that Aboriginal people had significantly higher levels of atherosclerosis and higher frequencies of CVD compared with Europeans. They also had significantly higher rates of smoking, glucose intolerance, and obesity. Significantly, Aboriginal people also had higher rates of unemployment and a lower annual household income. The study held conclusively that a significant proportion of Aboriginal people live in poverty, which is directly linked with higher rates of cardiovascular disease.⁴⁹ (The many health determinants that Aboriginal people face such as poverty have been noted in chapter 2 – the resulting diseases and conditions are the subject of this chapter.)

Not only is cardiovascular disease a major health problem in Canada, but also Aboriginal peoples carry the greatest burden of illness and death from this disease. These statistics and other estimates on the prevalence of CVD and the factors that heighten risk are important for monitoring the health of Aboriginal people.

3.6 Tuberculosis

Tuberculosis (TB, historically called “consumption”) is a serious disease that usually attacks the lungs. It also affects other parts of the body, including the lymph nodes, kidneys, urinary tract, and bones. TB kills almost two million people worldwide every year. In Canada, 1,600 new cases of TB are reported every year.⁵⁰ The tuberculosis bacteria are spread through the air when someone with active TB disease of the lungs exhales, coughs,

⁴⁸ Reading, *supra* note 20.

⁴⁹ S.Anand, S.Yusuf, R.Jacobs, et al, “Risk factors, atherosclerosis, and cardiovascular disease among Aboriginal people in Canada: the Study of Health Assessment and Risk Evaluation in Aboriginal Peoples,” *The Lancet*, Volume 358, Issue 9288, 1147-1153.

⁵⁰ Canada, Health Canada, “It’s your health: tuberculosis,” 2009, online: <http://www.hc-sc.gc.ca/hl-vs/iyh-vs/diseases-maladies/tubercu-eng.php#is> (accessed November 20, 2009).

sneezes etc.⁵¹ TB infection and resulting deaths are most common in developing nations, where poverty is high with little access to health care, and where inadequate living conditions persist.⁵² For many of the same reasons, Aboriginal people are severely affected by TB. Overcrowded living conditions increase the contact rate between individuals as well as the transmission of the disease. Health Canada notes:

The overall Canadian population has a housing density of 0.4 persons per room (0.4 ppr). The corresponding statistic for First Nations people living on reserve is 0.7 ppr. First Nations communities with higher average housing densities have higher TB rates (Figure 5). The ten communities with the highest number of reported TB cases between 1997 and 2000 all had housing densities of 0.8 or more, and eight of them had 1.0 ppr or more. Eight of these communities were also located in remote areas, with no road access.⁵³

For the Inuit, inadequate and overcrowded housing leads to high rates of respiratory illnesses as well as violence (from stressors resulting from chronic overcrowding). In 2004, the National Aboriginal Health Organization noted that tuberculosis rates in Inuit communities are 70 times the Canadian average.⁵⁴ The Inuit Tapiriit Kanatami reports that between 2002 and 2006, the tuberculosis rate among Inuit was 90 times higher than the rate of others born in Canada.⁵⁵

3.7 HIV/AIDS and Hepatitis C

TB is the leading cause of death in HIV/AIDS-infected individuals.⁵⁶ HIV/AIDS is a serious and increasing concern within the Aboriginal population.⁵⁷ HIV (Human Immunodeficiency Virus) attacks the human immune system, making it difficult to fight

⁵¹ *Ibid.*

⁵² WHO, Tuberculosis Retrieved August, 2005, online: <http://www.who.int/tb/en/> (accessed November 20, 2009).

⁵³ Canada, Health Canada, First Nations Inuit and Aboriginal Health: Tuberculosis 2009, online: <http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/tuberculos/index-eng.php> (accessed November 20, 2009). See also, Global TV, *Tuberculosis explodes on northern reserves*, Manitoba community has higher rate of infection than Bangladesh, online: <http://news.globaltv.com/health/Tuberculosis+explodes+northern+reserves/2173419/story.html> (accessed November 20, 2009).

⁵⁴ National Aboriginal Health organization, Inuit Tutturvingat, Factors Affecting Inuit Health, 2004, online: <http://www.naho.ca/inuit/e/healthfactors/#references> (accessed November 20, 2009).

⁵⁵ Inuit Tapiriit Kanatami, Mary Simon blog, 2009 online: <http://www.itk.ca/blog/mary-simon/oct-06-2009-inuit-infant-mortality-rates> (accessed November 20, 2009).

⁵⁶ J. Grange, A. Story, & A. Zumla, (2001), "Tuberculosis in disadvantaged Groups" *Current Opinion in Pulmonary Medicine*, 7(3), 160.

⁵⁷ RHS, *supra* note 20.

colds, flu, or more serious illnesses. When a person gets sicker with different diseases due to HIV, it then becomes AIDS (Acquired Immune Deficiency Syndrome). The Canadian Aboriginal Aids Network identifies how HIV/AIDS is spread:

- Unprotected anal or vaginal sex (less but still some risk for oral sex);
- Sharing injection drug needles, particularly when not properly cleaned with a bleach and water mixture;
- Sharing other substance use equipment (e.g, snorting, etc.); and
- HIV positive mother-to-child at birth or during breast feeding⁵⁸

The Public Health Agency of Canada reported on statistics⁵⁹ on Aboriginal people and HIV/AIDS:

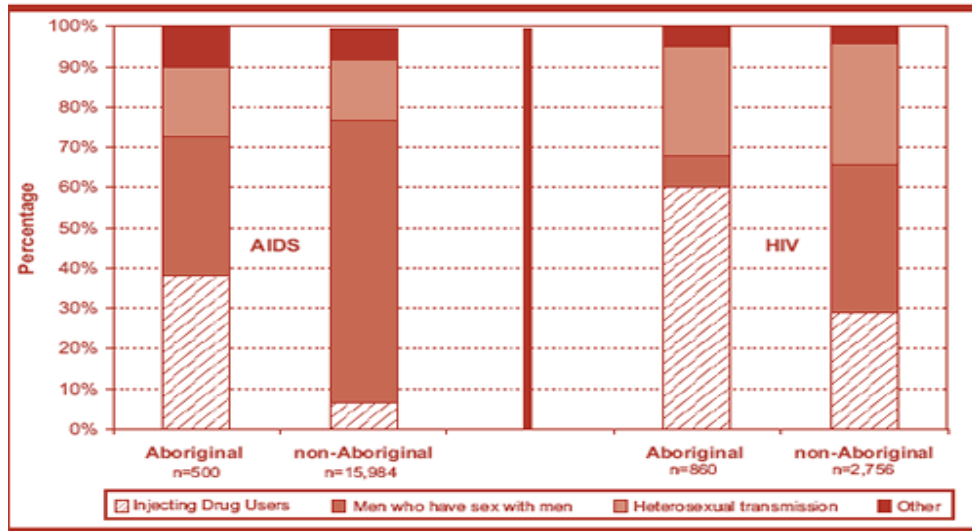
- Aboriginal peoples represent 23.4% of the positive HIV test reports that included information on ethnicity.
- In 1998, 18.8% of the positive HIV test reports were among Aboriginal peoples. This increased to 25.3% in 2003.
- During 1998–2003, females represented 44.6% of positive test reports among Aboriginal peoples.
- From 1998–2003, youth (<30 years) made up 31.4% of positive HIV test reports among Aboriginal peoples.
- Before 1993, 1.2% of reported AIDS cases were among Aboriginal peoples; this increased to 13.4% in 2003.
- Before 1993, females represented 11.9% of the reported AIDS cases among Aboriginal peoples. In 2003, this percentage increased to 44.0%.
- Before 1993, 40.6% of Aboriginal AIDS cases were among youth (<30 years).
- From 1999–2003, youth represented 13.0% of Aboriginal AIDS cases.⁶⁰

⁵⁸ Canadian Aboriginal Aids Network, “About HIV Aids” 2006, online: http://www.caan.ca/youth/html/basic_info_e.html (accessed November 20, 2009).

⁵⁹ Canada, Public Health Agency of Canada, “Understanding the HIV/AIDS Epidemic among Aboriginal Peoples in Canada: The Community at a Glance” 2005, online: <http://www.phac-aspc.gc.ca/publicat/epiu-aepi/epi-note/index-eng.php> (accessed November 20, 2009).

⁶⁰ *Ibid.*

Figure 1 Reported AIDS cases and positive HIV test reports by exposure category: A comparison of Aboriginal and non-Aboriginal peoples:*



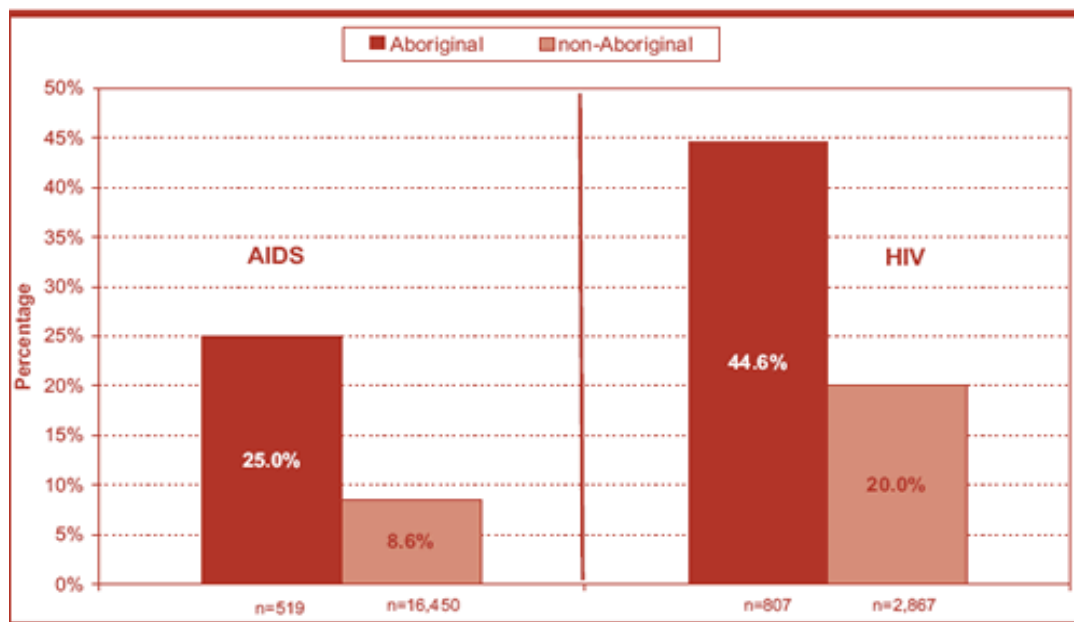
*For reported AIDS cases, includes data from 1979 to December 31, 2003. For positive HIV test reports, includes data from 1998 to December 31, 2003 and from provinces/territories with reported ethnicity (BC, YT, AB, NT, NU, SK, MB, NB, NS, PEI, NL).

Figure 1 indicates notable differences between Aboriginal and non-Aboriginal peoples in the category of exposure for both reported AIDS cases and positive HIV test reports.⁶¹

Compared with non-Aboriginal women, Aboriginal women are clearly more affected by HIV/AIDS:

⁶¹ *Ibid* at 2.

Figure 2 Reported AIDS cases and positive HIV test reports by percentage of females:



*For reported AIDS cases, including data from 1979 to December 31, 2003. For positive HIV test reports, including data from 1998 to December 31, 2003 and from provinces/territories with reported ethnicity (BC, YT, AB, NT, NU, SK, MB, NB, NS, PEI, NL).⁶²

Pauktutit, the Inuit Women's Organization, reports:

- HIV and hepatitis C are present in Arctic communities and pose a real threat to Inuit health.
- The most common route of HIV infection for Inuit is through unprotected heterosexual sex.
- High rates of pregnancy as well as sexually transmitted infections (STIs), such as Chlamydia and Gonorrhoea, are evidence that Inuit are engaging in behaviour that puts them at risk for HIV infection.
- Increased travel between Arctic communities and urban centres increases the chance of HIV and hepatitis C being introduced to a Northern community.

⁶² *Ibid* at 3.

- Inuit youth often leave home communities to pursue education in a southern city, which increases their risk of coming into contact with HIV or hepatitis C.
- Inuit inmates in federal prisons live in a high-risk environment for HIV and hepatitis C infection and may bring either or both diseases back to their home communities upon release from prison.
- Inuit living with either HIV and/or hepatitis C in urban centres may decide to return to their home communities as their diseases progress, which requires community members and health staff to have basic understanding of precautions and treatment.⁶³

In 2010, Correction Service of Canada reported that the HIV prevalence rate in federal prisons “rivals those of many countries in sub-Saharan Africa and is greater than the HIV prevalence rates in all other regions of the world.”

At 4.6 percent, the rate of HIV infection in federal prisons is 15 times greater than that in the community as a whole. As for hepatitis C in federal prisons, the 31 percent rate of infection is 39 times greater than the population as a whole. In both cases, incarcerated women and especially Aboriginal women — of whom 11.7 percent are infected with HIV—are disproportionately infected with HIV and hepatitis C.⁶⁴

Hepatitis C

Hepatitis C is a chronic liver disease caused by the hepatitis C virus (HCV). Health Canada estimates that 250,000 people in Canada are infected with HCV.⁶⁵ HCV in Aboriginal Peoples is 7–9 times higher than in non-Aboriginal Canadians.⁶⁶ Dr. Gilles Pinette reports on the sources of contracting HCV for Aboriginal people:

- Tainted blood from:
 - Transfusions;
 - Injections – tainted drugs or equipment;
 - Tattoos, piercing, acupuncture;

⁶³ Pauktutit, Sexual Health, HIV, AIDS Hep C, 2006, online: <http://www.pauktuutit.ca/hiv/hiv/#hivpopulation> (accessed November 20, 2009).

⁶⁴ Canadian HIV/AIDS Network, News Release, HIV and Hepatitis C Crisis in Federal Prisons, According to New CSC Report, April 21 2010, online: <http://www.aidslaw.ca/publications/interfaces/downloadDocumentFile.php?ref=1036> (accessed April 22, 2010).

⁶⁵ Canada, Health Canada, Hepatitis C 2009, online: <http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/diseases-maladies/hepc-eng.php> (accessed November 20, 2009).

⁶⁶ *Ibid.*

- Sex with HCV Carrier;
- Snorting drugs – tainted drugs or equipment;
- Health care worker, tainted medical equipment;
- Sharing personal hygiene items;
- Higher risk in prison, since 40% use drugs while in prison.
- 4–23% inject drugs while in prison.
- People return to their communities and can spread the HCV.⁶⁷

Dr. Pinette also reports that Aboriginal people acquire Hepatitis C mostly through injection drug use. Unknown sources stand at 17%, other sources are at 12 percent, while sources from health care workers and tainted equipment sources stand at 4 and 2 percent respectively.⁶⁸

3.8 Summary

Extreme health disparities exist in Canada between Aboriginal people and the rest of the population. This chapter focused specifically on the current health of Aboriginal people in Canada. Chapters 2 identified important health determinants and explored how they contribute to the disparities in Aboriginal health. Arguably, the simplest way to address the inequities in Aboriginal health may be to reduce the inequities in the health determinants—the social inequities. This strategy could catalyze any number of opportunities for improving the grim health outcomes that Aboriginal people face today. While the health determinants explored in chapter 2 are important, further research into the laws and policies, the historical health influences such as the epidemics that Aboriginal people faced and the historical nutritional factors will provide a more complete picture of Aboriginal health. These will be explored in the following chapters.

The following chapters will focus on how to reduce the social inequities for Aboriginal people. Rather than focusing on the disparities in health alone, this systemic approach holds the promise of leading to permanent positive change. The health determinants listed in chapter 2 contribute directly to a large array of diseases. Meeting them head on, instead of finding ways to treat the sicknesses they produce, will surely have a more long-term, positive effect on

⁶⁷ Dr. Gilles Pinette, Hep C, “The Writing is on the Wall,” 2005, online: www.allnationshope.ca/Presentations/Aborig%20HCV%202005.ppt (accessed November 20, 2009).

⁶⁸ Pinette, *ibid.*

Aboriginal health. Chapter 4 will examine some of the historical health practices of Aboriginal people.

4. Aboriginal Society and Good Health

4.1 Aboriginal Women: Balance of Healing

Traditionally, in early society Aboriginal women commanded the highest respect in their communities. They were the givers of life and the keepers of the traditions, practices, and customs of their nation. It was well understood by all - that women held a sacred status, since they brought new life into the world. Women also made integral decisions about health, family, property rights, and education.¹ The *Report of the Royal Commission on Aboriginal Peoples* acknowledges women's roles:

She did not have to compete with her partner in the running of the home and the caring of the family. She had her specific responsibilities to creation, which were different, but certainly no less important, than his. In fact, if anything, with the gifts given her, woman was perhaps more important ...²

Underlying principles of gender balance streamed through early Aboriginal society.³ However, Aboriginal understandings of balance are different from Eurocentric, feminist, or western legal-tradition understandings, which usually interpret balance as "equality." Aboriginal law is not ordered around Eurocentric values or perceptions of "balance" or "equality." For Aboriginal women, balance is about respecting the laws and relationships that Aboriginal women have as part of Aboriginal law and the ecological order of the universe. Professor Patricia Monture-Angus notes:

¹ Canada, Indian and Northern Affairs, "Aboriginal Women: Meeting the Challenges," online: Indian and Northern Affairs <http://www.ainc-inac.gc.ca/ai/ss/pubs/wnm/wnm-eng.asp> (accessed September 2, 2010).

² Canada, Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples: Gathering Strength* (Ottawa: Supply and Services Canada, 1996), Vol. 4, "Historical Position and Role of Aboriginal Women: A Brief Overview," quoting Osennotion (Marlyn Kane) [RCAP].

³ Many First Nations were primarily matriarchal societies:

Prior to European colonization efforts, many First Nation societies were matriarchal in nature. Missionaries and other Church officials discouraged matriarchal aspects of First Nation societies and encouraged the adoption of European norms of male dominance and control of women. According to the customary law of the Mohawk nation for example, the matrimonial home and the things in it belong to the wife and women traditionally have exercised prominent roles in decision-making within the community. (Martha Montour, "Iroquois Women's Rights with respect to matrimonial property on Indian Reserves" [1987] 4 Canadian Native Law Reporter 1; See also, Robert A. Williams, "Gendered Checks and Balances: Understanding the Legacy of White Patriarchy in an American Indian Cultural Context" (1990) 4 Ga. L. Rev. 1019).

... Aboriginal culture teaches connection and not separation. Our nations do not separate men from women, although we recognize that each has its own unique roles and responsibilities. *The teachings of creation require that only together will the two sexes provide a complete philosophical and spiritual balance. We are nations and that requires the equality of the sexes.*⁴ (emphasis in original)

As a well-documented example, the Iroquoian culture is based upon the principles of balance and equilibrium, and gender is considered only one component of a larger balance:

[E]quilibrium was the animating purpose behind “gendering,” or the interaction between male and female energies that dictated the separation of social functions by gender ... [T]he sexes functioned as cooperative halves. At once independent yet interdependent, they worked to create the perfect whole of society. In all the spheres – the social and the religious, the political and the economic – women did women’s half and men did men’s half, but it was only when the equal halves combined that community cohered into the functional whole of a healthy society.⁵

Unlike the European culture that was imposed through colonization, Iroquoian culture did not center on conflict or subordination. Each gender had a role, and each gender was superior in their own spheres of responsibility. Both gender roles were viewed as equal and necessary for the health and survival of the community.⁶ Author Barbara Mann explains the importance of women (also known as *gantowisas*) in Iroquoian society:

The *gantowisas* enjoyed sweeping political powers, which ranged from the administrative and legislative to the judicial. The *gantowisas* ran the local clan councils. They held all the lineage wampum, nomination belts and titles. They ran funerals. They retained exclusive rights over naming ... They nominated all male sachems as well as all Clan Mothers to office and retained the power to impeach wrongdoers. They appointed warriors, declared war, negotiated peace and mediated disputes.⁷

⁴ Patricia Monture-Angus, “The Lived Experience of Discrimination: Aboriginal Women Who are Federally Sentenced & The Law: Duties and Rights,” (*Submission of the Canadian Association of Elizabeth Fry Societies (CAEFS) to the Canadian Human Rights Commission for the Special Report on the Discrimination on the Basis of Sex, Race and Disability Faced by Federally Sentenced Women*, (2002), online: <http://www.elizabethfry.ca/submissn/aborigin/4.htm> at 6 (accessed January 14, 2010).

⁵ Barbara A. Mann, *Iroquoian Women: The Gantowisas* (New York: Peter Lang 2000) at 60 [Mann].

⁶ M. Annette Jaimes & Theresa Halsey, “American Indian Women: At the Centre of Indigenous Resistance in Contemporary North America” in M. Annette Jaimes, ed., *The State of Native America: Genocide, Colonialization, and Resistance* (Boston: South End Press, 1992) at 311- 344.

⁷ Mann, *supra* note 5 at 117.

The women controlled the economy by distributing the bounty. They also ruled the social sphere through certain social practices. For example, inheritance flowed through the female line. Women headed the households. Women could have pre-marital and extra-marital sexual relations. Women controlled fertility. Women allowed permissive child rearing and managed adoptions. Women could have trial marriages, mother-dictated marriages, and divorce on demand. Women also had custody of children upon divorce and in cases of polyandry.⁸

The Report of the *Royal Commission on Aboriginal Peoples* reported on the traditional gender roles:

[A]ccording to traditional teachings, the lodge is divided equally between women and men, and that every member has equal if different rights and responsibilities within the lodge ... The lodge governed our relationship with each other, with other nations, and with the Creator and all of Creation.⁹

In Inuit society,

[T]here is agreement that women were traditionally responsible for decisions about children, food preparation and the running of the camp. While clear divisions of labour along gender lines existed, women's and men's work was equally valued. If a woman was a sloppy sewer, her husband might freeze; a man who was a poor hunter would have a hungry family. Everyone in the camp worked hard and everyone had a specific role based on their age, gender and capabilities.¹⁰

Métis scholar, Leah Dorian comments on Métis society as being “matrilineal and matriarchal, which resulted in the high status of women.”¹¹ These women held “social and political power that was unseen in the lives of contemporary European and Euro-Canadian women.”¹²

⁸ *Ibid*, at 241.

⁹ RCAP, *supra* note 4, quoting Marilyn Fontaine.

¹⁰ *Ibid*, quoting Martha Flaherty.

¹¹ Leah Dorian, “Emerging Voices of Métis Women,” *The Virtual Museum of Métis History and Culture*, online: Gabriel Dumont Institute <http://www.metismuseum.ca/resource.php/01269> (accessed January 14, 2010).

¹² *Ibid*. See also, Sharon Blady, “Les Métissess: Towards a Feminist History of Red River” in Jill Oakes and Rick Riewe, eds., *Issues in the North*, vol. II, Occasional Publication # 41 (Calgary: Canadian Circumpolar Institute and the Department of Native Studies, University of Manitoba, 1997) at 179–86. See also, Jennifer S. H. Brown, *Strangers in the Blood: Fur Trade Company Officials in Indian Country* (Vancouver: University of British Columbia Press, 1980); Sylvia Van Kirk, *Many Tender Ties: Women in Fur-Trade Society in Western Canada* (Winnipeg: Watson and Dwyer, 1980); Diane Payment, ““La vie en rose”? Métis Women at Batoche 1870–1920” in Christine Miller and Patricia Chuchryk, eds., *Women of the First Nations* (Winnipeg: University of Manitoba Press, 1997) at 19–32; Jacqueline Peterson, “Prelude to Red River: A Social Portrait of the Great Lakes Métis” (1978) 25:1 *Ethnohistory* at 41–67; Maria Campbell, *Halfbreed* (Toronto: McClelland and Stewart, 1973).

The common thread running through all groups of Aboriginal society was the importance of maintaining the balance of gender in order to maintain good health. Equality of gender roles and gender balance were foremost. Men could not survive the harsh conditions without women, and women could not survive without their male counterparts. Professor Emma LaRocque notes:

Prior to colonization, Aboriginal women enjoyed comparative honour, equality and even political power in a way European woman did not at the same time in history. We can trace the diminishing status of Aboriginal women with the progression of colonialism. Many, if not the majority, of Aboriginal cultures were originally matriarchal or semi-matriarchal. European patriarchy was initially imposed upon Aboriginal societies in Canada through the fur trade, missionary Christianity and government policies.¹³

It is interesting to note that many Aboriginal languages, such as the language spoken by the Algonquins, do not distinguish between gender in pronouns, “he” and “she” are not specified. The M’ikmaq language has no gender distinction in its third-person singular either.¹⁴

O’Neil and Postl observe that, “by living balanced lives according to the principles of their respective traditions, Aboriginal people largely avoided sickness.”¹⁵ In addition to gender balancing, some individuals had special ceremonial or supernatural abilities, and others had specialized knowledge of medicinal plants. “[A]ll members of the community shared the responsibility to live balanced lives and all had some knowledge of traditional medicines.”¹⁶

Many scholars suggest that all Aboriginal traditions were marked by equality between men and women. Patriarchy and male dominance were introduced through the European missionaries¹⁷

¹³ Emma D. LaRocque, *Violence in Aboriginal Communities* (Ottawa: National Clearinghouse on Family Violence, Health Canada, 1994) at 73.

¹⁴ Ruth Holmes Whitehead, *The Old Man Told Us: Excerpts from Micmac History, 1500-1950* (Halifax: Nimbus Publishing, 1991) at 250 [Whitehead].

¹⁵ John D. O’Neil and Brian D. Postl, “Community Healing and Aboriginal Self-Government: Is the Circle Closing?” in John H. Hylton ed., *Aboriginal Self-Government in Canada: Current Trends and Issues* (Saskatoon: Purich Publishing, 1994) at 69 [O’Neil, Postl].

¹⁶ O’Neil, Postl, *ibid.*

¹⁷ Lilianne Ernisetine Krosenbrink-Gelissen, *Sexual Equality as an Aboriginal Right: the Native Women’s Association of Canada and the Constitutional Process on Aboriginal Matters 1982–1987* (Saarbrücken: Verlag breitenbach Publishers, 1991).

and then institutionalized through the *Indian Act*.¹⁸ The pre-contact Aboriginal balance of genders was critical to maintaining healthy Aboriginal communities.

4.1.1 Women as Healers

The many types of Aboriginal healers across North America included men as well as women:

In some tribes, a woman—usually the wife of a medicine man—learned secrets in healing natural illness with herbs by assisting the medicine man. In other tribal communities women learned the art of doctoring with herbs from their mothers and grandmothers. In general, if a woman inherited the right to become a medicine woman, her powers still had to be validated by a dream in which a spirit, in the form of a human, an animal, or perhaps just a voice, gave her personal knowledge.

...

Like her male counterpart, a medicine woman was considered by early Plains Indians to have a special connection to the spirit world and that link is what empowered her to heal.

...

In some tribes, women who acquired supernatural abilities became shamans. Shamans were believed to possess the power to influence the good and evil beings in the spirit world. A woman who wished to become a shaman usually sought training from an established shaman in her community. If the old shaman chose her as successor, the younger woman took over the shaman's position when she passed away. The new shaman used the songs and the formulas she inherited, as well as her own creations, to cure disease, predict the future or control the weather. Plains Indian women gained respect and prestige by practicing medicine in their communities. The realm of medicine women in the culture of early Plains Indians was probably one of the women's most powerful roles.¹⁹

Interestingly, the function of clan mothers in Iroquois culture and political systems (as important as it is to Iroquois society) was not mentioned within the *Jesuit Relations*,²⁰ which recorded the interaction between missionaries and the Iroquois in the 1600s. Neither was it mentioned in the journals of any of the other early historians of New France, such as La

¹⁸ Donna Greschner, "Aboriginal women, the constitution and criminal justice" (1992) U.B.C.L. Rev. (Special Edition) 338–59; See also, P.A. Monture-Okanee & M.E. Turpel, "Aboriginal peoples and Canadian criminal law: Rethinking justice" (1992) U.B.C.L. Rev. (Special Edition) 239-77.

¹⁹ American Indian Culture Research Center, "Women's Issues: Medicine Women," 2002, online: <http://www.bluecloud.org/medicine.html> (accessed January 14, 2010).

²⁰ Reuben Thwaites ed., *The Jesuit Relations and Allied Documents*, 1959 72 volumes, (New York: Pageant Book Co, 1959).

Potherie²¹ or Charlevoix.²² Either they were unaware of the role of clan mothers, or it was not of importance to them. Yet, few would argue that Iroquois society could have flourished as effectively without clan mothers.²³

While First Nations, Métis, and Inuit people had important ceremonies and rituals around childbirth, the women mostly assisted other women in having babies. Many may have turned to medicine men (and medicine women) for help as well. The women and midwives who were experienced with childbirth passed on the knowledge needed to ensure a safe birth. The historical evidence shows that pre-contact Aboriginal societies designated midwives formally as well as informally. The Nuu-chah-nulth people translated their word for “midwife” as “she can do everything.” The Coast Salish translated “midwife” as “to watch, to care,” and the Chilcotin people translated the word as the “women’s helper.”²⁴

Inuit families often accompanied women throughout the birth process in a separate snow house.²⁵ “No one was sheltered from birthing knowledge. Children and young adults gained experience from watching, and men often assisted their wives.”²⁶ Inuit women gave birth “in either a squatting or kneeling position with the midwife behind them, [and the] midwife would often enlist the help of the pregnant woman’s husband and female relatives, thus involving the whole family in the process of childbirth.”²⁷ In 1823, a government expedition to the Lake of the Woods observed that, among the Dakotas, “there are professed midwives but the women are sometimes delivered by their husbands, brothers, sisters [sic]; the medicine man is generally

²¹E. B. O’Callaghan ed., *1853-188. Documents Relative to the Colonial History of New York, 1853-1887*, vols. 9 and 10 (Albany: Weed Parsons).

²²P.F.X. Charlevoix, *History and General Description of New France*, ed. by John G. Shea (New York: Francis P. Harper, 1900).

²³See for example, Elizabeth Tooker, “The League of the Iroquois: Its History, Politics and Ritual” in Bruce Trigger ed., *Handbook of North American Indians*, vol. 15 (Washington: Smithsonian Institute, 1978).

²⁴Dena Carroll and Cecilia Benoit “Aboriginal Midwifery in Canada: Blending Traditional and Modern Forms” (2000) 4 *Canadian Women’s Health Network Magazine* 3, s.n. based on the Chapter “Aboriginal Midwifery in Canada: Ancient Traditions/ Emerging Forms” in *Reconceiving Midwifery: New Canadian Model of Care*, University of Michigan Press (2001).

²⁵Gillian Morantz-Ornstein, Louis-Patrick Haraoui, “Emerging Patterns In The Resistance To The Medicalization Of Birth In North America,” *McGill Journal of Medicine*, Volume 7, Number 1, 2003, online: <http://www.medicine.mcgill.ca/mjm/issues/v07n01/commentaries/commentaries.htm#comment3> (accessed September 2, 2010) [Ornstein].

²⁶Pauktuutit Inuit Women’s Association, “Special Report on Traditional Midwifery,” (1995) 10 *Suvaguug* 8.

²⁷Morantz - Ornstein, *supra* note 25.

present but never operates, his only business is to sing, and to assist by his prayers and incantations. They never bleed during labour.”²⁸

The same government expedition reported that the Potawatomi had “professed midwives, who are paid for their attendance; these are principally old women. Men are never allowed to assist at the delivery of a woman.”²⁹ Childbirth was seldom fatal, but when it was, “it is attributed to ignorance or carelessness on the part of the midwife.”³⁰ In 1866, it was reported that midwifery was never practiced by Ojibway medicine men but was “left entirely to the female [Ojibway] doctors. It was said that among the “Outchipwais,” (Ojibway) that some women held “great reputations as doctors.”³¹

In the 1600s, the “Gaspesian” or Acadian Indian (M’ikmaq) women in labour called on medicine men and medicine women. Isabel Dodo was an “Indian doctress” who lived near Halifax³² and was a well-known “Indian doctor woman.” Isobel was so well-known that the Chain Lakes near Halifax were called “Isobel’s Lakes” by the M’ikmaq.³³ M’ikmaq women had specific positioning and places for delivery—in the woods at the foot of a tree, where, “[i]f she suffers pains, her arms are attached above to some pole, her nose, ears and mouth being stopped up. After this, she is pressed strongly on the sides ... If she feels it a little too severely, she calls in the jugglers, who come with joy, in order to extort some smoking tobacco... .”³⁴ “Jugglers” was a term used by Europeans to describe medicine men, demonstrating that men were also sometimes involved in the birthing rituals. As author James A. Jones wrote in 1830, the “chief of the village was commonly invested with this dignity. The ceremonies and

²⁸ James Edward Colhoun, William H. Keating and Stephen Harriman Long, *Narrative of an expedition to the source of St. Peter’s River, Lake Winnepeek, Lake of the Woods, &c. &c.: performed in the year 1823 by order of the Hon. J.C. Calhoun, secretary of war, under the command of Stephen H. Long, major U.S. T.E.* (Philadelphia: H.C. Carey and I. Lea, 1824) at 417 [Colhoun].

²⁹ Colhoun, *ibid* at 131.

³⁰ Colhoun, *ibid* at 132.

³¹ The author makes a reference to Indians but is apparently referring to Cree or “Outchipwai”, referring to Ojibway, Robert Bell, “The ‘medicine-man’ or, Indian and Eskimo notions of medicine: a paper read before the Bathurst and Rideau Medical Association, 20th January 1886, (Montreal 1886) at 1-2 [Bell].

³² Oral history of Jeremiah Bartlett Alexis (Jerry Lonecloud), himself an Indian doctor, to Harry Piers, 22 July 1927, cited in Whitehead, *supra* note 14 at 275.

³³ Whitehead, *ibid*.

³⁴ Christien Le Clercq, *New relation of Gaspesia, with the customs and religion of the Gaspesian Indians* (Toronto: Champlain Society, 1910) at 90.

practices observed by the Acadian jugglers being common to the ‘profession’ throughout the Indian nations.”³⁵

Midwifery practices among the British Columbia tribes were highly developed. Before contact with Europeans, midwives were held in high regard among their people. The midwife was trained through a long apprenticeship and was knowledgeable about birth as well as cultural traditions associated with birth.³⁶ Many of the early visitors to British Columbia commented on the midwives in Aboriginal communities. In 1825, on a coastal visit by a whaling ship, Captain Beechey referred to the Aboriginal women on some islands he visited as having “all learned the art of midwifery: parturition generally takes place during the night-time; the duration of labour is seldom longer than five hours, and has not yet in any case proved fatal. There is no instance of twins, nor of a single miscarriage, except from accidents.”³⁷ It was recorded in 1868 of the Nootka, “[t]hey suffer little during pregnancy or at childbirth, but seldom bear children after the age of about twenty-five. As a rule they have few children and, I think, more boys than girls. Their female relations act as midwives.”³⁸

In the late 1880s, a committee looking at the northwest tribes in British Columbia observed that the Tlingit used midwives,³⁹ as did the Kwakiutl.⁴⁰ Like many First Nations women, the Kwakiutl woman giving birth was also isolated from others in the community during her labour, with the exception of the “professional midwives” who assisted her.⁴¹ The Bilqula, one of the Coast Salish tribes, had “professional midwives to assist the woman, who is delivered in

³⁵ James A. Jones, *Traditions of the North American Indians: being a second and revised edition of Tales of an Indian camp*, (London: H. Colburn and R. Bentley, 1830) at 72.

³⁶ Jessica A.D. Bailey, *The Experiences and Education of Midwives in Three Canadian Provinces: Saskatchewan, Ontario and Nova Scotia* (MA Thesis: Joint Women’s Studies Programme, Mount Saint Vincent University, Dalhousie University and Saint Mary’s University, 2002) [unpublished] at 11.

³⁷ F.W. Beechey, *Narrative of a voyage to the Pacific and Beering’s Strait, to co-operate with the polar expeditions performed in His Majesty’s Ship Blossom, under the command of Captain F.W. Beechey, R.N., F.R.S. &c. in the years 1825, 26, 27, 28* (London: H. Colburn and R. Bentley, 1831) at 129.

³⁸ Gilbert Malcolm Sproat, *Scenes and studies of savage life* (London: Smith, Elder 1868) at 94.

³⁹ Franz Boas and Horatio Hale, *Fifth Report of the committee: appointed for the purpose of investigating and publishing reports on the physical characters, languages and industrial condition of the north-western tribes of the Dominion of Canada* (London: The British Association for the Advancement of Science 1888) at 40 [Boas, Horatio].

⁴⁰ Franz Boas and Sir Daniel Wilson, “Customs regarding Birth, Puberty, Marriage and Death, “Committee on North-Western Tribes of the Dominion of Canada” *Seventh Report on the North-western tribes of Canada* (London : British Association for the Advancement of Science 1891?) at 11-12 [Boas Wilson].

⁴¹ Boas, Wilson, *ibid.*

a small house built for this purpose.”⁴² The Heiltsuk women gave birth in a special house as well.⁴³ Many rituals surrounded the midwives’ attendance at these births. As Professor Cecilia Benoit notes, traditional techniques and tools used by Aboriginal midwives included, among many others, herbal medicines, seal skins, string, and blades.⁴⁴

In 1900, the Squamish people would engage three or four midwives to attend a birth, and each had specific duties, ranging from cutting the umbilical cord to looking after the mother:

It was customary among the Sk’qo mie [Squamish] women to retire to the woods when they were about to give birth to their children. Usually a woman went alone or accompanied only by her husband. Midwives were called in for the first child, but afterwards only in cases of difficulty or when the labour was unduly prolonged. Usually the woman would fulfil her daily duties to within an hour of the child’s birth and be ready to take them up again a few hours afterwards. In the case of first children, parents of standing would engage three or four midwives or experienced women for the occasion. Each had her own special duties to perform. These were prescribed by long-established custom. It was the office of one to sever the umbilical cord and dispose of the after-birth; of another to watch and care for the baby; and of another to ‘cook the milk’ and generally look after the mother.⁴⁵

There were medicines specific to childbirth. The Potawatomi used pieces of the rattlesnake’s rattle to induce labour by administering it internally,⁴⁶ the Dakota also used the rattlesnake to “administer medicines in such cases, and among these, the rattle of the rattlesnake, in doses of one segment at a time.”⁴⁷ The M’ikmaq used a small bone from the heart of the moose to aid them in childbirth, “they reduce it to powder and swallow it in water, or in the soup made of the animal.”⁴⁸

⁴² Boas, Horatio, *supra* note 39 at 41.

⁴³ Boas, Wilson, *supra* note 40 at 12.

⁴⁴ Cecilia Benoit, & Dena Carroll, *Historical Trajectories in Canadian midwifery: Blending traditional and modern practices*. Report prepared for the Museum of Civilization, Ottawa, ON (2004).

⁴⁵ Leon Gerin, Charles Hill-Tout and Benjamin Sulte, *Report on the Ethnological Survey of Canada*, British Association for the Advancement of Science (Ethnological Survey of Canada: 1900?) at 479.

⁴⁶ Colhoun, *supra* note 28 at 129.

⁴⁷ Colhoun, *ibid* at 416.

⁴⁸ Nicolas Denys, 1598-1688, *The description and natural history of the coasts of North America (Acadia)* (Toronto: the Champlain Society, 1908) at 382-383.

Medicines were also used to assist with the delivery of the afterbirth. The Dene used a plant they called *hwujrej*, believed to be Devil's bush (*Fatsia horrida*), to assist in expelling the placenta. The bark of the plant was mashed "while fresh and taken internally with a few drops of water by women just delivered of a child but whose after-birth had not, or could not otherwise, be expelled."⁴⁹ If a Potawatomi woman had not expelled the placenta and if the medicines that were provided had not had an effect after several days, her husband would "[take] his wife upon his shoulders and carr[y] her about for some time; the motion is said to assist in its expulsion."⁵⁰

4.2 Health and Healing Practices

In addition to the intricate rituals surrounding midwives and birthing, various other kinds of healing practices were in place pre-contact and devolved to modern practices today. In 1969, Canada's Medical Liaison Officer, Dr. Graham-Cumming, reported that Aboriginal people had few health problems before contact with the Europeans:

Surprisingly little evidence has been found to suggest that the Eskimo and the Indian Populations did have any major health problems before the intrusions of venturing Europeans.⁵¹

Regarding the Inuit, Graham-Cumming noted:

Before the arrival of foreigners, health problems in the Far North had probably been largely reduced to getting enough to eat, keeping warm and avoiding being killed. Even tooth decay does not appear to have been a problem.⁵²

The *Royal Commission on Aboriginal Peoples* notes that, prior to European arrival, Aboriginal people enjoyed remarkably good health. They suffered few of the illnesses common today.⁵³

⁴⁹ A.G. Morice, *Notes archaeological, industrial and sociological, on the western Denes, with an ethnographical sketch of the same* (Canadian Institute: 1893?) at 132.

⁵⁰ Colhoun, *supra* note 28 at 132.

⁵¹ Graham-Cumming, C. 'Northern Health Services' Canadian Medical Association Journal, 100 (March 15, 1969) 526-531 at 526 [Graham-Cumming].

⁵² Graham-Cumming, *ibid*.

⁵³ Canada: *Report of the Royal Commission on Aboriginal Peoples: Gathering Strength*, vol. 3 (Ottawa: The Commission, 1996), ch. 3, "Health and Healing," quoting Nicholas Denys (1672), quoted in Cornelius J. Jaenen, *Friend and Foe: Aspects of French-Amerindian Cultural Contact in the Sixteenth and Seventeenth Centuries* (Toronto: McClelland and Stewart, 1976) at fn 6.

There was no plague, cholera, typhus, smallpox or measles. Cancer was rare, and even fractures were infrequent....There were, apparently, no [skin tumours]. There were no troubles with the feet, such as fallen arches. And judging from later acquired knowledge, there was a much greater scarcity than in the white population of...most mental disorders, and of other serious conditions.⁵⁴

Through archeological studies of tissue from bones, teeth and mummified remains, authors, Waldram, Herring, and Young give an account of Aboriginal health in the pre-contact period. These studies largely depict pre-contact Aboriginal people as a relatively healthy and disease-free population. Coupled with effective health practices and ongoing healing methods, the near absence (except for internal parasites and some types of warts and venereal disease) of lethal pathogens allowed Aboriginal people to survive and thrive until contact.⁵⁵ In 1796, Duke de la Rochefoucault noted that, while local Indians at Niagara had access to a physician paid for by the government, they preferred to treat themselves, and “more frequently take draughts which they prepare themselves.”⁵⁶

Author, John McLean wrote in the early 1800s that, in spite of being in Canada for twenty-four years at various Hudson’s Bay posts, he had never known “a single instance of an Indian being retained at any inland post for medical treatment.”⁵⁷ Instead, “[t]he knowledge the natives possess of the medical virtues of roots and herbs is generally equal to the cure of all their ailments; and we are, in fact, more frequently indebted to them, than they to us, for medical advice.”⁵⁸ These images of pre-contact good health and health care contrast starkly with the post-contact decimation wreaked upon Aboriginal populations. Diseases imported from overseas produced epidemics that forever altered the “social and biological structure of Aboriginal communities.”⁵⁹

⁵⁴ Canada: *Report of the Royal Commission on Aboriginal Peoples: Gathering Strength*, vol. 3 (Ottawa: The Commission, 1996), ch. 3, “Health and Healing,” citing Virgil J. Vogel, *American Indian Medicine* (Norman, Okla.: University of Oklahoma Press, 1970) at 159.

⁵⁵ J. Waldram, D.A. Herring, T.K. Young, *Aboriginal Health in Canada. Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995) [Waldram] at 23.

⁵⁶ William Canniff, *The medical profession in Upper Canada, 1783-1850: an historical narrative with original documents relating to the profession, including some brief biographies* (Toronto: W. Briggs, 1894) at 19.

⁵⁷ John McLean, 1799-1890, *Notes of a twenty-five year’s service in the Hudson Bay territories* (Toronto: The Champlain Society, 1932) at 315.

⁵⁸ *Ibid.*

⁵⁹ Waldram *supra* note 55 at 23.

The inherent right to health and traditional healthcare practices is, according to many people, simply part of a broader conception of Aboriginal rights.⁶⁰ For example, various methods of healing and maintaining good health have been documented and continue to be practiced today. Certain practices were integral to all Aboriginal peoples, both as individuals and as part of communities and societies. The World Health Organization describes traditional healthcare as:

The sum total of knowledge, skills and practices based on the theories, beliefs, and experiences Indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness.⁶¹

The Royal Commission on Aboriginal People also defined traditional healing:

Traditional healing has been defined as practices designed to promote mental, physical and spiritual well being that are based on beliefs which go back to the time before the spread of western ‘scientific’ biomedicine. When Aboriginal people in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well being using ceremony, counseling and accumulated wisdom of elders.⁶²

Aboriginal healing⁶³ is comprised of diverse practices, encompassing a tapestry of language, ceremonies, beliefs, laws, and traditions. Traditional healing methods reflect the varied and distinctive cultures of Aboriginal societies, and the corresponding rights are unique to specific groups. These are Aboriginal or inherent rights. Battiste & Henderson expressed that:

[T]he Supreme Court acknowledged that these cultural rights arise within a system of beliefs, social practices and ceremonies of Aboriginal people. They

⁶⁰M. Battiste & J.Y. Henderson, *Protecting Indigenous Knowledge and Heritage: A Global Challenge* (Saskatoon: Purich, 2000) at 212–213 [Battiste & Henderson] at 212 – 215.

⁶¹ World Health Organization, *Traditional Medicine, Key Facts*, online: <http://www.who.int/mediacentre/factsheets/fs134/en/> (accessed December 27, 2009).

⁶² RCAP *supra* note 2.

⁶³ Dawn Martin Hill, “Traditional Medicine in Contemporary Contexts. Protecting and Respecting Indigenous Knowledge and Medicine” (Ottawa, Ontario: NAHO), March 2003, 6,7 [Hill]:

It is recognized that the terminology used in this paper does not reflect true indigenous meaning to the words – “traditional” “medicine” “health” “healing”. Dr. Dawn Martin Hill notes:

- I. The term “traditional” is a British colonial concept, disliked by many Indigenous groups.
- II. Academic and institutional scholars introduced the term to Indigenous Peoples of North America. Most Indigenous groups would have relied on a complex set of medical practices and beliefs referred to simply as “medicine.” Only the Europeans, with a mandate to separate and prioritize beliefs that were not their own, utilized the term “traditional.”

are traced back to their ancestral Indigenous order and their relationship with ecology.⁶⁴

Traditional approaches to health and well-being are rich and diverse. The medicine societies manifest vast differences among them—from the Ojibwa Medewiwin to the Cree of Northern Saskatchewan to the Métis of Manitoba to the Inuit *angatquq* (shamans). Yet, they also hold many principles and values in common. Specifically, they share a commitment to healing, well-being, and balance. They practice preventative models, which have their roots in holism as a fundamental principle. Aboriginal peoples used their medicines to assist in developing not only their individual well-being but also healthy relationships amongst each other, within their communities, and between their nations.

Healing was viewed as an internal process, whereas sickness was seen as generated externally. Sickness in a person indicated the presence or location of an external force. Waldram, Young and Herring explain:

[T]he world is seen as a place in which harmony and balance exist between and among human beings and spiritual or ‘other than human’ entities, and serious illness is indicative of a disruption in this balance.⁶⁵

Aboriginal knowledge and heritage reveal that the healing environment pervades every community. Each has the capacity to renew itself by daily practices. However, certain families and healers act as animators, focusing or harnessing the healing energy that is present.⁶⁶ It is further suggested that early Aboriginal societies developed their medicine societies to create a complex pharmacopeia. They also refined their extensive ability to call applicable unseen spirits through complex and elaborate ceremonies. Altogether, these ways ensured complete health and a balanced lifestyle for individuals, families, and communities.

RCAP uses the term ‘healer’ to include:

⁶⁴ Battiste & Henderson, *supra* note 60.

⁶⁵ Waldram, *supra* note 55 at 101.

⁶⁶ See Gerald V. Mohatt, “Healing and Spirituality: Implication for Training and Practice of Psychologists” Education, Resources Information Center, 1991, online: http://www.eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=ED343739&ERICExtSearch_SearchType_0=no&accno=ED343739 (accessed January 14, 2010).

[A] wide range of people whose skills, wisdom and understanding can play a part in restoring personal well-being and social balance, from specialists in the use of healing herbs, to traditional midwives, to elders whose life experience makes them effective as counsellors, to ceremonialists who treat physical, social, emotional and mental disorders by spiritual means.⁶⁷

Many different types of healing practitioners exist today and have existed since pre-contact times. These include herbalists, ceremonialists, midwives,⁶⁸ spiritualists, diagnosis specialists, medicine men/women, and healers.⁶⁹ Aboriginal societies make important distinctions among healers based on their knowledge and skills. For example, some are skilled in first aid, which requires that a person possess a generic knowledge of medicinal plants and methods that heal. Others are specialized healers. They use spiritual assistance, often in combination with botanical substances. A medicine man/woman denotes a healer who uses supernatural forces to heal.⁷⁰ Shamanism was/is common among Aboriginal peoples. The Shaman is a soul doctor who heals people through contact with spirits. The cause of most diseases is thought to be an unbalance between an individual and the world around him/her. The Shaman uses music, herbs, plants, dreams, visions, and ceremonial dances to restore a balance.⁷¹ The work of Shaman is differentiated from that of a medicine man/woman as follows:

The ordinary medicine man may certainly heal the sick while in a light trance, but he does not sink down into the deep trance that is necessary for making contact with the supernatural world.⁷²

Waldram notes that, in reality, these differences are much more complex.⁷³ In general, though, the difference between practitioners lies in the extent to which spiritual help must be invoked.⁷⁴ For instance:

Eurocentric researchers may know the name of an herbal cure and understand how it is used, but without ceremony and ritual songs, chants, prayers, and relationships, they cannot achieve the same effect.⁷⁵

⁶⁷ RCAP, *supra* note 2 at 337.

⁶⁸ A. Lightning, "Sources of Healing", (1976) University of Manitoba Medical Journal 46/4:123-125.

⁶⁹ Hill, *supra* note 63 at 9.

⁷⁰ Waldram, *supra* note 55 at 103.

⁷¹ Gerald Robert Vizenor, *The People Named the Chippewa: Narrative Histories*, University of Minnesota Press: Minneapolis, 1984 at 146.

⁷² Hultkrantz in Waldram, *supra* note 55 at 104.

⁷³ Waldram, *ibid* at 104.

⁷⁴ Waldram, *ibid* at 103.

In 1886, Dr. Robert Bell explained these differences he recognized among the Cree:

[T]he term “medicine” does not mean strictly material remedies or the practice of the healing art, but rather a general power or influence, of which that of drugs is only one variety. Hence a “medicine man” is not simply a doctor of medicine, but a sort of priest, prophet, medium and soothsayer. He is also a juggler, conjurer, sorcerer or magician and general dealer in the supernatural. A mere knowledge of medicine proper is rather one of the lower or accessory branches of his profession, and it is often practiced by those who have no pretensions to be considered full-fledged medicine men. Even women sometimes obtain great reputations as doctors. To the medicine man a knowledge of drugs is valuable, principally to enable him to carry out different kinds of poisoning as may best serve his ends. His most important function and the secret of his power is his dealing in occult influences.⁷⁶

On traditional knowledge, Scholar Dawn Martin Hill notes:

None of the specialized categories are solely exclusive; rather, they are often interdependent and some practitioners may hold a number of specialized knowledges.⁷⁷

Each Aboriginal group uses a variety of methods with their diverse populations. The following section provides some examples of healing methods that have been witnessed and documented by various people, such as Jesuits, explorers, traders, anthropologists, and social scientists. May it be noted that the Eurocentrism is woven through many of these early accounts and is not only offensive but may have also given contributed to the genocidal assimilation campaign to annihilate traditional Aboriginal ways of living. Nonetheless, good information can be gleaned in spite of the Eurocentric renderings in many of these accounts.

4.2.1 Sweat Lodge

The process of sweating cleanses the body of toxins and boosts the immune system.⁷⁸ Ways to accomplish this have been used around the world for millennia. Ancient Greeks and Romans used hot baths and sweating techniques. The Finns have saunas to promote healing; the

⁷⁵Battiste & Henderson, *supra* note 60 at 43.

⁷⁶ Bell, *supra* note 31.

⁷⁷ Hill, *supra* note 63 at 10.

⁷⁸ R. Smoley (1992), First Nations Spirituality. *Yoga Journal*, January, 104-108.

Russians use a bania, which combines steam and hot air; the Turks have hammans; and the Japanese use hot tubs.⁷⁹ The sweat lodge has been used across many different Aboriginal groups for centuries. It is used to facilitate prayer, to maintain health, and to address particular health or social concerns. Among the many health problems that the sweat lodge addresses are febrile symptoms, chronic rheumatism, headache, fast pulse, catarrh, and sore muscles. In fact, the sweat lodge has been used for most health problems.⁸⁰ It was usually located in a separate structure, sometimes built into the side of a hill or made from wood. It was heated with hot stones. “Into this the patient creeps naked, and the heat soon throws him into such a profuse perspiration that it falls from him in large drops. As soon as he finds himself too hot ... he immediately plunges into the river.”⁸¹

The Faculty of Medicine at the University of Ottawa offers the following physical description of the ceremonial sweat lodge:

A ceremonial sauna used for healing and cleansing. It is made of a wooden framework covered by blankets or skins, usually igloo-shaped, about 1.5 metres high and large enough for eight people to sit in a circle on the ground. Hot stones are placed in a shallow hole in the centre of the lodge. A medicine man pours water on the stones to produce steam and participants may spend an hour sweating in the lodge. The lodge combines the four elements of fire, water, air and earth. Ceremonies include offerings, prayers, and reverence.⁸²

The sweat lodge is a method of health practice that was in place before contact and the Jesuits recognized its healing properties among the Montagnais as early as 1730:

It consists in boiling in a large kettle spruce-twigs with aromatic herbs, among which are placed some of those oily shrubs that are here called the “pepper-plant,” because their fruit, from which green wax is obtained, has in fact, if not the consistency and hardness, at least the appearance of pepper. A tub is prepared, across which a board is laid to serve as a seat; then, on the outside, to the hoops of the tub are nailed 4 or 5 small sticks, and their pliant tops are tied to a medium-sized hoop. This hoop is placed as high as the neck of him who is to sit in the tub, so that his head is outside, and the remainder of the body is well

⁷⁹ M. Aaland, (1978), *Sweat*. Santa Barbara, CA: Capra Press.

⁸⁰ *Ibid* at 110.

⁸¹ George Henry Loskiel, *The History of the Moravian mission among the Indians of North America: from its commencement to the present time, with a preliminary account of the Indians* (London: T. Allman, 1838) at 37.

⁸² University of Ottawa, Society, The Individual, Medicine, “Aboriginal Medicine and Healing Practices,” online: http://medicine.uottawa.ca/sim/data/Aboriginal_Medicine_e.htm (accessed December 27, 2009).

covered by means of the sticks that hold up the blankets and prevent their resting on the shoulders. When everything is thus prepared, the boiling kettle is put in the tub under the seat. A piece of board is put upon the kettle, to support the *captive's* [patient's] feet and prevent their being burned. The patient, wrapped up only in a sheet, slips gently into the sweating-bath, with a small stick which he uses to stir up the medicine as the heat abates. He remains thus until he feels the perspiration diminish; then quickly putting on a warm shirt, he goes to sweat once more in good robes of beaver-skin, or in a good and well-warmed bed, when he has one. This method of producing perspiration is a sovereign remedy for languor, rheumatism, inflammation, pains in the side, and minor aches; in a word, it is worth many baths.⁸³

Part of the initiation ceremony of the Medewiwin includes a visit to the sweat lodge for “vapor baths” to purify the spirit before the initiation can occur. The candidate for initiation is seated in the sweat lodge and is given water to pour over the hot rocks to create the vapors. The vapors are purifying agents that help the candidate ponder the serious nature of the upcoming Medewiwin initiation.⁸⁴

The Jesuit Priests described what they witnessed of the Algonquin people following the sweat lodge when they visited “New France”:

They keep themselves well (principally in Summer) by the use of hot rooms and sweat boxes, and by the bath. They also use massage, afterwards rubbing the whole body with seal oil, causing them to emit an odor which is very disagreeable to those not accustomed to it. Nevertheless, when this oiling process is over, they can stand heat and cold better, and their hair is not caught in the branches, but is slippery, so that rain and tempest do not injure the head, but glide over it to the feet; also that the mosquitoes (which are very vicious there in Summer, and more annoying than one would believe) do not sting so much in the bare parts, etc. They also use tobacco, and inhale the smoke as is done in France. This is without doubt a help to them, and upon the whole rather necessary, considering the great extremes of cold and bad weather and of hunger and overeating or satiety which they endure; but also many ills arise from it, on account of its excessive use. It is the sole delight of these people when they have some of it, and also certain Frenchmen are so bewitched with it that, to inhale its fumes, they would sell their shirts. All their talks, treaties, welcomes, and endearments are made under the fumes of this tobacco. They gather around the

⁸³ The Jesuit Relations and Allied Documents “Travels and Explorations of the Jesuit Missionaries in New France 1610—1791, Vol. VIII at 71 online: http://puffin.creighton.edu/jesuit/relations/relations_68.html (accessed January 11, 2010).

⁸⁴ Gail Guthrie Valaskakis, *Indian Country: Essays on Contemporary Native Culture*, (Wilfrid Laurier Press: Waterloo, 2005) at 19 [Indian country].

fire, chatting and passing the pipe from hand to hand, enjoying themselves in this way for several hours. Such is their inclination and custom.⁸⁵

Not only did the hot baths and sweat lodge predate contact, but they also evolved with the environmental and health changes that the Europeans brought. They have been so important that their use continues today. In addition to the practical aspects of the hot baths and sweat lodges, Waldram describes Graham's observations in the late eighteenth century. He pays special attention to "conjurors" or "jugglers" who were highly involved with spirits and the spiritual aspects of healing.⁸⁶ This aspect of healing practices bears further attention.

4.2.2 Conjurors and Jugglers

The ability to contact spirit helpers to assist in diagnosing and treatment was important. The degree to which a person could summon spirits denoted certain standing in society. Graham described this practice in the later eighteenth century:

Jugglers or conjurors are very numerous amongst them (Cree). They are generally men who are good hunters, and have a family; some of them are very clever at it. They are supposed to have intelligence with the Evil Spirit [actually the Creator'], and by that means can procure anything to be done for the good or injury of others, foretell events, pacify the malignant spirit when he plagues them with misfortunes, and recover the sick. They have also several tricks of sleight hand; such as swallowing a string with a musket ball hanging to it; taking it directly out at the fundament; pretending to blow one another down; swallowing bear's claws, and vomiting them up; extracting them from wounds, or the breast, mouth etc. of a sick person; firing off a gun and ball to remain behind; and a thousand other pranks which make them be held in great esteem by the rest.⁸⁷

Writing in 1771, Samuel Hearne described the effects of jugglery or conjuring as an important aspect of physical healing among the Dene people:

Though the ordinary trick of these conjurers may be easily detected, and justly exploded, being no more than the tricks of common jugglers, yet the apparent good effect of their laborers on the sick and diseased is not so easily accounted for. Perhaps the implicit confidence placed in them by the sick may at time, leave the mind so perfectly at rest, as to cause the disorder to take a favorable

⁸⁵ The Jesuit Relations and Allied Documents "Travels and Explorations of the Jesuit Missionaries in New France 1610—1791, Vol. III chapter VII.

⁸⁶ Waldram, *supra* note 55 at 104.

⁸⁷ G. Williams, 1969, *Andrew Graham's Observations on Hudson's Bay 1767-91* London: Hudson's Bay Historical Society in Waldram, *supra* note 55 at 105.

turn; and a few successful cases are quite sufficient to establish the doctor's character and reputation.⁸⁸

In 1823, among the Potawatomi of Muskwawasepeotan (town of the old red wood creek) near Fort Wayne, Indiana, American explorers confirmed the Potowatomie's use of established healing practices that were distinct from jugglery:

Among the Potawatomi, the practice of medicine is considered quite distinct from that of jugglery. Both are in great repute, but it appears that there is not interference. The man of medicine has, it is true, recourse to spells and incantations to add to the virtue of the plants which he uses: but this is totally unconnected with the avocations of the sorcerer and juggler whose object is amusement.⁸⁹

In his seminal work on the Medewiwin, William James Hoffman reviewed the work of Baron Lahontan, an early explorer (1703). Lahontan described some of the health practices of the Algonquin peoples and the overlap between ceremony and the application of medicinal plants:

When the Quack comes to visit the Patient, he examines him very carefully; If the Evil Spirit be here, says he, we shall quickly dislodge him. This said, he withdraws by himself to a little Tent made on purpose, where he dances, and sings houlng like an Owl; (which gives the Jesuits Occasion to say, That the Devil converses with 'em.) After he has made an end of this Quack Jargon, he comes and rubs the Patient in some part of his Body, and pulling some little Bones out of his Mouth, acquaints the Patient, That these very Bones came out of his Body; that he ought to pluck up a good heart, in regard that his Distemper is but a Trifle; and in fine, that in order to accelerate the Cure, 't will be convenient to send his own and his Relations Slaves to shoot Elks, Deer, &c., to the end they may all eat of that sort of Meat, upon which his Cure does absolutely depend. Commonly these Quacks bring 'em some Juices of Plants, which are a sort of Purges, and are called Maskikik.⁹⁰

It appears that the spirit helpers assisted the medical doctors for a complete and holistic cure.

⁸⁸ R. Glover, 1958, *A Journey from Prince of Wales's Fort in Hudson's Bay to the Northern Ocean, 1769, 1770, 1771, 1772*, by Samuel Hearne. Toronto: McMillan in Waldram, *supra* note 55 at 106.

⁸⁹ Colhoun, *supra* note 28 at 134.

⁹⁰ Lahontan, Baron, [Footnote 3: *New Voyages to North America*, London, 1703, vol. 2, pp. 47, 48.] in Gutenberg Hoffman, William J. 1891. "The Medewiwin or Grand Medicine Society of the Ojibway." *Seventh Annual Report of the Bureau of Ethnology, 1885-86*. Washington, D.C.: Government Printing Office [Gutenberg Hoffman].

4.2.3 Sucking Doctors

Another healing practice has been referred to as ‘sucking’ or ‘cupping,’ and its practitioners are referred to as ‘sucking doctors.’⁹¹ The technique is generally described as follows:

[T]his technique is called for particularly when it is believed that an object has entered the body and is causing a problem, or where an internal poison or body tissue is implicated. Most accounts suggest that a sucking horn or tube of some sort is used, although the healer may place his or her lips directly onto the flesh. By sucking and blowing, the object is ultimately removed, and is usually shown to the patient and the others attending. The ceremony involves prayer and singing, sometimes blowing on a whistle, all designed to summon the supernatural assistance required to locate and extract the object.⁹²

Among the Chippewa in 1763, Alexander Henry recorded this sucking practice:

After singing for some time, the physician took one of the bones out of the bison; the bone was hollow; and one end being applied to the breast of the patient, he put the other into his mouth, in order to remove the disorder by suction. Having persevered in this as long as he thought proper, he suddenly seemed to force the bone into his mouth, and swallow it. He now acted the part of one suffering pain but presently finding relief he made a long speech and after this returned to singing, and to the accompaniment of his rattle.⁹³

The Jesuit Priests recorded:

All that they do for their sick is to suck them Until Blood comes. I saw one in the hands of the old Medicine-men; one whistled and played on a gourd; another sucked; while the third sang the Song of the Crocodile, whose skin served him as a drum.⁹⁴

On sucking practices, Dr. Robert Bell noted in 1823:

In regard to the practice of medicine proper, the common Indian notion of disease is that it is caused by some evil influence, which must be removed, either by driving off its spirit with the tom-tom and singing, or by a charm, and by sucking or blowing upon the affected. The idea of drawing or sucking out the evil is the prevailing one in their theory of the practice of medicine.⁹⁵

⁹¹ Waldram *supra* note 55 at 107.

⁹² Waldram *ibid.*

⁹³ Alexandra Henry, 1976 *Travels and Adventures in Canada and the Indian Territories between the years 1760 znc 1776*, New York: Garland (Original Publication, 1809) in Waldram, *ibid.*

⁹⁴ The Jesuit Relations and Allied Documents “Travels and Explorations of the Jesuit Missionaries in New France 1610—1791, Vol. LVIX at 149.

⁹⁵ Bell, *supra* note 31 at 6.

It appears that the methods of sucking and/or blowing was useful as a healing art in some early Aboriginal societies.

4.2.4 Botanical Cures

There are many useful sources on the botanical medicines and the pharmacopeia created by various Aboriginal peoples. As noted Scholar, Olive Dickason notes, Aboriginal peoples were by nature, physicians, apothecaries, and doctors. They had a large knowledge of “certain herbs, which they use successfully to cure ills that seem to us incurable.... The process by which the Amerindians acquired their herbal lore is not clearly understood, but there is no doubt about the results. More than 500 drugs used in the medical pharmacopoeia today were originally used by Amerindians.”⁹⁶ A testament to the importance of Aboriginal medicinal knowledge lies in the fact that, when Europeans arrived in North America, the fur traders, whalers, missionaries, and traders all turned to the Aboriginal people and their medicines for help. There are numerous examples:

[P]revent scurvy by brewing teas from spruce bark (rich in Vitamin C); they were able to reduce pain by using Willow extract, which contains salicin (similar to the product aspirin); they had various kinds of anesthetics, emetics, diuretics and medicines that could induce labour or numb labour pains. Plant extracts also acted as antibiotics when applied to wounds.⁹⁷

There were cures for other ailments. Blood-root was said to be an “infallible cure for rheumatism” and was infused in whiskey for that purpose.⁹⁸ The root was the only part used in the medicine. It worked as a “powerful and valuable remedy, acting in small doses as a stimulant and expectorant, in over doses producing nausea and vomiting.”⁹⁹

Other medicinal plants included spignet, alecampaïne, wild turnip, coltsfoot, skunk cabbage, lady’s slipper, poke-root, gold thread, liverwort, white root, milkweed, white pond lily, and

⁹⁶ Olive Patricia Dickason, *Canada’s First Nations: A History of Founding Peoples from Earliest Times* (Toronto: McClelland and Stewart, 1992), at 43-44.

⁹⁷ Waldram, *supra* note 55 at 104, 105.

⁹⁸ Edward Talbot, *Five Year’s Residence in the Canadas: including a tour through a part of the United States of America in 1823* (London: Printed for Longman, Hurst, Rees, Orme, Brown and Green, 1824) at 314-316.

⁹⁹ Henry Youle Hind, *Explorations in the interior of the Labrador peninsula: the country of the Montagnais and the Nasquapee Indians*, (London: Longman, Green, Longman, Roberts & Green, 1863) at 191 [Hind].

thistle, as well as pennyroyal, lobelia, balm, winter green, Oswego bitters, white oak, butternut, elder, hemlock, spotted alder, red willow, wild cherry, iron-wood, slippery elm, sumac, beech, hemlock, and basswood.¹⁰⁰ The seeds and plant of the lobelia were used and were said to have been “a favourite with the medicine man among the Indians long before the settlement of Canada by the whites.... They are emetic and in small doses expectorant and diaphoretic.”¹⁰¹

The inner bark of the slippery elm was used by the Montagnais as a “valuable demulcent and emollient, and in the form of effusion has been found highly beneficial in inflammation of the stomach and bowels.”¹⁰² Wild cherry bark was strongest when gathered in the fall and acted as a tonic and a sedative.¹⁰³ Balsam was considered an excellent remedy for frostbite.¹⁰⁴

The M’ikma’q used a drop of “the secretion of skunks” to treat toothache and rheumatism, while the Montagnais used the roots of the white water lily and rushes both as a food and a medicine, along with the roots of the thistle. “[W]hen these fail they have recourse to the conjuror’s arts, for with many of the Montagnais Indians, when in the woods, the conjuror [medicine man] is still much esteemed and feared.”¹⁰⁵ The red willow was also used as a medicine by the Montagnais, who used it as a purgative, and by the Cree, who smoked the inner bark.¹⁰⁶

In 1823, Dr. Bell noted that the use of plant material among the Cree and lists their uses:

Their materia medica is divided into two branches, good medicines and bad. Among the Crees, if not among other Indians, twenty classes of drugs are recognized. The first nine are all good or beneficial medicines, and the rest are all more or less bad or injurious. The student is first made familiar with the good medicines and then the bad, the worst of all being taught last.¹⁰⁷

¹⁰⁰ Peter Jones, *History of the Ojebway Indians: with especial reference to their conversion to Christianity* (London: A.W. Bennett, 1861) at 153 [Jones].

¹⁰¹ Hind, *supra* note 99 at 190.

¹⁰² Hind, *ibid* at 191.

¹⁰³ Hind, *ibid* at 191.

¹⁰⁴ Hind, *ibid* at 189.

¹⁰⁵ Hind, *ibid* at 190.

¹⁰⁶ Hind, *ibid* at 189.

¹⁰⁷ Bell, *supra* note 31 at 6. In relation to “bad medicine” Dr. Bell noted that “some of their poisons, they pretend, are very dangerous to handle” considering the following, caution would be advised:

One of the most curious preparations in use amongst them is the “black Poison,” the effects of which are well known around the lakes of the Winnipeg basin and in the Swan River district.

...

The great majority of their medicines are vegetable, but some are derived from animals, as the beaver, the musk-rat, the skunk, the deer, toads, snakes, insects, etc., while others are mineral, as iron pyrites, gypsum, salt, ochres, clays, ashes, etc. Parts of rare animals, impossible to obtain at the time, may be prescribed as the only means of saving a patient, who appears sure to die in any case.¹⁰⁸

The following is a table of the more common medicines among the Cree, produced by Dr. Bell:

Table 1

<i>Acorus calamus</i> ,	sweet flag or “fire-root,” as infusion or in powder, or it may be chewed whole, for colds and flatulence.
<i>Nuphar advena</i>	yellow pond-lily, as a tonic and for poultices.
<i>Abies alba</i> and <i>A. nigra</i> , spruce	The fresh inner bark is beaten to a fine homogeneous pulp to form astringent poultices for healing obstinate sores. ... a decoction of the leaves or spray is used internally for scurvy and externally for rheumatism.
<i>Abies balsamea</i>	the balsam tree. The clear liquid “gum” from the blisters is applied freely to fresh wounds, and a decoction made from the bark is taken in large doses for diseases of the chest.
<i>Salix and Populus</i>	Decoctions of the bark of both willows and poplars are taken as bitter tonics and in fevers.
<i>Lonicera ciliata</i> , honeysuckle, and <i>Ribes rubrum</i> , wild red currant	The stems and twigs of these two shrubs are tied into bundles and boiled together in a comparatively small quantity of water; the strong decoction is taken in large doses for diseases of the bladder.
<i>Juniperus communis</i> , juniper	The Indians, generally, know the diuretic properties of the berries. In some parts of the country the stems are boiled and the inner bark beaten to a pulp to form poultices for foul sores.
<i>Ledum latifolium</i> , Labrador tea	A decoction of leaves and flowers is used for diarrhea. A weak infusion is sometimes taken as a poor substitute for tea. The chewed leaves applied to wounds and skin affections.
<i>Cornus circinata</i> , <i>C. sericea</i> and <i>C. stolonifera</i>	An infusion of the bark of any of the dogwoods is taken in moderate doses for diarrhea. A decoction of any of them in large doses is reported to be emetic. In small doses, the

Some time after administration, it changes the color of an Indian’s skin from brownish-yellow or copper-color to a sooty black, at the same time causing hair to grow on unusual parts, especially in an Indian, as on the cheek bones, etc. Its first effects are sickness, headache, and pains in the back and limbs. Afterwards, ulcerative sores break out in various parts of the body, chiefly over the joints, more particularly the knuckles. I have tried in vain to ascertain the composition of the “black poison,” or to obtain a specimen of it. I have been told by a person who professed to have seen it, that it is brown snuff-like powder, with a slight and rather sickening smell. A small quantity administered in food appears sufficient to produce the above effects. Bell, *supra* note 31 at 7, 8.

¹⁰⁸ Bell, *ibid.*

	decoction is taken for fevers, colds and coughs. The bark dried quickly at the fire is used to smoke, either alone or mixed with tobacco.
<i>Iris versicolor</i> , blue-flag	The dried root in powder is used as a cathartic.
<i>Prunus Pennsylvanica</i> , pigeon cherry	A decoction of the bark is employed as an invigorating tonic in debilitated states of the system.
<i>Pyrus Americana</i> , mountain ash	A decoction of the young shoots is used as a tonic. ...
<i>Mentha Canadensis</i> , wild mint	The infusion as a carminative.
<i>Prunella vulgaris</i>	self-heal ... sore throat.
<i>Polygala senega</i> , snake root	The word senega is one of the varieties of the Outchipwai name for this plant and means yellow-root. It grows principally in very calcareous soils and is not found beyond latitude 52 degrees in the region north of the great lakes. It is highly prized by the Indians, and is used by them in inflammation of the lungs, colds, coughs and sore throats. ¹⁰⁹

Robert Bell, "The 'medicine-man' or, Indian and Eskimo notions of medicine: a paper read before the Bathurst and Rideau Medical Association, 20th January 1886, (Montreal 1886) at 11-12.

4.2.5 Other Remarkable Cures

It is interesting to note how the Potawatomie used the rattlesnake in healing:

They are often bitten by rattlesnakes; the wound is cured among the Potawatomi by poultices of Seneca snake-root, draughts of violet tea can *Eupatorium perfoliatum*; they have other remedies which they keep secret; the venom of the snake is considered greater at some periods of the moon than at others; in the month of August it is most so. These Indians entertain a high degree of veneration for the rattlesnake, not that they consider it in the light of a spirit, as has frequently but incorrectly been asserted, but because they are grateful to it for the timely warning which it has often given them, of the approach of an enemy. They therefore seldom kill it.¹¹⁰

...

The fang of the snake is held to be a charm against rheumatism and other internal pains; the mode of applying it consists in scratching the affected part until it bleeds. In their rude midwifery, they use the rattle to assist in parturition; it is then administered internally. It is not however, used as an emmenagogue.¹¹¹

¹⁰⁹ Bell, *ibid* at 11,12.

¹¹⁰ Colhoun, *supra* note 28 at 128.

¹¹¹ Colhoun, *ibid* at 129. Emmenagogues are herbs which stimulate blood flow in the pelvic area and uterus; some stimulate menstruation. Women have used plants such as mugwort, parsley and ginger to prevent or terminate early pregnancy (see Abortifacient). Others use emmenagogues to stimulate menstrual flow when menstruation is absent for reasons other than pregnancy, such as hormonal disorders or conditions like oligomenorrhea (infrequent or light menses). Wikipedia, online: <http://en.wikipedia.org/wiki/Emmenagogue> (accessed January 4, 2010).

The Ojibway people used “Seneca snake,” (Seneca snake root) as a “sure remedy for the bite of the rattlesnake.”¹¹²

Anthropologist Dr. Frank Speck noted that the Montagnais used snakes for rheumatism and sometimes carried them around in their shirts, he noted:

...[A]ccording to the Penobscot belief [a snakeskin] becomes a cure for rheumatism when bound around the infected part. Such a skin must have been taken from a living snake. The idea is no doubt derived from the feeling in the native mind that a creature with so pliable a frame is not only free from stiffness himself, but that contact with him can cure stiffness in others. Similarly a snakeskin, the Malachite say, worn around the head or hatband, will ward off enemies. A snake’s tongue taken from a living snake, dried and carried about, will both cure and prevent a toothache. Further south the Mohegan and the Iroquois believe that a toothache can be cured by gently biting the body of a living Green snake.¹¹³

In relation to the multifaceted turtle, explorer John Josselyn noted in his records of his voyages in 1638 and 1663 that the Massachusetts Indians used the land turtles for the “Ptisick [cough], Consumption [tuberculosis], and some say the Morbus Gallicus [venereal disease].” Josselyn also noted that if the turtle was consumed for a twelve month period that the Consumption and “Great pox” [smallpox] would definitely be cured. The sea turtle mixed with oil or bear grease would make the hair grow; the shell or flesh of a land turtle burned and dissolved in wine and oil would heal sore legs; the shell and egg whites were burned together and pounded healed chapped nipples in women; if the turtle head was pulverized with it then the falling out of hair would be prevented; hemorrhoids could be cured by using this mixture if the hemorrhoids were first washed in white wine.¹¹⁴

Dr. Bell suggests that the Cree had surgical skills that surpassed “present day skills”:

In surgery, the medicine-men confine themselves to setting bones, dressing wounds and ulcers, and alleviating pain by any means in their power. They never attempt any grave operation, although their general knowledge of anatomy

¹¹² Jones, *supra* note 100 in Gutenberg Hoffman, *supra* note 90.

¹¹³ Frank G. Speck, *Reptile lore of the northern Indians* Journ. Amer. Folklore 36: 273-280 in LGK Carr, “Interesting animal foods, medicines and omens of the eastern Indians with comparison to ancient European practices” July 1951 J Wash. Acad. Sci 41 229-235 at 229 [Carr].

¹¹⁴ John Josselyn, *New England rarities discovered, London 1672* in Carr, *ibid* at 229-230.

is not to be despised. They resort to cupping by means of sucking-tubes. They sometimes bleed by opening a vein in the arm with a sharp chip of flint. I have some evidence, in the shape of relics discovered in mounds, which leads me to think that certain of the ancient Indians had a better knowledge of surgery than those of the present day.¹¹⁵

In 1830, James A. Jones described how “quacks or physicians” were able to set broken bones in a manner that allowed them to heal perfectly and “solid” within eight days. He also recalled how a French soldier in Acadia, suffering daily seizures from epilepsy, was treated by an Indian woman with “two boluses of a pulverized root, the name of which she did not disclose” and thereafter enjoyed a perfect state of health.¹¹⁶

4.2.6 The Shaking Tent

The “shaking tent” or “conjuring lodge” had a variety of functions, including the diagnosis of the cause of illness. It seemed to be common in a large geographical range in Canada, particularly among the Montagnais, Northern and Plains Cree, Ojibwa, Saulteaux, Blackfoot, and Assiniboine.¹¹⁷ In 1823, trader George Nelson described Northern Cree techniques:

[F]requently the shaman was bound hand and foot by his assistants before being placed in the lodge; sometimes he was gagged as well. Shortly after the commencement of the ceremony, with assistants and community members seated around the outside, the ropes that bound the shaman would be thrown out the door or the top of the tent. Then the shaman would sing and invite his spirit helpers, and indeed any spirits to enter the lodge. When they did so, the lodge would often shake violently back and forth. The people outside would then hear a succession of voices of the spirits as they entered and communicated with the shaman. These were not in the voice of the shaman, however, and were sometimes in a language unintelligible to those on the outside (often considered an ancient language). Some of the discussion in the tent was jovial with the spirits and the shaman exchanging jokes, but the spirits also provided important information at the shaman’s request. On occasion, an outside participant, such as the sick person, would be invited to enter the tent to see the spirits.¹¹⁸

Nelson’s reactions showed his exuberance for the ceremony:

¹¹⁵ Bell, *supra* note 31 at 9.

¹¹⁶ James A. Jones, *Traditions of the North American Indians: being a second and revised edition of Tales of an Indian camp*, (London: H. Colburn and R. Bentley, 1830) at 72.

¹¹⁷ Waldram, *supra* note 55 at 108- 109.

¹¹⁸ *Ibid* at 109.

I am fully convinced, as much so as that I am in existence, that Spirits of some kind did really and virtually enter [the shaking tent], some truly terrific, but others again quite of different character. I cannot enter into a detail by comparison from ancient and more modern history, but I found the consonance, analogy, resemblance affinity or whatever it may be termed so great, so conspicuous that I verily believe I shall never forget the impressions of that evening.¹¹⁹

The shaking tent ceremony that Nelson witnessed obviously left a deep impression. Each Aboriginal culture determines how one views illness and thus, their choice of healing. Some ancient healing rituals that are used in a contemporary mode include the Sun Dance, Yuwipi, Ojibwe Healing Ceremony, Shaking Tent and Shaker Healing Ritual.¹²⁰ The ancient knowledge garnered through these ceremonies is important in today's contemporary society.

4.2.7 The Pau wau

The term “pow wow” is a European term. “Pau wau” means medicine man or conjurer, but it was misconstrued by European settlers. When they witnessed the healing practices of the village shaman, they thought the word referred to “the gathering of natives” who surrounded the medicine man during the healing practices, rather than to the individual healer himself.¹²¹ On the east coast, shamans were called “powwow” from powin, meaning “shaman.”¹²² A pow wow has also been defined as a “medicine-man; the conjuring of a medicine man over a patient; a dance, feast or noisy celebration preceding a council, expedition, or hunt; a council; or a conference.”¹²³ Rev. Peter Jones was a member of the Medewiwin and an Ojibwa Episcopal clergyman who describes the healing properties of the pow wow:

Each tribe has its medicine men and women—an order of priesthood consulted and employed in all times of sickness. These powwows are persons who are believed to have performed extraordinary cures, either by the application of roots and herbs or by incantations. When an Indian wishes to be initiated into the order of a powwow, in the first place he pays a large fee to the faculty. He is then taken into the woods, where he is taught the names and virtues of the

¹¹⁹ *Ibid* at 98, 99.

¹²⁰ Roxanne Struthers, Valerie S. Eschiti, “Being healed by an indigenous traditional healer: sacred healing stories of Native Americans” Part II Volume 11, Issue 2, 78-86 (May 2005).

¹²¹ Indian country, *supra* note 84 at 192.

¹²² Whitehead, *supra* note 14 at 91.

¹²³ F.W. Hodge., ed. 1910, “Handbook of American Indians North Mexico,” *Bulletin of the US Bureau of American Ethnology* 11 Washington, DC: Smithsonian Institution in Indian Country, *supra* note 84 at 162.

various useful plants; next he is instructed how to chant the medicine song, and how to pray, which prayer is a vain repetition offered up to the Master of Life, or to some munedoo whom the afflicted imagine they have offended.

The powwows are held in high veneration by their deluded brethren; not so much for their knowledge of medicine as for the magical power, which they are supposed to possess. It is for their interest to lead these credulous people to believe that they can at pleasure hold intercourse with the munedoos, who are ever ready to give them whatever information they require.¹²⁴

The pow wow has been practiced historically for its healing powers and the ability to invoke special magic. The pow wow is practiced today throughout various parts of Canada and the ceremony continues to hold special healing and health powers.¹²⁵ The following section delves a bit deeper into the medicine society, where practices involving healers are complex and spiritual.

4.3 The Medewiwin

The Midewiwin is a highly evolved Indigenous, hierarchal, religious, and medical system and is sometimes referred to the “Grand Medicine Society.” It is comprised of a society of individuals who gather periodically to perform various healing ceremonies. These practices were recorded as early as 1666, when Father Claude Allouez arrived at Shagawaumikong. The Grand Medicine Society was practicing its “greatest purity.”¹²⁶ The Medewiwin spread from the Ojibwe to neighboring nations, such as Woodlands and Plains Indian groups, such as the Saulteaux, Dakota, and Plains Cree.

¹²⁴Jones, *supra* note 100 at 143,144 in Gutenberg Hoffman, *supra* note 90.

¹²⁵ For pow wow listings in Canada, see, Powwow listings in Canada, online: <http://drumhop.com/capowwow.html> (accessed September 2, 2010).

¹²⁶ The Mide'wiwin or "Grand Medicine Society" of the Ojibwa Seventh Annual Report of the Bureau of Ethnology to the Secretary of the Smithsonian Institution, 1885-1886, Government Printing Office, Washington, 1891, pages 143-300, The Project Gutenberg EBook of The Mide'wiwin or "Grand Medicine Society of the Ojibwa, by Walter James Hoffman, online: <http://www.gutenberg.org/files/19368/19368.txt> (accessed September 2, 2010).

Based on traditional Ojibwa beliefs, the Midewiwin was integral to the maintenance of health and the instruction of novices in identifying and preparing botanical medicine.¹²⁷ Frances Densmore explained that the concept of “The Medewiwin is not so much to worship anything as to preserve the use of herbs for use in prolonging life.”¹²⁸ The Grand Medicine Society included instruction on how to commune with the spirit world to enhance individual powers to heal. It also taught methods of health maintenance by maintaining harmony with the world and by refraining from breaking social norms. The Society taught that the “rectitude of conduct produces length of life and that evil inevitably reacts on the offender.”¹²⁹

Chippewa scholar Dr. Gail Guthrie Valaskakis¹³⁰ notes the Midewiwin as “more powerful and impressive to the Indian than Christianity is to us today.”¹³¹ The Medewiwin is based upon the mythical life of “Manabush,”¹³² who secured secrets from the underworld. The secrets contain the purposes of prolonging life and the use of herbs and medicines and spiritual power to cure illness. Although the Medewiwin has other purposes, the primary purpose is to cure the ill. The person who wishes to join the Medewiwin is usually ill and will apply to the Mide priest for membership in the hope of being cured. Other reasons to become a Mide priest include replacing a deceased member of the society, being accidentally “shot” with the Megis¹³³ while watching a ceremony, or responding to a dream or vision that directed the person to join.

¹²⁷ Indian country, *supra* note 84 at 187.

¹²⁸ Indian country, *ibid.*

¹²⁹ Indian country, *ibid.*

¹³⁰ Dr. Gail Guthrie Valaskakis (1939 - 2007) is the author of *Indian Country*, *ibid.* Dr. Valaskakis completed her master’s degree in 1964 with her thesis titled “A Study of the Theatrical Elements in the Grand Medicine Society (Midewiwin) Religious Cult as Practiced by the Northern United States Chippewa Indians” (unpublished on file with the author). Dr. Valaskakis also left as a legacy a series of personal vignettes about her life. In one of her vignettes, she stated that she felt pressured by her thesis supervisor to remove a portion of the thesis titled “Birth of the Midewiwin,” which she felt was a critical part of the thesis. While the author was writing this section, she was moved (since Dr. Valaskakis’s father, Ben M. Guthrie, supplied much of the Medewiwin research and evidence through his oral testimony) and contacted Dr. Valaskakis’s brother, Gregg J. Guthrie, at the Lac Du Flambeau Ojibwe Reservation. Guthrie spent a considerable amount of time and effort hunting for the draft notes Dr. Valaskakis made for the missing chapter. He was successful and these notes and section form the basis for the Medewiwin Chapter *infra*. The Aboriginal Healing Foundation was kind enough to produce bound copies of the complete thesis including the “Birth of the Midewiwin,” unpublished, on file with the author.

¹³¹ Indian country, *supra* note 84 at 10.

¹³² Also known as Nanabush, Nanabozo, Winabozho or Wenabozho – the “trickster”.

¹³³ See photograph 1.

The sacred Migiis shells (*cypraea moneta*) used by the Midewiwin, have been found in various North American earth mounds, lost and buried long before the first known white contact. Since they only grow in the South Pacific, their prevalence in pre-contact days is one of those

The person wishing to join must apply to a Mide priest, who then presents the request to the Mide council. If accepted, the council sets the fees for initiation, and an instructor is appointed to teach the applicant the Medewewin. During this period, the applicant is on probation. The applicant must collect his/her fees through blankets, pails, and other material possessions to pay the priests for their services while learning the rituals and medicines of the society. Normally, this probation period lasts for a year. Then the applicant has four or more degrees of initiation, each more complex than the last. If the applicant is seriously ill, then he or she has great incentive to progress rapidly.¹³⁴ Attendance at Midewewin rites is compulsory for applicants. The instructor tells his student:

His instructor tells him the origin, properties and the uses of gifts Great Manito has given the Medewewin to be used in the presence of the Mide Manitos, or the sacred spirits of the society. The first item discussed is the Mide drum. The drum is shown to the candidate and he is told in what ways it differs from drums commonly used in tribal ceremonies. He learns that it is the first gift of Great Manito and that it is used to summon his presence at Midewewin initiation ceremonies and at the bedside of the ill.

In like manner, the rattle used in initiation ceremonies and to expel evil spirits from the sick is explained to him. He is then shown the sacred “megis,” a small white shell which is the sacred emblem of the Midewiwin. This shell is the physical embodiment for the “spirit power” which the candidate receives when he is initiated into the Midewewin. As a symbol of the power of the manitos transmitted during initiation, the sacred megis is “shot” into the candidate in the climax of the ritual. Each Mide member keeps his or her megis in a sack termed a “medicine bag”. This bag is made from the skin of a specified class of animals. That denoting the first degree is usually made of otter skin. As other gifts of great Manito are explained to the candidate, he is told their traditional heritage and they are shown to him.

...

mysteries that is difficult to explain. Other cowries are larger, more colorful, and are liked for their ornamental value, but *cypraea moneta*, the Migiis shell, is revered. (Care2, online: <http://www.care2.com/c2c/groups/disc.html?gpp=9425&pst=677552>)

¹³⁴William J. Hoffman “The Medewiwin or ‘Grand Medicine Society’ of the Ojibway, “Annual Report of the US Bureau of American Ethnology, vol. VII (1886) in Gail Frances Guthrie, “A Study of the Theatrical Elements in the Grand Medicine Society (Midewiwin) Religious Cult as Practiced by the Northern United States Chippewa Indians” Thesis, Master of Arts, Cornell University 1964 at 14 [Midewiwin].

During this period of instruction, the candidate also learns the plants from which the Midewiwin medicines are made, since the list of plants used in preparing medicines is very long, the first degree candidate is told only a small portion of the information. As he progresses to the second, third, and fourth degrees, he learns more about all the mysteries of the order.¹³⁵

Photograph 1



Source: seashellplace.com/.../products_id/262

Each member of the society owns a medicine bundle or bag made of a pelt (usually an otter, after the origin myth) that contains sacred objects. During a curing or initiation, an initiate or patient was 'shot' with the medicine bag (the pelt of an otter or other animal) containing the sacred white shell in an elaborate ceremony. The patient then spit the shell out of his/her mouth at the end of the ceremony as proof that supernatural power had been carried into their bodies.¹³⁶

The Midewiwin went underground for many years but has since resurfaced, particularly among the Saulteaux of Manitoba. Currently, Midewiwin ceremonies are held yearly in Manitoba and Minnesota.¹³⁷

¹³⁵ Midewiwin, *ibid* at 16, 17.

¹³⁶ Midewiwin, *ibid* at 16.

¹³⁷ Waldram, *supra* note 55 at 131. For further information on the Midewiwin see the following: A. Balikci, 1956, "Note sur le midewiwin," *Anthropological*, 2: 165-217; Victor Barnouw, 1954, "Reminiscences of a Chippewa Mide Priest," *Wisconsin Archaeologist*, 35:4:83-112; Robert C. Dailey, 1958, "The Midewiwin, Ontario's First Medical Society," *Ontario History*, 50:3:133-138; Frances Densmore, 1929, *Chippewa Customs*, Washington, DC: Smithsonian Institutes, *Bulletin of the Bureau of American Ethnology*, 86:1-204 (reprinted xxx); A. Irving Hallowell, 1936a, "The Passing of the Midewiwin in the Lake Winnipeg Region," *American Anthropologist*, 38:1:32-51; Harold Hickerson, 1962a, "Notes on the Post-Contact Origin of the Midewiwin,"

4.4 Métis Healing

The term Métis refers to persons of mixed Indian and European blood, particularly of French Roman Catholic background. Over the years, various organizations and governments have proposed different criteria for who is Métis. For this reason, it is important that a more in depth explanation of who the Métis are in order to effectively examine their healing practice. For example, the *Métis Settlements Act*¹³⁸ defines a Métis as a person of Aboriginal ancestry who identifies with Métis history and culture.¹³⁹ It is extremely important to not only acknowledge that the criteria for Métis healing practices differ from those of Inuit or First Nations, but the tests that the courts have developed for Métis are different and are included in this section for clarity in understanding their healing activities.

Ethnohistory, 9:4:404-423; Harold Hickerson, 1962b, "The Southwestern Chippewa: An Ethnohistorical Study," *American Anthropologist*, 64:3:(Part 2), Memoir 92; Harold Hickerson, "The Sociohistorical Significance of Two Chippewa Ceremonials," *American Anthropologist*, 65:1:67-85; Harold Hickerson, 1970, *The Chippewa and Their Neighbors: A Study in Ethnohistory*, NY: Holt, Rinehart, and Winston; Hoffman, Walter James. "The Midewiwin; or 'Grand Medicine Society' of the Ojibwa," in *Bulletin of the Bureau of American Ethnology, Seventh Annual Report, 1885-1886*, (Washington, DC: Government Printing Office, 1891), pp. 143-300; Basil H. Johnson, *Ojibwa Ceremonies*, (Toronto: McClelland and Steward, 1982); Basil Johnston, *Ojibwa Heritage*, (N.Y.: Columbia University Press, 1976), pp. 80-93; L.J. Lafleur, 1940, "On the Mide of the Ojibway," *American Anthropologist*, 42:4:706-708; Ruth Landes, 1937b, *Ojibwa Sociology. Columbia Contributions to Anthropology*, 29:1-144. NY: Columbia University Press (reprinted, NY: AMS Press, 1969), pp. xxx; Landes, Ruth. *The Ojibwa Woman*, *Columbia University Contributions to Anthropology*, 31:1-247, (1938; reprinted, NY: AMS Press, 1969; reprinted NY: W.W. Norton, 1971), pp. xxx; Ruth Landes, 1968, *Ojibwa Religion and the Midewiwin*, Madison, WI: University of Wisconsin Press (reprinted, NY: AMS Press, 1969); Jean-Louis Michon, 1964, "La Grande Medecine des Ojibways," *Societe Suisse des Americanistes, Bulletin*, 27:33-34, 28: 13-14; Jean-Louis Michon, 1972, "La Grande Medecine des Ojibways," *Societe Suisse des Americanistes, Bulletin*, 36:37-72; Jordan Paper, 1980, "From Shaman to Mystic in Ojibwa Religion," *Studies in Religion*, 9:2:185-199; Ruth B. Phillips, 1984, "Zigzag and Spiral: Geometric Motifs in Great Lakes Indian Costume," *Papers of the Fifteenth Algonquian Conference*, 1983, ed. by William Cowan, (Ottawa: Carleton University, pp. 409-424; Vivian J. Rohrl, 1967, "A Chippewa Funeral," *Wisconsin Archaeologist*, 48:2:137-140; S.C. Simms, 1906a, "The Metawin Society of the Bungees or Swampy Indians of Lake Winnipeg," *Journal of American Folklore*, 19:330-333; 1197 from p. 136; Christopher Vecsey, 1983, *Traditional Ojibwa Religion and its Historical Changes*, Philadelphia: The American Philosophical Society, pp. 174-190; Christopher Vecsey, "Midewiwin Myths of Origin," *Papers of the Fifteenth Algonquian Conference*, Ed. by William Cowan (Ottawa: Carleton University, 1983), pp. 445-467; Winchell, Newton H. (ed.), *The Aborigines of Minnesota. . . .*, (St. Paul: Minnesota Historical Society, 1911).

¹³⁸ [Métis Settlements Act, R.S.A. 2000, c. M-14.](#)

¹³⁹ C. Bell, "Contemporary Métis Justice: The Settlement Way" (Native Law Centre: Saskatoon, 1999); see also: Métis Constitutional Rights in Section 35(1) (1997) 36(1) *Alberta Law Review* 180-217, reprinted in J. Borrows & L. Rotman (eds) *Aboriginal Legal Issues Cases and Materials* (Butterworths: Toronto, 1998) 489; "Who are the Métis in Section 35(2) (1991) 83 *Alberta Law Review* 351, reprinted in Thomas Isaac (ed.) *Aboriginal People and Canadian Law* vol. 5; reprinted in Samuel W Corrigan (ed.) *Reading in Aboriginal Studies* (Bearpaw Publishing 1996); reprinted in J. Borrows and L. Rotman (eds.) *Aboriginal Legal Issues Cases and Materials* (Butterworths: Toronto 1998) 467.

The Métis National Council (MNC) anchors the constitutionally protected Métis peoples within the Métis homeland in western Canada. Métis peoples have a shared history, common culture (song, dance, dress, national symbols, etc.), a unique language (Michif with various regional dialects), extensive kinship connections from Ontario westward, a distinct way of life, a traditional territory, and a collective consciousness.¹⁴⁰

Although Métis people were included within s. 35 of the *1982 Constitution Act*, debate has arisen about who the Métis actually are. In the 2003 *R. v. Powley*¹⁴¹ case, the Supreme Court of Canada wrestled with Métis citizenship issues and attempted to establish a definition of Métis. *Powley* concerned hunting rights in the geographical area surrounding Sault Ste. Marie. In its ruling, the Court affirmed that Métis have constitutionally protected rights:

The inclusion of the Métis in s. 35 is based on a commitment to recognizing the Métis and enhancing their survival as distinctive communities ... the inclusion of the Métis in s. 35 is not traceable to their *pre-contact occupation* ... s.35 as it relates to the Métis is therefore different from ... Indians or the Inuit. The constitutionally significant feature of the Métis is their special status as peoples that emerged between first contact and the effective imposition of European control.¹⁴² (emphasis mine)

The Court had previously developed a pre-contact test in *Van der Peet*¹⁴³ for First Nations. This test was based on the constitutional premise that Aboriginal communities are entitled to continue those practices, customs, and traditions that are integral to their distinctive existence or relationship to the land. Applying the core purpose of this test, the Court focused on identifying Métis practices, customs, and traditions that are integral to the Métis community's distinctive existence and relationship to the land and that developed before Europeans imposed European forms of legal and political control. The Court stated:

¹⁴⁰ Métis National Council, Who are the Métis? Definition of Métis, online: <http://www.metisnation.ca/who/index.html> and <http://www.metisnation.ca/who/definition.html> (accessed March 9, 2009) [MNC Definition].

¹⁴¹ *R. v. Powley*, [2003] 2 S.C.R. 207, [2003] 4 C.N.L.R. 321 [*Powley*]. See also: Larry Chartrand A Commentary on Métis Identity and Citizenship from an International Law Perspective Native Law Centre, *Justice as Healing*, 2001 Vol. 6., No.2; For *Powley* and the history of Métis case law development see: Jean Teillet, "Métis Law Summary" online: http://www.metisnation.org/Harvesting/Powley_Case/assets/docs/MLS-2004.pdf, (accessed March 3, 2009).

¹⁴² *Powley*, *ibid* at para. 13 and 17.

¹⁴³ *R. v. Van der Peet*, [1996] 2 S.C.R. 507, [1996] 4 C.N.L.R. 146.

This unique history can most appropriately be accommodated by a *post-contact but pre-control* test that identifies the time when Europeans effectively established political and legal control in a particular area. The focus should be on the period after a particular Métis community arose and before it came under the effective control of European laws and customs. This pre-control test enables us to identify those practices, customs and traditions that predate the imposition of European laws and customs on the Métis.¹⁴⁴ (emphasis mine)

The Court rejected the argument that Métis rights must find their origin in the pre-contact practices of the Métis' Aboriginal ancestors. To do so would deny the Métis their full status as distinctive rights-bearing peoples. The Métis' own practices are entitled to constitutional protection under s. 35(1). In *R. v. Powley*, the right being claimed was a practice of both the Ojibway and the Métis.¹⁴⁵ This is important, because healing practices of the Métis must be viewed not only through a post-contact lens but also through a control test that identifies when Europeans established controls over health in a given area. The Métis, used a variety of herbs to alleviate physical and other ailments. Although the Métis healing practices may have subsided with the arrival of modern medicine post contact, the Prince George Métis, among others, continue to practice their medicines in the following ways:¹⁴⁶

Table 1

<p>Red Willow Tea – General ailments Yarrow – clearing mucous discharge from the bladder, reduce clotting time for internal bleeding Sage – eliminate spasms of the Gastrointestinal tract Nettle – to expel gravel and stones from any organ Echinacea – as a cleaner and purifier, heals infections, fevers, lung infections, wounds Dandelion – as a tonic to the system, blood purifier and builder Burdock – blood purifier, reduce swelling and deposits in the joints in Arthritis Rosehips - Source of Vitamin C, for infection, colds, sore throat, cleansing toxins Cranberry Juice – prevent and heal infections of the bladder Prunes and prune juice - heal ailments of the digestive tract, encourage movement of the bowels Onion Poultice – to relieve chest cold, bronchitis Mustard Poultice – treatment of colds, croup and pneumonia Spruce Gum – to relieve cold, healer for cuts, sores Wild Ginger – prevent ailments of the stomach and intestines, help rid body of waste and toxins Frog leaves – healing cuts, sores, boils</p>

¹⁴⁴ *Powley, supra*, note 142 at para. 37.

¹⁴⁵ *Powley, ibid.*

¹⁴⁶ Prince George Métis Elders Society, “Traditional Métis Healing Herbs & Medicine” 2009, online: <http://www.pgmetiselders.com/> (accessed September 2, 2010).

Métis remedies for an earache include:

Warm olive oil, drop into the ear, then apply a warm salt bag (a bag filled with salt and heated in the oven). A salt bag can be made ahead of time out of cotton or sacks for use in an emergency.¹⁴⁷

Historically, an onion was also used for treating an earache. Boiling an onion made it soft, so that the core in the centre could be very carefully placed into the ear....¹⁴⁸

For high blood pressure:

Garlic or nettle tea was traditionally used for high blood pressure. One clove of garlic was cut into slivers and put into warm milk. The brew was drunk before retiring at night.¹⁴⁹

Other interesting cures/interventions may include,

I remember Grandma telling me when Uncles Jack and Alex were born, they were more than 2 months premature. She said they fit in the palms of her two hands. She put cotton balls soaked in olive oil in their armpits for nourishment. She wrapped them in cotton and put them in a basket on the oven door. She said they were not able to suck so she had to squeeze a few drops of breast milk in their mouths every hour.¹⁵⁰

Métis Elder George McDermot says, “If you want to learn about medicines, then you have to come for a walk with me in the bush.” Elder McDermot continues:

When we go into the bush, we are going home. I can introduce you to a plant and tell you what it is. It is up to you to get to know it, to talk to it, to give it an offering. Sometimes people throw all kinds of different herbs together into a pot and boil them just because they are herbs. Some of the herbs work together and some of them can make you very ill. You have to be careful which herbs you mix together because you can hurt someone. Just like there are good mushrooms and bad mushrooms, there are good and bad herbs. You have to know which are good, without a doubt. When you pick medicine, you must pick it clean. Talk to it, my little brother. You do not step all over the medicines. You do not disrespect any plants, whether they are big or small, because a small plant can be just as powerful as a large plant. That plant’s life is a whole new world to people

¹⁴⁷ Rita Flamand, Métis Centre, National Aboriginal Health Organization, [*Métis Cookbook & Guide to Healthy Living, Second Edition*](#) (2008) at 94 [Métis Cookbook].

¹⁴⁸ Métis Cookbook, *ibid* at 94.

¹⁴⁹ Métis Cookbook, *ibid*.

¹⁵⁰ Yvonne Boyer, Wanda McCaslin, *Métis Healing: From our Grandmothers*, (Forthcoming 2012).

not familiar. It is a different life altogether, it is a different world view. There is nothing to be afraid of in the bush.¹⁵¹

The criteria for Métis healing practices are different from Inuit or First Nations, since the Métis people came into being post contact. The healing practices of the Métis developed through the guidance of the First Nation grandmothers long before the Europeans established political or legal controls and the Supreme Court of Canada articulated tests to prove these rights in *R. v. Powley*. Hence, the practices described in this section should properly be viewed as medicinal treatments and practices which meet the legal requirements for proving that such healing practices were in place before European control.

¹⁵¹ George McDermot, *In the Words of Our Ancestors: Métis Healing and Health*, National Aboriginal Health Organization, Métis Centre, 2008 (Ottawa: NAHO) at 24.

4.5 Inuit Healing¹

Keenan rubs noses with her son Keepseeyuk, near Padlei, NU, 1950



© Estate of Richard Harrington (permission granted October 26, 2010).

Author, John O’Neil suggests that the Inuit sought explanations for their illnesses that were grounded in their relationships with the physical, social, and spiritual environment.² The Inuit have a holistic view of health care: “mind, body and spirit are intrinsically linked, and a weakness in one will surface as a weakness in another aspect.”³

¹ Portions of the research materials for this section were collected by Contentworks Inc. for the Qikiqtani Truth Commission (2007-2010), an independent inquiry set up by the Qikiqtani Inuit Association to investigate and understand the history of Inuit-government relations in the 1950-1975 period and for the preparation of Y.M. Boyer, W.D. McCaslin, “Fiduciary Responsibilities between the Federal/Territorial Governments and Inuit Peoples 1950 – 1980,” prepared for the Qikiqtani Truth Commission (April 2010).

² John D. O’Neil, ‘Self-Determination, Medical Ideology and Health Services in Inuit Communities.’ Northern Communities: The Prospects for Empowerment edited by Gurston Dacks and Ken Coates. Edmonton: Boreal Institute for Northern Studies, 1988: 33-50 at 37 [O’Neil].

³ Ootoova, I., Atagutsiak, Q.T. Ijjangiaq, T., and Pitseolak, J. Joamie, Aa., Joamie, Ak., and Papatsie, M. 2001 Interviewing Inuit Elders. Vol. 5 Perspectives on traditional health. Nunavut Arctic College, Iqaluit, Nunavut in Paleah L. Black, John T. Arnason, & Alain Cuerrier, “Medicinal plants used by the Inuit of Qikiqtaaluk (Baffin Island, Nunavut) Botany 86: 157-163 (2008) at 157 [Black Study].

For many Inuit, health signifies the link between the soul (*tanniq*) and the body (*tiimuit*). Consuming country food builds this connection. The belief is that country food strengthens the Inuit and connects them with the land. It reinforces a spiritual connection between health and the land. Hunting and eating seal in particular is essential for the life of the soul and the body.⁴ Hunting has always been critical to the Inuit for maintaining good health.⁵

Professor Michele Therrein notes that, among the Inuit of Povurnituq, three forces contribute to their good health. The body is the outcome between the *anirniq* (breath which confers vitality, energy, and warmth), the *tarniq* (immortal soul of a person), and the *atiq* (name and assurance of one's intellectual development and identity).⁶ Therrein states:

...the Inuit continue to believe that the *anirniq* disappears upon death, the *tarniq* continues on to survive beyond the individuals passing, and the *atiq* remains a direct bond to their ancestors, the source of life.⁷

The healing therapies used by the Inuit vary. Some involve touching or breathing upon an individual. Other healing methods engage a group of people, who accompany the healing process with songs, drums, dance, and spoken words:

The cure has equally a dimension of power. Not the unilateral power of healing but of participatory power in a context known to all: the power of evil spirits possessing the body, or that of a theft of one of the constituents of the person: the power of the *angakkuq* to do away with the illness affecting the body's integrity through the intermediary of his spirit helper; the desire of the illness to submit to the cure and to his prescriptions; to engage not only the individual in the healing but also the participation of the family group and of the community as a whole in the cure; to call out to the animals and the participatory forces of the external world to man through an association of the illness to the excesses found in nature.⁸

In 1823, Dr. Robert Bell noted:

⁴L. Borre, *Seal Blood, Inuit Blood, and diet: A biocultural model of physiology and cultural identity*. Medical Anthropology Quarterly. 5(1), 48-62 in Douglas Vasiliki, "Inuit healing and Southern Health Care: Conflicting Paradigms or Nested Epistemologies?" in *Breaking the Ice: Proceedings of the 7th ACUNS Student Conference (2003)* at 59 [Douglas].

⁵Borre, in Douglas *ibid*, at 60

⁶Therrein, M. *Corps sain, corps malade chez les Inuit: Une tension entre l'intérieur*. In *researches Amerindiens au Québec*. Vol. XXV(1)p 71-84 in Douglas at 60 [Therrien in Douglas].

⁷Therrien in Douglas *ibid* at 60.

⁸Therrien in Douglas *ibid* at 60.

The wild Eskimo appear to suffer fewer diseases than Indians or Whites. ... They also have a class of medicine-men whose pretensions to perform all kinds of miracles are one of the most extravagant characters. They appear to deal almost entirely in the supernatural, and to make little use of medicines. They have no hesitation in declaring to their own people that they can cure all kinds of disease and prolong life indefinitely, if they only choose to do so. They account for their own death by saying that they wish to die, or that they are overcome by a still greater, but unseen, medicine-man. They say they can and do make themselves larger or smaller at will, or change themselves into some other animal, or enter into a piece of wood or stone; that they can walk on the water or fly in the air; but there is one dispensable condition, - no one must see them. They find themselves powerless to perform these miracles if anyone is looking on.⁹

...

Some of the Eskimo women profess to be doctors. They have a few minor surgical appliances, and they alleviate the pains of rheumatism, scurvy, sprains, etc., by rubbing or manipulating the parts affected. But their chief mode of cure is by stroking the body with an air of mystery while repeating charms. The doctor is generally accompanied by other women, who join in the choruses of the charms.¹⁰

In relation to medicinal plants, Dr. Bell noted:

The Eskimo, who live entirely on raw animal food, appear to regard any edible vegetable substance as medicine. They eat with great relish the northern blueberries and cranberries, and where they cannot get these, they take the leaves of the dwarf willows, a plant of the parsley family, called "scurvy-grass" (*Lingusticum*), and almost any kind of seaweed. On the shores of Hudson's Straits they collect and eat the starchy roots of *Polygonum viviparum*, which grows there in considerable abundance. It is a singular circumstance that, notwithstanding the sameness of their food, and the fact that they never wash either their bodies or their clothing, the Eskimo appear never to be afflicted with scurvy, whereas white men, under a similar regimen, would be almost certain to be attacked.¹¹

The balance for Inuit healing was maintained between life, breath, soul, and identity as well as by relying on marine mammals and the goodness of plants.¹²

The Nunavut Arctic College Report, "Interviewing Inuit Elders: Perspectives on Traditional Health," provides an interesting study on healing methods used by the Inuit before contact. The

⁹ Bell, *supra* note 31 at 10.

¹⁰ Bell, *ibid.*

¹¹ Bell, *supra* note 31 at 10,11.

¹² Therrien in Douglas *supra* note 155 at 60- 61.

report shows the Inuit use of seal and other mammals as well as their use of the plants in the natural world to create a healthy balance. This healthy norm went “out of balance” only after European diseases were introduced.¹³ For instance, Ilisapi, an Inuit Elder, spoke about the medicinal uses of the seal:

Cuts and wounds

When a seal was caught, was the blubber saved so that it could be used for medicinal purposes, such as for covering wounds?

Ilisapi: When we caught a seal, we did not just think of cuts and wounds. What we thought of first was oil for the *qulliq*, the lamp, as that was our only source of heat. The thin layer beneath the blubber would be saved for the dogs. The blubber around the flippers was saved entirely for the lamp. Oil would also be used as ear drops for children with earaches to help them feel better. If a wound was too dry, oil would be applied to keep it moist. I do not know how this was done as I was born after *qallunaat* were already present. Sometimes, when new skin was being formed over a wound and it cracked, oil was applied. It was also applied to skin that had been sunburnt. We would not put much on; just enough to keep the skin from cracking. We grew up around the R.C.M.P. base so we had ointment. If it was packed away in the sled, then we would use seal oil to protect our skin from cracking while we were travelling.¹⁴

Although Ilisapi grew up around the RCMP base camp, the uses of the seal remained inherent in Inuit knowledge and practices, and the RCMP acknowledged the Inuit source of this knowledge.¹⁵

In a study on the Inuit use of plants to maintain good health and treat sickness, Professor Black (the Black Study) reports that, prior to the arrival of mass medical evacuations and nursing stations, Inuit Elders described their health practices as involving the mind, body, and spirit. In fact, the four Inuit Elders interviewed recalled a detailed pharmacopoeia. In 2006, Black et al noted the Inuit uses of plants in their ethno-botanical Nunavut study of 13 species. The study

¹³ See, Nunavut Arctic College, *Interviewing Inuit Elders*, Tununirmiut Elders (North Baffin), Sick Body: Diagnoses and Treatments, 2001, Vol. 5 Ch. 1 at 2, online: <http://www.nac.nu.ca/OnlineBookSite/vol5/chapters.html> for topics such as: Sick Body: Diagnoses and Treatments; Physical Disorders and Mental States: Cultural Representations and Answers; Aanniasiutigijauvaktuviniit, Materials Used for Healing and Childbirth [Mamisaijjusituqait: Counselling and Healing Practices](#); The Importance of Thoughts, Feelings, and Words; Piruqtuit, Plants of the Land [Interviewing Inuit Elders].

¹⁴ Interviewing Inuit Elders, *ibid.*

¹⁵ *Ibid.*

assessed the level of consensus among the Elders for their medicinal uses of the plant species as well as for the use of a particular plant for a particular illness.¹⁶

The Elders in the study stressed the importance of these plants as part of their regular diet to maintain health. One Elder stated, “We were very rarely sick before we moved into settlements. I was taught to eat some plants from the land so I was not sick.”¹⁷ Because the Inuit existed largely on an animal-based diet, the use of plants to maintain general health would have been important, as plants contain antioxidants.¹⁸ Additional studies confirm that willows and lichens contain antioxidant and antimicrobial properties.¹⁹ Brown algae possess antiviral properties, and fucoidan provides additional food components.²⁰

The results of the Black study are important; because they conclude that the Inuit’s medical knowledge is well preserved and was in existence before European contact. The Inuit developed knowledge over generations about how to survive and stay healthy under harsh

¹⁶Black Study, *supra* note 154 at 157.

Four open ended questions were asked during the 4 Elder interviews:

- (i) What local plants were used as medicines?
- (ii) What illnesses did the plants treat?
- (iii) How was the plant prepared to treat illness?
- (iv) Who taught you this information?

Other secondary methods of gathering information for the study were also used such as

“These secondary ethnobotanical data were obtained from archived CBC radio interviews, which included informants from Iqaluit and Cape Dorset, from Inuit Piquisingit (Medicinal Plants 1 and 2), and an Inuit Broadcasting Corporation video production, which included informants from Iqaluit and Pangnirtung and, finally, from interviews done in the context of Ootoova et al. (2001), which included informants from Iqaluit, Pond Inlet, Arctic Bay, and Igloodik. These recordings covered the time period from 1976 to 1999” (Black Study, *ibid* at 158).

¹⁷ Black Study, *ibid* at 161.

¹⁸ Medicinal plants with antioxidant activity as an obvious dietary supplement for people relying upon animal-based diets has been documented for boreal and arctic plants. See, McCune, L.M., and Johns, T. 2002. Antioxidant activity in medicinal plants associated with the symptoms of diabetes mellitus used by the Indigenous Peoples of the North American boreal forest. *J. Ethnopharmacol.* 82: 197–205; Fraser, M.-H., Cuerrier, A., Haddad, P.S., Arnason, J.T., Owen, P., and Johns, T. 2007. Medicinal plants of Cree communities (Québec, Canada): antioxidant activity of plants used to treat Type 2 Diabetes symptoms, *Can. J. Physiol. Pharmacol.* 85: 1200–1214.

¹⁹ Källman, S. 1993. Salicylater och antibakteriella substanser hos vilda växter. *Sven. Bot. Tidskr.* 88: 97–101; Müller, K. 2001. Pharmaceutically relevant metabolites from lichens. *Appl. Microbiol. Biotechnol.* 56: 9–16; Ingólfssdóttir, K. 2002. Usnic acid. *Phytochemistry*, 61: 729–736; Aslan, A., Güllüce, M., Sökmen, M., Adigüzel, A., Sahin, F., and Özkan, H. 2006. Antioxidant and antimicrobial properties of the lichens *Cladonia foliacea*, *Dermatocarpon miniatum*, *Everinia divaricata*, *Evernia prunastri*, and *Neofuscella pulla*. *Pharm. Biol.* 44: 247–252.

²⁰ Lee, J.B., Hayashi, K., Hashimoto, M., Nakano, T., and Hayashi, T. 2004. Novel antiviral fucoidan from sporophyll of *Undaria pinnatifida* (Mekabu). *Chem. Pharm. Bull.* (Tokyo), 52: 1091–1094.

conditions and how to make the best use of the overall species diversity, which is limited compared to the south. The Inuit's clear ability to use these sources came from their inherent traditional knowledge of how to practice good health in the land of their ancestors.

4.5.1 The Inuit Sled Dog and Healing

The *qimmiq* is also known as the Canadian Inuit dog, Inuit dog, Canadian Eskimo dog, or *canis familiaris borealis*. This topic is important because of the close human connection to dogs, the dog being the non-human person, the counterpart of the Inuit. The dog is the basis for Inuit health, has a close connection and elevated status in Inuit society. The dog served critical functions in Inuit health not only by providing hunting methods but also as a vital aid in healing the sick.

Author Frances Levesque describes the origins of the *qimmiq*:

Dogs arrived on the American continent about the same time as humans did, or right after them. However, over the centuries, various breeds of dogs came into the world on the American continent. This is the case for the *qimmiq*. Unlike the Siberian Husky and the Samoyede which are both Asian breeds that migrated towards the American continent, the *qimmiq* is, with the Malamute, the only dog breed that came into the world on the American continent. While the Malamute originated in Alaska and remained there until today, the *qimmiq* migrated towards Canada from Alaska with its Thule masters towards the year 1000.²¹

An Inuit Elder comments:

The most important part of the dog is that way back from the beginning of the world the Inuit have been having dog teams and they have saved lives from starvation and the dog team helped a lot to the Inuit, and that's the most important part of dog team.²²

²¹Francis Levesque, *The Inuit, Their Dogs and the Northern Administration, from 1950 to 2007* (footnotes omitted). *Anthropology of a Contemporary Inuit Claim*, 2008 at 31 [Levesque]. This also fulfills the Supreme Court requirement that the use of the *qimmiq* was in existence before the Europeans landed in North America and not as a result or response of the Europeans landing in North America (*R. v. Van der Peet*, [1996] 2 S.C.R. 507, [1996] 4 C.N.L.R. 146, at para. 73). The activity that is claimed to be an Aboriginal right must have developed before "contact." Practices that developed "solely as a response to European influences" do not qualify as an Aboriginal right. (paras. 60-62).

²² Elder interview in Kerrie Ann Shannon, 'The Unique Role of Sled Dogs in Inuit Culture: An Examination of the Relationship between Inuit and Sled Dogs in the Changing North.' Master's Thesis. Edmonton: University of Alberta, 1997 at 92[Shannon]

The Inuit Elder is clarifying that the Inuit sled dog has existed as long as the Inuit have.

The dog was used for a variety of purposes, yet the connection between human health and the Inuit sled dog was the most important. The *qimmiq* take part in many aspects of Inuit daily life and survival: hunting, clothing, warmth, hauling, and transportation. As a result, the dog team is tied to the physical, emotional, psychological, and spiritual health—indeed, the total well being—of the hunter and the hunter’s family.²³ Levesque notes some of the utilitarian purposes of the sled dog:

Transportation: The *qimmiq* pulled a sled in the winter and served as a pack animal in the summer. They often carried large loads of supplies and assisted with hunts and relocating families from camp to camp.

Aid in Hunting: The dogs actively participated in hunting. Levesque comments that, “it scents tracks, chases animals and may even become an essential partner, for instance, for bear hunting. In fact, for many Inuit populations, the dog was actually more useful for hunting than for transportation.”

Fur: Dogs who have outlived its usefulness are killed, and their fur is used for mitts or other clothing, since “dog skin does not freeze and keeps the hands warmer than sealskin mitts.”

Spare Meat: Dog meat was eaten, but only as last resort and exclusively during times of extreme famine.²⁴

In her Master’s thesis Kerrie Ann Shannon lists several other more modern uses of the dog that affect Inuit health.²⁵ These include:

Releasing Emotions: The interdependency of the hunter and his dogs is reflected in emotions. If the hunt is successful, the dogs, the hunter, and his family benefit. All enjoy or suffer the consequences of successful or failed hunts.

Fun: Inuit children play with puppies to develop the bond between dogs and their humans.

²³ Shannon, *ibid* at 49.

²⁴ Levesque, *supra* note 172 at 36-42.

²⁵ Shannon, *supra* note 173 at 37-56.

Racing: Dog racing is done for fun as well as for serious sport in some Arctic communities.

Responsibility: Working with dogs teaches Inuit youth the value and importance of being a good dog team master by training and caring for the dogs.

Predicting Weather: Dogs can sense and alert humans to imminent storms.

Safety: Dogs warn humans about polar bears and wolves; they alert the hunter to cracks, crevices, and thin ice; dogs will get the hunter(s) home during a blizzard; they help an unconscious or wounded/disabled hunter; and they remember previous trails and know how to get their master home.

Protection: Dogs protect their humans from polar bears, wolves, other dogs, and people who intend to hurt their master.²⁶

Shannon also mentions the cultural aspects of the dog team and the dog/Inuit relationship: “Dog teams are more than just a form of transportation; they are an integrated part of Inuit life.”²⁷ Quite simply, the Inuit could not have survived as a society without the sled dog.

I remember dogs as being part of our life, as part of our livelihood. I would get mad, scold them, if they were happy, we try to make them happy, you have to handle them properly, they too are alive, like today any person if he has good food is loved by his family, have a good life, dogs treated the same way, enjoyed the company of dogs, constant companions. If they accepted us as their masters, we were their humans, dogs were part of our livelihood, part of our tradition, and teach dogs to be good dogs, not to be naughty. If you are a good handler, I found out the benefits of having a dog team, not the ski-doo. If you get tired, you stop, your thumb. If you got tired with dogs, they did not stop, some of us would be brought home without noticing without giving any commands, they knew the trail, especially near home. How much of a partnership it was, when dogs felt that they were being abused, they themselves would become nasty and wilful dogs, by loving them, by treating them our constant companions, the dogs would reciprocate, it depended on the person, if you treat them properly, nicely, patiently, but a ski-doo if it breaks down, it won't start after that. Even when they feel asleep, without uttering another command, the dogs would take us home.²⁸

²⁶ Shannon, *ibid* at 38-56.

²⁷ Shannon *ibid* at 46.

²⁸ Interview of Isaac Qiyuapik 100695 PDF, Qikiqtani Truth Commission, Community Hearings 2008.

The *qimmiq* is not simply a method of transportation; the purposes fulfilled by the sled dog go to the core elements of Inuit-ness. The *qimmiq*–Inuit relation marks the central reality of Inuit society and fulfills the Supreme Court tests of determining what an Aboriginal right is. Levesque supports this view. Examining the role that the dog plays in the Inuit mythical universe, he reports that the dog has a place at both the origin and the end of Inuit life.²⁹ Direct evidence confirms that the *qimmiq* originated in North America and was not introduced from Europe and has always had an integral role in Inuit society. The dog forms a spiritual, symbolic, and economic whole with its master, and this bond can be traced to the dog’s place in the ancestral Inuit order and relationship with the ecology. Shannon offers the concept of sled dogs as non-human persons:

The reason for calling an animal a non-human person is to emphasize the relationship the animal has with human society according to some peoples' particular perceptions of the natural world.³⁰

He or she must be willing to accept that social life and communication among subarctic hunter-gatherers include a wider range of 'persons' than the language and culture of social science generally admit.³¹

In Inuit society, the *qimmiq* is distinguished as a member of human society: it is the only animal that is given a name (*atiq*); it has a social identity. Inuit children are also given an *atiq*. Levesque argues that because the dog is given an *atiq*, the dog is accorded the same social standing as a human being. As such, the dog is acknowledged as a vital and equal part of Inuit society:

The *atiq* of a dog is just like the *atiq* of a human being. It is an autonomous entity with its own characteristics, allowing the dog that carries it to integrate into a particular social network. Since it has an *atiq* as humans do, the dog is part of human society. By giving it an *atiq*, the dog is part of human society.³²

²⁹Frédéric Laugrand, & Jarich Oosten, 2002 “Canicide and Healing: the Position of the Dog in the Inuit Cultures of the Canadian Arctic,” *Anthropos (St-Augustin)*, 97(1): 89-105 [Laugrand Oosten]. Laugrand notes that it is significant that the myths entail the dog at the creation of life and at the end of life, see page 91 “On one side the dog is often represented as the first ancestor of human beings, on the other as the guardian of the realm of the dead. Those who enter the world of the dead have to get past the dog that is guarding the entrance. Thus the dog is at the beginning and at the end of life.”

³⁰ Shannon, *supra* note 173 at 1.

³¹ Shannon, *ibid* (footnotes omitted).

³² Levesque, *supra* note 172 at 58.

Levesque explains the significance of the *atiq*:

The *atiq* is an autonomous and immortal entity carrying a group of qualities, abilities and desires. Guemple writes that the *atiq* incorporates the status, the nature and the attributes of the one who possesses it. In fact, the *atiq* gives the one who holds it a defined social status within society.

Without an *atiq*, a human being is nothing, both at the personal and at the social level. As such, the *atiq* is the symbol of social continuity.

The *atiq* always comes from a deceased person or a person who is about to die. As a result, an elder may share with future parents the desire for his or her *atiq* to be attributed to the child about to be born. *The deceased who wants his or her atiq to be given to a child will appear in the dreams of the parents or the relatives of the new parents. In this way, elders and deceased people may decide to live again, through their atiq, in the bodies of newborns* (emphasis mine).³³

Dogs may be named after humans, deceased relatives, aunts, uncles, or grandparents. These deceased relatives may “decide to live again, through their *atiq*.” In these cases, the Inuit will therefore not only respect the social relationship through the dog’s *atiq*³⁴ but may also consider the dog as a deceased ancestor.³⁵ Levesque explains:

Hadwen points out that the Inuit from eastern Arctic Canada, for instance, did not want to sell or trade their dogs because of the “cultural attachment” they feel towards them. In terms of the Polar Inuit, a part of their population being relatives originally from Baffin Island, trading and selling dogs only occurs among close relatives. To this end, Freuchen recounts that one day an Inuk refused to sell him a dog telling him “I cannot sell it, for it is my grandfather”.³⁶

It is also interesting to note that when Christianity was brought into Inuit communities, at least in Repulse Bay, some sled dogs were also Christianized. In Naujaat (Repulse Bay), Freuchen reported that the sled dogs had to wear crucifixes on their necks. In the town of Iglulik, the Christian leader Umik asked that all visiting people shake hands with the dogs.³⁷ There are also reports of sexual activity between men and dogs and women and dogs. Laugrand and Oosten

³³ Levesque, *ibid* at 56 (footnotes omitted).

³⁴ Levesque, *ibid*.

³⁵ It is then easy to understand why the killing of Inuit dogs in the 1950s and 1960s caused great social harm. See the Qikqitani Truth Commission, online: <http://www.qtcommission.com/> (accessed January 17, 2010).

³⁶ Levesque *supra* note 172 at 60.

³⁷ Laugrand and Oosten *supra* note 180 at 94.

quote Rasmussen, who reports: “it was viewed as common practice and no shame was attached to it. Even respectable hunters might be involved in it. Specific rules had to be observed.”³⁸

The *qimmiq* played another critical role in Inuit health: the Inuit killed a dog when its death would help its owner heal.³⁹

4.5.2 Connection to Human Health

Some Inuit believe that the relation between humans and dogs makes the difference between health and sickness. In his article, "*Adaptive Innovation Among Recent Eskimo Immigrants in the Eastern Canadian Arctic*," Freeman claims that Inuit from Port Harrison (relocated to Grise Fiord in the 1950s) believe deeply in the correlation between human health and the dog.⁴⁰

Similar to Freeman's and Taylor's accounts, some Inuit spoke of the connection between human health and the dog,

The general notion is that when a sickness would come to a household it would be better if the sickness was taken by dogs or a dog rather than by any of the people. One elder explained: My father used to tell me always to have a dog because sometimes sickness came to the household but the dog took it from the people in the house; he used to tell me always to have a dog around the house. Furthermore, during another interview my interpreter explained that the reason some people keep a dog was because they were told by parents or elders to always have at least one dog around, in case of sickness.⁴¹

According to some people's beliefs, dogs can function to protect human health. In a different manner, Jensen mentions a connection between dogs and human health. He reports about the notion that dogs should not be beaten for biting a human. If the dog was beaten the wound would become worse because the *inua* [spirit] of the dog would be angry. He also mentions how some Inuit use hair from the dog to dress the wound of a dog bite.⁴²

In Northern Baffin Island, it was believed that the death of a dog that bit a person would prevent the person from healing, therefore dogs that had bitten people were killed only after the

³⁸ Laugrand and Oosten *ibid* at 95.

³⁹ See, Laugrand Oosten, *ibid* at 96 to 101.

⁴⁰ J.G. Taylor, (1993). "Canicide in Labrador: Function and meaning of an Inuit killing ritual." *Études/Inuit/Studies* 17:1 p.3-14 [Taylor]; Freeman, Milton M . R. 1967 "An Ecological Study of Mobility and Settlement Patterns Among the Belcher Island Eskimo," *Arctic* 20(3): 154-175. 1969 "Adaptive Innovation Among Recent Eskimo Immigrants in the Eastern Canadian Arctic." *Polar Record*, 14 (93): 769-781.

⁴¹ Bent Jensen, 1961 "The Folkways of Greenland Dog-Keeping." *Folk*, Vol. 3 43-66 [Jensen].

⁴² *Ibid* (footnotes omitted).

victim healed.⁴³ If the owner was ill, dogs could also be mutilated or killed to heal their owner, for instance, an Inuk Elder from Salluit recalls,

[W]hen a person or other members of his/her family became sick they would kill sometimes their most valued dog and subsequently would be healed from their sickness. [...] Whenever someone, an adult or a child was very ill, a dog had to be killed in hopes of becoming healed as we value people more than a dog and whenever they killed a dog that sick person would be healed.⁴⁴

Taylor also described dogs being mutilated or killed in Labrador, so that their owners may heal:

First, he describes the way an Inuk who is sick stabs one of his dogs and washes his hands with the blood. This act is meant to “help save him from death and the dog should die instead of him.” Then he describes a similar case in which a man who was sick was about to get on a boat, and because he wanted to prevent the disease from following him, he washed his hands with the blood of a dog he had just stabbed. He finally describes the way “[a] widow also requested her son to cut off the ears of one of his dogs so that she would recover [...] She specified that the dog should not be ‘livelier and healthier than herself’.”⁴⁵

Laugrand and Oosten also recall that Reverend Edmund James Peck, a missionary in Nunavik during the late 1800s, noted a similar circumstance. An Inuk who was ill killed his beloved dog in hopes of recovering from his illness.⁴⁶ Laugrand and Oosten also report that, when the dog is mutilated and killed for the purpose of healing its master, the assumption is that this works because the dog is part of society and forms a whole with the master.⁴⁷ The mere fact that the dog and its owner are one makes it possible for a transfer of relations between them: “by killing the dog or destroying part of the dog, significant others (spirits, enemies) will consider the patient as dead and there is no need to kill him anymore.”⁴⁸ Because these relationships occur within a whole,

[T]he transfer between the dog and its master is possible. The dog substitutes itself for its master and dies instead of him. This way, the master may heal. Therefore, it is only because the master and his dog form a whole that this

⁴³ Agiaq interview in Levesque, *supra* note 178 at 66 citing Laugrand and Oosten.

⁴⁴ Levesque, *supra* note 172 at 66 citing interviewee M-020.

⁴⁵ Taylor, *supra* note 191 cited in Levesque, *ibid* at 66.

⁴⁶ Laugrand and Oosten, *supra* note 180 at 97.

⁴⁷ Laugrand and Oosten, *ibid* at 102.

⁴⁸ Laugrand and Oosten, *ibid*.

transfer of relation is possible and that the mutilation or elimination of a dog can help its master to heal.⁴⁹

Peck also reports that west of Hudson's Bay, "the angakkuq questions the sick man of his past life and deeds. After confession the conjuror orders one of the sick man's dogs to be shot,"⁵⁰ quite likely for the same reasons as Laugrand and Oosten described.

In another story, when a woman went back for a dog that was lame, the dog uttered a song in response:

*My dog's down there
Its skin down there
Its foot-sole down there
My gift, my present,
The one without a pattern, ajai
There, there, yonder
A skin boat put off from land
At (the spirit) Manilik's he was born
Aijauna uwshale-una
Ufvatitaujaq
Niklatitaujaq
Poq poq poq!⁵¹*

The last few lines are "special dog words that cannot be turned into comprehensible human speech, but they are of powerful effect, driving out evil spirits, when uttered by a sick person."⁵² It may be that the song was a gift from the dog to the woman for her to use for future healing purposes.

Many healing substances are derived from the dog, which are known to possess strong healing powers:

⁴⁹ Levesque commenting and citing Laugrand and Oosten, *ibid* at 67.

Eliminating dogs to hasten the end of the world is a fascinating phenomenon. It is interesting to note that the Inuit who wanted to end the world in order to rush the coming of Jesus chose to kill their dogs. Not only were they putting their lives at risk by depriving themselves of the means to travel and hunt, moreover, they eliminated one of the central elements of their society. In this case, the dog was not killed because it threatened its symbolic unity with its master, but rather because the Inuit deliberately wanted to break this unity and thus jeopardize the society by breaking one of its most important components (Levesque, *supra* note 172 at 68).

⁵⁰ ANC/GSA/Peck Papers M56-1, XXXV no 19 in Laugrand and Oosten *supra* note 180 at 97.

⁵¹ Laugrand Oosten *ibid* at 100.

⁵² Laugrand Oosten *ibid* .

Various substances derived from the dog such as urine, saliva, and excrements were credited with strong healing powers. According to Salumi Ka&&ak Qalasiq from Kangir&iniq (Rankin Inlet), the urine of old dogs was used to cure patients. Felix Pisuk, from the same community, had to try the remedy as a child, but he immediately threw it up. Pisuk stated: “I have heard that some people when they are sick cut themselves a little, then get the dog to lick them because of its healing power.”⁵³

Manilaq, a Netsilik woman, explained to early explorer Knud Rasmussen:

When I was a girl my grandmother took me out with her and found old dog turds for me. Every single turd I had to wet with my tongue, and when it was softened I had to rub myself with it all over my breast and stomach. That made me vigorous, for the old shaman told me that dog turds, used in the right way, possess magic powers and a kind of fountain of youth.⁵⁴

Among the Copper Inuit, Rasmussen noted that the “saliva of a dog is good for certain ailments, especially those of long duration. The saliva must be swallowed, and then something must be given to the dog in payment, for instance a handsome collar of skin.”⁵⁵ Diamond Jenness referred to the healing qualities of dog saliva. He related that his dog was thought to restore lost souls of patients; a white caribou fur was attached to its neck in recognition of this.⁵⁶

The head of the dog could also be used for its healing properties:

In Mittimatalik, a dog’s head was given to a boy to eat when he is one year old, so that he will have a strong head.⁵⁷

Another way the dog may assist in healing its owner is very interesting:

⁵³ Salami Ka&&ak Qalasiq and Felix Pisuk. Interviews with H. Kablalik and F. Laugrand, December 1999. In south Baffin Island, Elders state that if you throw your tooth to a dog, you would have strong and excellent teeth (Therrien, M. & Laugrand F. 2001 Perspectives on Traditional Health. Iqaluit: Nunavut Arctic College, Nortext (Interviewing Inuit Elders, 5) at 210.

⁵⁴ Laugrand Oosten *supra* note 180 at 100 citing Rasmussen, Knud 1931, *The Netsilik Eskimos. Social Life and Spiritual Culture*. Copenhagen: Gyldendalske BoghAndel, Nordisk Forlag (Report of the fifth Thule Expedition 1921-24, 8/1-2) at 221 f.

⁵⁵ Laugrand Oosten *supra* note 180 at 100 citing Rasmussen, Knud 1932, *Intellectual Culture of the Copper Eskimo*. Copenhagen: Gyldendalske BoghAndel, Nordisk Forlag (Report of the Fourth Thule Expedition 1921-24 at 49.

⁵⁶ Laugrand Oosten *supra* note 180 at 100 citing Diamond Jenness, 1922, *The Life of the Copper Eskimos*. Southern Party 1913-16. Ottawa: F.A. Acland. (Report of the Canadian Arctic Expedition, 1913-18, 12 at 172.

⁵⁷ Laugrand Oosten *supra* note 180 at 100 citing Boas, Franz, 1907, *The Eskimo of Baffin Island and Hudson’s Bay* *New York* (Bulletin of the American Museum of Natural History, 15/2 at 514.

[W]hen a person falls sick the *angekut* changes his name in order to ward off the disease or they consecrate him as a dog to Sedna. In the latter event he gets a dog's name and must wear throughout life a harness over the inner jacket.⁵⁸

These reports of the healing properties of the *qimmiq* are very interesting and give indisputable evidence that the *qimmiq* is not “just a dog” as far as the Inuit are concerned. The sled dog is more than a beloved family pet or a loved sub-member of the family or even a working dog. It is a part of the circle of the Inuit family, an integral family member that is connected holistically to the individual, the family, the community, and Inuit society. The Inuit and dog live in a symbiotic interdependence: neither is able to exist without the other. One may even say that the Inuit may consider the dog as an ancestor. The life of the dog may even be sacrificed in certain circumstances to heal its human companion and family. The existence of the *qimmiq* bores directly into the Inuit's root of being and embodies a core value of Inuit society. Its existence and its use for purposes of health and healing can be considered an inherent right to life for the Inuit. It is also understandable that when the RCMP slaughtered the Inuit sled dogs in the 1950s to the 1970s that the core and spiritual being of the Inuit was torn and deeply affected causing great stress on the human body.⁵⁹

4.3 Summary

Although Aboriginal medical systems have often been misunderstood and undermined, they embody “sets of coherent beliefs and practices that were well integrated within society which served important social, religious as well as medical functions.”⁶⁰ As O'Neil and Postl note, much of what was written by the explorers and missionaries were presented from their vantage point. They did not share the world view of those they observed. As a result, they often failed to see Aboriginal medicine in its own terms—as practiced by its own practitioners.⁶¹

These healing practices were comprised of intricate ceremonies, which served to cement these practices into laws of their respective societies. Documented evidence amply supports the

⁵⁸ Laugrand Oosten *supra* note 180 at 100.

⁵⁹ The Honorable Jean-Jacques Croteau, “Final report of the Honourable Jean-Jacques Croteau, Retired Justice of the Superior Court, regarding the allegations concerning the slaughter of Inuit sled dogs in Nunavik (1950 – 1970)” Office of the Minister responsible for Native Affairs and Makivik Corporation, March 3, 2010.

⁶⁰ Waldram, *supra* note 55 at 99.

⁶¹ O'Neil & Postl, *supra* note 15 at 79-80.

conclusion that the therapeutic ceremonies and healing practices were integral to the existence of Aboriginal societies. The Jesuits, the explorers, and the traders who witnessed and wrote about these practices acknowledged their importance in the healing practices of Aboriginal people. The documented operations of these pre-contact and pre-control practices affirm an Aboriginal right to health and an Aboriginal right to achieve and maintain health by traditional Aboriginal means. Europeans did not teach Aboriginal people how to heal or practice healing methods; these methods of healing and health-preserving ways were already in existence when the Europeans arrived in North America.

A large body of historical evidence confirms that the explorers, missionaries, and traders witnessed healing practices by the people they encountered. Aboriginal healing practices cannot be dismissed as merely incidental to Aboriginal society in the pre-contact period.⁶² Nor were the practices common to all societies—another test outlined by the courts. Instead, they differed nation to nation. They are distinct, integral aspects of distinct Aboriginal societies. As such, they stand as generic rights under the larger umbrella of Aboriginal rights, which Chapter 7 will explore.

⁶² The Crown may argue that these rights were “extinguished” when “Indian medicine” was made illegal through the *Indian Act*, or that the fact that medicine is now regulated will justify that exclusion of Aboriginal traditional practices. The extinguishment of Aboriginal rights after the Constitutional amendments in 1982 make it very difficult for the Crown to prove, since any infringement of s. 35 rights after requires that the Crown consult and accommodate Aboriginal peoples’ interests.

5. Historical Health Influences

5.1 Historical Determinants of Health

Following European contact, the health of Aboriginal peoples declined dramatically. A number of factors contributed to this decline, including: epidemics of new diseases; loss of traditional lifestyles; change to a nutritionally inadequate diet; depletion of food resources; dislocation of life styles; confinement to reserve land; and the implementation of laws to force assimilation, the residential school system in particular.¹ Aboriginal people currently experience overall inferior health compared to the health of the non-Aboriginal population. Correlating these historical health influences to current Aboriginal health is the subject of this chapter. Maureen Lux's, *Medicine That Walks*² and the *Report of the Royal Commission on Aboriginal Peoples*³ document how the residential school system fostered the spread of disease through inadequate and overcrowded health facilities. These two works show how federal government policies caused suffering, hunger, starvation, disease, and death to Aboriginal peoples. Although not exhaustive, the following section will highlight some particularly poignant historical events and timeframes that influenced current federal Aboriginal health policies. It will also indicate how these historical events and policies have played a critical role in shaping the health of Aboriginal people today.

5.1.1 Epidemics

The absence of epidemics and “scourges” among small hunter-gatherer societies is not particularly surprising. Such “crowd” diseases, as they have been referred to, are only capable of being sustained in large populations, where they can move from area to area as immunities develop, awaiting the next generation of non-resistant children. Studies show, for example, that measles can only persist in populations of over half a million people, where the disease

¹Judith Bartlett & Richard Jock, *An Examination of Aboriginal Health Service Issues and Federal Aboriginal Health Policy*. A Presentation to the Standing Senate Committee on Social Affairs, Science and Technology, National Aboriginal Health Organization, May 30, 2001 [unpublished, on file at the National Aboriginal Health Organization] at 2.

²M. Lux, *Medicine That Walks: Disease, Medicine, and Canadian Plains Native Peoples: 1880-1940* (Toronto: University of Toronto Press, 2001) [Lux].

³Canada, *Report of the Royal Commission on Aboriginal Peoples* (Ottawa: Supply and Services Canada, 1996), online at http://www.collectionscanada.gc.ca/webarchives/20071115053257/http://www.ainc-inac.gc.ca/ch/rcap/sg/sgmm_e.html (accessed September 2, 2010) [RCAP].

“shift[s] from one local area to another, thereby persisting until enough babies have been born in the originally infected area that measles can return there.”⁴

Documentation confirms that the Aboriginal population must have been large enough to allow smallpox and other infectious diseases to spread far from their origins on the southern extremes of North America.⁵ Although other diseases were also spreading at the time—measles, influenza, typhoid and typhus—none were as virulent as the smallpox virus. Epidemics that cycled every 7 to 14 years meant that the existing population had no time to reproduce a fully immune generation or even to reproduce minimally.⁶ Babies born to survivors died in subsequent epidemics. In this way, population levels were depressed for centuries.⁷

At least until 1918, epidemics devastated Aboriginal people as far north as Alaska and as far west as British Columbia. Ninety to ninety-five per cent of the Indigenous population died “by epidemic disease, warfare, slavery, starvation and complete and utter despair, with most dying within one hundred years of contact.”⁸ High smallpox mortality continued among North American Indians of the northern Plains and Upper Great Lakes in 1781 to 1782, with as much as 60 per cent of some groups succumbing to the disease.⁹

Besides smallpox, other diseases spread rapidly: tuberculosis, cholera, scrofula, chickenpox, diphtheria, pertussis (whooping cough), venereal disease, and poliomyelitis.¹⁰ These diseases could not sustain themselves in small groups of hunters and gatherers, but their impact on larger groups of people who lacked immunity to them was enormous. Graham-Cumming describes the effects of the European diseases:

⁴ Jared Diamond, *Guns, Germs and Steel* (New York: W.W. Norton, 1999) at 203.

⁵ Noble David Cook, (1998). *Born to Die: Disease and New World Conquest, 1492-1650*. England: Cambridge University Press [N. Cook] in Cynthia C. Wesley-Esquimaux, Magdalena Smolewski in *Historic Trauma and Aboriginal Healing* prepared for the Aboriginal Healing Foundation (2004) [Historic].

⁶ Russell Thornton, (1987). “American Indian Holocaust and Survival: A Population History Since 1492”. Normand, OK: University of Oklahoma Press in *Historic ibid*.

⁷ N. Cook, *supra* note 5.

⁸ Cook, Sherbourne F. (1973). The Significance of Disease in the Extinction of the New England Indians. *Human Biology* 45(3): 485-508 in *Historic, supra* note 5.

⁹ Martin, Calvin L. (ed.) (1987). *The American Indian and the Problem of History*. New York: Oxford University Press in *Historic supra* note 5 at 19.

¹⁰ G. Graham-Cumming, *Health of the Original Canadians, 1867 – 1967*, Med. Ser. J. Can. 23, 115-166 at 142 [Graham-Cumming].

The European races, however, were heavily infected and had been for centuries. Chronic rather than acute cases were extremely common among them, persons not seriously incapacitated by the disease but still capable of actively spreading the infection.¹¹

These diseases ravaged the people and communities they touched. Death rates averaged as high as 40 to 90 per cent in some parts of North America shortly after contact.¹² In 1612, the Jesuits reported that the Indians were:

[A]stonished and often complain that since the French mingle with and carry on trade with them, they are dying fast and the population is thinning out ... One by one the different coasts according as they have begin to traffic with us, have been more reduced by disease...¹³

Later the Jesuits reported:

Between 1634 and 1640, a series of epidemics broke out, with smallpox being a principle component.

...

By 1640 there were only 10,000 Huron left out of an estimated 20,000 to 35,000 in the early 1600s ... The Iroquois themselves suffered a similar fate two decades later.¹⁴

An estimate of the death toll from smallpox since its introduction to North America was seventy percent or higher.¹⁵

In 1746, more than 1,130 M'ikmaq people were buried in one encampment when the "Indians, who flocked thither in great numbers for supplies of arms, ammunition, took the infection,

¹¹ *Ibid* at 129.

¹² John D. O'Neil and Brian D. Postl, "Community Healing and Aboriginal Self-Government: Is the Circle Closing?" [O'Neil & Postl] in John H. Hylton ed. *Aboriginal Self-Government in Canada: Current Trends and Issues* (Saskatoon: Purich Publishing, 1994) at 69.

¹³ Pere Biard, in R. G. Thwaites ed. *Jesuit Relations and Allied Documents* vol. 3 (Cleveland: The Burrows Brothers, 1897) at 105.

¹⁴ Historic, *supra* note 5 at 194-196.

¹⁵ Historic, *supra* note 5 at 20.

which spread with such rapidity, that it destroyed more than one-third of the whole tribe of Micmacs.”¹⁶

In 1843, Indian Agent Moses Perley told the Nova Scotia legislature that he had spoken with many older Indian people who said that they were childless. In reality, all of their children had died from these diseases:

[T]hat they had had from 8 to 12 Children each, who had died in infancy from Measles, Whooping Cough, Scarlet Fever, Croup, Typhus, Small Pox and a variety of other Diseases to which Children are subject. The Infants are much exposed by the wandering habits of their parents, who rely almost entirely upon their own modes of treatment with roots and herbs.”¹⁷

In 1849, the Shubenacadie chiefs signed a petition to the Queen indicating that with death and disease, and having been driven off their lands, their nation was “like a withering leaf in the summer sun.”¹⁸ The petition pointed out that “[b]efore you came we had no sickness, our old men were wise, and our young men were strong, now smallpox, measles and fevers destroy our tribe.”¹⁹ The suffering is described as,

The disease began with serious pains inside the intestines which made the liver and the lungs rot. It then turned into pox that were so rotten and poisonous that the flesh fell off them in pieces full of evil-smelling beasties ... the skin and flesh of the sick often remained stuck to the hands; and the smell was too strong to endure ... This was a form of smallpox or pox so loathsome and evil-smelling that none could stand the great stench that emerged from them. For this reason many died unattended, consumed by the worms that grew in the wounds of the pox and were engendered in their bodies in such abundance and of such great size that they caused horror and shock to any who saw them.²⁰

Tuberculosis also ran rampant throughout North America. Some reports claim that tuberculosis may have been present among ancient inhabitants of North America prior to the arrival of Europeans. Deformities in the bones of some very old skeletons (Huronian and Inca) suggest that they may have resulted from tubercular lesions. These findings have led some anthropologists to assume that tuberculosis has always existed in these peoples.²¹

¹⁶ Thomas Chandler Haliburton, in Ruth Holmes Whitehead, *The Old Man Told Us: Excerpts from Micmac History, 1500-1950* (Halifax: Nimbus Publishing, 1991) at 108.

¹⁷ Moses Perley, *Legislative Assembly of Nova Scotia Journals*, 1843, Appendix 49 at 127.

¹⁸ Petition, in the Acadian Recorder, Halifax, 24 February 1849.

¹⁹ Petition, *ibid.*

²⁰ Historic *supra* note 5 at 17.

²¹ Graham-Cumming, *supra* note 10 at 129.

However, Indian people had not developed an immunity to tuberculosis. If the Indian population ever had tuberculosis, they eradicated the disease through attrition and the natural elimination of the infected. At contact, exposure to the bacteria was followed by a reduction of the antibodies against it, which resulted in a low resistance to the disease. Evidence further suggests that, over centuries, Aboriginal populations eliminated most infectious diseases. The survival of the fittest created a race of healthy human beings who were, however, extremely vulnerable to alien invading organisms.²²

With the coming of the whites, however the disease (tuberculosis) appeared in a virulent form and early in the seventeenth century the Jesuits recorded in the “Relations” the presence among the natives of the glandular type - scrofula.²³

The Plains Indians stayed remarkably healthy until the end of the eighteenth century, when they were also ravaged by smallpox, measles, whooping cough, and venereal disease. Tuberculosis was not cited until 1800, when it surfaced along the Red and Saskatchewan Rivers. Tuberculosis became epidemic, destroying those unable to build up a resistance to it and lingering among who could. All forms were present, but glandular and pulmonary dominated.²⁴ The first case was recorded by H.Y. Hind in 1858.²⁵ By the time of the Northwest Conflict in 1885,²⁶ tuberculosis was killing Indian and Métis people on the prairies at an epidemic rate. Chief Poundmaker voiced:

Of old the Indian trusted in his god and his faith was not in vain. He was fed, clothed, and free from sickness. Along came the whites and persuaded the Indian that his God was not able to keep up the care. The Indian took the white man’s word and deserted to the new God. Hunger followed and disease and death.²⁷

²² Graham-Cumming, *ibid.*

²³ Thwaites, R.G. (ed.). *Jesuit Relations and allied Documents... 1610-1791*. Cleveland, Burrows, 1896-1901, v. 6, p. 263-5 cited by Lt. Maundrell in Graham-Cumming, *supra* note 10 at 130.

²⁴ Graham-Cumming, *ibid.*

²⁵ H.Y.Hind. *Narrative of the Canadian Red River Exploring Expedition of 1857 and of the Assiniboine and Saskatchewan Exploring Expedition of 1858*. London, Longman, Green, Longman and Roberts, 1860.

²⁶ Changed from the word rebellion as “rebellion” is a controversial term (and not applicable). The establishment of legitimate English sovereignty would first have to be established before any opposition could be characterized as a rebellion.

²⁷ R. Jefferson, “Fifty Years of the Saskatchewan in Canadian North-West Historical Society.” Publications. Battleford, 1926-31, v. 1 no 5.

In 1878, immigrants began entering Canada in large numbers bringing latent tuberculosis and settling close to the Indian reserves. Forced attendance at poorly ventilated residential schools, not only facilitated but also ensured the rapid spread of tuberculosis.²⁸

i) Tuberculosis in Residential Schools

In 1897, Inspector Benson, head of the Department of Indian Affairs school branch, wrote to Indian Affairs Department Secretary J.D. McLean about the dangerously unhealthy conditions at the schools. He followed up with another report about the deplorable building conditions, including extremely poor ventilation systems that should have been remedied immediately. Inspector Benson's recommendations were not heeded:

Outlets for the escape of foul air are provided in some rooms at a few schools but without adequate provision for the admission of fresh air, and it is scarcely any wonder that our Indian children who have a hereditary tendency to phthisis, [tuberculosis] should develop alarming symptoms of this disease after a short residence in some of our schools, brought on by exposure to draughts in school rooms and sleeping in over-crowded, over-heated and unventilated dormitories.²⁹

Tuberculosis was rampant in the residential schools. From 1884 and 1890, tuberculosis specialist Dr. R.G. Ferguson reported a mortality rate of the Qu'Appelle and File Hills Cree at 90 deaths per 1,000.³⁰ It was not until the early 1900s that the federal government finally acknowledged something was gravely wrong with the health of Aboriginal people in Canada. In 1904, Dr. Peter Bryce was appointed as General Medical Superintendent of the Department of Indian Affairs.³¹ He was the first to notice that cancer and kidney diseases were rare and that venereal disease and alcoholism were not as rampant as believed.³² He did, however, discover

²⁸ Graham-Cumming, *supra* note 10 at 130.

²⁹ Agnes Grant, No End of Grief: Indian Residential Schools in Canada, 1996 Winnipeg, MB: Pemmican Publications at 117-118 [Grant] in Larry N. Chartrand, Tricia E. Logan, Judy D. Daniels *Métis History and Experience and Residential Schools in Canada*, prepared for The Aboriginal Healing Foundation (2006) [Chartrand].

³⁰ R.G. Ferguson, *Studies in Tuberculosis* (Toronto: University of Toronto Press, 1955) at 6 cited in Graham Cumming, *supra* note 10 at 134. By 1929 the Indian death rate in this area was 20 times greater than for the non-Aboriginal population (*Ibid* at 134).

³¹ J. Waldram, D.A. Herring, T.K. Young, *Aboriginal Health in Canada. Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995) [Waldram] at 156.

³² P.H. Bryce, Memorandum, 1907 in Canada, Dept of Indian Affairs. Departmental Files (140-754) T.B. Among Indian Pupils.

that the mortality rates of many bands were extremely high and concluded that tuberculosis was an epidemic in progress. In 1906, Bryce issued a report to the government that stated that the “Native people had a death rate more than double that of the general population and in some provinces more than three times.”³³

In 1910, Duncan Scott introduced some measures to combat the conditions that were exposed by Bryce and others. However, as scholar Brian Titley clarifies:

The elimination of the worst of the industrial schools and the new regulations introduced by Scott in 1910 did not entirely eradicate the hazards of residential education. Ill-health, for instance, persisted at unacceptably high rates in places.³⁴

...

[S]tudents with contagious diseases were often enrolled merely to secure the per capita grant. Within the institutions, poor ventilation, inadequate diet and little medical attention combined to create the prime conditions for epidemics.³⁵

The federal government’s severe underfunding of health-related problems was one direct cause of student illness and death,

Regarding Jesse Williams, she appears to need a lot of hospital treatment, I am inclined to think that the state of her health is such that it might be wise to discharge her, she is becoming an expensive pupil.³⁶

In 1918, the year the Spanish flu epidemic hit Canada, Duncan Scott eliminated the medical inspector position “for reasons of economy.”³⁷ Prairie schools in Alberta were some of the hardest hit by both the flu and tuberculosis epidemics. At the Red Deer School:

Not surprisingly, the Spanish influenza epidemic that hit Canada along with most of the rest of the Western world at the end of the First World War proved devastating, particularly in prairie schools. The degree to which residential

³³P.H. Bryce, *The Story of a National Crime - Being a Record of the Health Conditions of the Indians of Canada from 1904-1921* (Ottawa: James Hope and Sons, 1922) [National Crime] cited in Lux, *supra* note 2 at 192.

³⁴Brian E. Titley, (1986a). *A Narrow Vision: Duncan Campbell Scott and the Administration of Indian Affairs in Canada*. Vancouver, BC: University of British Columbia Press at 87 [Titley] in Chartrand, *supra* note 29.

³⁵Brian E. Titley, (1986b). *Indian Industrial Schools in Western Canada* in Sheehan, N., J.D. Wilson and D.C. Jones (eds.). *Schools in the West: Essays in Canadian Educational History*. Calgary, AB: Detselig Enterprises Ltd. [Titley] in Chartrand, *supra* note 29.

³⁶James Miller, *Shingwauk’s Vision: A History of Native Residential Schools*. Toronto, ON: University of Toronto Press, 1996 at 302 [Miller, 1996].

³⁷Titley, *supra* note 34 at 87.

schools were not equipped to cope with a pandemic can be measured in the words of the principal of the Methodist Red Deer school, who described 'conditions at this school' as 'nothing less than criminal' and 'a disgrace.' Like almost all boarding and industrial schools, Red Deer had 'no isolation ward and no hospital equipment of any kind. The dead, the dying, the sick and the convalescent were all together.'³⁸

In 1922, Dr. Bryce released *The Story of a National Crime: An Appeal for Justice to the Indians of Canada*, a report on the conditions of the disease-infested residential schools. An excerpt of his publication, reads:

Regarding the health of the pupils, the report states that 24 per cent, of all the pupils which had been in the schools were known to be dead, while at one school on the File Hills reserve, which gave a complete return to date, **75 per cent, were dead at the end of the 16 years since the school opened.** (emphasis added)³⁹

He analyzed these shocking disease statistics from every perspective: the influences of climate, economic conditions, income, diet, and housing. He printed circulars in Cree and published a textbook on hygiene, which was distributed to Indian Agents throughout the country.⁴⁰ Dr. Bryce's report made recommendations to improve the health of the children in the schools. The federal government refused to act on these recommendations. It claimed the costs associated with such improvements were too high. In addition, the churches involved opposed such reforms.⁴¹ Apparently, they did not consider the cost effectiveness of shutting down the schools altogether. Dr. Bryce stated:

The degree and extent of this criminal disregard for the treaty pledges to guard the welfare of the Indian wards of the nation may be gauged from the facts of the widespread devastation being caused by tuberculosis.⁴²

Métis scholar Agnes Grant clarifies Dr. Bryce's responsibilities as a medical inspector for Indian Affairs:

³⁸ Miller, 1996 *supra* note 36 at 302-303. See also Maureen Lux, "The Great Influenza Epidemic of 1918-1920, U of S Communication: OCN October 17, 1997.

³⁹National Crime, *supra* note 33 at 3.

⁴⁰ Memorandum, February 18, 1914 in Canada. Dept of Indian Affairs. Departmental Files (93-101) General Secretary.

⁴¹ Waldram, *supra* note 31 at 156-157 and 136.

⁴²*Ibid* at 157.

He was asked to investigate the health of Aboriginal children in schools in the Prairie provinces. Bryce discovered a large number of instances in which children with infectious diseases had been admitted to schools and that the diseases were spreading rapidly in the sub-standard buildings. For schools that had been operating for ten or more years, Bryce found that seven percent of the present or former students were sick or in poor health, and twenty-four percent were dead. In one case two-thirds of those discharged died either at school or within a few months of being discharged. He was particularly appalled at the schools' lack of ventilation. In most schools, windows in the dormitories were sealed for seven months of the year in order to save on heating costs. The air became increasingly more lethal as infected students slept in the same room with others.... Bryce also reported that principals and teachers were inclined to minimize the dangers and were reluctant to give him information. The report caused an uproar. Church officials and principals responded defensively, but Indian agents generally substantiated Bryce's findings.⁴³

Bryce left his position as Chief Medical Officer in 1921 and his position was not staffed again until 1927. During the six-year gap, no efforts were made to contain the numerous epidemics that were rapidly spreading through the Aboriginal population in Canada.⁴⁴ Grant reports that inhumane treatment of sick children continued and was indeed the norm throughout the residential school years:

Staff censure for ill children was so severe that the children usually hid all signs of illness as long as they possibly could. Instances of inhumane treatment while the children were ill came from across the country as reporters interviewed ex-students regarding sexual abuse in 1991.... Example after example surfaced.

Winnipeg Free Press Nov. 10, 1990

Pam Sickles can never forget what happened to a sick friend:

She was sick and she threw up in her plate and she was forced to eat it all. I can see the nun pressing the spoon against her lips and she was pushing so hard there was blood on her lips. I can see it still so clearly after all these years. (St. Mary's Kenora [Ontario])

Winnipeg Free Press Aug. 6, 1991

Norman Whitford remembers a frail, eight-year old boy forced to sit for days on a pail inside a closet as punishment for having diarrhea:

It was extremely cruel because not only did they punish him for what I believe now was a medical problem, but the other children were expected to look at him and ridicule him.

(Fort Resolution) [Northwest Territories]

⁴³ Grant, *supra* note 29 at 302-303.

⁴⁴ Waldram, *supra* note 31 at 158.

Winnipeg Free Press Nov. 10, 1990

Phil Fontaine said one of his brothers is reluctant to talk about what happened to him when he broke his leg playing soccer and started crying:

Because he was crying he was kicked and forced to walk with a broken leg and he was kept in the school for I don't know how many days before they decided to do something.⁴⁵

ii) Tuberculosis Treatment

In 1924, the Canadian Tuberculosis Society reported that while Aboriginal people comprised 1/22nd of the total population of British Columbia, they accounted for one-quarter of all deaths in the province.⁴⁶ In 1934, the Department of Indian Affairs admitted that, "it is impossible to admit to a sanatorium more than a very small proportion of Indians who are recommended for such care."⁴⁷ In 1937, an editorial appearing in the *Canadian Tuberculosis Association Bulletin* stated:

[T]he facilities for early diagnosis, treatment and prevention that have been used to such good advantage in the White population have never been made available for the attack on the Indian problem.⁴⁸

At that time, official government procedure demanded that an Indian agent give permission for an Indian to be hospitalized and permission from the head office in Ottawa was a prerequisite for an Indian to be admitted to a tuberculosis sanatorium.⁴⁹

The high rates of tuberculosis among the Indian population were submitted as proof that "Native people were incapable of making the transition from nomadism to 'civilization.'"⁵⁰ Before tuberculosis was unmistakably evident as the cause of death and was shown to be killing Aboriginal youth in epidemic proportions, the medical profession did little to curtail its spread. The cost involved in treating Indians was clearly a factor behind this inaction, again, because the government claimed it lacked the funds to deal with the situation.⁵¹ It was not until

⁴⁵ Grant *supra* note 29 at 131-132.

⁴⁶ Lux, *supra* note 2 at 201.

⁴⁷ Waldram, *supra* note 31 at 160.

⁴⁸ *Ibid.*

⁴⁹ *Ibid* at 159-160.

⁵⁰ Lux, *supra* note 2 at 191.

⁵¹ Waldram, *supra* note 31 at 160-161.

anti-tuberculosis campaigns pressured the Medical Branch that they finally took action to curb the disease ravaging the Aboriginal population. Professor Maureen Lux explains:

The increasing cultural and professional authority of medicine in the first half of the twentieth century worked to construct Native people as biologically inferior and disease-prone. In the same vein, the anti-tuberculosis campaigns in Canada framed Native people as a disease menace to themselves and others. Although living conditions were often pointed to as a health concern, it was Native people's lack of resisting power that identified them as inferior. From this, it followed that what the people [Aboriginal people] most needed were those inherited qualities that separated the civilized races from the primitive – qualities that were subsumed in Dr. Ferguson's phrase 'white blood'. That prescription for good health, coming from one of the country's leading medical authorities on tuberculosis, lent medical certainty to what the department had always contended: that Native people would only gain the good health enjoyed by non-Native Canadians when they ceased being Native.⁵²

Although in Treaty 6 it was clear that the federal government had the obligation to provide health services, the federal government rejected any legal or treaty requirements to provide health services to Aboriginal people, they did so “for self-protection and to prevent the spread of disease to the white population.”⁵³

While the Indian population was regularly screened for tuberculosis, the Métis population was not. The rate of tuberculosis amongst the Métis, however, was high and remained so until the early 1960s, when the government's health advisors realized that the rate of tuberculosis might not be associated with the biological factor of having “Indian blood” but might be due to socioeconomic conditions, such as poverty. The 1963 report, *The Métis in Alberta Society*, suggested that the Métis occupied a class position of poverty within the context of the larger Euro-Canadian structure. It further suggested that the solution to the disease problem lay in “extending civilization northward and increasing Métis participation in it.”⁵⁴ In other words, if the Métis were “civilized” like the Euro-Canadian settlers, they would enjoy a health status that was comparable to the Euro-Canadian population.

⁵² Lux, *supra* note 2 at 224. See also Maureen Lux, ‘Perfect Subject : Race, Tuberculosis and the Qu’Appelle BCG Vaccine Trial’ vol. 15 : 1998, 277-295.

⁵³ P.E. Moore , *Indian Health Services* Canadian Journal of Public Health, V. 37: 140-2 1946.

⁵⁴ Waldram, *supra* note 31 at 175-176.

At the end of the nineteenth century, the Métis were living on the borders of the non-Aboriginal and the Indian populations. Many lived on road allowances on the outskirts of towns; others lived outside of the reserves, despite kinship ties to the reserves. The federal government denied the Métis the provision of health services, and the provinces provided services only when it was evident that the good health of the non-Aboriginal population was threatened.⁵⁵

In 1934, a Royal Commission was established in Alberta to examine the “problems of health, education and general welfare of the half-breed population.”⁵⁶ This Commission was known as the Ewing Commission.⁵⁷ The Commission’s brief report concluded that “...the Commission is of the opinion that while the health situation is serious, it is not, except as to the particular diseases mentioned, more serious than among the white settlers.”⁵⁸ The Commission made it clear that the Métis were not to become wards of the state, like the Indians, but did recommend that parcels of land be set-aside for the Métis where hospitals could be constructed and the services of a traveling physician could be provided.⁵⁹ The Métis, as well as First Nation and Inuit, were all subjected to residential schools and the health problems associated with them.⁶⁰

Extending the southern levels of health care to the North was difficult because of the large geographical areas involved and the harsh climate. Although the North continues to have

⁵⁵ Y.M. Boyer (2004), “Aboriginal Health – The Crown’s Fiduciary Obligations” Discussion Paper Series #2, National Aboriginal Health Organization and the Native Law Centre of Canada (May 2004) at 13.

⁵⁶ Waldram, *supra* note 31 at 174-175.

⁵⁷ Ewing, Justice (1935). Evidence and Proceedings, Half-Breed Commission. 25 February 1935. Edmonton, AB: Half-Breed Commission.

⁵⁸ Waldram, *supra* note 31 at 174-175.

⁵⁹ Under the provision of the *Métis Population Betterment Act of 1938*, Métis Settlements were established in the 1930s in response to recommendations contained in the 1932 Ewing Commission Report. Although twelve colonies were originally established, four of the colonies ceased to operate because the land was unsuitable for farming. Under the 1989 Alberta Métis Settlements Accord, and resulting 1990 legislation, the Settlements collectively acquired title to the Settlement areas and were established as corporate entities, similar to municipal corporations, with broad self-governing powers. Métis Settlements are comprised of eight distinct geographic areas in northern Alberta covering approximately 1.25 million acres with a total population of 6,500 in 1995. The Settlements are governed locally by elected 5-member councils and collectively by the Métis Settlements General Council. (Métis Settlements General Council, online: <http://www.msgc.ca/> (accessed September 2, 2010).

⁶⁰ See, Larry Chartrand, *Final Report: Métis Residential School Participation. A Literature Review 2002* [unpublished]; Tricia Logan, *The Lost Generations: The Silent Métis of the Residential School System: Interim Report 2001*. Brandon, MB: Manitoba Métis Federation; Judy Daniels, *Ancestral Pain: Métis Memories of Residential School Project 2003*, Edmonton, AB: Métis Nation of Alberta; Larry N. Chartrand, Tricia E. Logan, Judy D. Daniels, *Métis History and Experience in Residential Schools in Canada: Aboriginal Healing Foundation, 2006*.

several long-standing and particularly harmful health issues, tuberculosis remains a devastating and debilitating disease.

For the Inuit, tuberculosis was particularly virulent.⁶¹ The disease came to them from missionaries, whalers, and growing numbers of European settlers. In 1969, Dr. Graham-Cumming, the medical officer of National Health and Welfare, noted, “[s]urprisingly little evidence has been found to suggest the Eskimo and Indian populations have had any major health problems before the venturing Europeans.”⁶² Yet by the 1950s, at least one-third of all Inuit had tuberculosis; in 1956, one in seven Inuit or approximately 1,600 people were in a sanatorium in southern Canada. The average stay was two and half years, although many stayed longer.⁶³ At the time, bed rest, ample fresh air, and seclusion in sanatorium miles away from home and family was considered the cure for tuberculosis patients.⁶⁴

However, this treatment had harsh effects on Inuit people, families, and entire communities. The Inuit were considered untreatable in their tents and snow huts. They were also the last of the three groups of Aboriginal people to be provided tuberculosis treatment by the federal government.⁶⁵ From 1950 to 1969, the *C.D. Howe* coast guard ship made annual summer trips to the Eastern Arctic. It contained a small hospital, which included an operating room, a sick bay, a dental office, an X-ray machine, and a darkroom. The ship also removed TB patients socially from their home communities and took them to the south for treatment. This “treatment” proved devastating for individuals, families and communities.⁶⁶

When the doctors made their final decision on whether an individual should go to the hospital for treatment or stay in the North, the evacuees were sent down

⁶¹ Currently, the Inuit experience a tuberculosis rate at 90 times higher than for non-Inuit people. (*National Collaborating Centre for Aboriginal Health & UNICEF Canada*, “Leaving no child behind - national spotlight on health gap for Aboriginal children in Canada” 2009, online: http://www.nccah-ccnsa.ca/s_140.asp (accessed December 4, 2009).

⁶² C. Graham-Cumming, 'Northern Health Services' Canadian Medical Association Journal, 100 (March 15, 1969), 526-531 at 526 [Northern Health].

⁶³ CBC Archives, “Tuberculosis: Old Disease, Continuing Threat” January 20, 1989, online: <http://archives.cbc.ca/health/disease/topics/883-5325/> [CBC] (accessed December 4, 2009) [CBC].

⁶⁴ In the south at the same time it was claimed that the high rates of tuberculosis among the Indian population was submitted as proof that “Native people were incapable of making the transition from nomadism to ‘civilization.’” See Lux, *supra* note 2 at 191.

⁶⁵ Waldram, *supra* note 31.

⁶⁶ CBC, *supra* note 61.

to the Inuit quarters in the prow of the ship and the rest were sent ashore. The evacuees were not allowed to go ashore to collect belongings, to say goodbye, or to make arrangements for their families or goods. If a mother was judged sick but her children were not infected, the children (sometimes including unweaned babies) were given to an Inuk women going ashore. Fathers had no chance to arrange for someone to hunt for food for their families or to look after their dogs and equipment, mothers had no chance to arrange for someone to care for their children or to sew and process the skins needed to keep the family warm, virtually nothing was done from the social side. Those needing hospital treatment were kept on board, the rest sent ashore and on sailed the ship to the next settlement.⁶⁷

Waldram, Herring, and Young describe the appalling conditions that the federal government subjected the Inuit to:

It was not uncommon for individuals to board the medical or patrol ships for x-rays, and then be refused permission to return to shore when the results positively indicated tuberculosis. They were simply taken away ... The Inuit people were treated like cattle ... To the bulk of the federal staff in Ottawa they were just numbers. But these numbers kept getting mixed up ... Other patients were not even lucky enough to be returned to their families; in some cases they were dropped off at settlements hundreds of kilometres from home, often with little recollection of their families.⁶⁸

In 1959, the Eskimo Department reported on the fate of one particular Inuk grandfather in the Western Arctic:

Each spring the Dept. of Indian and Northern Health Services conduct a tuberculosis X-ray survey amongst the Eskimos in the Western Arctic and along the Arctic coast. This year during the X-ray survey, an old Eskimo who was blind was taken from his camp to be evacuated to the Charles Camsell Hospital in Edmonton for treatment. While staying at Cambridge Bay enroute to Edmonton there was some delay and the Eskimo, not knowing where he was going or what was going to happen to him, committed suicide by hanging himself.⁶⁹

On the totality of Inuit deaths, CBC reported:

⁶⁷Pat Sandiford Grygier, "A Long Way from Home: The Tuberculosis Epidemic among the Inuit" Montreal: McGill-Queen's University Press, 1994 at 96.

⁶⁸ Waldram, *supra*, note 31 at 169.

⁶⁹ RCMP Repository Archives, *Confidential Monthly Report May, 1959- G Division*, ID A04795 Collection GC 579-27 at 3.

When a TB patient died in the south, the hospital notified the Indian Health Service, which notified the Department of Northern Affairs. Northern Affairs then contacted someone in the patient's community — a missionary or RCMP officer — who was charged with telling the family that their loved one had died. Often, however, the message never got through.

These patients were buried in paupers' graves in a southern cemetery at the expense of Northern Affairs.⁷⁰

No one knows how many Inuit are still buried in exile. Frank Tester reports that, “Records show that between 1953 and 1961 a total of 5,240 Inuit, from toddlers to elders, were sent south, sometimes plucked right out of hunting camps on the land. The entire Eastern Arctic Inuit population at the time was only about 11,500.”⁷¹

It must be noted that in southern Canada in 1953 there was a peak of 19,000 sanatoria beds rising from 9000 in 1938.⁷² Although Inuit seemed to have a longer stay (if they managed to get home) of up to 3 years – it is reported that patients in southern Canada reached a peak of just over one year in the mid-1950s, although some stayed longer.⁷³ The treatment appears to be similar for the Inuit and non-Inuit, however there may have been a difference upon completion of treatment and/or death. It is abundantly clear that the federal government had the discretion to either return the patients home or not return them home. Perhaps we can reason that confusion arose due to unfamiliarity with traditional Inuit names. Government and professional officials could not spell, pronounce names or understand the meaning of the Inuit naming system. Some Inuit had European surnames, some had one name and others had first names which could change over time.⁷⁴

⁷⁰ CBC, *supra* note 61. It is suggested that further research be undertaken to ascertain how many people are buried away from their home and where they are located. See also. CBC Digital Archives “Polio Epidemic Strikes Northern Canada” March 7, 1949. Thirteen polio victims were removed from Chesterfield Inlet in 1949 and not returned home.

⁷¹ Canada East, “Inuit families spend years looking for graves of loved ones who died from TB” May 14th, 2009, online: <http://www.canadaeast.com/rss/article/667184> (accessed December 4, 2009).

⁷² Saskatchewan Lung Association, “Tuberculosis History – the Sanatorium Age”, online: <http://www.lung.ca/tb/tbhistory/sanatoriums/> (accessed September 2, 2010).

⁷³ *Ibid.*

⁷⁴ Waldrum, *supra* note 31 at 170-171.

Starting around the 1920's, a naming process was advanced by federal officials to provide a universal system of identifying the Inuit. In 1941, Inuit children were given an identity disk⁷⁵ and was told to wear it at all times, "at each registration [of vital statistics by the RCMP] the child be given an identity disk on the same lines as the army identity [sic] disk and the same insistence that it be worn [sic] at all times."⁷⁶ Each Inuk had to either memorize the number or wear an identity tag around their necks or wrists. The government saw it as an effective way not only to record vital statistics and medical records but also to facilitate an overall administration system for the Inuit and to help quell the problems the government found with the Inuit naming system.⁷⁷

The disc list system caused a great deal of confusion for officials: for various reasons some Inuit would comply and others would not. By 1966, the system was finally questioned.⁷⁸ In 1968, Professor Williamson, who understood the level of sophistication and complexity in Inuit naming, addressed the floor of the Northwest Territories Council and pleaded:

The situation in the Central and Eastern Arctic is such that there is always confusion between the Eskimo people and the white people who are working with them because of the way in which names are spelled. In many cases mail will go missing, cheques will be made out to the wrong people, even with the disc numbers being used all the time. One of the other effects here is that we would like to see the diminution of the use of discs numbers as sources of identity – but they have to use these numbers so often because the spellings are so inaccurate.

The importance of the Eskimo name is something I have spoken of before. It is very important for each individual to be properly identified. In the Eskimo tradition it had even a greater significance, and there is a persistence of the attitude derived from those traditional beliefs, whereby the name is the soul and the soul is the name. So if you misuse someone's name, you not only damage his own personal identity in the existing society but you also damage his immortal soul.⁷⁹

⁷⁵ See A. Barry Roberts, "Eskimo Identification and Disk Numbers, A Brief history", prepared for the Social Development Division of Indian and Northern Affairs, 1978 at 1 [Identification] at 12-15.

⁷⁶ Waldrum, *supra* note 31 at 171.

⁷⁷ Identification, *supra* note 75.

⁷⁸ Identification, *ibid* at 25.

⁷⁹ Identification, *ibid* at 30.

Considering the harmful methods that the government used to administer services to the Inuit and the fact that the Inuit (dead or alive) were often not returned to their homes, the Inuit were at the mercy of the federal government at all times during the tuberculosis epidemics. The Inuit suffered incalculable ill effects due to the loss of their names, as Professor Williamson described. These immense and multileveled damages to the Inuit warrant specific, legal analysis as to the government's responsibilities and culpabilities throughout this period but is outside the scope of this thesis.

5.1.2 Nutrition

The Canada Food Guide tells us that a healthy diet must include four food groups: vegetables and fruit; grain products; milk and alternatives; meats and alternatives. "Eating healthy" has numerous benefits, which include higher energy, lower risk of disease, healthy body weight, stronger muscles and bones, higher intellectual capacity, and better overall health. Unhealthy eating habits as specified by the Canada Food Guide have detrimental effects on human health (see Dr. Jay Wortman in section 5.1.3 ii).

Aboriginal people sustained high levels of health by maintaining complex relationships between the land and how food was obtained and prepared, their culture, and the transmission of knowledge between generations of First Nations, Métis, and Inuit. Colonization profoundly interrupted these relationships and introduced new crops; it appropriated land; and it moved Aboriginal people into the wage economy. In all these ways, colonization eroded Aboriginal hunting and food gathering, which affected the lifeblood of Aboriginal autonomy and self-determination.

Cutting Aboriginal peoples off from their traditional foods also cut them off from their traditional medicines, which had been part of the food security system. For Aboriginal peoples, food security and food sovereignty were solidly in place before contact. Colonization damaged, and in many cases, destroyed these processes.⁸⁰

⁸⁰ Food sovereignty is the ability to make substantive choices about what one is eating. This includes, what types of foods are eaten, and where, how, and by whom they are produced. Food security, as defined at the World Food Summit in 1996, exists when all people, at all times, have physical and economic access to safe and nutritious food, which meets dietary needs and food preferences, in sufficient quantity to sustain an active and healthy

The Coast Salish people of southern Vancouver Island are one example. Scholar Kathleen Turner examines the profound impacts of colonization on diet and cultural practices relating to food production, preparation, and consumption. The blue camas is a blue flowering plant of the lily family that has an edible bulb when properly cooked. It was the main staple on the Northwest Coast. However, due to a confluence of colonial pressures, the blue camas⁸¹ was eliminated from the diets of the Coast Salish peoples.

Before colonization, the Coast Salish held control over their food system and “derived their food security through a rich knowledge of their environment, passed down through oral tradition and longstanding land stewardship and plant cultivation practices.”⁸² According to the Elders, the blue camas was held to be the “Queen Root” and the “Number One vegetable.”⁸³ It was a principal carbohydrate and a valuable source of fibre, vitamins, minerals, and protein.⁸⁴ The harvesting, preparation, and consumption of the blue camas were critical components of Coast Salish knowledge and what was transmitted to subsequent generations. Turner writes:

In order to transform the insulin (a complex indigestible sugar) in camas into digestible fructose, the bulbs were pit-cooked⁸⁵ for approximately 24 to 36 hours, following which they were sometimes pressed to flatten them, dried and stored for winter or for trade.⁸⁶ There is little doubt that the Coast Salish livelihoods were procured and sustained, and food security insured, through

lifestyle. [World Food Summit, Declaration (Rome: Food and Agricultural Organization (FAO) of the United Nations, 1996).]

⁸¹ *Camassia quomash* and *C. leichtlinii*.

⁸² Wayne Suttles, “Coast Salish resource management,” *“Keeping it Living”: Traditions of Plant Use and Cultivation on the Northwest Coast of North America*, ed. by Deur and Turner (Seattle: University of Washington Press, and Vancouver: UBC Press, 2005), 181-193 [Suttles] in Kathleen Turner, “Food Security is what is Indigenous to Our People”: Colonization, Camas, and the Diet of the Coast Salish People of British Columbia, *Journal of Undergraduate Studies at Trent - Vol. 1, 2007* at 4 [Turner].

⁸³ Beckwith, quoting Tsartlip Elder Christopher Paul, from 1967 interview with anthropology student Marguerite Babcock. [Brenda R. Beckwith, “The Queen Root of this Clime”: Ethnoecological Investigations of Blue Camas (*C. leichtlinii* (Baker) Wats., *C. quamash* (Pursh) Greene; Liliaceae) and its Landscapes on Southern Vancouver Island, British Columbia (Ph.D. diss., University of Victoria at Victoria, 2004), 4 [Beckwith] in Turner at 42.

⁸⁴ Beckwith, *ibid* at 15.

⁸⁵ Pit cooking was a common culinary practice on the Northwest Coast. First a large pit is dug and a fire lit in the bottom. Rocks are then placed in the fire and heated until red-hot. Then, unburned materials are removed and the rocks spread over the bottom. On top of the rocks layers of plant materials, such as salal and sword fern, are piled. In the middle of the layers the foodstuffs are spread and then covered by more plant matter. Finally, water is poured onto the rocks through an opening left by holding a large stick in the middle of the pit while it is being filled. Once the water is poured, planks or mats are thrown over the pit and they are covered with dirt to prevent any of the steam escaping. The food is then left to steam until it is cooked. See Turner *supra* note 82 at 42.

⁸⁶ Bryce, C. 2005. Kwetlal "Camas". Camas Harvest and Pit Cook. Songhees Lands Department, Victoria, B.C.

significant ecological knowledge and management systems governing resource extraction rights, and cultivation practices.⁸⁷ Camas was a focal point for much of this activity and knowledge set, as well as a vital component of Coast Salish people's caloric intake.⁸⁸

The camas disappeared from Coast Salish society after the Europeans arrived around 1827. The Europeans imposed “real farming” as part of the colonial mission to “civilize” and assimilate First Nations.⁸⁹ The pressures on First Nations to abandon their traditional foods led to the loss of many dietary traditions, including the camas. European foodstuffs became the norm.⁹⁰ A settler described what he saw:

...the very old people who formerly lived entirely on fish, berries and roots suffer a good deal through the setting up of this country. The lands that once yielded berries and roots are now fenced and cultivated and even on the hills the sheep have destroyed them.⁹¹

The Coast Salish Nation is but one example. Every Nation in North America could undoubtedly provide many examples of how their nutrient-rich diets were depleted or destroyed and replaced by European diets. The following section describes the results of these changes from a nutrient-rich diet of sustainable food autonomy to a nutrient-depleted diet of unsustainable food dependency.

i) Hunger, Starvation, Disease and Death

As Canada was colonizing and industrializing, the Indians and Métis on the western prairies experienced severe hardship.⁹² While tuberculosis rates were climbing, the buffalo also disappeared. The tuberculosis epidemic coincided with a complete dietary change as well as a transition from an active migratory lifestyle to a non-nomadic one. The buffalo had provided a food staple, yet the herds started declining in 1870. Smallpox, which surely affected the health of the hunters and their ability to hunt, began to rage through First Nations. When the famine

⁸⁷ Suttles, *supra* note 82 at 181-193 debates the origins of these practices and explores the possibility that they were borrowed from European settlers. He concludes, however, that this is highly unlikely and that these techniques are Indigenous in origin.

⁸⁸ Turner, *supra* note 82 at 42.

⁸⁹ Turner, *ibid.*

⁹⁰ Turner, *ibid* at 43.

⁹¹ Douglas C. Harris, *Fish, Law, and Colonialism: The Legal Capture of Salmon in British Columbia* (Toronto, ON: University of Toronto Press, 2002) at 149.

⁹² For a discussion on the Métis, see, for example, D.N. Sprague, *Canada and the Métis, 1869-1885* (Waterloo: Wilfred Laurier University Press, 1988).

came in 1878 and 1879, the buffalo went south for the final time. In Blackfoot lands, six hundred people starved to death.⁹³ Starvation further reduced resistance to disease.

The federal government issued rations of white flour and salt pork and settled Indian people on reserves. It was the government's attempt to force them to farm and feed themselves. This transition from a nomadic and migratory lifestyle to a sedentary one further exacerbated the health problems. Many Aboriginal people knew nothing of cultivation or a non-nomadic lifestyle. While Aboriginal people were attempting this agricultural way of life, the numbered treaties were being negotiated.⁹⁴ Some agricultural provisions were specified in the treaties. Aboriginal people negotiated the treaties, accepted the "Queen's hand," and were promised government support to facilitate their transition from hunting buffalo to farming. Yet, the buffalo provided much more than meat. They also provided clothing, warmth, housing, medicine, and a range of tools—all essential to sustaining health. A field of wheat or a vegetable garden could not provide all that the buffalo provided. Once the buffalo disappeared, Aboriginal people were left without the basic necessities of life that the buffalo once provided. The impact on Aboriginal peoples was disastrous.

Bent on "discouraging indolence," the government issued their rations to the starving.⁹⁵ The Indian agent, acting on behalf of the Crown, provided rations to Indian bands.⁹⁶ Yet, the rations they provided were nutritionally inadequate. They consisted mainly of white flour, bacon, and a little fresh meat with insufficient nutritional value.⁹⁷ Before long, the teeth of the children began to rot, tonsils and adenoids became enlarged, and profuse nasal discharge became common, all of which indicated a lower resistance to disease. Rickets appeared from lack of

⁹³ H.Y. Hind North-West Territory; Reports of Progress. Toronto J. Lovell, 1859.

⁹⁴ See Aboriginal and Treaty Rights Chapter, *infra* Chapter 7.

⁹⁵ Lux, *supra* note 2 at 20.

⁹⁶ Following the signing of the first numbered treaty in 1871 the federal government created the 'Indian Agent'. The agents were used to implement the treaties and often worked in conjunction with physicians, missionaries and the police. The physicians conducted medical examinations, vaccinations and pulled teeth while the agent paid out treaty money. The 'medicine chest' clause represented the embodiment of medical services through the Indian agent. Waldram, *supra* note 31 at 154-155. See also Graham-Cumming, *supra* note 10 at 133. When a formal 'Medical Branch' was established within Indian Affairs, Col. E.L. Stone, the newly appointed Medical Superintendent, wrote of the branch's position on Indian health:

The Indian agent ... is responsible for every matter affecting the interests of the Indians under his charge, including ... the administration of the medical and health services (Waldram, *supra* note 31 at 159).

⁹⁷ Lux, *supra* note 2 at 70, Graham-Cumming, *supra* note 10 at 133, Waldram, *supra* note 31 at 155.

sunshine and Vitamin D and the rapid change in diet.⁹⁸ Professor Maureen Lux elaborates on the purpose of the rations and their devastating effects:

The starvation at Fort Walsh was a cynical and deliberate plan to press the government's advantage and force the Cree from the area to allow the government a free hand in developing the prairies.

The department was well aware of the horrific effects of its policy. The year before, Dr. John Kittson of the NWMP had warned the Indian Department that the rations were inadequate for subsistence. Working from figures he received from prisons and asylums in Europe, Kittson reckoned that a minimum daily ration for a man in moderate health with an active life should be one pound of meat, 0.2 pounds of bread, and 0.25 pounds of fat or butter. State prisoners in Siberia were given more than twice the ration. In severe weather or hard labour, the NWMP minimum daily ration was 1.5 pounds of meat, and 1.25 pounds of bread, plus tea, coffee, sugar; and abundant beans and dried apples. The daily ration for Native people of a half-pound of meat, and half pound of flour was, according to Kittson, 'totally insufficient.' And the consequences were appalling: 'Gaunt men and women with hungry eyes were seen everywhere seeking or begging for a mouthful of food – little children ... fight over the tid-bits. Morning and evening many of them would come to me and beg for the very bones left by the dogs in my yard. When I tell you that the mortality exceeds the birth rate it may help you to realize the amount of suffering and privation existing among them.'⁹⁹

For those who survived, the transition from a high protein diet to one of limited nutritional value had a devastating and long lasting intergenerational impact.

Not only was illness present, but also some evidence indicates that these rations may have been deliberately or inadvertently poisoned. Professor Lux notes that Treaty Seven oral history states that the rations were intentionally poisoned. The Indian Agent directed the Indians to "mix a yellow substance into the flour ..." Lux cites Tom Yellowhorn:

The people who lived around the agency camp were those that got sick. Those who were away did not get sick ... So many died so fast they did not have time to bury them; they just left the bodies on top of the ground. Today this place is

⁹⁸ Graham-Cumming, *supra* note 10 at 133.

⁹⁹ Lux, *supra* note 2 at 38.

known to the Indians as Ghost Coulee ... The Indians always used 'The time the flour burned' for a counting date; that was around 1882.¹⁰⁰

Peigan Elder Alan Pard explained that the substance in the flour was believed to be sulfur. Bluestone and lye were allegedly found in the meat (bluestone is also called blue vitriol and is used as an insecticide or fungicide). Elder Pard's grandfather confirmed that it was sulfur in the rations, and "Belly sickness" was the term used for the distended abdomens resulting from eating these rations. Rations on the Blood Reserve were also contaminated: "the food was treated with a kind of chemical. The Indians believed it was a poisonous substance. The meat discoloured with the use of this substance that was mixed with flour. The people who died from this food poisoning were all buried at the Belly Butte site."¹⁰¹ Blood Elder George First Rider corroborated these stories:

The meat was treated with some kind of chemical. Shortly after it would turn blue and not be eatable. Those were the days when people were dying off. Bodies were hauled out of the camps at a high rate and carried to the burial grounds. During the time of issuing the rations, many people got sick and very many died... That was the first time we were poisoned by the Queen and the government. Those people were just about wiped out by the first ration.¹⁰²

Although it is difficult to say what the purpose of the substances mixed with the rations were, the Elders viewed the contaminations as deliberate acts.¹⁰³

Even when rations were not deliberately poisoned, diets were not markedly improved over the next forty years. Canada's Medical Officer Dr. Graham-Cumming reported that, in 1927 and 1928, only 13.9 per cent of the Native people living in the west lived on a "white man's diet" of milk, butter, eggs and meat, vegetables, and fruits. On the other hand, 34.7 per cent of Aboriginal people lived on a monthly rations diet comprised of 50 pounds of flour, two pounds of tea, three pounds of rice per month, thirty pounds of bacon in the summer, and thirty pounds

¹⁰⁰ Lux, *supra* note 2 at 59. Indian History Film Project (Saskatchewan Indian Federated college Library, Regina Saskatchewan), IH 245 Interview with Tom Yellowhorn, Peigan, 7 Mar. 1975; IH 234, 234a interview with Useless Good Runner, Blood Elder; M.K. Lux Peigan Field notes, Alan Pard interview, Dec, 1999; IH233, 233a, interview with George First Rider, Blood Elder.

¹⁰¹ Lux, *supra* note 2 at 60.

¹⁰² Lux, *supra* note 2 at 60 fn 109.

¹⁰³ The author sees this testimony as an opportunity to delve further into these allegations and take samples from the bodies at Belly Butte and Ghost Coulee to determine what the cause of deaths were with so many people and to determine what substances were ingested.

of beef in the winter. Also, 34.7 per cent of Aboriginal people lived on a slightly “better” diet, adding either vegetables *or* milk and eggs. The remaining 25.3 per cent of Aboriginal people lived on the same rations with *two* of the following added: milk, eggs, or vegetables.¹⁰⁴

Dr. Graham-Cumming noted that, because of the poor diet, the tonsils and adenoids of Aboriginal people were enlarged, and constipation was a problem. He also noted that, before the buffalo disappeared, dental caries were non-existent. Scurvy became a problem in the northern residential schools where it was difficult to get fresh fish and meat most of the time. Doctor Graham-Cumming stated in his report that the federal government sent canned goods to the children who suffered, preventing the deaths of many of them. Before iodine was added to salt, a lack of iodine in the diet caused goiter, which was endemic in several areas.¹⁰⁵

(a) A Case Study of Scurvy

*I saw an Indian child die of scurvy within 100 yards of a trading post, and yet not an orange or a tin of tomatoes could be bought there.*¹⁰⁶

In the 1500s, scurvy broke out among the crew of explorer Jacques Cartier at Stadacona. According to Fournier and Crey, an Indian medicine man said, “All fools soon dead if eat old meat—no greens. Take spruce tree buds—make strong tea—drink every day.” This wise advice stopped the outbreak of scurvy among Cartier’s men. Later, when scurvy broke out among the Chinese labourers who were building the railroads in British Columbia, Indian medicine men told them to drink pine needle tea.¹⁰⁷ This simple measure stopped the outbreak of scurvy among the Chinese workers.

While some Indian bands managed to succeed in developing agricultural methods, many more succumbed to disease and subsequent death on a rations diet.¹⁰⁸ Scurvy was common, and other lifestyle changes led to disease and death as well. While many Indians formerly lived in teepees, they now lived in 12 by 18 foot wooden buildings with roofs and mud floors. Two or

¹⁰⁴ Graham-Cumming, *supra* note 10 at 158.

¹⁰⁵ Graham-Cumming, *ibid* at 159.

¹⁰⁶ Cameron Corrigan, “Scurvy in a Cree Indian” *Canada M.A.J.* April 1946, vol. 64 at 380 [Corrigan].

¹⁰⁷ Graham-Cumming, *supra* note 10 at 120.

¹⁰⁸ Waldram, *supra* note 31 at 156.

more families lived in these buildings. Sanitary habits were problematic, and the houses became centres of infection. Any relief measures appeared to be geared towards protecting the non-Aboriginal population from the diseases that plagued the Aboriginal populations.¹⁰⁹

ii) Residential School Hunger

In the residential schools, the children were hungry. A survivor recalls:

Hunger is both the first and last thing I can remember about that school. I was hungry from the day I went into the school until they took me to the hospital two and half years later. Not just me. Every Indian student smelled of hunger.¹¹⁰

...

The only time I did not feel hunger during those two years was when my grandparents came.... When they came they brought deer meat and bannock and other real food you could get full on. Nobody thought to want candy when we had not seen meat for so long. For weeks before they would come I could not think of anything besides the food they would bring with them. The food always crowded out the people. It was not my grandfather who was coming. It was meat, dried fruit, and roots. Hunger like that numbs your mind.¹¹¹

Cree leader, John Tootoosis also recalled,

Sometimes some children did not want to eat ... [as] there were these big iron pots on the stove, that's where they boiled clothes before washing ... This one spring the meat was probably thawing and about to get bad. Didn't they go and boil the meat in these pots and that's what they tried to feed us. It was very difficult to eat the food.¹¹²

Métis scholar, Agnes Grant, claimed that when school inspectors visited, it was a very different story:

Schools were inspected at intervals and inspection meant that food would temporarily improve. The children viewed these inspections with considerable cynicism as corn flakes, oranges, toast, and eggs would suddenly appear at breakfast time, and thick, wholesome stew appeared for lunch and supper.¹¹³

Historian John Milloy cites;

¹⁰⁹Lux, *supra* note 2 at 5, Graham-Cumming, *supra* note 10 at 123.

¹¹⁰Manuel, George and Michael Posluns (1974). "The Fourth World: an Indian Reality." Don Mills, ON: Collier-Macmillan Canada at 65 [Manuel].

¹¹¹Manuel, *ibid* at 66.

¹¹²Jean Goodwill, and Norma Sluman (1984). John Tootoosis: Biography of a Cree Leader. Winnipeg, MB: Pemmican Publications at 100.

¹¹³Grant, *supra* note 29 at 116.

The Sisters didn't treat me good - they gave me rotten food to eat and punished me for not eating it - the meat and soup were rotten and tasted so bad they made the girls sick sometime. I have been sick from eating it ... I used to hide the meat in my pocket and throw it away. I told the Sisters to look at the meat as it was rotten, and they said it was not rotten and we must eat it. The Sisters did not eat the same kind of food as they gave the girls. If we didn't eat our porridge at breakfast, it was given to us for our dinner, and even for supper, and we got nothing else till it was eaten.¹¹⁴

Children became sick in large numbers. John Milloy describes their arduous work schedule and food scarcity situation:

Rising early, the boys and girls were to spend half their day in the classroom and the rest of the day in barns and coops or field and wood lots, in the laundry and bake house. The daily grind was ... exhausting. Benson calculated that the school day was fifteen hours long ...

There was, unfortunately, no guarantee in any of this that the children would be fed adequately at the end of the day and considerable evidence that the commercialization of the school operation contributed to malnutrition. The sale of dairy products, milk, cream, and butter was common throughout the system and a good revenue source. It meant in many cases, however, that the children were denied these important foods.¹¹⁵

For the Inuit who attended residential schools,

Between 1955 and 1961, the advice from the Department of Health and Welfare, the mission schools decided what food should be given to the Inuit. The churches in Inuvik and Chesterfield Inlet decided on a combination of traditional and Western foods for their students. The Department of Northern Affairs agreed that Inuit students could be fed a traditional diet. By 1961, with allegations of smaller caribou herds and more Inuit going to school, less traditional foods and more Western foods were being served at the schools. In this same year, the Department of Health and Welfare advised the Department of Northern Affairs to ban the eating of raw meat in the schools and to teach the students that eating raw meat was the cause of sickness.¹¹⁶

Children died in large numbers because of malnutrition. Scarcity of food and poor diet contributed to the students' susceptibility to disease and has led to long-lasting effects for

¹¹⁴ See, J.S. Milloy, J.S. A National Crime: The Canadian Government and the Residential School System: 1879-1986. Winnipeg, MB: University of Manitoba Press 1999 at 143. [Milloy].

¹¹⁵ Milloy, *ibid* at 120.

¹¹⁶ David King, A Brief Report of The Federal Government of Canada's Residential School System for Inuit Prepared for the Aboriginal Healing Foundation (2006).

future generations. The genetic impacts of these conditions and events will be discussed in the following section.

5.1.3 Genetic Changes due to Nutritional Deficiency

When the nutrient dense diets changed to one of large amounts of simple sugars and saturated fats an increase in chronic diseases occurred. These less healthy diets were characterized by a decrease in protein, iron and zinc,¹¹⁷ and inadequate intakes of Vitamin A, calcium, folate and dietary fibre.¹¹⁸

We now know that complex interactions occur between genes and environment. The study of genetics has revealed complex pathways between genes and metabolic outcomes, which means that multiple genes are involved with these gene-environmental interactions. In some cases, "epigenetic" effects due to environmental factors may cause changes in gene function that persist over generations. We know, for example, that the survivors of famine in Holland following World War II suffered multigenerational effects. We also know that Aboriginal people suffered starvation and famine in Canada. Comparing the diets of both cohorts is instructive about the impact of starvation on First Nations. *In utero* famine victims from the Dutch famine suffered increased cardiovascular disease. It is reasonable to assume, then, that the *in utero* Aboriginal people whose mothers suffered starvation and a rapid decrease in nutritional deficiency also have increased cardiovascular disease for the same reasons.

Epigenetics refers to genome¹¹⁹ data that is superimposed on a DNA sequence¹²⁰ to make an individual of a species. Simply, epigenetics have been described as “the interactions of genes with their environment, which bring the phenotype into being.”¹²¹ The phenotype is the visible characteristics of an organism that result from the interaction between its genetic makeup and

¹¹⁷ Kuhnlein HV, Kubow S, Soueida R. Lipid components of traditional Inuit foods and diets of Baffin Island. *J Food Comp and Analysis* 1991; 4:227-236.

¹¹⁸ Receveur O, Boulay M, Mills C, Carpenter W, Kuhnlein HV. Variance in Food Use in Dene/Métis Communities. Final Report. McGill University, Montreal. 1996; Receveur O, Boulay M, Kuhnlein HV. Decreasing traditional food use affects diet quality for adult Dene/Métis in 16 communities of the Canadian Northwest. Final Report. McGill University, Montreal. 1997.

¹¹⁹ A genome is defined as “All of the genetic information, the entire genetic complement, all of the hereditary material possessed by an organism”. Medicinenet.com, online:

<http://www.medterms.com/script/main/art.asp?articlekey=3580> (accessed September 2, 2010).

¹²⁰ DNA sequence is defined as “The precise ordering of the bases (A,T,G,C) from which the DNA is composed. DNA sequencing involves determining the exact order of the base pairs in a segment of DNA.” Medicinenet.com, online: <http://www.medterms.com/script/main/art.asp?articlekey=3101> (accessed September 2, 2010).

¹²¹ Waddington, C.H. (1942). *The epigenotype*. *Endeavor* 1, 18-20.

the environment. Epigenetics accounts for the origin of the phenotype, or gene expression, as it emerges from the genotype base.¹²²

The process that creates different members of a honeybee colony provides a good example of epigenetics at work.¹²³ All bees are born genetically identical at the larva stage. When a new queen is needed, worker bees have the job and the ability to feed the queen-to-be larva royal jelly or bee bread. Bee larvae that are fed royal jelly become queens in 16 days, while worker bees take 21 days.¹²⁴ The different honeybee prototypes emerge through epigenetic changes, namely, the type of honey that the larvae are fed. This indicates a clear link between diet-induced epigenetic changes and different paths of development, when both originate from the same genetic background and material.¹²⁵ This is an example of what is well known scientifically: the phenotype of many organisms may be epigenetically altered by nutrition variants.¹²⁶

Epigenetics is recognized as one of the most important mechanisms that regulate gene function. The environmental overlay on gene functions preserves or adapts patterns for different cell types. The way that a cell determines its path through development,¹²⁷ aging,¹²⁸ and disease¹²⁹ is encoded not only in the genome but also in the epigenome.¹³⁰ As in the honeybee example,

¹²² Simonetta Friso, Sang-Woon Choi eds. "Nutrition and Epigenetics" (CRC Press: Boca Raton, 2009) at 2 [Friso].

¹²³ In the 1980s the author was a bee keeper and studied the wondrous complexities of the bee colony while working with her hives.

¹²⁴ AI Root, "ABC and XYZ of Bee Culture" (Medina: AI Root Company, 1940) aka "The Bible for Beekeepers".

¹²⁵ Kucharski, R. Maleszka, J. Foret, S. and Maleszka, R. (2008) Nutritional control of reproductive status in honeybees via DNA methylation. *Science* 319, 1827-1830.

¹²⁶ Friso, *supra* note 122 at 1.

¹²⁷ See Lunyak, V.V and Rpsenfeld, M.G. (2008), Epigenetic regulation of stem cell fate. *Hum Mole Genet* 17, R28-R-36; Chen, L. and Daley, G.Q (2008) Molecular basis of pluripotency, *Hum Mol Genet* 17, R. 23-R 27.

¹²⁸ Choi, S.W. Friso, S. Keyes, M.K. and Mason, J.B., "Folate supplementation increases genomic DNA methylation in the liver of elder rats," *BrJ Nutr*, (2005) 93, 31-55; Fraga, M.F. and Esteller M. "Epigenetics and aging: The targets and the marks" (2007) *Trends Genet* 23, 413-418.

¹²⁹ Jones, P.A. and Baylin, S.B., "The fundamental role of epigenetic events in cancer," *Nat Rev Genet* (2002) 3, 415-428; Laird, P.W. (2003). The power and the promise of DNA methylation markers *Nat Rev Cancer* 3, 253-266.

¹³⁰ Epigenome is defined "The epigenome is the overall epigenetic state of a cell. As one embryo can generate a multitude of cell fates during development, one genome could be said to give rise to many epigenomes. Taken to its extreme, this represents the total state of the cell, with the position and modification of each molecule accounted for." The Epigenome, *Network of Excellence*, online: <http://www.epigenome-noe.net/consulting/glossary.php?ab=e> (accessed September 2, 2010).

epigenetics decides if a gene will be active or silent from a common base of DNA sequencing.¹³¹

These epigenetic changes are very important for embryonic development where nutrition is a key factor. Over the last decade, multiple areas of research have focused on congruent events that occur normally during fetal development. These congruent events may have long lasting effects and could influence health during adulthood. Genetics has made great progress in identifying the epigenetic processes and gene expression patterns that lead to tissue differentiation and organ formation in the embryo.

For instance, in humans, most of the embryonic organs have formed by 8 weeks. After the embryonic period, the fetus grows and “tries out” its organs as they develop and begin to function. This fetal period of development is obviously essential to survival after birth. The organs that will sustain life must go through a process of maturing. They must establish physiologic pathways in preparation for life outside the uterus. During this fetal developmental period, the *in utero* processes have the potential for affecting not only the individual but also the genetic programming of later generations. In other words, fetal development can have trans-generational effects.¹³²

Not surprisingly then, diet is one of the most important environmental factors that human beings are exposed to during their lifetime—both *in utero* and after birth:

¹³¹ Friso, *supra* note 122 at 2. In his 1962 paper “Diabetes Mellitus: A 'Thrifty' Genotype Rendered Detrimental by 'Progress'?" Human Genetics Professor James Neel proposed the "thrifty genotype" hypothesis which suggested the resolution to diabetes is that genes which predispose to diabetes (called 'thrifty genes') were historically useful as a genetic predisposition was adaptive to the feast and famine cycles of paleolithic human existence, allowing humans to fatten rapidly and profoundly during times of feast in order that they might better survive during times of famine, but they became detrimental in the modern world thus causing diabetes and obesity. In 1989, Neel recanted his research but noted, "The data on which that (rather soft) hypothesis was based has now largely collapsed." However, he clarified that "...the concept of a 'thrifty genotype' remains as viable as when first advanced...". Neel stated that the thrifty genotype concept be thought of in the context of a "compromised" genotype that effects several other metabolically-related diseases. (Neel JV (1962). "Diabetes mellitus: a 'thrifty' genotype rendered detrimental by 'progress'?" *Am. J. Hum. Genet.* 14: 353–62. PMID 13937884; (Neel JV (Oct-Dec 1989). "Update to The Study of Natural Selection in Primitive and Civilized Human Populations." *Human Biology* 61 (5-6): 811–23).

¹³²JG. Hall, “The importance of the fetal origins of adult disease for geneticists,” *Clin Genet* (2007) 72: 67–73.

It is well known that nutrients and bioactive food components found in a typical daily diet can modulate the epigenetic phenomena in our cells, thereby affecting critical gene expression. This is one mechanism by which lifestyle factors affect physiologic and pathologic processes in our body. Thus we can speculate that a certain nutrient deficiency may induce an abnormality in the epigenetic condition, and a proper nutritional intervention program may reverse disordered epigenetic patterns.

...

Nutrients can modify our physiologic and pathological processes through epigenetic phenomena. Modulation of these processes through diet or specific nutrients may maintain biological homeostasis and health. There is a growing list of nutrients and bioactive food components that have shown effects on epigenetic phenomena.¹³³

Historical famines have provided a powerful, quasi-experimental setting for discovering epigenetic marks that may be modified by the prenatal environment.

i) The Dutch Hunger Winter Families Study

The Dutch experienced a famine during the winter of 1944 to 1945, known as the “Hunger Winter.”

Beginning in September 1944, Allied troops had liberated most of the South of the country, but their advance towards the North came to a stop at the Waal and Rhine rivers and the battle of Arnhem. In support of the Allied war effort, the Dutch government in exile in London called for a national railway strike to hinder German military initiatives. In retaliation, in October 1944, the German authorities blocked all food supplies to the occupied West of the country.

Despite the war, nutrition in the Netherlands had generally been good up to October 1944, when food supplies suddenly became scarce.¹³⁴ By November 26, 1944, official rations consisted of little more than bread and potatoes, and the kilocalorie count fell below 1000 kcal per day. By April 1945, it fell as low as 500 kcal per day. Starvation was seen everywhere, most particularly in the cities of the western Netherlands.¹³⁵

¹³³ Friso, *supra* note 122 at 229.

¹³⁴ G. Trienekens, “The food supply in The Netherlands during the Second World War” in: Smith DF, Phillips J, eds., *Food, Science, Policy and Regulation in the Twentieth Century: International and Comparative Perspectives* (2000) Deel. London: Routledge. 117–33.

¹³⁵ Trienekens, *ibid*. See also, Stein ZA, Susser M, Saenger G, Marolla F. *Famine and Human Development: The Dutch Hunger Winter of 1944–1945* (1975) New York: Oxford University Press; De Jong L. Het Koninkrijk der Nederlanden in *de tweede Wereldoorlog 1939–1945* (1981) Deel 10b. Vol. Deel 10b. ‘s-Gravenhage, The

The average daily rations, which the authorities distributed during the famine, were less than 700 kcal (cf. normal daily requirements for women and men are 2,000 kcal and 2,500 kcal, respectively).¹³⁶

Because the Dutch population was typically well fed before and after the famine, the circumstances of the famine created what can be regarded as a “natural experiment.” Maternal under-nutrition was studied during specific gestational time windows. Researchers could track how starvation in mothers affected the subsequent life course of their offspring who experienced the famine *in-utero*.

Many studies have shown a link between low birth weight and subsequent disease. Fetal origins hypothesis suggests that exposing the fetus to an adverse environment *in utero* permanently programs tissue functions and increases the risk of cardiovascular disease. Other researchers hypothesize that low birth weight and adult cardiovascular disease are independent features of a genetic predisposition to cardiovascular disease. They explore the intergenerational effects of both birth weight and cardiovascular disease across a number of generations.¹³⁷

Studies have found that people who were exposed to famine in early gestation and those who were conceived during the famine had higher rates of coronary heart disease than people who had not been exposed to famine *in utero*. This evidence directly suggests that maternal starvation during gestation is linked to coronary heart disease in the offspring. Researchers also reported that people who were exposed to famine in late gestation had a reduced glucose tolerance at age 50, whereas those exposed to famine in early gestation had higher levels of obesity in women and more atherogenic lipid profiles¹³⁸ in both men and women.

Netherlands: Staatsuitgeverij; Lumey LH, Van Poppel FW, “The Dutch famine of 1944–45: mortality and morbidity in past and present generations,” *Soc Hist Med* (1994) 7:229–46.[Abstract]; Burger GCE, Drummond JC, Sandstead HR. *Malnutrition and Starvation in Western Netherlands, September 1944 to July 1945, Parts I and II* (1948) 's-Gravenhage, The Netherlands: Staatsuitgeverij.

¹³⁶ *Ibid.*

¹³⁷ A J Drake and B R Walker, “The intergenerational effects of fetal programming: non-genomic mechanisms for the inheritance of low birth weight and cardiovascular risk”, *Journal of Endocrinology* (2004) 180, 1–16 [Drake and Walker]. See also, “The Dutch Hunger Winter Families Study”, The study was set up by L.H.Lumey et al in collaboration with Ana Diez-Roux at Columbia University, New York, NY. The Dutch Hunger Winter Families Study included 3307 singleton births in three clinics that were affected by the famine.

¹³⁸ Leading to higher [Cholesterol](#) and [triglycerides](#) levels in the blood.

The impacts of prenatal exposure to famine on fetal growth on the one hand and coronary heart disease and its risk factors on the other suggest that an adverse fetal environment contributes to various cardiovascular problems in adult life. The specific effects depend on the time of exposure to famine during gestation. Because the famine ended abruptly, the women who conceived during the famine (or were exposed in early pregnancy) were well nourished in later pregnancy. Their babies had above-average birth weights. The fact that these babies had higher rates of coronary heart disease in adult life suggests that the transition from starvation in early gestation to nutritional adequacy later on set up metabolic conflicts, which manifested in a higher risk of coronary heart disease.

Geneticists Drake and Walker conclude that starvation and malnutrition have intergenerational effects:

The association between low birth weight and subsequent disease has been well documented; however, it is also clear that fetal programming effects may not be limited to the first generation. Indeed, intergenerational effects may masquerade as a genetic predisposition to cardiovascular disease in subsequent generations. There is some evidence from human studies that non-genetic effects may be associated with the intergenerational transmission of disease risk. However, any impact of such intergenerational effects will result from the interaction of genes and the pre and postnatal environment, and will also occur against a heterogeneous background of genetic susceptibility. Thus, the importance of any effects in different populations will be variable, and it will be difficult to tease out the relative importance of each in any one human population. Nevertheless, there is compelling evidence from animal studies that non-genomic intergenerational effects could operate to produce programming effects across a number of generations. Intergenerational effects of fetal programming may have major public health implications for developed and developing worlds. Additionally, there may be unforeseen long-term and intergenerational effects of interventions that impact on early human development. Finally, policies aimed at improving the health of one generation, in particular those directed at improving maternal, fetal and infant health and at reducing obesity, may have important benefits for a number of succeeding generations.¹³⁹

The Dutch Famine and the periods of starvation in Aboriginal Nations bear many similarities, and the high rates of disease among Aboriginal people may correlate to the same type of environmental pressures, namely, starvation and under-nourishment.

¹³⁹ Drake and Walker, *supra* note 137.

In the 1800s, the rations given to Aboriginal people were hardly sufficient to sustain life, and not only lowered their resistance to disease but also may have genetically altered the DNA sequences of the people starving across generations. The mothers who were pregnant or conceived during or following this period had children who would suffer not only from cardiovascular disease but also from a myriad of other conditions and problems. We can still see the damaging effects in the health of the Aboriginal population today.

Even in the 1920s and 1930s, conditions did not improve. Many if not most Aboriginal people remained malnourished and sick. In the 1940s, the Dutch famine provided an opportunity to study the effects of starvation on mothers and their children. Cardiovascular disease (among other conditions) was clearly documented as prevalent in their offspring. The Dutch were fortunate: they suffered only for a few months, and only a small percentage of their population was affected. Aboriginal people were not so lucky. Starvation and malnutrition continue today.

ii) Aboriginal Diets – Dr. Jay Wortman

Dr. Jay Wortman studied the role of traditional diets in the treatment and prevention of obesity, metabolic syndrome, and type 2 diabetes among First Nations people. Dr. Wortman advocates that Aboriginal people avoid starches and sugars, because they were not components of their traditional diets. Permitted foods include beef, pork, chicken, fish, or seafood, all salad greens, but not milk as it contains lactose which is a sugar. Dr. Wortman claims that introducing starches—especially pasta, rice, potatoes, bread, and sugar—has caused the rise of obesity and diabetes. He does recommend oolichan grease, which is very healthy and was a part of the traditional diet. It is one of the reasons why the traditional diet was a healthy diet.¹⁴⁰

The Canada Food Guide and Dr. Wortman do not agree on what constitutes a healthy diet. Dr. Wortman says the Canada Food Guide promotes a high-carbohydrate diet and has not been updated since the first version came out in 1982. Yet, a growing body of scientific evidence suggests that a low-carbohydrate diet is a valid, healthy option for many people, especially First Nations, and that a high-carbohydrate diet can be highly damaging to health. Rates of obesity

¹⁴⁰ See Dr. Jay's Blog, "My Big Fat Diet" online at <http://www.drjaywortman.com/> (accessed September 2, 2010).

and diabetes are higher than ever in Aboriginal communities, and these diseases are not being reduced by a high carbohydrate diet. Dr. Wortman is justifiably concerned that the agricultural and food-processing sectors may be influencing what should be a purely evidence-based guideline for healthy eating. He writes, “[t]he growing evidence in support of low-carbohydrate diets will encounter resistance from economic interests threatened by changes in consumption patterns.”¹⁴¹ A problem remains that many Aboriginal people who suffer from diabetes and cardiovascular disease do so because they do not have the economic means to buy nutritionally good food.

5.1.4 Summary

Without a doubt, diet, health, and disease are related. The Dutch Famine Study clearly showed that prenatal starvation detrimentally affected the health of offspring. Further studies have shown that poor nutrition and other diseases, including increased risks of cardiovascular disease, are related. Many of these linkages were dependent on the sex of the exposed individual and the timing of the exposure during gestation.¹⁴²

Dr. Wortman claims that the Canada Food Guide contributes to health problems by advocating a high carbohydrate diet. His study has proven useful in linking diets to disease. It has also provided hope that the devastating effects of starvation can be rectified and even reversed through diet. The history of starvation and nutritionally inadequate diets has demonstrated conclusively that dietary change must be made in order to change the future health of Aboriginal people.

Changing policies and reforming laws are necessary to cement positive changes. This means that current policies that affect nutrition among Aboriginal peoples must be reviewed and altered to reflect First Nation cultural, spiritual, traditional, and nutritional differences. It has taken generations of starvation and poor nutrition to alter the genetics to produce an unhealthy and sick population. It may take generations to reverse the genetic codes by restoring healthy

¹⁴¹ Lucretia Schanfarber, *Alive Magazine*, Dr. Jay Wortman, online: http://www.alive.com/print_version.php?chosen_topic_id=6201&site... (accessed September 2, 2010).

¹⁴² Drake and Walker, *supra* note 137.

nutrition habits that are closer to the eating habits of Aboriginal ancestors. Starting now, though, we can ensure that future generations may be healthy.

5.2 How Federal Government Policies Affect Aboriginal Health

Early government policies implemented health care to Aboriginal people on an *ad hoc* basis. Care or lack of it was wholly dependent upon the contagiousness and severity of the diseases that might have an impact on the non-Aboriginal population. Health policies were geared toward protecting the good health of non-Aboriginal people. This motive, coupled with the complex jurisdictional conflicts (noted in Chapter 6.3) arising over the provision of health care to Aboriginal people, have also contributed to a disjointed policy framework for Aboriginal health.

As noted in Chapter 5.1, Professor Maureen Lux¹ and the *Report of the Royal Commission on Aboriginal Peoples*² document how the policies of the federal government created today's health crisis among Aboriginal peoples. The failure of Aboriginal health policies stems from a set of false assumptions: that Aboriginal people were inherently unhealthy and inferior; that they were therefore biologically predetermined to vanish; and that their traditional cultures caused them to pursue harmful lifestyles. The federal government's policies were presumably designed to implement the treaty promises of settlement. However, in practice, they actually diminished the treaty-secured avocations of hunting, fishing, and trapping in the transferred lands. The loss of these sources of food resulted in suffering, starvation, disease, and ultimately death for Aboriginal people.

“Colonization” has been defined as “the act of bringing into subjection or subjugation by colonialism and as” as “the aggregate of various economic, political and social policies by which an imperial power maintains or extends its control over areas or people.”³ Power and control play dominant roles in colonialism. The colonial system creates a hierarchy that puts considerable stress on the health of people who find themselves on the bottom of the power and

¹ M. Lux, *Medicine That Walks: Disease, Medicine, and Canadian Plains Native Peoples: 1880-1940* (Toronto: University of Toronto Press, 2001).

² Canada, Royal Commission on Aboriginal People, *Report of the Royal Commission on Aboriginal Peoples: Gathering Strength* Vol. 3 (Ottawa: Supply and Services Canada, 1996) [RCAP] online at http://www.ainc-inac.gc.ca/ch/rcap/sg/sgmm_e.html (accessed September 8, 2010).

³ "Colonization," "Colonialism," Merriam-Webster Online Dictionary, 2010, Merriam-Webster Online, 20 May 2010 <http://www.merriam-webster.com/dictionary/colonization> (accessed September 7, 2010).

control hierarchy.⁴ Colonization has also been described as inflicting severe social trauma, which causes “a soul wound” to Aboriginal people. This soul wound reaches “into the very essence of a person’s being, a wound of great intensity and depth.”⁵

In Canada, colonialism was implemented through various policies of assimilation, such as the *Indian Act* and residential schools. These policies proved acutely traumatizing to Aboriginal people, damaging both the health and the social fibre of Aboriginal communities. Professor Sákéj Youngblood Henderson describes colonialism as a “dominant intellectual and educational movement that postulates the superiority of Europeans over non-Europeans.”⁶ Henderson notes that, in academic settings, the identity, heritage, and thought of Aboriginal students have been viewed as inferior to Eurocentric thought. After being subjected to a Eurocentric environment during schooling, Aboriginal students often come to support and endorse the Eurocentric thought patterns of their mentors. These thought patterns maintain colonial domination in Aboriginal communities.

Euro-colonial domination holds not only in education but also in most, if not all, colonial institutions—certainly in the field of health. Dr. Pertice Moffitt describes health Euro-centrism through the case of pregnant Dogrib women and Inuit women who have been forcibly moved from community birthing and subjected to “institutional birthing dictated by a White bureaucratic health care authority.”⁷

The results of colonization are measured in losses of cultural identity, marginalization, and a quality of health that falls well below that of mainstream Canadians. Further, the loss of cultural identity and the marginalization of Aboriginal voices have contributed to an inner, spiritual erosion that has provided a pathway for substance abuse, sedentary lifestyles, and family violence that were never a part of the traditional Aboriginal ways to enter the lives of

⁴ R. G. Evans, M. L. Barer & T. R. Marmor, 1994, *Why are some people healthy and others not? The determinants of health of populations*, New York: Aldine de Gruyter in Pertice Moffitt, Colonialization: A Health Determinant for Pregnant Dogrib Women, *Journal of Transcultural Nursing*, Vol. 15 No. 4, October 2004 323-330 [Moffitt] at 323.

⁵ Moffitt, *ibid.*

⁶ J. Sákéj Henderson, “Postcolonial Ghost Dancing: Diagnosing European Colonialism” in Marie Battiste, ed., *Reclaiming Indigenous Voice and Vision* (Vancouver: University of British Columbia Press, 2000) 57 at 58.

⁷ Moffitt, *supra* note 4.

Aboriginal people.⁸ Racism has flourished, as a new descriptive language developed: Aboriginal people have been labeled “savages,” “barbarians,” and “dirty, lazy Indians”⁹; Aboriginal women have been called “squaws.”¹⁰ The correlation to policies that implement health and medical services follow.

5.2.1 Provision of Health Services

*The experience of Aboriginal people as they access health care services has been described as an encounter of isolation, alienation, and marginalization and health care systems are seen as “powerful colonial forces” and agents of social control.*¹¹

Before Confederation, Indian agents, missionaries, traders, and the Hudson’s Bay Company provided periodic medical services to Indian people.¹² The term “Indian agent” was used to describe the person who was responsible for administering treaties on behalf of the Queen. The agents worked closely with physicians, missionaries, and the police. The physician was paid from treaty money to provide vaccinations, medical examinations, and dental extractions.¹³ These health services have been described as:

...Indian agents, missionaries, traders and the Hudson Bay Company provided periodic medical services to Indian people. In 1873, the North West Mounted

⁸ RCAP, *supra* note 2 in Moffitt, *supra* note 4 at 324.

⁹ Moffitt, *supra* note 4 at 324.

¹⁰ See, Marge Bruchac, *Reclaiming the Word “Squaw” in the Name of the Ancestors*, online: <http://www.nativeweb.org/pages/legal/squaw.html> 9 (accessed September 8, 2010).

¹¹ A. Browne, & V. Smye, “A post-colonial analysis of healthcare discourses addressing aboriginal women,” *Nurse Researcher*, (2002) 9(3), 28-41; A. J. Browne, “The meaning of respect: A First Nations perspective” *Canadian Journal of Nursing Research*, (1995) 27(4), 95-109; F. Hart-Wasekeesikaw, “Challenges for the new millennium: Nursing in First Nations communities” in M. McIntyre & E. Thomlinson (Eds.), *Realities of Canadian nursing professional, practice, and power issues*, 447-492, (Philadelphia: Lippincott Williams & Wilkins, 2003); J. O’Neil, “Self-determination, medical ideology, and health services in Inuit communities” in G. Dacks & K. Coates (Eds.), *Northern communities: The prospects for empowerment* 33-50 (Edmonton, Canada: Boreal Institute for Northern Studies, 1988); J. Smylie, (2001) Society of obstetricians and gynaecologists policy statement. “A guide for health professionals working with Aboriginal peoples”; M.D. Stout, & G.D. Kipling *Aboriginal women in Canada: Strategic research direction for policy development*. (Ottawa, Canada, 1988); Status of Women of Canada, “Cross cultural understanding” *Journal for Society of Obstetrics and Gynecologists*, 100, 157-167;

¹²G. Graham-Cumming, *Health of the Original Canadians, 1867 – 1967*, Med. Ser. J. Can. 23, 115-166 at 122 [Graham-Cumming]. See also J. Waldram, D.A. Herring, T.K. Young, *Aboriginal Health in Canada. Historical/Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995) [Waldram] at 122-123.

¹³ Waldram, *ibid* at 194. See also Graham-Cumming, *ibid* at 133.

Police (N.W.M.P.) was formed and began providing some services as agents for the Department of Indian Affairs. Besides their role in controlling Indian access to alcohol, N.W.M.P. surgeons provided routine medical services to Indians into the early part of the twentieth century. The N.W.M.P. also played a significant role in the quarantine of groups of Indian people when smallpox, whooping cough, influenza, and tuberculosis swept through the Indian populations.¹⁴

Over the years, nurses and doctors who were employed full or part-time by the federal government were placed in Aboriginal communities. They either replaced or worked in conjunction with the Indian Agents. In 1930, the first on-reserve nursing station opened in Fisher River, Manitoba.¹⁵

Following the Second World War, the organized medical services available to Inuit and Indian people increased. In 1944, the National Health and Welfare Department (NHWD) was formed and the Department of Indian and Northern Health transferred all aspects of Indian health services to the NHWD. All other administration of “Indians, and Lands reserved for the Indians” remained with the Department of Indian Affairs. Indian agents were renamed “Superintendents.” They retained control over health by virtue of their designation as Health Officers on reserves, even though a different department was now delivering the actual medical services.¹⁶

By the 1950s, the federal department of National Health and Welfare was operating a network of 33 nursing stations, 65 health centres, and 18 small regional hospitals for registered Indians and Inuit. This undertaking was motivated by the post-war spirit of humanitarianism that propelled the emerging Canadian welfare state and by fear of the threat posed to Canadians by sky-high rates of tuberculosis in Aboriginal communities.¹⁷

¹⁴ Yvonne Boyer, *Discussion Paper Series in Aboriginal Health: Legal Issues no. 2 First Nations, Métis and Inuit Health Care the Crown's Fiduciary Obligation* (Ottawa: National Aboriginal Health Organization, June 2004) at 10 [NAHO Discussion Paper No. 2]. See also Graham-Cumming, *supra* note 12 at 122. Waldram, *supra* note 12 at 181 -182.

¹⁵ Raymond Obomsawin, *Historical and Scientific Perspectives on the Health of Canada's First Peoples*, (2007), online: <http://www.nativepeoples.com/article/attachments/First%20Peoples%20Health%20History%20Canada%20&%20Intl%20OV.pdf> (accessed April 29, 2010) [Obomsawin].

¹⁶ Waldram, *supra* note 12 at 197.

¹⁷ Canada, *Gathering Strength: Canada's Aboriginal Action Plan*, 1998, Chapter 3 in Obomsawin, *supra* note 20 at 19 [Gathering Strength].

In 1956, the NHWD had grown sizably due to a funding increase of more than \$17 million dollars and a corresponding increase in medical professionals employed. In 1962, the Medical Services Branch of the NHWD was created, which assumed responsibility for all Indian and Inuit health services. Federal government expenditures to Indian health increased, and by the end of the 1960s, the budget was more than \$28 million, compared to \$4 million in the 1950s.¹⁸

The government health system operated on the assumption that Aboriginal peoples would welcome Western-style health care services. Even in cases where this may have been true, Aboriginal people faced some basic and severe functional problems such as:

Aboriginal people with serious illnesses were often sent unaccompanied, to distant medical facilities for treatment and placed alone in strange and sometimes hostile environments.

In their own communities, Aboriginal people were offered health care services without any relation to local values, traditions, or conditions. At worst, some Aboriginal people were forced (or convinced) to suffer invasive medical procedures, including sterilization. (See Chapter 5.2.3 *infra*)

Virtually all providers of health and social services were non-Aboriginal. Many had little interest in the cultural practices or values of their Aboriginal clients. Encounters were often clouded by suspicions, misunderstandings, resentments, and racism.

Indigenous healing skills and knowledge of plant medicines and other traditional treatments were devalued by medical personnel. As a result, those who still used or even remembered them had to hide their knowledge and practices. Much knowledge was eventually lost.

Aboriginal people learned that they were not in charge; non-Aboriginal people learned that they were. This legacy has been difficult for both sides to put behind them.¹⁹

The James Bay and Northern Quebec Agreement, also known as the first modern treaty, was signed in 1975.²⁰ Sections 14 and 15 of this agreement encompass the administration of Cree

¹⁸ Waldram, *supra* note 12 at 198.

¹⁹ Gathering Strength, *supra* note 17.

and Inuit health and social services (respectively).²¹ This Agreement specifies that the Inuit of Nunavik exercise a certain degree of control over the health service delivery in their region. The centre that developed from this Agreement has since become a model of integrative health services. Today, Canada has completed (in force and in effect) approximately twenty comprehensive land claims (modern treaties) that contain specific clauses dealing with health services.²²

In 1979, the *Federal Indian Health Policy* ('Three Pillars Policy') was released. It strengthened community development and clarified the relationship between Indian people and the federal government. Relative to Canadian health services, the Three Pillars Policy required that provincial governments, municipal governments, the private sector, and Indian reserves work together to achieve higher levels of health in Aboriginal communities. The Policy stated:

[T]he first, and most significant, [pillar] is community development, both socio-economic development and cultural and spiritual development, to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental and social well-being.” Indeed, the overarching goal of the new federal policy was to “achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves.”²³

The goal of this policy was to integrate Aboriginal health services with the standard health care system in ways that were positive and collaborative for Aboriginal people. It began to involve

²⁰ The signatories of this agreement were the Grand Council of the Crees (Quebec), the (then) Northern Quebec Inuit Association, the government of Quebec, the Bay James Energy Society, the Development Society of Bay James, Hydro Quebec, and the federal government.

²¹ Under the s. 14 of the agreement the Cree Regional Board is responsible for the health services of for all persons normally resident or temporarily present in their Region. Furthermore, under s. 15 of the agreement the Kativik Health and Social Services Council in conjunction with the Regional Government are responsible for administrating for health services to the residents or people temporarily present in the Hudson Bay Sector and the Ungava Bay Sector.

²² Nine of these are termed “modern treaty agreements” because they include self-government provisions within a single final agreement. The remaining 11 were concluded under the 1993 Council for Yukon Indians Umbrella Final Agreement and have separate Self- Government Agreements. (Indian and Northern Affairs Canada. General Briefing Note on the Comprehensive Land Claims Policy of Canada and the Status of Claims, online: http://www.ainc-inac.gc.ca/ps/clm/gbn/gbn_e.pdf (accessed April 8, 2009). See also: Canada, Indian and Northern Affairs Canada, “General Briefing Note On The Comprehensive Land Claims Policy Of Canada And The Status Of Claims”, (Ottawa: Canadian Government Publishing Directorate, 2008), online: <http://Www.Ainc-Inac.Gc.Ca/Al/Ldc/Ccl/Pubs/Gbn/Gbn-Eng.Asp>.

²³ Canada, *Indian Health Policy*, Government of Canada, issued 1979, online: http://www.hcsc.gc.ca/fnih-spni/services/indi_health-sante_poli_e.html in Obomsawin *supra* note 15 at 21, 22.

First Nation and Inuit communities in the delivery of health care services.²⁴ Yet, this step alone was not enough.

The same year, Canada adopted the international *Alma Ata Declaration*, which defined and acknowledged the basic requisites of health:

Equitable Distribution addresses the multiple root causes of ill health and ensures that health resources are equitably distributed among all groups and across geographic regions.

Community Involvement ensures that local communities are vested with decision-making powers in matters of health.

Multisectoral Approach recognizes in practical ways the key influence of environmental, nutritional, economic, and social factors, as well as health services on the health of individuals and communities.

Appropriate Technology ensures that technical health interventions are socio-culturally acceptable and relevant.²⁵

The hope was that this Declaration would help to reduce health inequities. However, it too was not enough. In 1980, Justice Thomas Berger issued a report that called for a consultative process to transfer the control of health services to First Nation communities.²⁶ In 1983, the Report of the Special Committee on Indian Self-Government (also known as the Penner Report) also advocated for improvements in Aboriginal health care. The report stressed the need to take a more holistic approach to health care by incorporating traditional with western approaches as well as by focusing more on preventative measures.²⁷ Transferring health services to Aboriginal control became the new hope for achieving more equitable health results for Aboriginal people.

The first steps toward “health services transfer” began in 1982 with the *Community Health Demonstration Program*. This program experimented with different models of health service

²⁴ Canada, Indian and Northern Affairs Canada, Health and Welfare, Communiqué 1979-88, “Statement on Indian Health Policy” (Ottawa: Canadian Government Publishing Directorate, September 19, 1979).

²⁵ Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, online http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (accessed September 8, 2010) in Obomsawin, *supra* note 15.

²⁶ T. R. Berger, (1980). *Report of the Advisory Commission on Indian and Inuit Health Consultation*. Ottawa, ON: House of Commons.

²⁷ Waldram, *supra* note 12 at 235-239.

delivery and different levels of control.²⁸ Again, the goal was to lead to more positive health results for Aboriginal people.

In 1986, "...the Sechelt Indian Band signed the first Self-Government agreement in which a First Nation community assumed control of their health services."²⁹ Furthermore, in 1989, with the approval of both the Canadian cabinet and the treasury board, the federal government proceeded with its health transfer policy. This involved assigning the control of resources allocated for health-based programs to communities south of the sixtieth parallel. In the fall of 1989, 58 pre-transfer projects were underway, involving 212 Aboriginal communities in Canada.³⁰ The same year, during a national conference on health transfer, First Nation delegates called for the removal of some of the constraints built into the process. By the fall of 1990, an additional eight transfer agreements had been signed, and 67 more First Nations were involved in pre-transfer planning.³¹

To help move the transfer along, in 1995, the federal government published "[t]he Government of Canada's Approach to Implementation of the Inherent Right and the Negotiation of Aboriginal Self-Government".³² One aspect of negotiations involved the transfer of health services from the federal government to Aboriginal communities and jurisdiction over health.

Raymond Obomsawin discusses the process:

By early 1996, 141 First Nations communities had assumed administrative responsibility for health care services, either individually or collectively through multi-community agencies or tribal associations, and a total of 237 First Nations communities were involved in the pre-transfer process. As the transfer process has evolved, the benefits have been notable. Gains include more flexibility in the use of program funds, greater freedom to adapt services to local needs and priorities, a lessening of paperwork in accounting to Health Canada, and a

²⁸ Waldram, *ibid.*

²⁹ Canada, Health Canada, First Nations And Inuit Health Branch, Ten Years Of Health Transfer First Nation And Inuit Control, (Ottawa: Canadian Government Publishing Directorate, 2009), online: http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/_agree-accord/10_years_ans_trans/2_intro-eng.php (accessed September 8, 2010).

³⁰ Waldram, *supra* note 12 at 269-270.

³¹ Waldram, *supra* note 12 at 235-239.

³² Canada, Indian and Northern Affairs, "The Government of Canada's Approach to Implementation of the Inherent Right and the Negotiation of Aboriginal Self-Government", *Federal Policy Guide – Aboriginal Self Government* (Ottawa: 1995), online: <http://www.ainc-inac.gc.ca/al/ldc/ccl/pubs/sg/sg-eng.asp> (accessed September 10, 2009).

greater sense of ownership of services. But there have also been noted some disadvantages, too. The drawbacks include the restricted nature of the programs and services that can actually be transferred, the brief time made available for pre-planning and community preparation for assuming program responsibility, the cap on funds regardless of need levels, and the possible failure of the Canadian government to fulfill the fiduciary obligations that Aboriginal peoples deem due.³³

Phil Fontaine, former National Chief of the Assembly of First Nations summarized the health transfer process:

Nearly half of First Nation communities now control and deliver their own health services under the Federal Health Transfer Policy. There are successful community-based projects aimed at improving the integration of health services. Provinces such as Manitoba, Ontario, Alberta and New Brunswick are reaching out to include First Nations in establishing electronic health records and telehealth networks to provide timely access to patient information and care...During the historic Canada-Aboriginal Peoples Roundtable of April 19, 2004... I stated that our vision for improved health revolves around a First Nations controlled and sustainable health system that builds effective capacity and asserts First Nations jurisdiction in health, aligned with a holistic and culturally appropriate approach... The role of research in further informing First Nations' united efforts to improve the health and well-being of our peoples cannot be underestimated.³⁴

On September 11, 2000, the First Ministers agreed that, "improvements to primary health care are crucial to the renewal of health services" and emphasized the importance of multi-disciplinary teams.³⁵ The Government of Canada then established the \$800 million Primary Health Care Transition Fund (PHCTF).

Over a six-year period (2000-2006), the PHCTF funded provinces and territories in their efforts to reform the primary health care system. The PHCTF itself had a time-limited mandate. The programs and services it supported were intended to have a lasting and sustainable impact on the health care system.

³³ *Gathering Strength*, *supra* note 17 at Chapter 3 in Obomsawin, *supra* note 15 at 23.

³⁴ Phil Fontaine, *Forward from the Assembly of First Nations*, Ottawa, Canadian Public Health Journal Vol. 96, Supplement 1, Jan/Feb., 2005, on Aboriginal Health Research and Policy: First Nations-University Collaboration in Manitoba at 8.

³⁵ First Ministers, First Ministers' Meeting, Ottawa, Ontario - September 11, 2000, First Ministers' Meeting, Communiqué On Health, online: http://www.scics.gc.ca/cinfo00/800038004_e.html (accessed August 26, 2010).

Among other funding envelopes, the Aboriginal envelope of the PHCTF was open to application from federal, provincial, and territorial governments, First Nations and Inuit communities and health organizations, and not-for-profit non-governmental organizations. The PHCTF responded to the needs of Aboriginal communities by:

- promoting more productive and cost-effective primary health care service delivery by integrating existing services and resources;
- enhancing the coordination of service delivery between Health Canada, provincial and territorial governments, and First Nations/Inuit communities and health organizations;
- making the federal, provincial, and territorial systems more accountable to each other and to their publics through collaborative information development;
- improving the quality of services delivered to Aboriginal peoples, especially by honoring cultural appropriateness; and
- improving the linkages between primary health care services and social services.³⁶

In addition, all the initiatives that applied for funding had to address one or more of the common objectives of the PHCTF. They also had to complement provincial/territorial direction in primary health care reform. Health Canada selected the initiatives to be funded by consulting with provincial and territorial governments.³⁷

Today, the government department responsible for health services to First Nations and Inuit people is the First Nations and Inuit Health Branch (FNIHB) of Health Canada (formerly called the Medical Services Branch). In 2009, their mandate included:

- ensuring the availability of, or access to, health services for First Nations and Inuit communities;
- assisting First Nations and Inuit communities in addressing health barriers and disease threats and in attaining health levels comparable to other Canadians living in similar locations; and
- building strong partnerships with First Nations and Inuit to improve the health system.³⁸

³⁶ Health Canada, Primary Health Care Transition Fund, online: <http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index-eng.php> (accessed August 26, 2010).

³⁷ *Ibid.*

³⁸ Canada, Health Canada, First Nations and Inuit Health Branch *Mandate and Priorities* (Ottawa: Canadian Government Publishing Directorate, 2009), online: <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/mandat-eng.php> (accessed September 8, 2010). [Mandate and Priorities].

FNIHB provides primary health care for community-based health programs and services, which include 200 remote communities.³⁹ FNIHB works with First Nations and Inuit organizations and communities to carry out activities that keep people healthy and prevent chronic and infectious diseases. FNIHB supports community-based programs on-reserve and in Inuit communities. They provide drug, dental, and ancillary health services to First Nations and Inuit regardless of residence (as long as First Nations have status). They also provide primary health care services on-reserve in remote and isolated areas where provincial services are not available.

The Non-Insured Health Benefits Program is available through FNIHB. It offers a safety net to ensure that basic needs are still accessible if they are not met by other private or public insurance plans. The program provides a range of “medically necessary goods and services to status Indians and Inuit that supplement benefits provided by private or provincial/territorial programs including: dental and vision care, prescription drugs, medical supplies and equipment, transportation to medical services, short-term/crisis mental health counselling and payment of health insurance premiums in British Columbia and Alberta.”⁴⁰ Working with First Nations and Inuit, FNIHB’s community programming includes:

- healthy child development;
- community mental wellness;
- youth suicide prevention;
- addictions prevention and treatment;
- healthy nutrition and activity promotion;
- disease/injury risk factor prevention; and
- community capacity building initiatives.⁴¹

FNIHB provides community care in over 600 communities and primary health care in over 200 remote communities. It also maintains 223 health centers in semi-isolated communities and nursing stations in 74 remote and semi-remote areas. Public Health programs monitor communicable diseases, drinking water on reserves, and environmental health issues (waste water management and mould).⁴²

³⁹ Mandate and Priorities, *ibid.*

⁴⁰ Canada, Health Canada, “Fact Sheet - First Nations and Inuit Health Branch” (2008), online: <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/fact-fiche-eng.php> (accessed September 8, 2010).

⁴¹ *Ibid.*

⁴² *Ibid.*

On the surface, it appears that the health system should be effective, at least for First Nations and Inuit people, with the changes every decade or so in government programs and initiatives that have been underway. However, it is abundantly clear that it is not, evidenced by the health statistics noted in Chapter 3. The following section reviews the current organizations and initiatives that continue to deal with Aboriginal health.

i) National Organizations Related to Aboriginal Health

In response to the current health system's failure to ensure the health of First Nation people and communities, the government has formed and funded several national organizations to address various aspects of the ongoing Aboriginal health inequities, using advocacy, research, community-based, and other unique approaches. The following are some of the leading national organizations devoted to Aboriginal health and healing.

The Aboriginal Healing Foundation (AHF) is a non-profit private corporation established on March 31, 1998, with a mandate to operate for eleven years (exceeding this timeframe now with short extensions). Its purpose is

...to encourage and support, through research and funding contributions, community-based Aboriginal directed healing initiatives which address the legacy of physical and sexual abuse suffered in Canada's Indian Residential School System, including intergenerational impacts.⁴³

In 2012, the Aboriginal Healing Foundation is slated to close its doors:

Today, the Aboriginal Healing Foundation (AHF) Board of Directors acknowledged Canada's decision not to provide funds to the Aboriginal Healing Foundation in the 2010 Federal Budget. This decision by the Federal Government means that a nation-wide network of one hundred and thirty-four community-based healing initiatives will no longer have AHF support after March 31, 2010, when current funds run out.⁴⁴

⁴³ Aboriginal Healing Foundation, *Frequently Asked Questions* (Ottawa: Canadian Government Publishing Directorate, 2009), online: <http://www.ahf.ca/faq> (accessed September 8, 2010) [AHF].

⁴⁴ AHF, *ibid*, March 5, 2010 Announcements, online: <http://www.ahf.ca/announcements> (accessed September 8, 2010).

In 2000, the National Aboriginal Health Organization (NAHO), a government funded, Aboriginal-designed and controlled non-profit entity, was created. Its mandate is to advance the health and well-being of Aboriginal Peoples by carrying out knowledge-based strategies:

With Aboriginal communities as its primary focus, NAHO gathers, creates, interprets, disseminates, and uses both traditional Aboriginal and contemporary western healing and wellness approaches. At all times, the organization reflects the values and principles contained in traditional knowledge and traditional knowledge practices.⁴⁵

NAHO's work is guided by five main objectives:

- To improve and promote Aboriginal health through knowledge-based activities.
- To promote an understanding of the health issues affecting Aboriginal Peoples.
- To facilitate and promote research on Aboriginal health and develop research partnerships.
- To foster the participation of Aboriginal Peoples in delivery of health care.
- To affirm and protect Aboriginal traditional healing practices.⁴⁶

Like the AHF, NAHO's funding arrangements are not ensured indefinitely.

In 2005, the National Collaborating Center for Aboriginal Health (NCCAHA) was created. It is one of six National Collaborating Centers established and funded by the Public Health Agency of Canada to support public health renewal in Canada. "Its aim is to help improve the response to public health threats, chronic disease and injury, infectious diseases and health disparities in aboriginal populations in Canada."⁴⁷

The Canadian Institute of Health Research (CIHR) is comprised of 13 distinct institutes, all of which share CIHR's objective:

The objective of CIHR is to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system.⁴⁸

⁴⁵ National Aboriginal Health Organization, online: www.naho.ca, (accessed September 8, 2010) [NAHO].

⁴⁶ NAHO, *ibid.*

⁴⁷ National Collaborating Center for Aboriginal Health, Home (British Columbia, 2009), online: http://www.nccah-ccnsa.ca/m_5.asp (accessed September 8, 2010).

⁴⁸ Canada, Canadian Institutes of Health Research, online: <http://www.cihr-irsc.gc.ca/e/7155.html> (accessed September 8, 2010).

The Institute of Aboriginal Peoples' Health (IAPH) is one of the 13 CIHR Institutes. Established in June 2000, it promotes

...the advancement of a national health research agenda to improve and promote the health of First Nations, Inuit and Métis peoples in Canada, through research, knowledge translation and capacity building.⁴⁹

The IAPH focuses on individual community-research priorities coupled with Indigenous knowledge, values, and cultures. The 15 to 18 member board of IAPH links the CIHR and the stakeholder communities. The board also provides advice to its Scientific Director on strategic directions for the Institute. In 2007–2008, CIHR expended \$974.1 million dollars and supported 12,000 health researchers and trainees at 280 research institutions in every province of Canada.⁵⁰

Pandemics

In spite of these positive advancements in research and knowledge based organizations, there are concerns about how a pandemic would affect Aboriginal people, particularly in the North or in remote communities. In August 2008, the “Ontario Health Plan for an Influenza Pandemic” was published by the province and included the following statement:

[t]he provincial government and public health units have been collaborating informally to meet the health needs of First Nations communities; however, they have *not clearly defined their roles* during a public health emergency.⁵¹

In 2009, outbreaks of H1N1 spread through northern Manitoba and Ontario First Nations, yet these communities witnessed delays in receiving urgently needed medical supplies. They also experienced breakdowns in communications between provincial and federal governments, and a lack of consistency in managing the outbreaks among the provinces. Measures aimed at containing the virus were ill-suited to the social realities of First Nations. For example, Aboriginal people were told to avoid contact with others, yet many live in cramped and

⁴⁹ Canada, Institute of Aboriginal Peoples' Health, Canadian Institutes of Health Research, online: <http://www.cihr-irsc.gc.ca/e/8668.html> (accessed September 8, 2010).

⁵⁰ Canada, Canadian Institutes of Health Research, Facts and Figures, online: <http://www.cihr-irsc.gc.ca/e/38008.html> (accessed September 8, 2010).

⁵¹ See Ontario, Ministry of Health and Long Term Care, *Ontario Health Plan for an Influenza Pandemic August 2008: ch. 20. Guidelines for First Nations Communities* (Toronto: Ontario Government Publishing Directorate, 2008), online: http://www.health.gov.on.ca/english/providers/program/emu/pan_flu/ohpip2/ch_20.pdf at 20-1 (accessed September 20, 2009).

overcrowded conditions; they were also told to wash their hands frequently, yet they had no access to running water. The Assembly of First Nations cited a lack of national standards for many of these inconsistencies.⁵² In Saskatchewan, the Sturgeon Lake First Nation Health Centre took the initiative to adopt a western approach combined with a traditional holistic approach to plan the means to fight a pandemic through the establishment of a program of traditional medicine and the gathering of medicinal plants to be used in case of a health crisis. The use of traditional medicines and spiritual protections are used to protect the good health of Sturgeon Lake First Nation peoples, their report states:

- Maintaining health is a personal commitment rooted in the family organization, history and our view of the world.
- Every family will have to stay united at the very onset of a pandemic.
- Every family will commit itself to a quarantine period at home.
- If every person and every family took responsibility for personal health, that would lessen the impact of a pandemic on the community.
- Every member of a family will take care of the health of the other members.⁵³

The World Health Organization recognizes the link between the severity of influenza cases and social conditions: pre-existing chronic diseases, poor and overcrowded housing, poor-quality drinking water, and sub-standard healthcare.⁵⁴ Conditions in reserve communities are comparable to conditions in developing countries, which makes these communities susceptible to the greatest risk. In September 2009, the Government of Canada and the Assembly of First Nations signed a communications protocol that confirmed a mutual commitment to work together on pandemic preparedness.⁵⁵

Many remote and isolated communities have higher incidence of underlying chronic medical conditions than the national average. This puts them at increased risk of severe illness from

⁵² Assembly of First Nations, “AFN says urgent measures on H1N1 must be in place before the fall” June 23, 2009,

online: <http://www.afn.ca/article.asp?id=4552> (accessed August 26, 2010).

⁵³ Sturgeon Lake First Nation, “Presentation on the holistic pilot project against pandemics,” January 2009, Vancouver, B.C. online: <http://fnpublichealth.ca/wp-content/uploads/PDF/SturgeonLakeFN-PandemicPlanning-FNHM2009.pdf> (accessed September 20, 2010).

⁵⁴ World Health Organization, “Influenza Pandemic Plan. The Role of WHO and Guidelines for National and Regional Planning” WHO/CDS/CSR/EDC/99.1 Geneva, Switzerland April 1999, online: <http://www.who.int/csr/resources/publications/influenza/whocdscsredc991.pdf> (accessed August 26, 2010).

⁵⁵ The Communications Protocol: *Working Together on H1N1 Preparedness*, online: http://www.phac-aspc.gc.ca/alert-alerte/h1n1/faq/faq_rg_h1n1-amic-eng.php (accessed September 8, 2010).

new viral infections infection. Some of these communities face other public health challenges, such as overcrowding, that may increase the opportunities for these viral infections to spread.

A further concern for people living in remote and isolated areas is the availability of emergency help. If someone in a remote or isolated area develops severe complications from a viral infection and needs hospitalization, it may take some time to get the person to a hospital. This is especially true for fly-in communities, which is why vaccination is recommended for all people in remote and isolated communities.⁵⁶

The 2009 Federal Budget allocated \$305 million over two years for current health programs for First Nations and Inuit. This included \$135 million for improving health services infrastructure in First Nations communities, such as health clinics and nurses' residences.⁵⁷ In many cases, this system simply does not account for the needs of Métis or Inuit—birthing practices and midwifery legislation (discussed in Chapter 5.2.1 iv) being two examples. Despite the best efforts of Aboriginal communities to regain control of their health services and to ensure their good health, statistics show that more improvements are needed. On average, Aboriginal health still falls well below that of the non-Aboriginal Canadian population. Piecemeal programming and lackluster funding arrangements continue to jeopardize the security of the initiatives.

ii) The National Aboriginal Organizations

The five National Aboriginal Organizations (NAOs) promote their constituents' best interests, and all address health issues to a certain degree. The five National Aboriginal Organizations are: the Native Women's Association of Canada; the Assembly of First Nations; the Métis National Council; the Inuit Tapiriit Kanatami; and the Congress of Aboriginal People. A brief description of each organization follows.

⁵⁶ See Canada, Health Canada, *First Nations and Inuit Health Branch, Problems with existing programs* (Ottawa: Canadian Government Publishing Directorate, 2005), online: http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/suicide/prev_youth-jeunes/section3_8-eng.php, (accessed September 8, 2010).

⁵⁷ Canada, The Public Health Agency of Canada, H1N1 in Aboriginal, First Nation and Inuit Communities, online: http://www.phac-aspc.gc.ca/alert-alerter/h1n1/faq/faq_rg_h1n1-anic-eng.php (accessed April 29, 2010).

The Native Women's Association of Canada (NWAC)

NWAC promotes the equitable engagement of Aboriginal women in all processes that impact their health. Implementing a culturally relevant, gender-based approach to health issues is critical. Women clearly benefit from higher levels of engagement, and the results are improved health outcomes. The Health Unit currently manages a number of initiatives, such as the Aboriginal Human Health Resource Initiative (AHHRI), the Aboriginal Health Transition Fund (AHTF), the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS), and the Aboriginal Diabetes Initiative (ADI).⁵⁸

Assembly of First Nations (AFN)

The AFN Health and Social Secretariat describes the organization's responsibilities as protecting, maintaining, promoting, supporting, and advocating for inherent, treaty, and constitutional rights, as well as for (w)holistic health and the well-being of nations. The AFN conducts policy analysis and advocates on behalf of First Nations' communities and individuals. Their goal is to secure First Nations' control of the development and delivery of all health and social services, so that the services and programs are delivered at the same level enjoyed by all Canadians.⁵⁹

Métis National Council (MNC)

The MNC represents the Métis Nation in Canada at the national level. The Métis Nation's homeland includes the three Prairie provinces and extends into Ontario, British Columbia, the Northwest Territories, and the northern United States. There are approximately 350,000 – 400,000 Métis Nation citizens in Canada. The MNC advocates on behalf of Métis health needs in Canada at the national and international levels.⁶⁰

Inuit Tapiriit Kanatami (ITK)

Inuit Tapiriit Kanatami (ITK) is the national advocacy organization for 55,000 Inuit living in 53 communities across the Inuvialuit Settlement Region (Northwest Territories), Nunavut,

⁵⁸ The Native Women's Association of Canada, online: <http://www.nwac-hq.org/en/healthback.html> (accessed April 29, 2010).

⁵⁹ Assembly of First Nations, online: <http://www.afn.ca/article.asp?id=103> (accessed April 29, 2010).

⁶⁰ Métis National Council, online: <http://www.metisnation.ca/>(accessed April 29, 2010).

Nunavik (Northern Quebec), and Nunatsiavut (Northern Labrador) land claims regions. At the national level, ITK represents and promotes the interests of Inuit on a wide variety of environmental, social, cultural, and political issues and challenges.⁶¹

Congress of Aboriginal Peoples (CAP)

The Congress of Aboriginal Peoples was established to represent the interests nationally of Métis and non-status Indians. CAP's Health Policy Program advances off-reserve Aboriginal and Métis perspectives on health, and fosters positive working relationships and collaborative approaches to health and healing. CAP states that they implement a grassroots approach to health issues, so that holistic changes are pursued that reflect identified needs and are consistent with traditional teachings.⁶²

iii) Midwifery and Traditional and Western Medicine

Midwifery had been the customary, respected practice even among the colonists, the emphasis on supposedly necessary modern medical intervention was spread by doctors to Aboriginal health services. The result is that many ancient birthing and midwifery practices have been lost and few Aboriginal midwives are left to pass along Indigenous knowledge in this and other areas. The removal of births from many Aboriginal communities has had profound spiritual and cultural consequences, which are difficult to quantify. The loss of traditional birthing practices has been linked to the loss of cultural identity.⁶³

Many First Nation, Métis, and Inuit communities are successfully involved in delivering health service programs to their communities by combining western medicine with their own traditional⁶⁴ knowledge and medicine as their foundation.⁶⁵ Good examples abound of this

⁶¹ Inuit Tapiriit Kanatami, online: <http://www.itk.ca/> (accessed April 29, 2010).

⁶² Congress of Aboriginal Peoples, online: http://www.abo-peoples.org/index.php?option=com_content&view=article&id=17&Itemid=4 (accessed April 29, 2010).

⁶³ National Aboriginal Health Organization, *Midwifery and Aboriginal Midwifery in Canada*, 2004, online: http://www.naho.ca/english/pdf/aboriginal_midwifery.pdf [NAHO midwifery] at 7.

⁶⁴ Dr. Dawn Martin Hill examines the terminology "traditional" in her paper "Traditional Medicine In Contemporary Contexts: Protecting and Respecting Indigenous Knowledge and Medicine", prepared for the National Aboriginal Health Organization, 2003, online: http://www.naho.ca/english/pdf/research_tradition.pdf, (accessed September 8, 2010) at 6, 7.

⁶⁵ For a list of publications, see National Aboriginal Health Organization, online: http://www.naho.ca/english/tk_Pub.php (accessed April 29, 2010).

collaborative approach. This section provides a few cases of how both systems can be successfully blended to address health issues in Aboriginal communities.

For instance, the White Horse General Hospital negotiated agreements with local First Nations to meet the ongoing needs of Aboriginal people within the communities it serves. The seven programs implemented at WHGH to address First Nations needs are: First Nations Health and Social Liaison Workers, Child Life Workers, Traditional Diet, Traditional Medicine, Interpretation Services, In-Service Training/Education, and Community Liaison Health Promotion.⁶⁶ Patients at this hospital can “choose to receive the services of a traditional healer, including traditional medicines.”⁶⁷

iv) Status of Midwifery in Canada for Aboriginal Women

In the North, childbirth has been medicalized. Pregnant women are evacuated thousands of miles from their families and homes to give birth in southern hospitals. Dr. Aaron Johnston explains the difficulties:

Here in the north obstetrics is made trickier by the issues of distance. Women from communities all over the island come down to Iqaluit at 36 weeks to wait to give birth. It can be a difficult experience for women who may have to be distant from their families for as long as a month while waiting to deliver. Obstetrical practice here on Baffin Island is fairly busy for a small hospital and there are between 400 and 450 births a year here (busy by the standards of small hospitals in Canada). We have about 5 Family Doctors who practice obstetrics, and a general surgeon who can do C-sections when required. In the arctic we are distant from help (evacuating a patient to a tertiary care centre typically takes 12 hours if the weather is good, and a plane is available for transport), and we try to limit those births to ones where problems aren't expected. In a perfect world that means that pregnancies that are at high risk for complications are sent on to a higher level of care early on, in order to avoid complications. As a general rule we try to limit deliveries to women who are relatively uncomplicated, at least 35 weeks along, and who have neither major maternal medical issues, nor known fetal abnormalities.⁶⁸

⁶⁶ White Horse General Hospital, (White Horse 2002), online: http://www.whitehorsehospital.ca/content/EN/ENFirst_Nations_H77a4.html, (accessed September 8, 2010).

⁶⁷ National Aboriginal Health Organization, *An Overview of Traditional Knowledge and Medicine and Public Health in Canada* (NAHO: January 2008), online: <http://www.naho.ca/publications/tkOverviewPublicHealth.pdf>, (accessed September 8, 2010) [Traditional Knowledge] at 13. See also, National Aboriginal Health Organization, online: http://www.naho.ca/english/pub_tk.php (accessed September 8, 2010).

⁶⁸ Dr. Aaron Johnson, Blogspot, online: <http://northmed.blogspot.com/2007/09/why-low-risk-obstetrics-isnt.html>, (accessed September 8, 2010).

This forced separation from families has been linked to increased stress and lower birth weights, an increase in birthing complications, an increased likelihood of post-partum depression, and an unnecessary strain on family relations.⁶⁹ A smattering of centres throughout the North, covering different Inuit regions, offer varying degrees of access to childbirth programs and services. Sheba Pikuyak comments:

The majority of fathers in Nunavut had never seen their children being born, missing one of the most important things in life. More support is needed for expecting parents. The mother has to deal with her pregnancy mostly alone when she has to deliver a baby, and raising a child is both parents' responsibility. After all the woman did not get pregnant alone in the first place. If we need to have a good solid future for our children, then it has to start at home and right in the delivery room.⁷⁰

It makes sense to provide childbirth services to Inuit women at home and in their home communities.

Nunavik's *Inuulitsivik* midwifery service and education program have been providing childbirth services in Inuktitut to the communities of the Hudson Bay region since 1986. Three maternity centers serve seven villages on the Hudson Bay Coast. The midwives who are involved with the women in this region are both traditional Inuit midwives and western medical practitioners. An interdisciplinary council sets the protocols for maternal care. *Inuulitsivik Centre* also provides "on the job" midwifery training. Inuit midwives are the lead caregivers for maternity clients, including pre-natal and post-natal care. They have access to a variety of western medical services with onsite physician services. Specialist consultations are conducted by phone or by medevac. The Centre also provides well-woman and baby care within the three communities where the maternity centers are located.⁷¹

⁶⁹ NAHO midwifery, *supra* note 63.

⁷⁰ Nunatsiaq News, "Expectant fathers need travel assistance", October 20, 2006.

⁷¹ Midwifery in Canada – Quebec (Quebec 2008), online: <http://www.canadianmidwives.org/quebec.htm>, (accessed September 8, 2010).

The Rankin Inlet Birthing Centre was established in Nunavut in 1996. Although the Centre initially had difficulty recruiting and maintaining midwife services,⁷² in 2005 it achieved stable staffing, which helped the Centre expand.⁷³ The Rankin Inlet Birthing Centre integrates western medicine with traditional methods, and both are funded by health services for the region.⁷⁴ In developing government institutions, programs, and services (including health services), the Nunavut Government places priority on integrating *Inuit Quajimajatuqangit*, or Inuit knowledge, and has developed six primary guiding concepts and principles for doing so.⁷⁵

The importance of childbirth issues in the North cannot be stressed enough. The problems that Inuit mothers encounter from the confusing and discriminatory midwifery legislation prove devastating to generations of families in the North. Competing midwifery legislation in Canada has its own problems and requires more thorough examination.

The biggest defect is that Aboriginal traditional midwives are not recognized by all legislation. In the North, women have been routinely removed from their homes to give birth, usually transported to the south or Iqaluit by medevac. In Arviat, Nunavut the total population is 2100 and the birth rate is the highest in Canada (35 per 1000, national average of 10.3 to 1000). Arviat has no permanent doctor, no hospital, no midwife, no public health nurse and no one to assist the estimated 70 women who get pregnant every year (except for seven overworked nurses at the health centre). Most women are flown 1200 kilometers south to Winnipeg.⁷⁶

⁷² See Inuit Tuttarvingat, NAHO, [Irmisuksiiniq Inuit Midwifery Network](http://www.naho.ca/inuit/midwifery/english/index.php), online: <http://www.naho.ca/inuit/midwifery/english/index.php> (accessed April 29, 2010).

⁷³ Midwifery in Canada – Nunavut (Quebec 2008) online: <http://www.canadianmidwives.org/nunavut.htm>, (accessed September 8, 2010).

⁷⁴ Traditional Knowledge, *supra* note 64.

⁷⁵ These principles are: Piliriqatigiinnngiq: working together for the common good; Avatimik Kamattiarniq: the maintenance of environmental wellness; Pijittsirarniq: the contribution to the common good through services to others and leadership, concepts which are not mutually exclusive, but inherently part of the same ideal of wisdom in Inuit culture; Pilimmaksarniq: empowerment; Qanuqtuurunnarniq: resourcefulness and adaptability; Aajiiqatigiinnngiq: co-operation and consensus. Pauktuutit Inuit Women's Association, *Applying Inuit Cultural Approaches in the Prevention of Family Violence and Abuse*, (Ottawa, Ontario) 2005.

⁷⁶ This is an example of the health inequities in that an Inuit baby is 3.5 times more likely to die before its first birthday than a non-Inuit new born – the Inuit infant mortality rate is 15.1 deaths per 1000 the national average is 5.1. (Patrick White, Globe and Mail, "Inuit mothers fight lonely battle for their children's health" June 5, 2010).

In 1999, the Quebec provincial government legalized midwifery, but it recognized only one midwifery training program in the Province.⁷⁷ At present, Quebec’s midwifery law recognizes Inuit midwives who are already trained, certified, and working in Nunavik, but it excludes those who are in training. Nunavik health officials have been lobbying to change this legislation.⁷⁸ The National Aboriginal Health Organization provided a status update in 2008.⁷⁹ Most women in Canada now have nominal access to regulated and funded (paid for as part of the provincial health care system) midwifery care. They also have a choice of birth location (home, hospital, or birth centre). Access varies by province, as the following table shows:

Table 1 Source, Midwifery Across Canada, online:
<http://www.babycenter.ca/pregnancy/labourandbirth/planningyourbabysbirth/midwifery-across-canada/>

Province	Regulated	Funded	Birth options with a midwife
Alberta	Yes	No	Hospital, Home, or Birth Centre
British Columbia	Yes	Yes	Hospital or Home
Manitoba	Yes	Yes	Hospital or Home
Newfoundland and Labrador	No	No	Hospital (only in certain areas)
New Brunswick	No	No	Home
Northwest Territories	No	No	Home
Nova Scotia	No	No	Home
Nunavut	Pilot project	Yes	Most flown to other locations for birth
Ontario	Yes	Yes	Hospital or Home
Prince Edward Island	No	No	Home
Quebec	Yes	Yes	Birthing centre, Hospital, or Home
Saskatchewan	No	No	Home
Yukon	No	No	Home

⁷⁷ There are 14 Inuit communities in the Nunavik region of Quebec. The provincially accredited midwifery program is offered in Trois Rivières, a southern, urban centre, approximately 2,000 kilometers from the regional centre of Kuujuaq. There are significant cultural, linguistic and geographical barriers to participation and completion of the program by Inuit students in Nunavik (NAHO Midwifery *supra* note 63).

⁷⁸ Nunatsiaq News, February 15, 2002 in NAHO Midwifery, *supra* note 63 at 27.

⁷⁹ NAHO Midwifery, *supra* note 63. See also, National Aboriginal Health Organization, Midwifery Publications, online: http://www.naho.ca/english/mwif_celebratingBirth.php.

The Nunavut midwifery legislation is particularly problematic for Inuit women. It forces traditional Inuit midwives to be registered under the *Consolidation of Midwifery Professions Act*,⁸⁰ yet traditional midwifery is not recognized. The Act only goes so far as allowing traditional knowledge into the curriculum for teaching. What is worse, the Act may criminalize women who act as midwives.⁸¹

On January 11, 2008, the Nunavut Tunngavik Inc.⁸² submitted their concerns about Bill 20, the *Midwifery Profession Act*, to the Nunavut Health and Education Standing Committee, on possible infringements on Aboriginal rights by way of extinguishing traditional birthing ways through the imposition of legislation that excluded traditional midwifery. They also expressed concerns that the Inuit were not consulted in any meaningful fashion yet their objections apparently went unheeded. The Nunavut midwifery legislation passed. Yet, the legislation remains highly problematic for the same concerns that the Nunavut Tunngavik Inc. expressed.

In their submissions to the Standing Committee, the Nunavut Tunngavik Inc.⁸³ used the example of British Columbia's *Midwifery Act*⁸⁴ and showed how it could be blended into legislation that would serve the needs of the Inuit. They stated:

⁸⁰ *Consolidation of Midwifery Profession Act*, S.Nu. 2008,c.18.

⁸¹ Section 55 states:

Offence and punishment

(4) Every person who contravenes this Act or the regulations is guilty of an offence and liable on summary conviction

(a) for a first offence, to a fine not exceeding \$2,000;

(b) for a second offence, to a fine not exceeding \$4,000; and

(c) for a third or subsequent offence, to a fine not exceeding \$6,000 or to imprisonment for a term not exceeding three months or to both.

⁸² Nunavut Tunngavik Incorporated (NTI) is the organization that ensures that promises made under the Nunavut Land Claims Agreement (NLCA) are carried out. See online: <http://www.tunngavik.com/about/>.

⁸³ Nunavut Tunngavik Inc., online: <http://www.tunngavik.com/about/> :

Nunavut Tunngavik Incorporated (NTI) ensures that promises made under the Nunavut Land Claims Agreement (NLCA) are carried out. Inuit exchanged Aboriginal title to all their traditional land in the Nunavut Settlement Area for the rights and benefits set out in the NLCA.

The management of land, water and wildlife is very important to Inuit. NTI coordinates and manages Inuit responsibilities set out in the NLCA and ensures that the federal and territorial governments fulfill their obligations.

⁸⁴ *Health Professions Act* [RSBC 1996] Chapter 183, the *Midwives Regulation BC Reg 155/2009*, and the *College Bylaws*.

As an example of how Traditional Inuit Midwifery can adapt or evolve into the contemporary world, the province of British Columbia has defined aboriginal midwifery under the Midwives Regulations of the *Health Professions Act* (1995) as the following;

1. (a) traditional aboriginal midwifery practices such as the use and administration of traditional herbs and medicines and other cultural and spiritual practices,
- (b) contemporary aboriginal midwifery practices which are based on, or originate in, traditional aboriginal midwifery practices, or
- (c) a combination of traditional and contemporary aboriginal midwifery practices.⁸⁵

The large Inuit population of Nunavut needs the support of legislation similar to British Columbia's model, so that those who wish to learn and practice Inuit Traditional Midwifery in Nunavut can do so.

To summarize, the examples in this section illustrate the legal foundation on which current Aboriginal health policies are built. Early government policies dispersed Aboriginal health care on an *ad hoc* basis, depending on the potential threat of those diseases affecting non-Aboriginal populations (ie smallpox, tuberculosis). In other words, health policies were geared toward protecting the good health of non-Aboriginal people.

Aboriginal women have always faced social, economic, political and cultural changes that have negatively affected health, cultural identity and social and family structures. Years of assimilation have led to the medicalization of birthing and the decline of traditional midwifery practice. More recently, government legislation and political interest in the role of traditional Aboriginal midwives has begun to bring to the forefront the rebirth of a model that may blend ancient traditions with modern techniques thus enabling Aboriginal women to bring childbirth back to their communities.

⁸⁵ Nunavut Tunngavut Submission on Bill 20, the *Midwifery Profession Act*, submitted to the Health and Education Standing Committee, January 11, 2008 Government of Nunavut.

5.2.2 Residential Schools

The Canadian government sought to assimilate Aboriginal people by forcibly removing their children from their homes, families, cultures, languages, and traditions; sending them far away to residential schools; teaching them English or French; and giving them a Christian education. Officially, residential schools operated in Canada from 1892 until 1969. At one time, Canada operated 88 schools. Although the Government of Canada officially withdrew in 1969, a few of the schools continued operating through the 1960s, 70s and 80s. Akaitcho Hall in Yellowknife did not close until 1996.⁸⁶

These schools were run through a “partnership” between the federal government, the churches, and Aboriginal people. The federal government paid for capital expenditures and salaries for the staff. The churches were responsible for school activities and daily operations. Aboriginal parents were forced to supply their children. An estimated 150,000 First Nation, Métis, and Inuit children attended residential schools. Thousands of former students have since come forward to claim that physical, emotional, and sexual abuse were rampant in the school system and that little was ever done to stop it or to punish the abusers.⁸⁷

As this thesis has shown throughout, historical research and the *Report of the Royal Commission on Aboriginal Peoples*⁸⁸ document how the residential school system⁸⁹ fostered the spread of disease. Inadequate health facilities contributed to the spread of European diseases, which seriously affect the health of Aboriginal people today. Although some former students have reported that life in residential schools was not that bad, the mere fact that attendance was legally mandatory and enforced by threats indicates that not all Aboriginal families shared this view. The many dimensions of abuse, including physical and sexual,

⁸⁶ Assembly of First Nations, *Residential School Update* (Ottawa: Assembly of First Nations, 1998 [Update]).

⁸⁷ Update, *ibid.*

⁸⁸ RCAP, *supra* note 2.

⁸⁹ See, The Aboriginal Healing Foundation, online: www.ahf.ca. There was also the policy of removing Aboriginal children and placing them in non-Aboriginal homes. This was called the “Sixties Scoop” and occurred over a period of over 20 years which ended in the mid 1980s. See, Fournier, S. and E. Crey (1997). *Stolen From Our Embrace: The Abduction of First Nations Children and the Restoration of Aboriginal Communities*. Toronto: Douglas and McIntyre [Fournier and Crey]; The Justice System and Aboriginal People: The Aboriginal Justice Implementation Commission, online: <http://www.ajic.mb.ca/volume1/chapter14.html#6>.

inflicted by the residential school system forever damaged the souls of the children who were forced to attend. Given the cultural, social, and psychological damage, these schools have left a painful legacy that Aboriginal people must now face for generations.

i) History of the Residential School System

Residential schools were opened in (what is now) Canada to Christianize Aboriginal children as early as 1620. Historian John Milloy explains:

The first known boarding-school arrangements for Aboriginal youth in Canada began in 1620 under the control of the Recollets, an order of Franciscans who had settled in New France. The primary objective of the school was the evangelization of indigenous people through the education of children.⁹⁰

...

Several boarding schools were opened throughout the seventeenth and eighteenth centuries by other religious orders, such as the Friars and the Jesuits, and were characterized by intense competition between religious orders. This trend continued throughout the duration of the residential school system.⁹¹

To further colonial regimes and goals, the government established the Bagot Commission (1842–1844), which instituted policies through a series of government reports. The Bagot Commission Report formalized early assimilation policies and solidified the place of the residential school system.⁹² The Commission set up the reserve system and recommended that a central Indian administration be established. Later in 1868, the Department of the Secretary of State of Canada was created⁹³ and given authority over Indians and their lands.⁹⁴ The

⁹⁰ James Miller, *Shingwauk's Vision: A History of Native Residential Schools*. Toronto, ON: University of Toronto Press, 1996 at 302 [Miller, 1996] in Caroline L. Tait et al prepared for the Aboriginal Healing Foundation, *Fetal Alcohol Syndrome Among Aboriginal People in Canada: Review and Analysis of the Intergenerational Links to Residential Schools*, Ottawa: 2003, online: <http://www.ahf.ca/publications/research-series> (accessed September 8, 2010) at 58 [Tait].

⁹¹ Tait, *ibid* at 58.

⁹² Bagot Report, 1844 in the Royal Commission on Aboriginal Peoples, 1996: Volume 1, RCAP, *supra* note 2 [Bagot].

⁹³ See *An Act providing for the organisation of the Department of the Secretary of State of Canada, and for the management of Indian and Ordinance Lands*, S.C. 1868 (31 Vict.) c. 42 [Assented to 22nd May, 1868] [SOS] at s. 1:

There shall be a department to be called "The Department of the Secretary of State of Canada," over which the Secretary of Stat of Canada for the time being, appointed by the Governor General commission under the Great Seal, shall preside; and the said Secretary of State shall have the management and direction of the Department, and shall hold office during pleasure.

See also SOS *ibid* at s. 26 where there Secretary if State was also assigned jurisdiction of Indians in Quebec and Lower Canada:

Commission urged that Indians be converted to Christianity and educated in church-run schools.⁹⁵ It claimed that Aboriginal communities were in a “half-civilized state” and should be infused with “characteristics of civilization,” such as industry and knowledge.⁹⁶

Manual labour schools, such as the Mohawk Institute (1834) and Mount Elgin (1850), were established in Ontario with hopes that pupils would “imperceptibly acquire the manners, habits and customs of civilized life”.⁹⁷

Most residential schools operated on the “half-day” system until the middle of the twentieth century.⁹⁸ Half a day was dedicated to academic subjects, while the other half was spent learning a trade, such as sewing for girls or working on the school farm for boys. Each day followed a strict regimen.⁹⁹ Non-compliance generally resulted in punishment. Although residential schools were designed to give Aboriginal children a basic English or French knowledge of reading, writing, and arithmetic,¹⁰⁰ they were also designed to assimilate children into mainstream society.¹⁰¹ Colonizing forces adopted the strategy of removing Aboriginal children from their homes and sending them to residential schools for two reasons: to

The Secretary of State is hereby substituted for the Commissioner of Indian Lands for Lower Canada, under the fourteenth chapter of the Consolidated Statutes for Lower Canada, respecting Indians and Indian lands, which shall continue to apply to Indians and Indian lands, in the Province of Quebec, in so far as it is not inconsistent with this Act, and shall have all the powers and duties assigned to such Commissioner by the said Act, except that the lands and property heretofore vested in the said Commissioner shall henceforth be vested in the Crown, and shall be under the management of the Secretary of State, who shall manage the same on behalf of the Crown, and the suits respecting them shall be brought in the name of the Crown. . . .

⁹⁴ SOS, *ibid* at s. 5: “The Secretary of State shall be the superintendent General of Indian Affairs, and shall as such have the control and management of the lands and property of the Indians in Canada.” See also s. 6 of SOS:

All lands reserved for Indians or for any tribe, band or body of Indians, or held in trust for their benefit, shall be deemed to be reserved and held for the same purposes as before the passing of this Act, but subject to its provisions; and no such lands shall be sold, alienated or leased until they have been released or surrendered to the Crown for the purposes of this Act.

See also SOS *ibid.* at s. 34: “The Secretary of State is hereby substituted for the Commissioner of Crown Lands as regards the Ordnance and Admiralty lands transferred to the late Province of Canada and lying in the Provinces of Quebec and Ontario.” See also *ibid.* at s. 35.

⁹⁵ Canada, RCAP Vol. 1, *supra* note 2 at 268.

⁹⁶ J.S. Milloy, (1999). A National Crime: The Canadian Government and the Residential School System 1879-1986. Winnipeg: University of Manitoba Press at 12-13.

⁹⁷ Bagot Report, *supra* note 92.

⁹⁸ Miller 1996, *supra* note 90 at 64.

⁹⁹ Miller 1996, *ibid* in Tait *supra* note 90 at 64, 65.

¹⁰⁰ Miller 1996, *ibid.*

¹⁰¹ Standards of education were much lower than those of neighbouring provincial schools for non-Aboriginal children, see Miller 1996 in Tait *supra* note 90 at 65.

Christianize (the goal of the church), and to assimilate (the goal of government) Aboriginal people.¹⁰²

Nicholas Flood Davin of Regina, a Member of Parliament backbencher, promoted the American boarding school system model for use in Canada. In 1878, American Captain Richard H. Pratt opened the infamous Carlisle Indian School at an abandoned military post in Pennsylvania. A year later, the Department of Indian Affairs implemented the Davin Report, which marked the “beginning of one of the most damaging and destructive forms of assimilation strategies in the history of Aboriginal and non-Aboriginal relations in Canada.”¹⁰³

The report suggested that the ‘Christian’ obligation to Aboriginal people could be realized “only through the medium of children.” Aboriginal adults, the report argued, could not be rescued from “their present state of ignorance, superstition and helplessness [because they were] physically, mentally and morally ... unfitted to bear such a complete metamorphosis.”¹⁰⁴

...

Department bureaucrats advised Macdonald that residential schools were a “good investment” to prevent indigenous children from becoming “an undesirable and often dangerous element in society.”¹⁰⁵

The federal government began constructing large, industrial-type schools throughout Canada.

¹⁰²Miller 1996, *ibid* at 58.

¹⁰³Miller 1996, in Tait *supra* note 90.

¹⁰⁴Fournier and Crey, *supra* note 89 at 55-56.

¹⁰⁵Fournier and Crey, *ibid*.

Photograph 1



Shingwauk Indian Residential School — Sault Ste. Marie, ON, online: <http://archive.anglican.ca/rs/history/schools/shingwauk.htm>

The Canadian residential school system has been overwhelmingly damaging for Aboriginal people and has had destructive intergenerational effects as well: this is well documented.¹⁰⁶ The social problems that Aboriginal communities continue to face stem directly from residential school experiences and their impacts across generations.¹⁰⁷ These social problems, which are not limited to substance abuse, family dysfunction, and suicide, are inextricably linked to the health of Aboriginal people in Canada.

ii) Life in the Residential School

From 1910 to 1932, the residential school system grew rapidly and for one reason: the *Indian Act* made attendance mandatory for children over six years old. By 1930, approximately seventy-five per cent of all First Nations as well as many Métis and Inuit children between the

¹⁰⁶ See Fournier and Crey, *supra* note 89.

¹⁰⁷ Miller 1996, in Tait *supra* note 90.

ages of seven and fifteen were forced to attend the schools.¹⁰⁸ John Milloy comments that academically, sixty to eighty per cent of the students did not advance past grade three:

Academic failure was attributed to factors such as under-funding, poorly qualified staff and the ‘stunted mental capacity’ of Aboriginal children.¹⁰⁹

The moment the children entered the schools, their physical and cultural markers (e.g., clothing, long hair) were removed.¹¹⁰ Student activities were strictly regimented, and students who broke the rules were severely punished. Students were controlled military-style at all times.¹¹¹ Many schools adopted harsh punishments, such as “food deprivation, strapping and solitary confinement.”¹¹²

Innocuous acts were also punishable by physical force. Students could be punished for bed-wetting, speaking or communicating with children of the opposite sex, speaking an Aboriginal language, stealing food, running away, talking back to staff, and being outside of school grounds:¹¹³

The intention behind such excessive discipline and punishment of students was to cause pain and humiliation. Humiliation, such as that caused by public strapping, sought to diminish the student’s sense of dignity and value of self and identity. Public humiliation has been reported by former students as one of the most devastating aspects of their experience while they attended residential school. At some schools, such as the Mohawk Institute and Mount Elgin, abuse was so frequent that students were classified based on the number of punishments they received and the reasons why they received them.¹¹⁴

In most cases, the excessive disciplinary actions and severe punishments that students experienced went unreported. Even when it was reported, nothing was done to stop the behaviour.¹¹⁵

¹⁰⁸ Fournier and Crey, *supra* note 89.

¹⁰⁹ Miller 1996, in Tait *supra* note 90 at 63, 64.

¹¹⁰ Miller 1996, *ibid.*

¹¹¹ Miller 1996, *ibid.*

¹¹² Milloy, 1999, in Tait *supra* note 90.

¹¹³ Miller 1996, in Tait *supra* note 90 at 63, 64.

¹¹⁴ Agnes Grant, “No End of Grief: Indian Residential Schools in Canada,” 1996 Winnipeg, MB: Pemmican Publications at 117-118 in Tait, *supra* note 90 at 66.

¹¹⁵ Miller 1996, in Tait *supra* note 90 at 66, 67.

iii) Abuse in the Residential School System

*The nightmare began as soon as Emily [eight years old] and her sister Rose, then eleven years old, stepped on the small boat that would bear them away. "I clung to Rose until Father Jackson wrenched her out of my arms ... I searched all over the boat for Rose. Finally I climbed up to the wheelhouse and opened the door and there was Father Jackson, on top of my sister. My sister's dress was pulled up and his pants were down. I was too little to know about sex; but I know now he was raping her."*¹¹⁶

Some have described the residential school system as "institutionalized pedophilia"¹¹⁷ at the hands of priests, nuns, staff, and other children. The stories are disgusting and horrifying, and the legacy it has left is equally disgusting and horrifying.

Institutionalized violence, rapes, and ongoing sexual abuse permeate the history of the residential school system, and sexual violence and abuse lie at the root of many of the social ills that Aboriginal people face today. Parents lost the ability to parent, and children lost the ability to function in a family. The collective nature of the assault on Aboriginal identity and culture has been described as nothing less than cultural genocide.¹¹⁸ In 1991, the number of former residential school student survivors was approximately 105,300. By 2004, the number had dropped to approximately 87,500.¹¹⁹ The initial flood of claims totaled 13,044¹²⁰ and currently there are a number of class action law suits in various stages before the courts.

On Nov. 23, 2005, Ottawa announced a \$2-billion compensation package for those who were forced to attend residential schools. In 2007, the federal government announced a further \$1.9-billion compensation package. The Indian Residential Schools Settlement Agreement includes an initial payout for each person who attended a residential school of \$10,000, plus \$3,000 per

¹¹⁶ Fournier and Crey, *supra* note 89 at 47.

¹¹⁷ Fournier and Crey, *ibid.*

¹¹⁸ Tait, *supra* note 90 at 73.

¹¹⁹ Assembly of First Nations, Fact Sheet, 2010, online: <http://www.afn.ca/article.asp?id=766> (accessed September 8, 2010) [AFN fact sheet].

¹²⁰ AFN fact sheet, *ibid.*

year of attendance.¹²¹ In June 2008, Canadian Prime Minister Stephen Harper, apologized to the former residential school students and their families:

To the approximately 80,000 living former students, and all family members and communities, the Government of Canada now recognizes that it was wrong to forcibly remove children from their homes and we apologize for having done this. We now recognize that it was wrong to separate children from rich and vibrant cultures and traditions that it created a void in many lives and communities, and we apologize for having done this. We now recognize that, in separating children from their families, we undermined the ability of many to adequately parent their own children and sowed the seeds for generations to follow, and we apologize for having done this. We now recognize that, far too often, these institutions gave rise to abuse or neglect and were inadequately controlled, and we apologize for failing to protect you. Not only did you suffer these abuses as children, but as you became parents, you were powerless to protect your own children from suffering the same experience, and for this we are sorry. The burden of this experience has been on your shoulders for far too long.

The Government of Canada sincerely apologizes and asks the forgiveness of the Aboriginal peoples of this country for failing them so profoundly.

Nous le regrettons
We are sorry
Nimitataynan
Niminchinowesamin
Mamiattugut¹²²

The Indian Residential Schools Settlement Agreement was signed on September 19, 2007. Part of the Agreement included the creation of the Indian Residential Schools Truth and Reconciliation Commission.¹²³ The Truth and Reconciliation Commission of Canada has a mandate to inform all Canadians about what happened in Indian Residential Schools. The Commission's task is to document the experiences of survivors, families, communities, and anyone personally affected by the residential school experience; with a five year mandate.¹²⁴

¹²¹ Indian Residential Schools Settlement - Official Court Website, online: <http://www.residentialschoolsettlement.ca/English.html> (accessed April 24, 2011).

¹²² Aboriginal Healing Foundation, Healing Words, Volume 6 Number 1 (Spring 2009), at 2, online: <http://www.ahf.ca/> (accessed September 8, 2010) [Healing Words].

¹²³ Healing Words, *ibid.*

¹²⁴ Canada, Truth and Reconciliation Commission of Canada, online: http://www.trc-cvr.ca/index_e.html, (accessed September 8, 2010).

A 2009 article in the Saskatoon Star Phoenix shows clearly what the longterm effects of the residential school system are:

He observed his father shooting at his brother and his brother beating his father severely. Beatings also took place between his father and other brothers, as well as his father and mother. Additional incidents of the use of weapons and police involvement were involved in his experiences growing up. He and other siblings were also sexually abused by family members. Both of Badger's parents had attended residential schools and had a long history of substance abuse, the judge noted.¹²⁵

Research into the students, who died or went missing while attending residential schools, are a priority for the Indian Residential Schools Truth and Reconciliation Commission. The Missing Children Research Project was launched in 2008 with the aim of documenting how many children died, went missing or were buried in unmarked graves at residential schools.¹²⁶

Archeological evidence and school records suggests that between 27 and 65 people were buried in rudimentary graves on the bank of a creek 10 minutes west of the Red Deer School. On June 30, 2010 an honoring ceremony was held by members of the local Cree bands and 325 names were read off while an Honour Song was sung.¹²⁷

The abuse and the legacy of the residential school is clearly devastating. Yet, despite this experience and the toll it took, the resilience of former students, families, and their communities are incredible. In many cases, they did not go willingly or without resisting. Miller observes that, in the first six decades of the modern residential school system, resistance occurred at the level of the band, the family, and the student.¹²⁸ Considerable literature documents First Nation resistance to the residential school regime. Accounts of resistance can be found in the general histories of the schools,¹²⁹ accounts of particular schools or peoples,¹³⁰

¹²⁵ Lor Coolican, Star Phoenix November 13, 2009 "Badger declared dangerous offender."

¹²⁶ CBC News, "Residential school graves research a daunting task" *Tuesday, March 2, 2010*, online: <http://www.cbc.ca/canada/story/2010/03/02/residential-school-deaths.html#ixzz1069CbzS> (accessed September 20, 2010).

¹²⁷ Times Colonist: June 29, 2010, online: www.timescolonist.com/extras (accessed September 8, 2010).

¹²⁸ Miller 1996, *supra* note 90 at 343-344. A more recent instance of community resistance to residential school is described in Maura Hanrahan, "Resisting Colonialism in Nova Scotia", (2008) 17:1 *Native Studies Review*....., which describes the resistance of the Kesukwitk Mi'kmaq in Nova Scotia in the 1940s to centralization and to sending their children to residential school.

¹²⁹ John S. Milloy, *A National Crime: The Canadian Government and the Residential School System 1879 to 1896* (University of Manitoba Press, 1999), chapter 6 at 109-127; Agnes Grant, *No End of Grief: Indian Residential*

or in individual memoirs, oral histories, and personal accounts.¹³¹ These stories must be told too.

5.2.3 Forced Sterilization

The eugenics movement began in nineteenth-century England with Sir Francis Galton, (1822-1911), who was Charles Darwin's cousin. Eugenics is:

The study of agencies under social control which may improve or impair the racial qualities of future generations either physically or mentally.¹³²

The term "eugenics" came from a Greek term meaning "well born" or "good breeding."¹³³ In 1904, the Eugenics Movement was launched just as Gregory Mendel was "rediscovering" hereditary laws that governed the reproduction of simple traits of plants. The Eugenists assumed that Mendel's laws and principles could be applied to complex traits in human beings. They argued that "mental illness, mental retardation, epilepsy, criminality, pauperism and various social defects" were biologically hereditary. Social eugenics sprang from these

Schools in Canada (Winnipeg, Pemmican Publications Inc., 1999) chapter X at 209-220; Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50* (Vancouver, UBC Press 1998); Madeleine Dion Stout and Gregory Kipling, *Aboriginal People, Resilience and the Residential School Legacy*, Aboriginal Healing Foundation Research Series, 2003.

¹³⁰ See for instance, Celia Haig-Brown, *Resistance and Renewal: Surviving the Indian Residential School* (Vancouver, Arsenal Pulp Press, 1998) chapter IV at 98-114 [Alberni Indian Residential School]; Elizabeth Furniss, *Victims of Benevolence: The Dark Legacy of the Williams Lake Residential School* (Vancouver, Arsenal Pulp Press, 1992 and 1995); Isabelle Knockwood (with Gillian Thomas), *Out of the Depths: The Experiences of Mi'kmaw Children at the Indian Residential School at Shubenacadie, Nova Scotia* (Roseway Publishing, Lockport Nova Scotia, 2001); Agnes Jack, *Behind Closed Doors: Stories from Kamloops Indian Residential School* (2d ed.) Penticton BC, Theytus Books, 2006, especially 45-106; Nuu-chah-nulth Tribal Council, *Indian Residential Schools: The Nuu-chah-nulth Experience (Report of the Indian Residential School Study 1992-1994)*; Elizabeth Graham, "The Uses and Abuses of Power in Two Ontario Residential Schools: The Mohawk Institute and Mount Elgin," chapter 11 in David T. McNab, ed. For Nin.Da.Waab.Gig, *Earth, Water, Air and Fire*, Wilfrid Laurier University Press, 1998.

¹³¹ Agnes Grant, *Finding My Talk: How Fourteen Native Women Reclaimed Their Lives After Residential School* (Calgary, Fifth House Ltd., 2004). Gillian Weiss, ed. *Trying to Get it Back: Indigenous Women, Education and Culture*, Wilfrid Laurier University Press, 2000. Sources of individual memoirs are listed in Royal Commission on Aboriginal Peoples (RCAP), *Report*, Vol. I, Part 2, ch. 10, fn 276. These include transcripts of testimony from the RCAP hearings. This testimony and other resources from RCAP are available on the searchable data base *For Seven Generations* described in Budd L. Hall, "Breaking the Educational Silence: For Seven Generations", an Information Legacy of the Royal Commission on Aboriginal Peoples," chapter 12 in George J. Sefa Dei, et al. eds, *Indigenous Knowledges in Global Contexts* (an OISE/UT Book, U of T Press, 2000) at 202; Chrisjohn, R. and Young S. (1997). *The Circle Game: Shadows and Substance in the Indian Residential School Experience in Canada*. Penticton, BC: Theytus Books Ltd.; Churchill, Ward (2004). *Kill the Indian, Save the Man: The Genocidal Impact of American Indian Residential Schools*, City Lights Books.

¹³² Law Reform Commission of Canada, *Sterilization: Implication for Mentally Retarded and Mentally Ill Persons* (Working Paper 24) (Ottawa: Minister of Supply and Services Canada, 1979) at 25 [Law Reform].

¹³³ *Ibid.*

notions.¹³⁴ Also at this time, surgical techniques were developed that were considered safe and effective for preventing procreation.¹³⁵

The term “survival of the fittest” came to refer to human levels of intelligence and technological innovativeness, which were the Eurocentric, “scientific” criteria for determining if a person was fit for survival or not. A related notion of the time was that the most fit were facing depopulation, because the unfit were reproducing at a faster rate. The unfit included “mentally retarded persons, alcoholics, epileptics, schizophrenics, criminals, prostitutes, and others whose physical and behavioral characterizations were considered to be genetically determined and inherited.”¹³⁶

In 1911, the Research Committee for the Eugenics Section of the American Breeders Association suggested that sterilization and life segregation held the greatest potentials for “purging from the blood of the [human] race the innately defective strains.”¹³⁷ These ideas devolved into eugenic policies that spread to the United States, Canada, and several European countries. They later gained infamy in Germany.¹³⁸ A policy of involuntary surgical sterilization (a blatant breach of the later UN Genocide Convention¹³⁹) was carried out on human beings thereafter until the legislation was repealed.

Tommy Douglas (the “father” of socialized health care) was an early proponent of sterilization. In 1932, he completed a Masters degree from McMaster University entitled, “The Mentally and Morally Subnormal Family.” He claimed that, “Any woman who was morally subnormal needed to be sterilized, because immoral mothers produce immoral children.”¹⁴⁰ Dr. Margaret W. Thompson, professor emeritus at the University of Toronto, was awarded an Order of

¹³⁴ Law Reform, *ibid* at 25.

¹³⁵ Law Reform, *ibid* at 24.

¹³⁶ Law Reform, *ibid* at 25.

¹³⁷ Law Reform, *ibid* at 25.

¹³⁸ Many countries enacted various eugenics policies and programs, including, promoting differential birth rates; compulsory sterilization, marriage restrictions, genetic screening, birth control, immigration control, segregation, extermination, online: Wikipedia the Free Encyclopedia, Eugenics <http://en.wikipedia.org/wiki/Eugenics> (accessed September 8, 2010).

¹³⁹ *Convention on the Prevention and Punishment of the Crime of Genocide*, 9 December 1948, Article Two Text: U.N.T.S. No. 1021, vol. 78 (1951), at 277. Canada signed the Genocide Convention on November 28th 1949 and ratified the Convention on September 3rd 1952.

¹⁴⁰ Mark Lemstra, “Douglas shows value of evidence -based change”, The Star Phoenix, December 17, 2009.

Canada (1988), even though she was a member of the Alberta Eugenics Board.¹⁴¹ Although Nellie McClung successfully advocated for women to vote, she also advocated for the forced sterilization of people with disabilities when she was an Alberta MLA.¹⁴² Referring to the father of a young girl with a mental disability, Ms. McClung stated that the father:

[P]reserved just enough of the religion of his forefathers to believe that everyone had a right to propagate their kind, no matter how debased or marred the offspring might be.¹⁴³

Emily Murphy, J. S. Woodsworth, and Margaret Sanger are other notables who promoted involuntary sterilization.¹⁴⁴ Many physicians supported sterilization as well. Helen MacMurchy, first Chief of the federal Division of Maternal and Child Welfare in Ottawa, pointed out the special dangers posed by those whom she called “the feeble minded” or those who were too physically disabled to care for themselves to those who were “borderline cases who could pass as normal in society.”¹⁴⁵ “It was almost like germ theory,” stated Professor Angus McLaren. Just as a person who appeared healthy might be a carrier of an infectious disease, so, too, normal looking people could be “borderline cases” and could carry defective genes.¹⁴⁶

Now called the Michener Center, Alberta’s “Provincial Training School for Mental Defectives” (PTS) was considered a progressive facility for nearly 70 years in Red Deer, Alberta:

Original custodial care was upgraded to include occupational therapy and vocational training, and then supplemented by fashionable efforts to reintegrate residents into the mainstream. The school came not only to be Red Deer’s biggest employer but to boast its own working farm, elegant gardens, and well-equipped classrooms, plus a small village of neatly-painted dorms, and even its

¹⁴¹ Rob Wells, “Meritorious service?” Edmonton Journal, February 24, 2010.

¹⁴² Kevin Rollason, “Human rights lawyer opposes McClung statue, Winnipeg Free Press, April 23, 2010.

¹⁴³ Naomi Lakritz, Calgary Herald “McClung doesn’t deserve new statue” May 5, 2010.

¹⁴⁴ Paul Primeau, Fort William First Nation, “Human Genome” March 9, 1999.

¹⁴⁵ Heather Pringle, Saturday Night Magazine, June 1997 The Mannings and Forced Sterilization in Canada, online: <http://statismwatch.ca/1997/06/01/alberta-barren-the-mannings-and-forced-sterilization-in-canada/> (accessed September 20, 2010) [Pringle].

¹⁴⁶ Pringle, *ibid*. There is very little written about Aboriginal people with disabilities, however author Michael Oliver reviews cultural factors in the social model of disablement in his book “The Politics of Disablement” (London : Macmillan Education, 1990) and M. Oliver, & C. Barnes, “[Disabled People and Social Policy: From Exclusion to Inclusion](#)” (Harlow, Longman, 1998).

own freestanding clinic and surgery. Involved with the community, it staged Christmas pageants and supplied the local county fair with crafts.¹⁴⁷

The PTS also carried out massive sterilizations of almost 3,000 Albertans between 1928 and 1973, many of whom were First Nations, Métis, and Inuit children who came from the “wrong social groups.”¹⁴⁸

[P]eople deemed to be “mentally defective” were deprived of the ability to be part of their families and communities. Children admitted into Michener Center were kept separate from their families during their first year in the institution, because supposedly this would help them acclimatize better to institutional life. As a result, the children quickly became anonymous members of a separate society, cut off from any “normal” human childhood experiences. Eventually, many were abandoned by parents and family.¹⁴⁹

The Medical Superintendent of Alberta’s Provincial Training School, Dr. Leonard le Vann, had a personal agenda that involved surgically removing the testes of some students:

His personal research into the formation and development of sperm in Down’s syndrome boys, for example, called for human testicular tissue. To lay hands on suitable supplies, he presented Down’s syndrome boys from the school to the Eugenics Board on fifteen occasions between 1953 and 1971, requesting not just vasectomy but the complete removal of a testis. Medical experts had already discovered that Down’s syndrome males—then called mongoloids—were incapable of fathering children, but MacEachran’s Eugenics Board—which boasted one of Canada’s leading medical geneticists, Margaret Thompson, on its roster for a year and a half during this period—approved the surgery anyway.

Thompson, who has the Order of Canada, testified at the Muir trial. Under questioning, she agreed that her own textbook, *Genetics in Medicine*, recognized that there were no known cases of mongoloids fathering children. But, she said, nothing would be lost by sterilizing them “to make assurance doubly sure.”¹⁵⁰

LeVann also callously proposed that young lesbian woman be subjected to a complete removal of the ovaries (oophorectomies), instead of a simple salpingectomy as it was thought that this

¹⁴⁷ Pringle, *ibid*, See also, Claudia Malacrida, Lethbridge Herald, “Humanity, history, intellectual disability in Alberta” March 10, 2010, online: <http://www.lethbridgeherald.com/content/view/163418/184/> [Herald].

¹⁴⁸ Herald, *ibid*.

¹⁴⁹ *Ibid*.

¹⁵⁰ Pringle, *supra* note 145.

more invasive type of surgery did much to extinguish sexual desire. Castration was performed for the most sexually aggressive boys.¹⁵¹

John MacEachran was the chair of the Eugenics Board at the Alberta hospital, and he complied with nearly all of le Vann's requests:

... briskly signing sterilization order after sterilization order: for battered children who later graduated from grade twelve; for native kids from families who spoke only Cree or Blackfoot; for abused girls whose complaint was incest or sexual assault in their family homes; for bewildered teenagers with hearing or speech problems, cerebral palsy, multiple sclerosis, rare genetic defects of the hands or feet.¹⁵²

Dutifully, MacEachran did not question le Vann on why he wanted these children sterilized. Instead, he complied with the Medical Superintendent's wishes to render the children incapable of producing babies.¹⁵³

The debilitating harm left by forcible confinement and sterilization has harmed Aboriginal people today and certainly left a legacy that, in addition to the effects of residential schools, has added to the damage already encountered through the residential schools. Certainly the /seemingly maliciousness of those in charge of the institutions has left irreparable harms on the people sterilized.

In Canada, both Alberta (1928) and British Columbia (1933) enacted eugenics legislation. Between 1929 and 1972, 2,800 people were sterilized under the authority of the Alberta's *Sexual Sterilization Act*.¹⁵⁴ Although many provinces considered the idea of eugenics, British Columbia and Alberta were the only provinces that legislated in favor of eugenics. Alberta

¹⁵¹ Pringle, *ibid*.

¹⁵² Pringle, *ibid*.

¹⁵³ The CBC NEWS reported a modern form of Vann's methods in its article "BC suspends penile sex tests on young offenders" July 28, 2010. These tests were suspended after the British Columbia's Children's Representative Mary Ellen Turpel-Lafond raised concerns with the testing. The test attaches a device to the youth's penis to measure his physical sexual arousal while adults show the youth images of adults having sex, then show the youth images of naked children and infants. These images are accompanied by the male voice that describes forced intercourse with male and female infants as young as two years old (*forced intercourse sounds like rape to me*). These tests are conducted by the Youth Forensic Psychiatric Services, Ministry for children and Family Development – the British Columbia government.

¹⁵⁴ *Sexual Sterilization Act (S.A.)* (1928) c.37; *Sexual Sterilization Act (R.S.A)* (1955) c.311 [repealed 1972].

sterilized far more people than did British Columbia, which sterilized 400 people under the BC law.¹⁵⁵

Even though neither the Alberta nor the BC Sterilization Acts overtly discriminated against women and/or Aboriginal people, their implementation had devastating effects on both groups, since both provinces have always had high Aboriginal populations. Because of their social strata, a disproportionately high number of women¹⁵⁶ and Aboriginal people were referred and sterilized:

Although Indian and Métis constituted only 3.4% of the Alberta population, they constituted 25.7% of total of all people sterilized. Between 1969 and 1972 more Indian and Métis persons were sterilized than British, which is particularly telling because Indian and Métis had the least population and the British had the highest population.¹⁵⁷

i) Aboriginal People and Eugenics

The *Sexual Sterilization Act* was intended to stop “mental defectives” from having children. The Eugenics Board was comprised of four people who were mandated to authorize sterilization in Alberta.¹⁵⁸ The *Act* initially required the consent of patients unless they were “mentally incapable,” in which case “the consent of the next of kin had to be obtained.”¹⁵⁹ In 1937, however, the *Act* was amended: consent by patients or the next of kin was no longer required if the patient was considered “mentally defective.”¹⁶⁰ The 1937 amendment also

¹⁵⁵ *Sexual Sterilization Act*, R.S.B.C. 1960, c. 353 repealed by S.B.C. 1973, c. 79.

¹⁵⁶ Of patients approved for sterilization [in Alberta] 35.3% were male and 64.7% were female. Thus, not only did the Eugenics Board approve the sterilization of more females, but a disproportionately high number of them were sterilized", See Law Reform *supra* note 133 at 42.

If positive eugenics consists of promoting the procreation of those individuals considered desirable by society, negative eugenics concentrates on the elimination in the gene pool of undesirable traits. Eugenists believed that these policies would have the result of increasing the proportion of desirable [perhaps eliminate the first 'desirable', or find a synonym for one of them?] individuals. See Law Reform *supra* note 132 at 2.

¹⁵⁷ T. Christian, "The Mentally Ill and Human Rights in Alberta: a Study of the Alberta Sexual Sterilization Act" (1974) [unpublished] cited in K.G. McWirther and J. Weijer, "The Alberta Sterilization Act: A Genetic Critique" (19) 19 University of Toronto Law Journal 424 in *Clémentine Sallée*, Reflection on *The Legal Status of Sterilization in Contemporary Canada in Institute of Comparative Law, A thesis* Master of Laws, McGill Montreal 2002.

¹⁵⁸ Jana Grekul, Harvey Krahn, Dave Odynak, “Sterilizing the “Feeble-minded”: Eugenics in Alberta, Canada, 1929–1972” *Journal of Historical Sociology* Vol. 17 No. 4 December 2004 at 363 [Grekul].

¹⁵⁹ Grekul, *ibid.*

¹⁶⁰ Gekul, *ibid.*

targeted “individuals incapable of intelligent parenthood.”¹⁶¹ Aboriginal peoples were easy targets for the new amendment, since the prevailing government view was that Aboriginal people were incapable of intelligent parenthood. In 1988, the Alberta government destroyed many of the 4,785 files created by the Eugenics Board. The government of Alberta maintained 861 of those files. Professor Jana Grekul reviewed them and commented:

[M]ost noticeably over-represented were Aboriginals (identified as “Indian,” “Métis”, “half breeds”, “treaty” and “Eskimo”). While the province’s Aboriginal population hovered between 2% and 3% of the total over the decades in question, Aboriginals made up 6% of all cases represented.¹⁶²

Further:

[F]ew exceptions particularly in the 1930’s [8%] more women than men appeared before the Board... We found that people were being referred to the board for reasons related to their social class, gender, and ethnicity, and there was no genetic condition for them to be considered for sterilization.¹⁶³...

[W]e conclude that Aboriginals were the most prominent victims of the Board’s attention. They were over-represented among presented cases and among those diagnosed as “mentally defective.” Thus they seldom had a chance to say “no” to being sterilized. As a result 74% of all Aboriginals presented to the Board were eventually sterilized (compared to 60% of all patients represented). In contrast, because patient consent was so often required, less than half (47%) of both Eastern and Western European patients were eventually sterilized.¹⁶⁴

Inuit women in the North were sterilized in the 1970s without their consent in staggering numbers.¹⁶⁵ Missionary Father Robert Lechat reported that in 1976:

26% of women of Igloodik between 30 and 50 are sterilized thanks to the Canadian Government.¹⁶⁶

...

If there is no precise policy for sterilization there is at least a very definite will to prevent the increase of Inuit in the Canadian North.¹⁶⁷

¹⁶¹ Grekul, *ibid* at 375.

¹⁶² Grekul, *ibid* at 359.

¹⁶³ Wanda Vivequin, “Prof Reveals Eugenics Machine” *Express News* (July 18, 2003).

¹⁶⁴ Grekul, *supra*, note 158.

¹⁶⁵ Annette J. Browne and Jo-Anne Fiske, “First Nations Women’s Encounters with Mainstream Health Care Services”, *West J Nurs Res* 2001; 23; 126. See also: J. D. O’Neil, (1988) Self-determination, medical ideology and health services in Inuit communities in G. Dack & K. Coates (Eds.), *Northern communities: The prospects for empowerment*. Edmonton, Canada: Boreal Institution for Northern Studies, University of Alberta.

¹⁶⁶ Robert Lechat “Intensive Sterilization for the Inuit” *Eskimo Fall Winter 1976-1977* at 5 [Lechat].

¹⁶⁷ Lechat, *ibid*. The original count was 23% but an official recount, made at Ottawa’s request, has disclosed two more cases, which brings the proportion to 26%.

A letter written to David Lewis, from the Regional Director of the Alberta Region on October 21, 1970 states “Congratulations for urgent intervention. Same butchery is exercised to Eskimo women elsewhere --- under civilized blankets.”¹⁶⁸

Father Lechat explains the effects of tubal ligation on Inuit women:

For the Inuk woman—and I speak again of the traditionally educated Inuk—there is no danger of upsetting the psychological equilibrium by too many births: on the contrary it would be easily upset by her not being able to bear children. She does not feel that she is a real woman unless she has a baby in her hood or a child to hold her hand: that is why you see women past the menopause and already grandmothers adopting children.¹⁶⁹

Barry Gunn, former Regional Administrator in Frobisher, confirmed that:

[B]ecause of communication problems, many women agreed to operations and signed papers without realizing what they meant.¹⁷⁰

When the issue of sterilization of Inuit women was challenged in the House of Commons, the regulations were changed. The medical staff were required to clarify the permanence of the sterilization surgical procedure and to use consent forms that were translated into Inuktitut.¹⁷¹

In 1998, the *Windspeaker* newspaper reported that the Government of the NorthWest Territories had been telling women that were sterilized at Edmonton's Charles Camsell Hospital, to access support if they believed they had been wrongfully sterilized.¹⁷²

ii) Institutional Eugenics

Sterilization has been a popular method for preventing reproduction of a species. It is also a method for controlling prisoners. Yet, without consent or with coerced consent, sterilization is an act of violence.

In a Department of Justice Canada document accessed by the *Access to Information Act*, in December 2007, an unnamed source questioned why Ontario psychiatrists were prescribing

¹⁶⁸ HR 7055.C73R37 Letter to David Lewis, from Regional Director, Alberta Regions, re: Sterilization of Eskimo Women. 1970/10/21. Deschatelets Archives - Commission Oblats des Oeuvres Indiens & Eskimaux.

¹⁶⁹ Lechat, *supra* note 166 at 6.

¹⁷⁰ Inukshuk, “Feature: Sterilization of Women” June 1, 1973, at 10, 11.

¹⁷¹ Grekul, *supra* note 158 at 303.

¹⁷² Sabrina Whyatt, *Windspeaker*, August 1, 1998 “Sterilization victims urged to come forward”.

“chemical treatments”—i.e., castration—to prisoners of moderate risk and first time sexual offenders. The letter refers to a 1990s class action lawsuit filed by several patients in the 1960s of the Province of Alberta mental health system against the Alberta government, which the patients won. The plaintiffs argued that the institution’s use of castration was unfounded and a gross violation of their human rights. It lacked proven evidence that castrating patients was an appropriate or necessary means of controlling them, that it was appropriate as a condition of parole, or that it was a valid method of mental health management.¹⁷³ The following chart shows the harsh side effects of chemical castration:

Table 2

APPENDIX - A

Sex Drive Reduction “Chemical (Castration) Treatment” Family: Lupron, Etc.

Chemical:

LUPRON DEPOT 7.5 mg contains Leuprolide Acetate as sustained-release microspheres reconstituted with a special diluent prior to intramuscular administration.

LUPRON DEPOT Kit: No. 3629
 LUPRON DEPOT 7.5 mg vial: No. 3624
 Sterile Diluent for LUPRON DEPOT: No. 3625

Side-effects and complications in men can include:

- Estrogen level increase
- Increased risk blood clot embolisms to the heart and lungs leading to sudden de:
- Testosterone level decrease and fluctuations
- Pituitary Gland size reduction
- Penis size reduction
- Testical size reduction
- Irreversible effeminate breast enlargement
- Breast pain and soreness
- Effeminate narrowing of the chest
- Effeminate broadening of the hips
- Effeminate voice change
- Severe bone pain
- Severe hot flashes
- Heavy sweating
- Severe chest or abdominal pain
- Abnormal swelling or numbness of the limbs
- Persistent nausea or vomiting
- Rapid heart beat
- Increased nervousness
- Increased depression
- Bone calcium loss
- Bone density loss: 2 - 4%
- Increased bone density fractures
- Phosphorous loss
- Loss of facial hair
- Liver, kidney, pancreas, lung and prostate changes

¹⁷³ Document 140028, Letter to The Honourable Minister of Justice, House of Commons, Ottawa and dated April 29, 2002 Accessed through an ATIP request to the Department of Justice Ottawa, December 2007.

Section 51 of the *Indian Act*¹⁷⁴ authorizes the Minister of Indian Affairs or his delegate to appoint third parties to act on behalf of mentally incompetent Indians. Because registered Indians are under federal jurisdiction, the purpose would be to pursue claims for damages for the wrongful sterilization of mentally incompetent Indians while they were confined to provincial institutions. According to documents accessed under the *Access to Information Act* in 2007, seven or more Indians were, in fact, wrongfully sterilized, and a class action lawsuit was brought on their behalf.

The people were wrongfully sterilized at “Deerhome”¹⁷⁵ in Red Deer, Alberta, under the guardianship of Alberta (or under private guardianship). The Alberta Public Guardian took the position that the Minister of Indian Affairs and Northern Development were the trustees of the estate of mentally incompetent Indians and, therefore, had a responsibility to safeguard the rights of the wrongfully sterilized people. Section 51 of the *Indian Act* vests the Minister of Indian Affairs with all jurisdiction over the property of mentally incompetent Indians, including the power to initiate legal proceedings. Section 2(1) of the *Indian Act* defines a person as an Indian who has been found to be mentally incompetent according to provincial law. It allows the government to administer the estates of mentally incompetent Indians.

Pursuant to s.s. 4(3), this authority does not extend to those who do not reside on reserve, unless the Minister orders otherwise. In this case, five of the seven claimants lived on reserve; the residence of the other two could not be ascertained. The Minister used his exception powers to include them as well. The appointed litigation guardian, Peter M. Owen Q.C., retained the law firm of Field, Atkinson, and Perraton as legal counsel to pursue the claims against Alberta. In 1999, seventeen other plaintiffs joined in making these claims. All of the actions name the same Defendant, Her Majesty the Queen in Right of Alberta. Sixteen of the seventeen actions allege wrongful sterilization. All but one allege wrongful admission into provincial institutions. Two of the actions allege physical abuse. Two of the actions allege sexual assault and sexual

¹⁷⁴ *Indian Act*, R.S.C. 1951, c. 1-5.

¹⁷⁵ Deerhome is another wing of Alberta’s Provincial Training School, now called Michener Centre.

abuse. Seven of the plaintiffs allege that they were improperly administered medications for the purposes of drug trials.

In *J.L. v. Alberta*,¹⁷⁶ the Defendant applied to the courts to have portions of the Examinations for Discovery struck, because the testimony was from Dr. T who worked at the provincial institution and was 92 years old at the Examination. The Defendant claims he was (ironically) mentally incompetent. The Defendant was unsuccessful.

In 1965, the Province of Alberta used the following consent form¹⁷⁷ for a “salpingectomy” (surgical removal of one or more fallopian tubes). Note the language: “... should be sexually sterilized to eliminate the danger of procreation, with its attendant risk of transmission of the disability to progeny, or the risk of mental injury to her progeny”:

¹⁷⁶ *J. L. v. Alberta*, [1999] A.J. No. 1568 (*J.L., J.M.T., V.C.B., H.B.R., G.G.B., R.H.T., M.S., O.S., J.M., D.F., W.W.R., L.R., L.B., S.G.S., C.A.R., M.A.T., H.I.S., G.R.S., E.D.C., A.A.C., P.J.K., K.K.R., D.Y.K., M.A.R., C.S.J., S.C., R.V.F., P.M.H., J.M.W.S., L.C.M., R.J., F.A.B., M.K.C., G.E.F.M., R.C., M.A.S., I.C., JOHN DOE 1-100, JANE DOE 1-100, plaintiffs*). Also accessed was various documents referring to *Hodgson and Hodgson v. HMTQ of Alberta and HMTQ of Canada*, a claim for wrongful confinement and wrongful sterilization. The claim against Alberta was filed March 1996 and on October 10, 1996 Canada was added as a party.

¹⁷⁷ Accessed through ATIP, 2007.

Directions by Eugenics Board for the Province of Alberta E.B. 4145

000038

WHEREAS, [redacted] of [redacted] in the Province of Alberta, a Patient at the [redacted] or a Patient at The Alberta Guidance (Mental Hygiene) Clinic, [redacted] has pursuant to Section 4 of The Sexual Sterilization Act, been personally interviewed and his case history investigated by the Board created by the said Act.

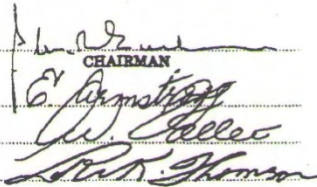
AND WHEREAS as a result of such examination the Board is unanimously of the opinion that the said [redacted] should be Sexually Sterilized to eliminate the danger of procreation, with its attendant risk of transmission of the disability to progeny, or the risk of mental injury to him/her, or to him/her progeny.

AND WHEREAS the provisions of the said Act have been complied with in regard to the matter of consent to the performance of an operation for Sexual Sterilization on the said [redacted]

THE BOARD therefore directs that a surgical operation for Sexual Sterilization of the said [redacted] be performed and that such operation be as follows: **Salpingectomy**

THE BOARD hereby appoints Dr. J. Roes Vant or Dr. R. MacGregor Parsons as surgeon to perform the said operation at the Alberta Hospital, PONOKA, or the Alberta Hospital, EDMONTON, or The Alberta School Hospital, RED DEER.

DATED at Red Deer, in the Province of Alberta, the 26th day of February, 1965.


CHAIRMAN
[redacted]
[redacted]
[redacted]

In *D.E. (guardian ad litem of) v. British Columbia*,¹⁷⁸ eighteen plaintiffs sued the Crown for wrongful sterilization between 1940 and 1968. At least two plaintiffs were Aboriginal. C.M. was admitted in 1955 at the age of 17. The Eugenics Board summarized their views:

Patient is a mentally defective Indian girl who has always been incorrigible, wild, undisciplined and promiscuous.... At this hospital she has had to be kept

¹⁷⁸ *D.E. (Guardian ad litem of) v. British Columbia*, [2003] B.C.J. No. 1563 [DE].

locked up to prevent her escaping or misbehaving with men patients on the grounds....

Reason for Referral:

Patient is a mental defective, with numerous behaviour problems, particularly being promiscuous and associating with undesirables. Sterilization is, therefore, strongly recommended to prevent patient from having illegitimate children which the community would have to care for and for whom it would be very difficult to find foster homes.¹⁷⁹

The Superintendent, Dr. Bryson, recommended that she be sterilized. He stated that C.M., if “discharged without sterilization, would have children with a tendency to serious mental disease or deficiency.”¹⁸⁰ He added:

This twenty-six year old woman is a mental defective who has shown promiscuous sexual behaviour as a component of her erratic and disturbed mental condition. She has required constant supervision.... She cannot be granted privileges as she always consorts with male patients on the grounds and indulges in promiscuous sexual behaviour. Rehabilitation plans and her release from hospital without the benefit of an operation for sexual sterilization would undoubtedly result in illegitimate children who would run a grave risk of a mental disorder.¹⁸¹

The Eugenics Board authorized C.M.’s sterilization, which occurred on May 18, 1965.¹⁸²

R.D. was admitted to the same British Columbia institution on September 1, 1945 when she was 16. She was also Aboriginal. The only record on file is a request to the Indian Commissioner asking for consent for sterilization. The Eugenics Board shared their rationale for sterilizing this young woman:

This mentally defective young woman who has suffered from a psychotic illness, has now made a relatively satisfactory recovery from her psychosis. However, her social background reveals a history of promiscuity, venereal disease, tuberculosis, and one illegitimate pregnancy. Because of limited intelligence, lack of supportive family supervision, and a propensity for illicit sexual behaviour, her rehabilitation through the auspices of the Indian Affairs Department, is most problematical. She, nevertheless, cannot likely remain in a mental hospital when she has gained a good remission of her gross symptoms of mental illness, and it is, therefore, desirable to offer her the protection of sexual sterilization.

¹⁷⁹ DE, *ibid* at para 287.

¹⁸⁰ DE, *ibid* at para 288.

¹⁸¹ DE, *ibid* at para 288.

¹⁸² DE, *ibid* at para 289.

...The test results indicate that she is functioning as a Mental Defective, near the bottom of the moron range... . She could obviously not manage her own affairs... . The only sort of environment she could fit into would be one where she has close and supportive supervision and any measure which would help lessen her problems, such as sterilization would be of benefit.

Reason for Referral: Miss [D.] is being referred for sexual sterilization because of her very limited intelligence, her lack of social judgment, and her lack of possible social supervision. While she will undoubtedly continue to be a social problem on discharge from this hospital, sexual sterilization would prevent her from having further children who might become social problems because of possible inherited mental deficiency, congenital or acquired venereal infection, and lack of healthy parental controls.¹⁸³

Even though R.D. was no longer suffering from a psychotic illness, the Board authorized her sterilization because of her social background.

Although the legislation may have allowed residential school officials who stood *in loco parentis* to their charges to sterilize under the Acts, it is unknown at this time how many children were sterilized in the schools. Additionally, it is unknown if the Crown ever acted in their capacity as *parens patriae* to exercise their jurisdiction to intervene on behalf of a child or “mentally incompetent person” that they believed was in danger of sterilization. We do know that the Access to Information Request of December 2007 has led to sterilization violations becoming part of residential school claims.¹⁸⁴ Clearly, further research needs to be conducted in this area.¹⁸⁵

A 1974 study of the Indian Health Services (IHS) by the Women of All Red Nations (WARN) revealed that “as many as 42 percent of all Indian women of childbearing age had by that point been sterilized without their consent.”¹⁸⁶ These estimates were confirmed by a General Accounting Office (GAO) investigation of four IHS facilities that examined records only for 1973–76. The investigation that concluded that “during this three-year sample period, 3,406

¹⁸³ DE, *ibid* at para 319.

¹⁸⁴ Document 2-81887, Letter from Susan Ayala, Aboriginal Law Services, Department of Justice Canada to Merchant Law Office: Bruce G. Neill discussing the joinder issue.

¹⁸⁵ See, Elizabeth Adjin-Tettey, “Righting Past Wrongs Through Contextualization: Assessing Claims Of Aboriginal Survivors Of Historical And Institutional Abuses,” (2007) 25 Windsor Y.B. Access Just. 95.

¹⁸⁶ M. Annette Jaimes & Theresa Halsey, “American Indian Women: At the Centre of Indigenous Resistance in Contemporary North America” in M. Annette Jaimes, ed. *The State of Native America: Genocide, Colonization, and Resistance* (Boston: South End Press, 1992) at 311–44 [Jaimes].

involuntary sterilizations (the equivalent of over a half-million among the general population) had been performed in just these four hospitals.”¹⁸⁷ Jane Lawrence recounts that Native Americans accused the Indian Health Service of sterilizing 25 percent of Native American women between fifteen and forty four years during the 1970s.¹⁸⁸ She recalls a particularly sad story:

A young Indian woman entered Dr. Connie Pinkerton-Uri’s Los Angeles office on a November day in 1972. The twenty-six-year-old woman asked Dr. Pinkerton-Uri for a “womb transplant” because she and her husband wished to start a family. An Indian Health Service (IHS) physician had given the woman a complete hysterectomy when she was having problems with alcoholism six years earlier. Dr. Pinkerton-Uri had to tell the young woman that there was no such thing as a “womb transplant” despite the IHS physician having told her that the surgery was reversible. The woman left Dr. Pinkerton-Uri’s office in tears.¹⁸⁹

In the 1970s, 35 percent of all women in Puerto Rico had been sterilized. Between 1973 and 1976, 3,406 women were sterilized at one Indian Health Services Hospital in Oklahoma, representing one quarter of the Aboriginal women admitted to the hospital.¹⁹⁰

In October 1989, Leilani Muir discovered that the Government of Alberta had sterilized her without her consent. She then brought “legal action against the Government of Alberta for wrongful confinement and for wrongful sterilization,” and she won.¹⁹¹ In Ms. Muir’s case, “a single IQ test” had been enough to deem her mentally defective and therefore a candidate for

¹⁸⁷ Jaimes, *ibid.* at 326.

¹⁸⁸ Jane Lawrence, “The Indian Health Service and the Sterilization of Native American Women” *American Indian Quarterly*/ summer 2000/vol. 24, no. 3 See also, “Killing Our Future: Sterilization and Experiments,” *Akwesasne Notes* 9 (early spring 1977): 4; Brint Dillingham, “Indian Women and Indian Health Services Sterilization Practices,” *American Indian Journal* 3 (January 1977): 27–28; Janet Karston Larson, “And Then There Were None,” *Christian Century* 26 (January 1977): 62–63; “Marie Sanchez: For the Women,” *Akwesasne Notes* 9 (December 1977): 14–15; and James Robison, “U.S. Sterilizes 25 Percent of Indian Women: Study,” *Chicago Tribune*, 22 May 1977, sec. 1, p. 36.

¹⁸⁹ Gail Mark Jarvis, “The Theft of Life,” *Akwesasne Notes* (September 1977): 30–32.

¹⁹⁰ Thomas Shapiro, *Sterilization and Reproductive Choice* Philadelphia: Temple University Press, 1985 at 63 in Carolyn Egan and Linda Gardner, *Race, Class and Reproductive Freedom: Women must have real choices!* 1994 Vol 14 number 2, Canadian Women Studies at 96. See also, [Can.J Public Health](#), 1978 May-Jun; 69 (3):222-4. For Sterilization patterns in a Northern Canadian population see for instance, [Cohen J, Baskett TF](#); McLaren, Angus, *Our Own Master Race*, Toronto: McClelland & Stewart 1990; Frost, E. Mary. 1942. “Sterilization of Alberta: A Summary of the Cases Presented to the Eugenics Board for the Province of Alberta from 1929 to 1941”. Master’s Thesis. University of Alberta.

¹⁹¹ See, [Muir v. Alberta, \[1995\] A.J. No. 1656](#); [Muir v. Alberta, \[1995\] A.J. No. 658](#); [Muir v. Alberta, \[1996\] A.J. No. 37](#).

sterilization.¹⁹² Upon Ms. Muir’s physical examination and the discovery that she had been sterilized, her doctor reported that her insides “looked like she had been through a slaughterhouse”.¹⁹³

When Leilani Muir won her case, the Government of Alberta’s responded with a proposition to override the *Charter of Rights and Freedoms* using s. 33 to limit the compensation to victims.¹⁹⁴ This proposition was met with a massive public outcry. The Government of Alberta finally apologized in 1999 and offered several individuals and groups the option to settle out of court. Many more victims of sterilization remain unnamed.

iii) Summary

Eugenics debates continue today with a number of controversial issues. For example, when young Aboriginal women enter the prison system and are released later in life, they may well be past the ideal time for having children—safely at least. Many are incarcerated in their teens and paroled in their 30s. Again, further research is needed on how women who have been incarcerated cope—both those with their reproductive organs and those without.

Whether or not to sterilize mothers who deliver children with Fetal Alcohol Spectrum Disorder (FASD) is another current topic in the news. According to the Canadian Centre of Substance Abuse, Canada spends \$4 billion dollars annually on children with FASD, with a lifetime cost of \$1 million per child. Columnist Dr. Gifford-Jones proposes that the mothers be sterilized to prevent FASD babies.¹⁹⁵

Such a “rational” policy to sterilize “at-risk” women would seem to apply to all mothers equally. In reality, however, Aboriginal mothers would be sterilized in far greater numbers, disproportionate to their percentage of the total population. Addictions are classic symptoms of historical unresolved grief and trauma and ongoing race-based social injustices. To use

¹⁹² James Horner, “The Sterilization of Leilani Muir” *Canadian Content* (February 1999), online: Canadian Content, <http://www.canadiancontent.ca/issues/0299sterilization.html> (accessed September 8 2010) [Horner].

¹⁹³ Horner *ibid.*

¹⁹⁴ Veit, J. (1996) *Muir v. The Queen in Right of Alberta*. *Dominion Law Reports*, 132(4th series): 695-762.

¹⁹⁵ Dr. Gifford-Jones, *Whig Standard*, “Should Moms who Deliver FAS kids be Sterilized?” Feb 11, 2010; *Toronto Sun*, February 8, 2010.

addictions as a justification for preventing births in a distinct cultural, national group is arguably a form of genocide according to the UN's definition. Such a policy of sterilization would certainly allow the dominant society to avoid holding itself accountable for the systemic causes of addictions among Aboriginal peoples.

For Aboriginal women, the consequences of having been wrongfully institutionalized and sterilized are terrible. Their lives are changed irreversibly. Their hopes for having children and families are impaired if not destroyed, and their ancestral lineage as a person, family, and people is, for many, brought to a brutal, violent end.

5.2.4 Experiments

At the Port Alberni Residential School children were denied basic dental treatment and then “studied” as to the dental caries and gingivitis that would result, “No specialized, over-all type of dental service should be provided, such as the use of sodium fluoride, dental prophylaxis or even urea compounds” Dr. Brown, chief of the dental health division of the federal government wrote in a 1 page directive on October 3, 1949. Parental consent was not obtained.¹⁹⁶

Professor Maureen Lux recounts her studies on the use of the experimental BCG tuberculosis vaccine in the 1930s and 1940s on Indian children. The death rates revealed about 12 per cent of the patients actually died before their 5th birthday from other causes, vaccinated or not.¹⁹⁷

Aboriginal women have been subjected to other long-standing forms of abuse as well. The Canadian government has used Aboriginal people to conduct experiments on humans without their consent in the corrections system as well as in other institutions.¹⁹⁸ In the 1960s, women imprisoned at the Kingston Prison for Women were subjected to lysergic acid diethylamide (LSD) and electro convulsive therapy (ECT) experiments. These experiments had devastating consequences and long-term effects on generations of Aboriginal women and their families. Evidence indicates that the government understood these dangers.

¹⁹⁶ Southam News, the Vancouver Sun “Native Kids used for experiments” April 26, 2000.

¹⁹⁷ Maureen Lux, “Perfect Subjects: Race, Tuberculosis and the Qu’Appelle BCG Vaccine Trial” vol. 15: 1998 277-95.

¹⁹⁸ Leilani Muir who was wrongfully sterilized reviewed her chart and noted that regular doses of phenobarbital, chlorpromazine and haloperidol were tranquillizers that were administered to her without her consent or knowledge. (Pringle, *supra* note 145.)

For instance, an Access to Information request to Health Canada in December 2007 revealed a December 21, 1962 letter to the Canadian Commissioner of Penitentiaries from the Department of National Health and Welfare. The letter's author, Dr. Donald Ewen Cameron, is infamous for his central involvement in the US CIA's Project MKULTRA—a project to conduct mind and drug experiments on civilians without their informed consent to develop “interrogation” and torture techniques. The torture techniques used today at Abu Ghraib, Guantanamo, and other prisons for political prisoners stem directly from Cameron's research. This 1962 letter was about regulating the use of LSD in one of Canada's prisons. He wrote to assure the Health Minister that he would have the authority to approve the drug for continued use at the Prison for Women in Kingston. He stated, “I have no hesitation at all in assuring you that the type of work which is going on in the prison at Kingston would be approved by my Minister for continuation.” About the drug's effects, he continued, “You will understand that all the evidence we have been able to gather from experts outside the Department, as well as inside, points to the fact that this is a potentially dangerous drug, especially if it were to get into the wrong hands.”¹⁹⁹

i) Dorothy Proctor

Dorothy Proctor was 18 years old and of M'iqmaw heritage. She was also incarcerated in the Prison for Women in Kingston from 1961 to 1963. She was one prisoner of at least 23 who were given LSD and electro convulsive therapy as research experiments. Dorothy was told that if she took the treatments, she would not have to go back to segregation. In her words:

I was taken to a room set aside for such treatments next to the prison infirmary. The prison nurse wordlessly strapped me to a hospital bed, both legs and arms, and a fifth strap held my head down. Sodium pentothal was injected into my arm. “Begin counting backwards from one-hundred,” said the nurse.

In walked a short man holding a little black box.

...

I have no idea what happened to me while I was unconscious and helpless, but I do know that when I awakened back in my cell, my arms and legs twitched uncontrollably and I had a terrific headache. It felt like someone was inside my head with a jackhammers going at full trip. I do know I didn't want to see the man or his black box again....

¹⁹⁹ Access to information Request of 2007, December 21, 1962 letter from Department of National Health and Welfare Dr. Cameron to A.J. Mac Leod Esq. Commissioner of Penitentiaries.

I screamed but no sound came out....
I would faint all over the place. I went back to stuttering.²⁰⁰

In relation to the LSD experiments, she stated:

Dr. Mark Eveson was the doctor who administered the drug to me. The first time, he overdosed me by accident. Five days later, I was still on a trip without any luggage.²⁰¹

I don't think it was fifteen or twenty minutes before Dante's Inferno. It was obvious. I am locked in. I can't get away. And the walls start to move in on me, and they melt. The bars turn to snakes, there was an awful physical vibration in my body. It was just awful, just awful, and of course, any mind that I had to think in reality, I just thought I had gone mad, that's it.²⁰²

When asked why she thinks she was chosen for these experiments, she thought it was because she was an aggressive prisoner, young, and Aboriginal:

I believe I was targeted from the very beginning. I don't want to play the race card but I really can't help but think that perhaps I was targeted because first of all I was very, very young. I think I was the youngest inmate there. I didn't have any family support. I didn't come from a background of influence or power and plus I am Native and Black Canadian.²⁰³

Thirty-four years later, Ms. Proctor began a legal action against the perpetrators of the abuse she suffered in Prison for Women at Kingston. In October 1995, Dorothy Proctor contacted the Correctional Service of Canada (CSC) and stated her complaint. She was

...subjected to the experimental use of LSD 25, as well as to electro-convulsive therapy (ECT) without her informed consent, during her incarceration at the Prison for Women from March 22, 1960 to August 1, 1963. She considers that the Correctional Service of Canada did not properly protect her from such medical interventions. She further alleges that "being subjected to LSD 25 has had negative long term effects on her life: it precipitated her use of that and other drugs after her release; drew her into her role as an RCMP informant; prevented her from obtaining normal employment and reaching her potential and continues to have consequences for daily life."²⁰⁴

²⁰⁰ Dorothy Proctor, Fred Rosen, *Chameleon*, (New Horizon Press: New Jersey) 1994 at 61, 62 [Proctor].

²⁰¹ Proctor, *ibid* at 62.

²⁰² Interview, Monday November 09, 1998 CBC Radio (National) THIS MORNING Rosie Rowbotham Interview with: Dorothy Proctor, Allen Hornblum, and Dr. George Scott Secret Experiments On Canada's Convicts, online: <http://www.raven1.net/rowbothm.htm> (accessed September 8, 2010) [Interview].

²⁰³ Interview, *ibid*.

²⁰⁴ Norbert Gilmore and Margaret Somerville, *A Review on the use of LSD and ECT at the Prison for Women in the early 1960s*, McGill Centre for Medicine, Ethics and Law, September 19, 1998 at 1 [Review].

In response to Dorothy's allegations, CSC requested that a Board of Investigation review the issues. CSC also asked McGill Centre for Medicine, Ethics, and Law to review the allegations as well. Dr. Cameron had worked at the Allan Memorial Institute at McGill from 1957–64 to carry out potentially deadly experiments on non-US citizens. McGill subsequently produced *A Review on the use of LSD and ECT at the Prison for Women in the early 1960s*. The Report written by Professors Norbert Gilmore and Margaret Somerville was to review the medical research and ethical context regarding the 23 female prisoners who were given LSD and electroconvulsive treatment (ECT) at the Kingston Prison. The Report chronicled that the administration of LSD caused "substantial debilitating, long term negative effects."²⁰⁵ They concluded that:

[T]he research itself was carried out in an unethical fashion: inmates returning alone to their cells, after being administered LSD, for instance, were heavily sedated "because there were no personnel available to provide overnight surveillance, support and, if needed, intervention," states the report. Also, LSD was administered, to at least one inmate, in quantities that were known to risk causing hallucinations.²⁰⁶

Compared to their proportion of the general population, Aboriginal people of both sexes in Canada are over-represented in federal, provincial, and territorial prisons. This fact has been well documented by inquiries and task forces. Aboriginal people comprise approximately 3 percent of the population in Canada, yet they represent roughly 18.5 percent of the federally sentenced prison population.²⁰⁷ Given these inequities and the documented patterns of racist

²⁰⁵Review, *ibid* at 42, Accessed through ATIP request 2007. See also, Elizabeth Fry Society, "LSD Experiments at the Prison for Women A letter to the Correctional Service Commissioner" Elizabeth Fry Society (3 March 1998), online: <http://www.elizabethfry.ca/eLSD.html> (accessed September 8, 2010). See also Elizabeth Fry Society, "Another Bad Trip: CSC Malingering in LSD Compensation Case" *Annual Report 2000* (2000), online: Elizabeth Fry Society <http://www.elizabethfry.ca/areport/ar2000e/page20.htm> (accessed September 8, 2010). In 1998, Solicitor General Andy Scott's incredulous response was "...How much informed consent in a circumstance like that can you really believe exists? Why women?" (Prison Activist, "Solicitor General's response to LSD experiments" Ottawa Citizen (4 March 1998), online: Prison Activist Organization <http://prisonactivist.org/pipermail/prisonact-list/1998-April/001617.html> (accessed September 8, 2010). Also, Prison Activist, "LSD Tests Kingston Prison for Women 60's" Ottawa Citizen (28 February 1998), online: Prison Activist Organization <http://prisonactivist.org/pipermail/prisonact-list/1998-March/001335.html> (accessed September 8, 2010).

²⁰⁶Bronwyn Chester, *Report on LSD raises hackles*, McGill Reporter, Nov. 5, 1998.

²⁰⁷Office of the Correctional Investigator, online: <http://www.oci-bec.gc.ca/rpt/annrpt/annrpt20052006info-eng.aspx> (accessed August 26, 2010).

treatment of Aboriginal people by the government and the criminal justice system, it is likely that a large number of the prisoners who were subjected to the LSD and ECT experiments were Aboriginal.

These historical inhumane policies, laws, and practices have had devastating effects on Aboriginal women that continue today. And they contribute to the poor levels of health that is evident in Aboriginal populations.

5.2.4 Murdered and Missing

In October 2004, Amnesty International released the *Stolen Sisters Report (Report)*.²⁰⁸ This report was commissioned partly in response to the fact that, according to estimates by the Native Women's Association of Canada (NWAC), over five hundred Aboriginal women have been murdered or gone missing over the past twenty years.

The *Report* highlights a 1996 Canadian government statistic that Aboriginal women with status under the *Indian Act* between the ages of 25 and 44 are five times more likely than all other women of the same age to die as the result of violence.²⁰⁹ Decades of government policies have been a major factor in negatively affecting generations of Aboriginal women and children. Social strife, years of uprooting of women and children involuntarily, and lack of economic and educational opportunities in many Aboriginal communities: these and other factors have contributed to a steady growth in the number of Aboriginal people living in towns and cities. Urban life exposes Aboriginal people to stresses and dangers that they did not face in their home communities. It also cuts them off from the traditional supports of kinship, culture, ways of life, and community.

The *Report* concludes that the historical legacy has contributed to a heightened risk of violence for Aboriginal women. Many face desperate personal and economic circumstances. The dangers to them are compounded by sexist stereotypes and racist attitudes towards Aboriginal

²⁰⁸ Amnesty International, "Stolen Sisters Discrimination and Violence Against Indigenous Women in Canada - A Summary of Amnesty International's Concerns" (4 October 2004), online: Amnesty International <http://web.amnesty.org/library/Index/ENGAMR200012004> (accessed September 8, 2010) [Stolen Sisters].

²⁰⁹ Canada, Indian and Northern Affairs, "Aboriginal Women: A Demographic, Social and Economic Profile," online : Health Canada, http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/aborauto_e.html (accessed September 8, 2010).

women and girls as well as by a general apathy and indifference to their welfare and safety. Men have exploited the vulnerability of Aboriginal women and carried out acts of extreme brutality against them.²¹⁰

In spite of the large number of Aboriginal women who have been murdered or gone missing, their fate has not been adequately addressed by Canadian authorities, including the RCMP, police, and the public.²¹¹ Instead of vigorously protecting Aboriginal people, across the country, Canadian authorities have vigorously arrested and criminally prosecuted Aboriginal people in numbers that far outweigh the size of the Aboriginal population. In 2001, the Manitoba Aboriginal Justice Implementation Commission suggested that many police have come to view Aboriginal people not as a community deserving protection, but as a community from whom the rest of society must be protected.²¹² This attitude echoes the earlier view that non-Aboriginal people needed protection from Aboriginal diseases and epidemics, even though non-Aboriginal people brought the diseases.

In 1996, 408,140 women self-identified as Aboriginal.²¹³ The *Report* confirms that 500 First Nations women went missing between 1995 and 2005. If Canadian women in general had disappeared at this rate, 17,501 would have gone missing during the same period—a population

²¹⁰ Stolen Sisters, *supra* note 208. See also, *R. v. Kummerfield*, [1997] S.J. No. 149; *R. v. Edmondson*, [2005] Sask. D. Crim. 270.90.65.00-03; [2005] Sask. D. Crim. 250.90.65.00-03; [2005] Sask. D. Crim. 260.80.25.00-01; [2005] Sask. D. Crim. 260.30.32.80-01. See also *R. v. Pickton*, [2002] B.C.J. No. 2830.

²¹¹ In conducting its research, Amnesty International interviewed a number of police officers, the majority of whom stated that they handle all cases the same and do not treat anyone differently because they are Aboriginal. These statements, however, can be contrasted to the accounts of families. Many families reported that police did little when they reported a sister or daughter missing. Police response was that the majority of people who are reported missing have voluntarily “gone missing,” that many choose to run away or have chosen to break off ties with their families. Regardless of the circumstances, this does not justify incidents where, despite the serious concern of family members that a missing sister or daughter was in serious danger, police failed to take basic steps such as promptly interviewing family and friends or appealing to the public for information. (Stolen Sisters, *supra* note 213) Muriel Venne, founder of the Institute for the Advancement of Aboriginal Women, noted that hundreds of Aboriginal women have been killed or have gone missing across the country – yet it has been largely met with indifference.” (Edmonton Sun, “Wake-up Needed-Says Advocate” (21 November 2005), online: Edmonton Sun, <http://www.edmontonsun.com/News/Edmonton/2005/11/21/1316363-sun.html> (accessed April 10 2009).

²¹² Paul Chartrand & Wendy Whitecloud, “The Aboriginal Justice Implementation Commission Final Report” Reports (29 June 2001), online: Reports http://www.ajic.mb.ca/reports/final_toc.html (accessed September 8, 2010).

²¹³ Statistics Canada, “Population By Aboriginal Groups and Sex, Showing Age Groups for Canada, 1996 Census- 20% Sample data” (18 December 2001) online: Statistics Canada <http://www.statcan.ca/english/census96/jan13/can.htm> (accessed September 8, 2010). The statistics were only collected for status Indians and have not been recorded for non-status Indian, Métis and Inuit women who have “disappeared.” Considering this fact, the statistics will likely be much higher.

equal to a small city. If non-Aboriginal people had suffered a loss of this magnitude—about 875 women per year—the crimes would have triggered a massive response from the public, from police, and from all levels of government.²¹⁴ The societal depravity demonstrated by non-Aboriginal indifference to these clearly race-based crimes is difficult to comprehend.

In 2005, NWAC secured funding for the *Sisters in Spirit* initiative. This five-year research, education, and policy program looked at the causes, circumstances, and trends of missing and murdered women. The conclusion was that violence caused their disappearance and/or death which is not surprising news.

On March 31, 2010, NWAC released its report on the latest figures: 582 Aboriginal women have gone missing or have been murdered since 1995. The report, entitled *What Their Stories Tell Us: Research Findings from the Sisters in Spirit Initiative*, raised three important research questions:

What are the circumstances, root causes and trends leading to violence against Aboriginal women in Canada? How many Aboriginal women and girls have gone missing or have been found murdered in Canada? And, why this violence has led to such disturbingly high numbers of missing and murdered Aboriginal women and girls in Canada without connection by police or justice authorities?²¹⁵

The report concluded that colonization has had a devastating intergenerational impact on Aboriginal women and girls, which heightens their vulnerability to the violence. NWAC's "Key Findings" are telling:

- There are a disproportionately high number of missing and murdered Aboriginal women and girls in Canada. Between 2000 and 2008, 153 cases of murder have been identified in NWAC's Sisters In Spirit database. These women represent approximately ten per cent of the total number of female homicides in Canada despite the fact that Aboriginal women make up only three per cent of the total female population in Canada. The majority of women and girls in NWAC's database were murdered, while 115 women and girls are still missing.

²¹⁴ Y.M. Boyer (2006), "First Nation, Métis and Inuit Women's Health – A Constitutional Analysis" Discussion Paper Series #4, National Aboriginal Health Organization and the Native Law Centre of Canada (March 2006).

²¹⁵ NWAC, "What Their Stories Tell Us Research findings from the Sisters In Spirit initiative", 2010, online: <http://www.nwac.ca/programs/sisters-spirit> (accessed September 8, 2010) [NWAC].

- The majority of disappearances and deaths of Aboriginal women and girls occurred in the western provinces of Canada. Over two thirds of the cases were in British Columbia, Alberta, Manitoba, and Saskatchewan.
- A great majority of the women were young. More than half of the women and girls were under the age of 31. Measures designed to increase safety must take into account the needs of young Aboriginal women and girls.
- Many of the women were mothers. Of the cases where this information is known, 88 per cent of missing and murdered women and girls left behind children and grandchildren. These children must have access to culturally appropriate supports to deal with this trauma.
- Aboriginal women and girls are as likely to be killed by an acquaintance or stranger as they are by an intimate partner. Aboriginal women and girls are more likely to be killed by a stranger than non-Aboriginal women.
- Nearly half of murder cases remain unsolved. Nationally, 53 per cent of murder cases have been cleared by charges of homicide, while no charges have been laid in forty per cent of cases. However, there are differences in clearance rates by province. The clearance rate for murdered women and girls ranges from a low 42 per cent in Alberta to 93 per cent in Nunavut.
- The majority of cases occurred in urban areas. 70 per cent of women and girls disappeared from an urban area, and 60 per cent were murdered in an urban area. But resources are also needed to respond to the needs of families in rural and on-reserve communities.
- In addition to the above key findings, NWAC research has found links between missing and murdered Aboriginal women and girls, to FASD (Fetal Alcohol Spectrum Disorder), hitchhiking, gangs, mobility, and jurisdictional issues. All of these emerging issues require further attention and inquiry. NWAC aims to conduct further research in these areas during the second phase of the SIS initiative as [NWAC] moves from knowledge to action.²¹⁶

Not only do Aboriginal women face a risk just by being born Aboriginal, but they are also subjected to incredible violence in their everyday lives. They are three times more likely than non-Aboriginal women to suffer violence, including serious forms of life-threatening violence and emotional abuse at the hands of a marital or common-law partner.²¹⁷ Those who are between 25 and 44 are 5 times more likely than other women in Canada of the same age to die of violence.²¹⁸ Over a five-year period, 24 per cent of Aboriginal women experienced spousal violence, compared to 8 per cent for their non-Aboriginal counterparts.²¹⁹ Aboriginal women are 8 times more likely to be killed by a spouse after a separation than non-Aboriginal

²¹⁶ NWAC, *ibid.*

²¹⁷ Victimization and offending among the Aboriginal population in Canada, Canadian Centre for Justice Statistics, 2004 General Social Survey (GSS).

²¹⁸ Stolen Sisters, *supra* note 208.

²¹⁹ Canada, Statistics Canada, *Women in Canada*, Fifth Edition, Statistics Canada, 2006

women.²²⁰

5.3 Summary

This section has used historic examples to illustrate the foundation upon which current health policies for Aboriginal peoples are built. A somewhat grim but realistic picture has emerged of how the government has used health services to control, harm, oppress, or exterminate Aboriginal people. Given this historical pattern, it is not surprising that health services to Aboriginal people continue to fall far short of supporting full and robust health or even strive to a status that is equal to non-Aboriginal Canadian health. Government policies dispersed health care to Aboriginal communities on an *ad hoc* basis according to the threat of contagion and the severity of diseases that might affect the non-Aboriginal population. In other words, health policies were geared toward protecting the good health of non-Aboriginal people. For Aboriginal people, government policies of abuse, negligence, or outright racial malevolence and criminality have had devastating effects for Aboriginal people and communities, especially Aboriginal women.

In addition to the health determinants noted earlier in this thesis, the provision of health services as well as the affects of legislation that may infringe on Aboriginal rights through a possible infringement on Aboriginal women's birthing practices may also be considered serious health determinants. Other key factors have been noted for their particularly harmful effects on Aboriginal people (especially on Aboriginal women). These additional factors include (but not limited to), residential schools, forced sterilization, drug and electro convulsive experiments and societal apathy for large numbers of murdered and missing Aboriginal women. These factors have caused erosions that have not only left a destructive legacy on the health and well-being of individuals, but on their families, and communities.

²²⁰ NWAC, *supra* note 215.

6. The Law is a Determinant of Health

The law plays a major role in shaping the social and structural factors that affect health. For example, public health policies enacted in the mid 19th century were designed to improve the public health of Canadians through legislation and regulations. For instance:

The law ... is used to influence norms for healthy behaviour, identify and respond to health threats, and set and enforce health and safety standards. The most important social debates about public health take place in legal fora -- legislatures, courts and administrative agencies -- and in the law's language of rights, duties and justice.¹

Public health lawyer Scott Burris states, “[l]egal scholars in public health ... have contended that human rights, laws and legal practices are powerfully linked to health.... Social epidemiology and health-oriented legal scholarship are complementary in their focus.”²

The law can also provide the proverbial teeth for enforcing public health standards and changing existing patterns that damage health. For instance, the Canada-wide tobacco controls rely extensively on statute law and the enforcement of those laws through the courts. The criminal law power found in subsection 91(27) of the *Constitution Act, 1867* has great influence on health outcomes. The federal government has jurisdiction over “[t]he Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters”³ (found in section 2.4.5). In other words, the federal government holds tremendous power over health issues, because it can decide what is criminally harmful and what is permissible and good for human health.

It may seem harsh to invoke criminal law power in matters of public health. However, where public health regulations are concerned, the criminal law power can be either extremely useful

¹ L.O. Gostin, *Public Health Law: Power, Duty, Restraint* (Berkeley: University of California Press, 2000) at 5.

² Burris S, Kawachi I and Sarat A “Integrating law and social epidemiology” (2002) 30 *Journal of Law Medicine and Ethics* 510.

³ *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c.3, reprinted in R.S.C. 1985, App. II, No. 5. The *British North America Act, 1867* (U.K.), 30 & 31 Vict., c.3 (*B.N.A. Act, 1867*) was the original name of the legislation that provided for the formation of the Dominion known as Canada. See s.92(16). [CA, 1867].

or extremely harmful. It is extremely useful when it prohibits the sale of poisoned or food that has been tampered with, advertising tobacco, and making false therapeutic claims for medicines. These are all important public health regulations that come under federal criminal law power.⁴ However, this same federal criminal law power wields a heavy hand when it comes to regulating the use of traditional medicine. In this as in many other instances, at times Canadian laws may work against Aboriginal people and unnecessarily criminalize actions that are positive and normal in an Aboriginal context.

This chapter will review how law and health are interconnected and intersect. It will consider the effects of law on the health of Aboriginal people. It will also explore how the law has a role in shaping, recognizing, and addressing the determinants of Aboriginal health. To address these issues, this chapter will focus on two streams. First, this chapter will consider how the constitutional division of powers and the ensuing conflicts over jurisdiction has created havoc with Aboriginal health. Associated laws and policies and the histories shed light on the present and can be instructive for creating a different and better legal framework for the future. Without question, Canada's legal framework and its history link directly to the current realities of ill health for Aboriginal people. Secondly, this chapter will review federal legislation designed to assimilate Aboriginal people into non-Aboriginal society and show that ill health among Aboriginal people has resulted. Canada adopted an aggressive, brutal, and sometimes violent campaign to colonize and assimilate Aboriginal people into western, Euro-based society. Laws and policies were created for this purpose. In matters of health, the priority has been to protect the non-Aboriginal population from the ill health of the Aboriginal population. Yet, it was the non-Aboriginal population who not only brought disease but also destroyed the pre-existing Aboriginal lifestyles and medicine practices that maintained good health over countless generations.

⁴ See, *RJR-MacDonald v. Canada (A.G.)*, [1995] 3 S.C.R. 199, 127 D.L.R. (4th) 1; *R. v. Wetmore*, [1983] 2 S.C.R. 284, 2 D.L.R. (4th) 577 [cited to S.C.R.].

6.1 Why is the Constitution a Determinant of Health?

Canadian Confederation officially occurred on July 1, 1867, when Canada as a united nation state was formed. Canadian constitutional governance was established, and powers were delineated between the federal and the provincial governments. At the time, the British Parliament omitted any mention of Canada's legislative power over health and health care. As a result, health does not expressly fall under the ambit of either the federal or the provincial governments. Former Supreme Court of Canada Justice Estey stated in *Schneider v. The Queen*:

Health is not a subject specifically dealt with in the Constitution Act either in 1867 or by way of subsequent amendment. It is by the Constitution not assigned either to the federal or provincial legislative authority.⁵

Because the Constitution is silent on health, the courts have defined (and continue to define) how governmental powers should be distributed to meet health needs and concerns. As Professor Claude Emanuelli notes, health is the subject of ongoing federal-provincial negotiations and is subject to “jurisdictional currents”:

Beginning with the adoption of the Constitutional Law of 1867, the evolution of Canadian constitutional law regarding health suffered the influence of different jurisprudential currents and of the political negotiations between the Federal Government and the provinces.⁶

⁵ *Schneider v. The Queen*, [1982] 2 S.C.R. 112 at 141.

⁶ Claude Emanuelli, “Canada” in Hernan L. Fuenzalida-Puelma/Susan Scholle Conner, eds., *The Right to Health in the Americas: A Comparative Constitutional Study* (Washington : Pan American Health Organization, 1989) 138 at 141. See, also, Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Canada - Final Report* (Ottawa: Canadian Government Publishing, 2002), online: Health Canada, <http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html> (accessed October 25, 2010) at Ch. 1 at 3 stated the reason for silence in the allocation of legislative power is that the concept of health care is a modern one to British society with assumptions and meanings that could not have been predicted by the Constitution:

A simple analogy to ‘health and health care’ would be ‘the environment,’ another contemporary concept foreign to 19th century thinking and, therefore, absent from the original constitutional division of powers.

Emanuelli explains that in 1867, health was considered a private or local matter. The state intervened in health issues only during emergencies, such as epidemics. Otherwise, health matters were considered regional or municipal concerns. The *Constitution Act, 1867* stated that navy hospitals and the power to quarantine vessels fell within the federal sphere of power. Jurisdiction over hospitals, asylums, institutions, and orphanages as well as "...all Matters of a purely local or private Nature..." fell within the provincial sphere.⁷

Although the Constitution's silence on matters of health and the provision of health care is problematic generally, it has been the cause of major concern for Aboriginal people. Without naming health specifically, several sections of the Constitution can nonetheless impact Aboriginal health.

Health and health care issues cut across federal, provincial, and territorial jurisdictions and permeate important constitutional law principles. Constitutional law prescribes how the federal and provincial governments exercise their powers (including any limitations) through the legislative, executive, and judicial function. A country's constitution has been described as reflecting the soul of the nation, because its job is to recognize and protect the nation's values.⁸ The term "Constitutionalism" is used to describe a form of government that is limited by laws. The term "rule of law" is used in the same manner.⁹

In 1998, in *Quebec Secession Reference*, the Supreme Court of Canada clarified the principle of constitutionalism and the rule of law and explained the similarities between these two concepts:

The constitutionalism principle bears considerable similarity to the rule of law, although they are not identical. The essence of constitutionalism in Canada is embodied in s. 52(1) of the Constitution Act, 1982, which provides that "[t]he Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect." **Simply put, the constitutionalism principle requires that all government action comply with the Constitution.**

⁷CA, 1867, *supra* note 3.

⁸ Cheffins & Tucker, *The Constitutional Process in Canada* (2d ed., 1976) at 4 cited in P.W. Hogg, *Constitutional Law of Canada*, 4th ed.(Scarborough: Carswell, 2002) at 1-1 [Hogg].

⁹ *Ibid* at 1-2.

The rule of law principle requires that all government action must comply with the law, including the Constitution. This Court has noted on several occasions that with the adoption of the Charter, the Canadian system of government was transformed to a significant extent from a system of Parliamentary supremacy to one of constitutional supremacy. The Constitution binds all governments, both federal and provincial, including the executive branch (*Operation Dismantle Inc. v. The Queen*, [1985] 1 S.C.R. 441, at p. 455). They may not transgress its provisions: indeed, their sole claim to exercise lawful authority rests in the powers allocated to them under the Constitution, and can come from no other source. (Emphasis mine.)¹⁰

The Court further explained that understanding the scope and importance of these two principles—the rule of law and constitutionalism—and their explicit hierarchy in the *Constitution Act, 1982*, places constitutional rights above and beyond the reach of legislative changes by simple majority rule or ordinary legislation. The Court provided three overlapping reasons for this:

- Constitutional supremacy provides an added safeguard for fundamental human rights and individual freedoms that might otherwise be susceptible to government interference.¹¹
- The Court stated that a constitution may seek to ensure that vulnerable minority groups are endowed with the institutions and rights necessary to maintain and promote their identities against the assimilative pressures of the majority.¹²
- A constitution provides for a division of political power that allocates power amongst different levels of government. These purposes would be defeated if a democratically elected level of government could usurp the powers of another government simply by exercising legislative power to allocate to itself unilaterally additional political power.¹³

The Court acknowledged that, although the text of the Constitution has a primary place in determining constitutional rules, its text is not exhaustive.¹⁴ Certain unwritten principles generate the internal structure of the Constitution. These implicit principles operate together with the text to create an interpretative framework for the Constitution. The Supreme Court stated that this interpretative framework “embraces the entire global system of rules and

¹⁰ *Re Reference by the Governor General in Council Concerning Certain Questions Relating to the Secession of Quebec*, [1998] 2 S.C.R. 217 at para. 32 (hereinafter *Quebec Secession Reference*) at para 72.

¹¹ *Ibid* at para 74.

¹² *Ibid* at para 74.

¹³ *Ibid*.

¹⁴ *Quebec Secession Reference*, *supra* note 10.

principles which govern the exercise of constitutional authority.”¹⁵ The Court further elaborated the importance of reading the whole of the Constitution and not simply sections or selected parts; to do otherwise would be misleading.¹⁶ The court stated:

A superficial reading of selected provisions of the written constitutional enactment, without more, may be misleading. It is necessary to make a more profound investigation of the underlying principles animating the whole of the Constitution, including the principles of federalism, democracy, constitutionalism and the rule of law, and respect for minorities.¹⁷

These unwritten principles reveal the meaning and unity of selected texts, which may differ from their apparent meaning if the texts were read in isolation or out of context. The Constitution’s unwritten principles inform the overall understanding of constitutionally protected rights and obligations,¹⁸ which include Aboriginal and treaty rights to health.

Although subject to the justification test found in *Sparrow*, the Courts have determined that governments cannot override Aboriginal or treaty rights under this framework of constitutional supremacy.¹⁹ This is important. From a health perspective, Aboriginal and treaty rights include health and health practices, and governments have no power or authority to override them, whether by action or inaction. Although it is possible to amend the constitution through a process of constitutional negotiation, the process must nonetheless ensure that these constitutionally defined Aboriginal and treaty rights remain respected and in force, no matter what changes may be introduced. In this way, the principle of democracy may function in harmony with constitutional supremacy.²⁰ The Supreme Court of Canada clearly explained the proper relationship of constitutional supremacy to the rule of law and all political and regulatory decisions:

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ *Ibid* at headnote.

¹⁸ *Ibid.*

¹⁹ *Ibid* at para. 74-76. The *Sparrow* Court held that only imperial statutes can extinguish Aboriginal rights and these rights cannot be altered or extinguished by federal policy or law and only imperial statutes can extinguish those rights. They however, may be infringed by federal law or policy as per the justification test that was developed in *Sparrow*. The Crown must prove that the infringing measures serve a "valid legislative objective"; that they are in keeping with the special trust relationship and responsibility of the government; the infringement has been minimal; whether fair compensation has been available in a context of expropriation, and whether the affected Aboriginal group has been consulted. See *Sparrow*, *infra* note 172.

²⁰ *Ibid.* at para. 77.

Constitutionalism facilitates—indeed, makes possible—a democratic political system by creating an orderly framework within which people may make political decisions. Viewed correctly, constitutionalism and the rule of law are not in conflict with democracy; rather, they are essential to it. Without that relationship, the political will upon which democratic decisions are taken would itself be undermined.²¹

The Court also emphasized another integral principle that protects treaty rights from ordinary politics: the “tradition of respect for minorities.” It stated:

Consistent with this long tradition of respect for minorities, which is at least as old as Canada itself, the framers of the Constitution Act, 1982 included in s. 35 explicit protection for existing aboriginal and treaty rights, and in s. 25, a non-derogation clause in favour of the rights of aboriginal peoples. The "promise" of s. 35, as it was termed in *R. v. Sparrow*, [1990] 1 S.C.R. 1075, at p. 1083, recognized not only the ancient occupation of land by aboriginal peoples, but their contribution to the building of Canada, and the special commitments made to them by successive governments. The protection of these rights, so recently and arduously achieved, whether looked at in their own right or as part of the larger concern with minorities, reflects an important underlying constitutional value.²²

The Court stresses that both the nation-to-nation relationship in s. 35 “on its own right” and “as part of the larger concern with minorities” protects treaty rights. Under the theory of constitutional interpretation, the Court has held that constitutional principles or text cannot be read or defined in isolation from the other constitutional principles or text, nor can any single principle or text trump or exclude the operation of any other. They are equal; one is not more important than the other.²³ These principles challenge law and policy makers not only to accept the existence of Aboriginal and treaty rights to health in Canada but also to honor these rights in how health care is delivered to Aboriginal peoples.

Legal scholar Brian Slattery underscores the importance of viewing the Constitution from a holistic or organic perspective. This perspective invites us to reconcile the original constitutional documents with the 1982 reforms that protect Aboriginal rights and treaty rights. As it stands today, the Constitution melds and merges the philosophy and legal developments

²¹ *Ibid.* at para. 78.

²² *Ibid.* at para. 82.

²³ *Ibid.* at para. 49-50.

that were put in place by the original *British North America Act* with current commitments to Aboriginal and treaty rights.²⁴ Constitutional law requires that we analyze all the social contexts, historical and contemporary, within which Constitutional principles operate. Slattery explains that, rather than relying on formal conceptions of the Constitution, constitutionalism rests on an “organic” understanding of a living constitutional experience. He writes that constitutionalism,

[I]s the product of slow and continuing growth, as molded in part by local Canadian influences and tradition ... [and] is grounded in ancient practices generated by interaction between aboriginal nations and British and French officials in eastern North America during the seventeenth and eighteenth century.²⁵

This perspective opens the door to recognizing Aboriginal peoples as federal actors and constituent peoples. An organic understanding of our Constitution leads to the conclusion that Aboriginal nations have been active participants in molding the Canadian federal state, whatever the written constitution might say or however the Constitution might be viewed.

Slattery explains that, after the 1982 amendments to the Constitution, the outdated views based on the Imperial Model of the Constitution were replaced by Constitutional common law, which recognizes the Doctrine of Aboriginal Rights. The Imperial Model had three main characteristics: it traced Aboriginal laws back to sources in Britain or France; it portrayed government authority as originating from a single source—the Crown; and it subscribed to the notion that law and government were products of legislation and derived their power and authority from the Crown’s power to demand obedience. In other words, Canada’s constitution was “(1) alien in origin; (2) monistic in structure; and (3) positive in nature.”²⁶ According to Slattery the two basic premises of the Imperial Model was North America was juridically empty when Europeans arrived and, further, even if Aboriginal nations had laws upon European arrival, they were lost when Europeans gained control. These concepts he argues, are

²⁴ The *British North America Act, 1867 supra* note 3.

²⁵ Brian Slattery, “The Organic Constitution: Aboriginal Peoples and the Evolution of Canada” (1996) 34 *Osgoode Hall L.J.* 101 at 108-09 [Organic].

²⁶ Organic, *ibid* at 106.

“wrong in principle and profoundly out of harmony with our history and traditions.”²⁷ In fact, Canada and Canada’s Constitution have been shaped by the Aboriginal nations who have lived here all along. These rich bodies of experience must be recognized when reforming our basic understandings of the Constitution.

In the view of John Ralston Saul, Canada has developed from a “Métis civilization,” not from British or French law, Greek democracy, or Judeo-Christian morality. He states that Canada sprang from, and was shaped by the Indigenous peoples who inhabited Canada before colonization. To think otherwise is to misunderstand reality:

So it is both curious and troubling that we cannot bring ourselves to talk about how profoundly our society has been shaped over four centuries in its non-monolithic, non-European manner by the First Nations. Our immigrant society was fragile, tiny and poor everywhere in Canada until well into the nineteenth century. This was true even of the concentrated older enclaves of francophone and anglophones in the Maritimes and the Canada, people who had long before stopped thinking of themselves as immigrants. In some areas it was still fragile late into the nineteenth, even into the twentieth century. In part because of this reality, the relationship between the First Nations and the immigrants varied from region to region. And so the new Canadians, even those who had been here for two or three centuries, were in different ways still dependant on the First Nations for their survival.²⁸

In 1982, Canada repatriated the Constitution and added several important clauses affirming specific rights of Aboriginal people. Since then, less emphasis has been put on the Imperial Model. As Slattery argues, this “new approach may be called the Organic Model because it emphasizes that the Constitution is the product of slow and continuing growth, as molded in part by local Canadian Influences and traditions.”²⁹ Saul’s theory supports Slattery’s organic model which is inclusive of the rich tapestry of Aboriginal society and the Aboriginal and treaty rights within.

²⁷ Organic, *ibid* at 107.

²⁸ John Raulston Saul, *A Fair Country: Telling Truths about Canada* (Penguin: Ottawa, 2008) at 6, 7.

²⁹ Organic, *supra* note 39 at 25.

The doctrine of Aboriginal rights originates from practices maintained by Aboriginal nations when the British and the French arrived during the seventeenth and eighteenth centuries. These practices crystallized into a distinctive body of common law. This common law was partially expressed by the *Royal Proclamation, 1763*, which dealt with land rights by limiting colonial expansion westward. The Proclamation was not the source but merely a voice affirming the actual inter-societal custom of the day.³⁰

Understanding the Constitutional division of powers is critical to understand the protections extended to Aboriginal and treaty rights (and among other rights - to health) by virtue of their place in the Constitution, it is important to understand Slattery's "Imperial Model." In the same context that powers were delineated between the federal and provincial powers in Canada – the same British Royal Prerogative power was delineated through the BNA to the Constitution of Canada through its constitutional documents. This then also is true for the 1982 Constitutional amendments when s. 35 of the *Constitution Act, 1982* was created that entrenches Aboriginal Peoples and Aboriginal and treaty rights.

It follows then that constitutional protection and the rule of law was extended to these same rights. Aboriginal rights are derived from Aboriginal knowledge and heritage and through this process have become an integral part of the Constitution of Canada.³¹ Battiste and Henderson note that the necessary relationship was forged between Aboriginal knowledge and heritage (Aboriginal rights) and the old prerogative regime that created and protects treaty rights.³² Aboriginal and treaty rights can therefore be seen to be comprised of and carry the same royal prerogative powers that are the substance of Slattery's Imperial Model. Although these are inherent rights that originate in North America by virtue of Aboriginal people as possessors of these rights, they actually include a hybrid mix of both organic and imperial models, holding the mix of Aboriginal nations forming and shaping the Constitution as well as possessing the royal prerogative power of the Imperial model that Saul alludes to and Slattery, Battiste and Henderson have described.

³⁰ Organic, *ibid* at 109.

³¹ Battiste, M. & Henderson, J.Y. *Protecting Indigenous Knowledge and Heritage: A Global Challenge*. Saskatoon: Purich, 2000 at 205.

³² *Ibid*.

For Aboriginal health, constitutional supremacy means that the constitutional reform of 1982 and the judicial interpretations that affirm Aboriginal and treaty rights must be upheld no matter what. No federal, local or provincial government can violate them or pass laws to diminish them (subject to the *Sparrow* justification test³³). Quite the opposite, law and policy makers must accept their existence and move forward on implementing Aboriginal and treaty rights in Canada. Among the Aboriginal and treaty rights to be protected and secured, Aboriginal rights to health are paramount. In essence, Aboriginal people have the same rights to good health as other Canadians; in addition to those rights they possess constitutionally protected Aboriginal and treaty rights to health.

6.1.1 Federal Powers Applicable to Aboriginal Health

For instance, the *Constitution Act, 1867*³⁴ assigns Parliament a number of “heads of power” to legislate in areas that affect the practice of Aboriginal health and healing. They include:

Peace, Order and Good Government

Parliament has a residual jurisdiction over “Peace, order and good government” under section 91. This section permits Parliament to legislate where there may be “gaps” in jurisdiction under the Constitution, or where there is a national emergency or national concern. In order for there to be a “national concern,” the matter must (a) have attained significant national importance, (b) be so single and distinct that giving jurisdiction to Parliament will be consistent with and not overly disturb the Federal-Provincial balance of power, and (c) be a matter which the provinces could not effectively regulate themselves. Examples of the exercise of this power include legislation regulating air and water pollution.³⁵ Parliament’s jurisdiction to regulate aspects of health products falls under two heads of power: first, criminal law and, second, peace, order and good government.

³³ See Chapter 7, *infra*.

³⁴ *CA, 1867*, *supra* note 3.

³⁵ *Re Canada Metal Co.* (1982), 144 D.L.R. (3d) 124 (Man.Q.B.) (upholding *Federal Clean Air Act*); *R. v. Crown Zellerbach*, [1988] 1 S.C.R. 401 (upholding *Federal Ocean Dumping Control Act*).

Criminal Law

Under section 91(27) of the Constitution, Parliament has exclusive jurisdiction over criminal law. In addition to the *Criminal Code*, various criminal statutes have been enacted to protect public health and safety, such as: *Controlled Drugs and Substances Act*,³⁶ *Food and Drugs Act*,³⁷ and the *Hazardous Products Act*.³⁸ The implementation of these statutes may affect the use of traditional medicines.

Public debt and property

Section 91(1A) of the Constitution gives Parliament the power to make laws in respect of federally owned property.³⁹ This is one of the heads of power relied upon for legislation such as the *Canada Wildlife Act*⁴⁰ and the *Canada National Parks Act*.⁴¹ These statutes may impact the Aboriginal and treaty right to hunt, gather and/or fish, which of course affects the quality of diet and nutrition of Aboriginal peoples.

Intellectual Property Rights

Sections 91(22) and (23) of the *Constitution Act, 1867*, give Parliament exclusive jurisdiction to legislate in the area of “patents of invention and discovery” and copyrights. These heads of power do not directly affect the practice of Aboriginal health and healing, but they may impact intellectual property rights associated with traditional Indigenous knowledge about health and medicine.

Spending

Perhaps the greatest means of influence that the federal government exercises in the area of health is through federal spending power.⁴² This power has its source in a number of sections of

³⁶*Controlled Drugs and Substances Act*, S.C. 1996, c. 19.

³⁷*Food and Drugs Act*, R.S.C. 1985, c. F-27.

³⁸*Hazardous Products Act*, R.S.C. 1985, c. H-3.

³⁹Professor Hogg notes that the existence of exclusive federal power does not exclude provincial laws from federal public property if the laws are otherwise competent to the province. Peter W. Hogg, *Constitutional Law of Canada*, 3ed. (Carswell, 1992) at 28.2 [Hogg].

⁴⁰*Canada Wildlife Act*; R.S.C. 1985, c.23.

⁴¹*Canada National Parks Act*, S.C. 2000, c.32.

⁴²See Martha Jackman, “The Constitutional Basis for Federal Regulation of Health” (1996), 5 Health L. Rev. No. 2, 3-10.

the *Constitution*.⁴³ By imposing conditions on federal contributions to the provinces through the *Canada Health Act*, the federal government can exercise considerable control in areas of health, which may otherwise fall exclusively under provincial jurisdiction.

Indians and Lands Reserved for the Indians

Under s. 91(24), Parliament has constitutional jurisdiction over “Indians and Lands Reserved for the Indians.” For the purpose of 91(24) and the determination of constitutional jurisdiction, Inuit are included within the term “Indians” in s.91(24).⁴⁴ Pursuant to s. 91(24) and as the operative arm of s. 91(24), Parliament enacted the *Indian Act*.⁴⁵ The *Indian Act* is the key federal statute enacted pursuant s. 91(24) of the *Constitution Act, 1867*, which authorizes the passage of laws regarding “Indians, and Lands reserved for the Indians” by the Parliament of Canada. The *Indian Act* since Confederation effectively regulates much of the daily life of First Nations.

The Constitution was repatriated in 1982, and at least three distinct categories of Aboriginal Peoples were recognized: Indian, Inuit, and Métis. Section 35 of the *Constitution Act, 1982*, states:

(2) In this Act, "aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada.

Although the *Constitution Act, 1982*, recognized the three Aboriginal groups equally, Chapter 1 also recognized that a vast cultural and linguistic diversity exists between and among them. They all, however, possess s. 35 Aboriginal rights. Some possess treaty rights as well. They all have common experiences resulting from how the federal and provincial governments have treated them historically and currently.

⁴³*CA, 1867, supra* note 3 at s. 91(1a), 92(3), 102, 106.

⁴⁴*Reference re Whether the Term “Indians” in s.91(24) of the B.N.A. Act 1867, includes Eskimo Inhabitants of Quebec*, [1939] S.C.R. 104.

⁴⁵Note that the *Indian Act* limits the definition of “Indian” for the purposes of the Act as Indians registered or entitled to be registered under the *Indian Act*, commonly referred to as ‘status Indians’ (*Indian Act*, R.S.C. 1985, c.I-5 at s.6).

Under section 91(24) of the *Constitution Act, 1867*, the federal government has constitutional authority and responsibility for “Indians, and Lands reserved for the Indians.” Judicial interpretation of the Constitution has determined that the Inuit are a federal responsibility.⁴⁶ The *Constitution Act, 1867*, determined that health matters outside of Indian jurisdiction in s. 91(24) may be found in several subsections of s. 92.

The provinces have primary responsibility for health care delivery for Métis and non-status Indians, which is no different from their responsibility to non-Aboriginal Canadians. Since the Yukon, Nunavut, and the Northwest Territories are under federal jurisdiction, each territory is responsible for delivering health care services to all of their respective residents, including non-Aboriginal peoples living within their jurisdictions. Within this general framework, jurisdictional problems, conflicts, and ambiguities of enormous proportions have arisen and have devastating effects on Aboriginal health.

6.1.2 Provincial Powers Applicable to Aboriginal Health

The *Constitution Act, 1867*, addressed health matters in general—outside of Indian jurisdiction—in s. 91(24) as well as in the following sections:

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

Health Institutions

Section 92(7) of the Constitution gives provincial legislatures the authority over the “establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions.” The provinces thus have exclusive authority over the regulation of hospitals and other health institutions.

Property and Civil Rights

Section 92(13) of the Constitution gives the provinces jurisdiction over “property and civil rights in the province.” This is the broadest head of power for the provincial legislatures. It gives the province the constitutional jurisdiction to, among other things,

⁴⁶ *Re: Eskimos*, [1939] 80 S.C.R. 104, [1939] 2 D.L.R. 417 [*Re: Eskimos*].

regulate medical and health care professionals, impose health and safety standards, and set requirements for valid consent to medical treatment requirements. This head of provincial power is most likely to have an impact upon traditional healers, who are often caught between various definitions of health care professionals, health information custodians, and even physicians.

Natural Resources

As part of their powers over property and civil rights in s. 92(13), the management and sale of public lands in s. 92(5), and their control of forestry resources in s. 92A, the provinces also have jurisdiction generally over natural resources in the province. This includes the jurisdiction to regulate the collection of certain flora and fauna in the province. Regulations are generally established through legislation and are aimed at protecting endangered species. These federal and provincial powers have a close connection to Aboriginal practitioners and the collection of medicines.

Local or Private Matters

Section 92(16) of the Constitution contains a residual power for the provinces to deal “generally with matters of a merely local or private nature in the province.” The Supreme Court of Canada has held that this head of power gives extensive authority over public health to the province.⁴⁷

Taxation and Spending

In addition to these powers, provinces also have jurisdiction over direct taxation and spending.⁴⁸ This authority gives the province the power to implement health insurance schemes as well as to fund (or not fund) health programs and health institutions, etc.

Although provincial laws can apply *ex proprio vigore* to Indians, section 88 of the *Indian Act* also notes the application of provincial laws:

⁴⁷*Schneider v. The Queen*, [1982] 2 S.C.R. 112.

⁴⁸*Constitution Act, 1867 supra* note 3 at s.92(2).

Subject to the terms of any treaty and any other Act of Parliament, all laws of general application from time to time in force in any province are applicable to and in respect of Indians in the province, except to the extent that those laws are inconsistent with this Act or the First Nations Fiscal and Statistical Management Act, or with any order, rule, regulation or law of a band made under those Acts, and except to the extent that those provincial laws make provision for any matter for which provision is made by or under those Acts.⁴⁹

Some provincial laws apply to Indians. However, the Constitution sets the parameters. Provincial legislation cannot apply to Indians if the laws directly overlap and impair the core of federal authority over “Indians, and Lands reserved for the Indians” as set out in s. 91(24) of the *Constitution Act, 1867*.

In relation to health matters, the *Indian Act* has the following references:

73. (1) Regulations The Governor in Council may make regulations
(f) prevent, mitigate and control the spread of diseases on reserves, whether or not the diseases are infectious or communicable;
(g) to provide medical treatment and health services for Indians;
(h) to provide compulsory hospitalization and treatment for infectious disease among Indians.⁵⁰

In s. 81:

The council of a band may make by-laws not inconsistent with this Act or with any regulations made by the Governor in Council or the Minister, for any or all of the following purposes, namely,
(a) to provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases;⁵¹

Also in s. 81, First Nations may control the geographic location for the practice of health and healing practitioners:

(g) and the dividing of the reserve ... into zones and the prohibition of the construction or maintenance of any class of buildings or the carrying on of any class of business, trade or calling in any such zone.”⁵²

⁴⁹ *Indian Act*, R.S., 1985, c. I-5, s. 88.

⁵⁰ *Indian Act*, *ibid* at s.73(1)(f)-(h).

⁵¹ *Ibid*, at s.81(1)(a).

⁵² *Ibid*, at s.81(1)(g).

The relationships between the federal and provincial governments are complex and multifaceted. These relationships form a core element of decision making within the government as well as all policy making that affects Aboriginal people. Provincial regulation has had a major impact on many areas of traditional Aboriginal practices, but none have been as severely impacted as traditional healers and practitioners.

6.1.3 Jurisdiction Conflicts

In January 2005, the Health Council of Canada explained that “[a]n accurate description of the actual health status of First Nations, Inuit and Métis cannot be presented yet...” They further explained that “there are clear indications that the health of the First Nations, Inuit and Métis” are well below the Canadian average and that this situation “is problematic and disturbing.”⁵³

The difficulties in obtaining accurate statistics are aggravated by the fact that federal and provincial/territorial governments are continuously bickering about their responsibilities to Aboriginal people. The First Nations and Inuit Health Branch (FNIHB) strives to maintain partnerships between stakeholders. Yet, even with good intentions, health care services for Aboriginal people are in a transitory state, which can lead to fragmentation and gaps in delivery. For example, a gap may arise because of a recently completed self-government agreement or a modern treaty. Unclear divisions of power and responsibilities between Aboriginal communities and Canada’s governments—federal, provincial, or territorial—may also cause gaps. Additional gaps occur for all residents living off-reserve, including First Nations, Métis, and Inuit. In these cases, the provinces and territories are directly responsible for providing health care and public health programs and services, yet they often fail to do so.

The gaps created by jurisdictional conflicts between the federal and provincial governments have had a severe impact on the health of Aboriginal people in Canada. They constitute a major determinant of ill health, disease, and death. For instance, provincial governments hold that the federal government is responsible for “Indians” under the *Indian Act*. Additionally, Aboriginal

⁵³ Health Council of Canada, *The Health Status of Canada's First Nations, Métis and Inuit Peoples: A background paper to accompany Health Care Renewal in Canada: Accelerating Change* (January 2005), online: <http://healthcouncilcanada.ca.c9.previewyoursite.com/docs/papers/2005/BkgrdHealthyCdnsENG.pdf> (accessed May 24, 2010) at 38.

people have significant concerns with the federal government as well because of its system of classifying Indians as having or lacking status.⁵⁴ The endless arguments between the federal and provincial/territorial governments over who has jurisdiction over whom has resulted in a complex and convoluted system of delivering—or not delivering—health care to First Nations and Inuit. It has also resulted in an assortment of provincial “hit or miss,” under-funded programs for the Métis and non-status Indian populations. The problems we see today have a historical basis in how the government has delineated between First Nations, Métis and Inuit.

i) Inuit

Although services are delivered to the Inuit through FNIHB, the Inuit have unique jurisdiction issues distinct from Indian or Métis peoples. Under section 91(24) of the *Constitution Act, 1867*, the federal government has constitutional authority and responsibility for “Indians, and Lands reserved for the Indians.” Judicial interpretation of the *Constitution* has determined that the Inuit are a federal responsibility. In 1912, for example, Quebec gained the northern territory that contained a large Inuit population. Quebec quickly categorized the Inuit as Indians under the *British North America Act, 1867* (now the *Constitution Act, 1867*) and therefore regarded them as a federal responsibility under subsection 91(24) of that Act. Law Professor Kent McNeil notes:

Confederation and the assignment to Parliament of legislative jurisdiction over "Indians, and Lands reserved for the Indians" did not alter the nature of the Crown's fiduciary obligations to Aboriginal peoples. Those obligations continued, but primary responsibility for meeting them now rested on the Canadian government.⁵⁵

But the federal government did not agree and regarded the Inuit as Quebec citizens. After much debate and confusion, the federal government assumed legal responsibility for the Inuit in 1924 through an amendment to the *Indian Act* that extended medical services to the Eastern Arctic.⁵⁶ When the legislation was originally drafted, it read:

⁵⁴J. Bartlett & R. Jock, *An Examination of Aboriginal Health Service Issues and Federal Aboriginal Health Policy* (A Presentation to the Standing Senate Committee on Social Affairs, Science and Technology, National Aboriginal Health Organization, May 30, 2001) [unpublished, on file at the National Aboriginal Health Organization] at 8.

⁵⁵K. McNeil, “Section 91(24) Powers, the Inherent Right of Self Government, and Canada’s Fiduciary Obligations” (Paper presented to the Canadian Aboriginal Law Conference, Vancouver: Pacific Business and Law Institute, December, 2002) [McNeil, “Section 91(24)”] at 12, 13.

⁵⁶*Indian Act*, S.C. 1906, c.81, s.1 am. S.C. 1924, c.47, s.1.

The Superintendent General of Indian Affairs shall have the control and management of the lands and property of the Eskimos in Canada and the provisions of Part I of the Indian Act shall apply to the said Eskimo in so far as they apply to their condition and mode of life, and the Department of Indian Affairs shall have the management, charge and direction of Eskimo affairs.⁵⁷

The opposition leader iterated, “That simply means that hereafter the Eskimos are to be considered wards of the Dominion with all the consequences of that relationship.”⁵⁸ After debate, the Minister clarified that, “In subsection 2 of section 1 we now simply say that the Superintendent General of Indian Affairs shall have charge of Eskimo affairs, and that he will grant such relief to the Eskimos as may be necessary from time to time.”⁵⁹ Diamond Jenness describes the incident as follows: “The bill was then amended so that it would in no way change their legal status.” He quotes several official internal memos in the 1920s and 1930s that reinforce this point.⁶⁰ Richard Diubaldo looked at this period in some detail and found that both the initial amendments and the later changes to those amendments were vague and confused. However, all were consistent with the intent of keeping the status of Inuit separate from that of Indians.⁶¹

In 1932, the *Indian Act* was amended to delete the Inuit provision.⁶² In the 1939 decision, *Re: Eskimos*,⁶³ the Supreme Court of Canada settled the issue and determined that the Inuit (at least in Quebec) were “Indians” under the *British North America Act, 1867*, therefore were a federal responsibility. Eskimos were included within the definition of Indian under Section 91(24) of the *BNA*. In spite of this ruling, Canada continued the debate whether or not the Inuit should be included under the *Indian Act* or if they should have an act of their own. Ultimately, no Inuit

⁵⁷ Canada. Parliament. House of Commons. *Debates*, 30 June 1924, pp. 3823-25 at 3824.

⁵⁸ Canada. Parliament. House of Commons. *Debates*, 30 June 1924, pp. 3823-25 at 3825.

⁵⁹ Canada. Parliament. House of Commons. *Debates*, 14 July 1924, at p. 4409.

⁶⁰ Diamond Jenness, *Eskimo Administration: II, Canada*, Arctic Institute of North America Technical Paper No. 14, Montreal: Arctic Institute of North America, 1964. 186 pp. at 32.

⁶¹ Richard Diubaldo, *The Government of Canada and the Inuit*. (Ottawa: Department of Indian Affairs and Northern Development, 1985) at 32-38.

⁶² *Indian Act*, S.C. 1932-33, c.42.

⁶³ *Re: Eskimos*, *supra* note 46.

Act was created, and the government department that managed northern affairs also managed Inuit affairs.⁶⁴

In 1945, the responsibility for Inuit health was transferred to the Department of National Health and Welfare. For the first time, the federal government “publicly recognized the Eskimos as citizens of the Dominion by distributing among them family allowances to which a bill enacted a few months before had entitled all Canadian citizens.”⁶⁵ The 1951 *Indian Act* was amended to specifically exclude the Inuit, even though Inuit affairs continued to be administered federally.⁶⁶ In 1966, the Department of Indian and Northern Development was created. Quebec then negotiated a funding formula with the federal government based on the “recognition of the exclusive federally legislative authority”⁶⁷ that administered to the Inuit. This arrangement remains in place today. Relying on *Re: Eskimos*, the Métis have argued that they should be included under subsection 91(24) of the *BNA Act* as well.⁶⁸

ii) Métis

By the end of the nineteenth century, most western Métis could be found living on the margins of both First Nation and Euro-Canadian societies. Many lived on lands adjacent to First Nation reserves. Others lived along road allowances on the outskirts of Euro-Canadian settlements and were considered squatters on provincial lands. Although most held strong ties of kinship with people on reserves, they were denied treaty and other benefits and services because of their ambiguous legal status. The more northern Métis settlements, like those in the south, were impoverished. Infectious diseases, particularly tuberculosis and syphilis, became rampant.

In 1932, the Government of Alberta set aside a modest land base for the Métis of the region. This region is now home to eight communities, known collectively as the Métis Settlements of

⁶⁴ Canada, Department of Indian and Northern Affairs, *Canada's Relationship with the Inuit: A History of Policy and Program Development*, Ottawa: Minister of Supply and Services Canada, 2006 at 6 [INAC].

⁶⁵ *Ibid.*, at 7.

⁶⁶ *Ibid.*

⁶⁷ Frank James Tester, Peter Kulchyski, *Tammarnit (Mistakes): Inuit Relocation in the Eastern Arctic 1939-63*, Vancouver: UBC Press, 1994 at 40.

⁶⁸ Clem Chartier, “‘Indian’: An Analysis of the Term as Used in s.91(24) of the BNA Act”, (1978-79) 43 Sask. L. Rev. 37.

Alberta.⁶⁹ In 1934, the Ewing Commission was created to examine the problems of health, education, and general welfare of the Métis population in Alberta. The Métis Association of Alberta produced evidence of widespread infectious diseases from six doctors and Indian agents in the Grouard area.⁷⁰ However,

The reliability of these testimonies was challenged by the Alberta government in the person of Harold Orr, a physician employed by the Alberta Department of Health. Earlier, Orr had alerted his minister to the political implications of increased health expenditures on the Métis.⁷¹

When the very concise Ewing Commission report was released, it reported that the Métis did, in fact, experience ill health:

- [M]any Métis lived far from any health professionals and lacked money both to cover travel costs to consult them and to pay for medical services rendered. Traveling doctors and nurses, who commonly visited “*Indian reserves*,” rarely came to these Métis communities;
- And ... poor sanitary conditions which characterized Métis homes and the lack of proper food (implying in fact that some Métis were, in effect, periodically starving).⁷²

The Commission stated that, as a result of the federal government scrip policy,⁷³ “large numbers of the Métis population are at this time, in this Province, destitute, and their health is jeopardized, their education neglected, and their welfare in the worst possible condition.”⁷⁴ Further, a Métis “is an outcast, and he is in far worse plight than the Indian, the Indian is far

⁶⁹Métis National Council, *Canada and the Métis*, Ottawa, October 1989; Yvonne Vezina, Supporting Métis Needs, Publication of Canadian Aboriginal AIDS Network, Ottawa, March 2005. See also: D.N. Sprague, *Canada and the Métis, 1869-1885*, Wilfrid Laurier University Press, Waterloo, 1988.

⁷⁰ The town of Grouard is seventeen kilometers east of High Prairie Alberta.

⁷¹ Raymond Obomsawin, *Historical and Scientific Perspectives on the Health of Canada’s First Peoples*, (2007), online:

<http://www.nativepeoples.com/article/attachments/First%20Peoples%20Health%20History%20Canada%20&%20Intl%20OV.pdf> (accessed April 29, 2010) [Obomsawin] at 20. See also, Larry Chartrand, *Maskikiwenow: The Métis Right to Health*, 2008, Prepared for the National Aboriginal Health Organization.

⁷² Obomsawin, *ibid*.

⁷³ The federal government created a scrip system for Métis by awarding a certificate redeemable for land or money of either 160 or 240 acres or dollars, depending on their circumstances. Scrip was intended to be used in Manitoba to “fulfill” the terms of the *Manitoba Act, 1870*. See also, [University of Saskatchewan Archives](http://scaa.sk.ca/ourlegacy/exhibit_scrip), “Our Legacy,” online: http://scaa.sk.ca/ourlegacy/exhibit_scrip (accessed April 21, 2011).

⁷⁴ Ewing, Justice (1935). *Evidence and Proceedings, Half-Breed Commission*. 25 February 1935. Edmonton, AB: Half-Breed Commission at 11.

better treated than the Half-breed.”⁷⁵ However, the report concluded that, while the health problems were serious, they were not any more serious than among the white settlers. The Commission advised against making the Métis wards of the state, as the Indians were, but the Commission recommended that parcels of land be set aside for the Métis where hospitals could be constructed and the services of a traveling physician could be provided. Métis colonies were established under the authority of the *Métis Population Betterment Act of 1938*.⁷⁶ Some of these recommendations were carried out, but it remains unclear to what extent the Métis were required to pay for the medical services.⁷⁷

The 1963 report, *The Métis in Alberta Society*, suggested that the Métis occupied a class position of poverty within the context of the larger Euro-Canadian structure. It further suggested that the solution to the disease problem lay in “extending civilization northward and increasing Métis participation in it.”⁷⁸ In other words, if the Métis were civilized like the Euro-Canadian settlers, they would enjoy a health status that was comparable to the Euro-Canadian settlers.⁷⁹ They just had to cease being Métis.

iii) “Jordan’s Principle”

Jordan River Anderson, a First Nations boy from Norway House Cree Nation in Northern Manitoba, was born on October 22, 1999 with a rare neuromuscular disorder. He had complex medical needs that could not be managed on reserve near his home. Jordan was referred for treatment to Winnipeg, where as his illness progressed and he became wheelchair-bound,

⁷⁵ Malcolm Norris, (1935), Evidence and Proceedings, Half-Breed Commission, 25 February 1935. Edmonton, AB: Half-Breed Commission at 17.

⁷⁶ Although, twelve colonies of the Métis Settlements were originally established, four of the colonies ceased to operate because the land was unsuitable for farming. Under the 1989 Alberta Métis Settlements Accord, and resulting 1990 legislation, the Settlements collectively acquired title to the Settlement areas and were established as corporate entities, similar to municipal corporations, with broad self-governing powers. Métis Settlements are comprised of eight distinct geographic areas in northern Alberta covering approximately 1.25 million acres with a total population of 6,500 in 1995. The Settlements are governed locally by elected 5-member councils and collectively by the Métis Settlements General Council. (Alberta, Department of Learning, “Aboriginal Studies Glossary” in *First Nations, Métis and Inuit Education Policy Framework* (Edmonton: Government of Alberta, 2004), online: <http://www.learning.gov.ab.ca/nativeed/nativepolicy/Glossary.asp> (accessed August 10, 2010)).

⁷⁷ Obomsawin, *supra* note 71.

⁷⁸ J. Waldram, D.A. Herring, T.K. Young, *Aboriginal Health in Canada. Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995) at 175-176.

⁷⁹ Y.M. Boyer (2004), “Aboriginal Health – The Crown’s Fiduciary Obligations” Discussion Paper Series #2, National Aboriginal Health Organization and the Native Law Centre of Canada (May 2004) at 13.

ventilator dependent, and unable to speak. He required a wide variety of medical services. Jordan was formally diagnosed with Carey-Fineman-Ziter syndrome.

By 2001, Jordan's medical team decided to discharge him to specialized foster home care near his home reserve where he could get the kind of health services that would substantially improve his quality of life. His medical team and his family agreed that this decision was best for Jordan, as he would have a nurturing environment in a loving home.

However, the federal government and Manitoba's provincial government could not agree on who was financially responsible for Jordan's care. Squabbles over who would pay for every mediocre detail, including who would be responsible for Jordan's showerhead, lasted for two years. Jordan died waiting for medical care. He was four years old.

Trudy Lavallee, Policy Analyst for Assembly of Manitoba Chiefs, authored a paper titled, "Honouring Jordan: Putting First Nations children first and funding fights second." She addressed the absurdity of the financial arguments to avoid payments between the bickering governments:

If the use of public funds in a responsible manner were at the centre of the storm of government disagreements, it was not evident because they paid the hospital twice the rate of what it would have cost to place him in a foster home.

If we are talking about accountability, governments would have been far more accountable to provide this child with a home than to allow him to languish in hospital until he died. I cannot imagine, as a mother and grandmother, what it must have been like for his parents to know that their son did not have access to a home in the final two years of his life.⁸⁰

The battle raged between Indian and Northern Affairs Canada and the First Nations and Inuit Health Branch, as well as inter-jurisdictionally between the federal government and the provinces. None of the parties in conflict had any hesitation about doling out much higher costs for institutional care instead of paying for family or community-based care, even to the detriment and death of the child. If Jordan had been living off reserve, the entire per diem cost

⁸⁰ Trudy L Lavallee, "Honouring Jordan: Putting First Nations children first and funding fights second," *Paediatric Child Health*. 2005 November; 10(9): 527–529, online: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2722633/> (accessed September 25, 2010).

would have been provided by the non-Aboriginal child welfare agency, with full reimbursement from the province ready at hand. The child's needs would have been met first, and Jordan would not have been thrown into a jurisdictional tug of war.

On April 3, 2007, the Assembly of Manitoba Chiefs released an article regarding thirty-seven disabled children at Norway House at risk of losing essential services because of the jurisdictional squabbling between the federal and provincial governments. The article entitled, *Disabled children lose services because governments won't pay*, stated the following:

A recent research report in Manitoba found that First Nations parents often place their children with disabilities in child welfare care, so they can be sure the children get access to the specialized services they so desperately need. Yet children whose parents want to keep them at home may suffer physical pain without those services.

Even today mothers and fathers are having to give up their children to the state in order to ensure that they receive adequate care because we fail to provide, as a federal government, adequate funding to ensure that these children get the care they need in their homes.⁸¹

Funding mechanisms for delivering health services to children in First Nation communities simply do not exist. The federal departments responsible for services and programs in these communities are Indian and Northern Affairs Canada and the First Nations and Inuit Health Branch. Both have claimed that the social or health costs are too high. The province will not provide services on reserve either, as it is not within their provincial jurisdiction.

From a legal perspective, Jordan was wronged on several levels:

- Canada is a party to the 1989 *United Nations Convention on the Rights of the Child*, which states:

⁸¹ The Assembly of Manitoba Chiefs, Nation Talk, *Disabled children lose services because governments won't pay* April 3, 2007, online: <http://www.nationtalk.ca/modules/news/article.php?storyid=1034> (accessed September 25, 2010). See also, Private members Bill, Jean Crowder, 39th Parliament, 1st Session Edited Hansard , Number 157 Friday, May 18, 2007.

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the *best interests* of the child shall be a primary consideration.⁸² (Emphasis mine.)

Jordan's best interests fell on deaf ears. Jurisdictional squabbling took precedence. Canada was clearly in breach of this treaty.

- The *Charter of Rights and Freedoms* forbids discrimination. The services that Jordan needed would have been provided for another boy in the same circumstance who was living off reserve. It appears Canada fell short of this non-discrimination requirement as well.
- The *Constitution Act, 1982*, recognizes and affirms Aboriginal and treaty rights. The governments, both federal and provincial, have fiduciary obligations to all Aboriginal people. This obligation obviously extends to Aboriginal children and, as Chapter 7 argues, in the health capacity. It would be ludicrous to claim that the governments fulfilled these obligations.

In honor of Jordan, the First Nations Child and Family Caring Society of Canada has asked the governments to immediately adopt a *child first* principle for resolving jurisdictional disputes that involve the care of First Nations children:

Under this principle, where a jurisdictional dispute arises between two government parties (provincial/territorial or federal) or between two departments or ministries of the same government, regarding payment for services for a Status Indian child which are otherwise available to other Canadian children, the government or ministry/department of first contact must pay for the services without delay or disruption. The paying government party can then refer the matter to jurisdictional dispute mechanisms. In this way, the needs of the child get met first while still allowing for the jurisdictional dispute to be resolved.⁸³

⁸²United Nations, United Nations Convention on the Rights of the Child, online: www.ohchr.org/english/law/pdf/crc.pdf (accessed July 9, 2007).

⁸³ First Nations Child and Family Caring Society of Canada, *Joint Declaration of support for Jordan's principle to resolving Jurisdictional Disputes Affecting Services to First Nations children*, 2010, online: <http://www.fncfcs.com/jordans-principle/index.php> (accessed September 25, 2010) [FNCFSC].

In 2009, Jordan's Child First Principle⁸⁴ gained 2773 supporters, including the Canadian Medical Association Journal (CMAJ). In fact, they advocate legal action against the government:

Consistent with the Convention on the Rights of the Child, we endorse putting the medical needs of First Nations' children first. We also make this recommendation: that if the provincial, territorial and federal governments ignore Jordan's Principle and entangle themselves in financial or jurisdictional battles first, then governments deserve to be sued, in the most winnable test case that First Nations' advocates can manage. Let the courts decide, if the bureaucrats and politicians continue to refuse to find a timely resolution.⁸⁵

On February 26, 2007, the Assembly of First Nations and the First Nations Child and Family Caring Society of Canada filed a Canadian human rights complaint about the lack of funding for home and community health care for First Nations children. At the time, more than 27,000 First Nations children were in institutional care. Three times more children had been removed from their families than at the height of the residential schools system. Between 1995 and 2001, the number of registered Indian children entering care rose by 71.5 per cent nationally. The situation is particularly dire in British Columbia, where over 50 per cent of the children in permanent institutional care are Aboriginal. In Saskatchewan and Manitoba, the situation is even worse: 80 per cent of the children in institutional care are Aboriginal.⁸⁶

As the screening body for complaints, the Canadian Human Rights Commission sent the complaint to the Canadian Human Rights Tribunal, where it has met with various stalling, avoidance, and wrangling techniques by the federal government. On June 2 and 3rd, 2010, the Canadian Human Rights Tribunal heard Canada's motion to dismiss the First Nations child welfare tribunal on the grounds that the *Canadian Human Rights Act (CHRA)* does not give the Tribunal jurisdiction to hear the case. The Crown argued that the CHRA only covers discrimination in cases of services, accommodations, or goods. The Crown argued that its funding program for First Nations child and family services is not a service. Therefore, Canada

⁸⁴ FNCFSC, *ibid.*

⁸⁵ Noni MacDonald & Amir Attaran, "Jordan's Principle, governments' paralysis", CMAJ, August 14, 2007; 177 (4), online: <http://www.cmaj.ca/cgi/content/full/177/4/321>.

⁸⁶ Trocmé, N., Knoke, D., & Blackstock, C. (2004). Pathways to overrepresentation of Aboriginal children in Canada's child welfare system. *Social Services Review*, 78(4), 577–601. See also, First Nations Child and Family Caring Society of Canada, online: <http://www.fncaringociety.com/> (accessed October 25, 2010).

should not be held accountable for discrimination under the CHRA, no matter how inequitable its funding patterns have been.

Opposing Canada are the Assembly of First Nations, First Nations Child and Family Caring Society of Canada, the Chiefs of Ontario, Amnesty International Canada, and the Canadian Human Rights Commission.

The Tribunal rendered its ruling on Monday, March 14, 2011 and granted the motion of the Attorney General of Canada while dismissing the complaint of the Assembly of First Nations and First Nations Child and Family Caring Society of Canada against Indian and Northern Affairs Canada. The most significant finding was that the Act does not recognize a valid comparator grouping between two different service providers (Federal and Provincial) with two different service recipients therefore the complaint must be dismissed. The Canadian Human Rights Commission has filed a Notice of Application on April 5, 2011 with the Federal Court of Canada, seeking judicial review.

6.1.4 Does Aboriginal Health Have Charter Protections?

The *Canadian Charter of Rights and Freedoms* is Part 1 of the *Constitution Act, 1982*. Sections 1 to 34 outline the rights and freedoms that **individual** Canadians possess. These include:

- the right to vote (s. 3);
- the right to life, liberty and security of the person (s. 7);
- equality rights (s. 15);
- legal rights of persons accused of crimes (s. 10);
- language rights (s. 16); and,
- the protection of multicultural heritages (s. 27).

The *Charter* outlines other freedoms (s. 2) as well, including the freedom of conscience; the freedom of religion (s. 2(a)); the freedom of thought, belief, and opinion; the freedom of expression, including the freedom of the press (s. 2(b)); the freedom of peaceful assembly (s. 2(c)); and the freedom of association (s. 2(d)).

Section 25 is the anti-“abrogation and derogation” clause. It is critical to Section 35 of the *Constitution Act, 1982*, and must be read jointly with the Act.

25. The guarantee in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada including
a) any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and
b) any rights or freedoms that now exist by way of land claims agreements or may be so acquired.

Aboriginal people in Canada not only possess section 35 rights individually and collectively, but they also possess the individual-based rights identified in the *Charter*. Moreover, the equality provisions in section 15 of the *Charter* do not invalidate Aboriginal or treaty rights. Professor Peter Hogg explains the advantages that s.35 rights possess by virtue of being situated outside of the *Charter* rights. For instance, s.35 is not subject to s.1 of the *Charter*,⁸⁷ which allows lawmakers to impose “such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.” Section 35 Aboriginal and treaty rights are not subject to legislative override through s.33 either, nor are the rights effective only against government action through s.32. Section 25 further provides that the *Charter* must not “derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada.”⁸⁸ For Aboriginal health this means that Aboriginal people not only possess the Aboriginal and treaty rights to health through the *Constitution Act, 1982*, but also the individual rights in the *Charter*.

i) Equality, s. 15

In 1985, when the *Charter* came into effect, the conception of equality articulated through the equality provisions in section 15 was that the law accords substantive equality to all members of a group. Yet, putting into place the concepts of equality and nondiscrimination that underlie section 15 of the *Charter* has involved a development: How is equality put into practice? A true commitment to equality must take into account the effects of a law on those affected by a distinction. The Supreme Court of Canada has repeatedly upheld principles of substantive

⁸⁷ The Court in *Sparrow* noted the existence of the implicit justificatory clause in section 35. See *infra* Chapter 7.

⁸⁸ Hogg, *supra* note 8 at 27–35.

equality (equality of result), not just formal equality (equality of treatment). The notion of formal equality (equal treatment) was firmly rejected.⁸⁹

This is important. It affirms that equality should not be assessed by Eurocentric or western legal tradition understandings of “balance” as an adequate measure of “equality.” Aboriginal thought or law is not ordered around Eurocentric values or perceptions of what is “balanced” or “equal.” Rather, for Aboriginal people, balance is understood as respecting the laws and relationships that order Aboriginal society (and laws) and the ecological order of the universe. To deny equality of result is to perpetrate the discrimination of colonialism—the *Indian Act* and all the laws, legislation, and policies that have created and fostered a society of Aboriginal ill health.

Yet, even with the Supreme Court’s mandate to achieve equality of result, the path to equality remains open to contest. For example, the Supreme Court held that it was unconstitutional not to give people who are deaf and hard of hearing sign language interpretation when they went to the hospital. Otherwise, they would be less able to access the care available to everyone. However, in *Auton*,⁹⁰ the Court also held that autistic children and their parents cannot use the *Charter* to argue that the children should have Intensive Behavioural Intervention (IBI) treatment through the health system. This would allow them to claim new services, rather than simply assure them equal access to existing services. Both of these cases were decided under section 15.

Under section 15, it may be argued that Aboriginal people living on reserve are being denied the equal benefit of the law because they do not have health treatment and benefits equal to the health services provided under provincial law to those Aboriginal and non-Aboriginal people living off reserve. In *Corbiere*,⁹¹ the Court decided that off-reserve Indian status was an

⁸⁹ *Benoit v. Canada*, [2002] 2 C.N.L.R. 1 at para. 366. *Lovelace v. Canada*, [2000] 1 S.C.R. 950, [2000] 4 C.N.L.R. 145 at para 60. See also *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203, [1999] 3 C.N.L.R. 19 at para. 94 [*Corbiere*].

⁹⁰ *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, 2004 SCC 78.

⁹¹ *Corbiere*, *supra* note 89.

analogous ground for arguing the case under section 15, so on-reserve status might qualify as a ground of distinction—and hence inequitable results. The First Nation Family Caring Society case at the Canadian Human Rights Tribunal provides support for arguing that the differences in services are dramatic to those living on and off reserves. Arguments based on s.15 seeking equality of result are valid and compelling. They address the de facto, everyday realities that Aboriginal people face coming from a long history of discrimination.

S.15 may also be used to make pointed arguments targeting particular health scourges, such as diabetes and cardiovascular disease, that Aboriginal people living on reserve face. In many (if not most cases) Aboriginal people do not receive the same quality of health care or access to health resources as non-Aboriginal people with the same conditions. Again, s.15 can be used to address this disparity.

ii) Life, Liberty and Security, s. 7

Section 7 protects the life, liberty, and security of the person and the right not to be deprived thereof except in accordance with fundamental justice. The Supreme Court is clear on the principles it has articulated in that laws, legislation and policies must be created to safeguard individual's liberty, security and fundamental justice.⁹² Based on s. 7, an argument could be made that the government not only failed to honor its treaty obligations to provide health care without adequate consultations with Aboriginal peoples, but also a violation of s. 7 rights (life, security, liberty and fundamental justice). In the Aboriginal context, consultation and accommodation are among the principles of fundamental justice. This argument would certainly hold for nations whose treaty with Canada includes the provision of health benefits. However, since failure to provide health care can result in the loss of life itself, the government's failure to provide quality health care to all Aboriginal people can arguably

⁹² In *Chaoulli* the Supreme Court evaluated the government's role in developing social policy that infringe *Charter* rights and noted that the courts are the "last line of defence" when governments make promises and do not take action but rather "focus the debate on a sociopolitical philosophy" (at para. 89) and also stated that "[i]nertia (by the government) cannot be used as an argument to justify deference" (at para. 97) (*Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791).

constitute an extreme breach of s. 7. The statistics of high rates of disease, shortened life spans, and high infant mortality among Aboriginal people clearly demonstrate this breach.

6.2 Legislation

6.2.1 *The Indian Act*

This section deals with two aspects of the *Indian Act*: how it affected traditional healing practices; and how it caused discrimination and the devastating effects it had on the health and well being of Aboriginal women and families.

i) Healing Practices

Chapter 4 details Aboriginal healing practices that maintained good health for generations. However, Canadian legislation severely limited the use of these practices and, in some cases, criminalized them. Aboriginal healing practices were labeled “witchcraft and idolatry.” They were ridiculed, denounced, prohibited, suppressed, and invalidated.⁹³ Western-based health care practices took over and suppressed Aboriginal healing practices.⁹⁴ The *Report of Royal Commission on Aboriginal People* describes how this dominance began and then took form in legislation prohibiting Aboriginal health practices:

Traditional healing methods were decried as witchcraft and idolatry by Christian missionaries and ridiculed by most others. Ceremonial activity was banned in an effort to turn hunters and trappers into agricultural labourers with a commitment to wage work. Eventually, the Indian Act prohibited those ceremonies that had survived most defiantly, the potlatch and the sundance. Many elders and healers were prosecuted.⁹⁵

The Potlatch ceremony of coastal British Columbia Aboriginal peoples was forbidden. The 1884 *Indian Act* provision reads as follows:

3. Every Indian or other person who engages in or assists in celebrating the Indian festival known as the “Potlatch” or in the Indian dance known as the “Tamanawas” is guilty of a misdemeanor, and shall be liable to imprisonment

⁹³ Canada, *Report of the Royal Commission on Aboriginal Peoples*, Volume 3, Chapter 3: Health and Healing (Ottawa: Minister of Supply and Services Canada, 1996) at 114.

⁹⁴ Eduardo Duran and Bonnie Duran, *Native American Postcolonial Psychology*, (Albany, NY: State University of New York Press, 1995) at 19.

⁹⁵ Canada, Royal Commission on Aboriginal People, *Report of the Royal Commission on Aboriginal Peoples: Gathering Strength* Vol. 3 Appendix 3A at 1(Ottawa: Supply and Services Canada, 1996) [RCAP].

for a term not more than six nor less than two months in any gaol or other place of confinement; and any Indian or other person who encourages, either directly or indirectly an Indian or Indians to get up such a festival or dance, or to celebrate the same, or who shall assist in the celebration of same is guilty of a like offence, and shall be liable to the same punishment.⁹⁶

The Sundance ceremony of the Plains peoples was also outlawed by the 1895 *Indian Act*:

Every Indian or other person who engages in, or assists in celebrating or encourages either directly or indirectly another to celebrate, any Indian festival, dance or other ceremony, goods or articles of any sort forms a part, or is a feature, whether such gift of money, goods or articles, takes place before, at, or after the celebration of the same, and every Indian or other person who engages or assists in any celebration or dance of which the wounding or mutilation of the dead or living body of any human being or animal forms a part or is a feature, is guilty of an indictable offence and is liable to imprisonment for a term not exceeding six months and not less than two months; but nothing in this section shall be construed to prevent the holding of any agricultural show or exhibition or the giving or prizes for exhibits thereat.⁹⁷

The 1914 *Indian Act* also prohibited Indians on reserve from dancing off reserve or from participating in

[A]ny show, exhibition, performance, stampede or pageant in aboriginal costume without the consent of the Superintendent general of Indian Affairs or his authorized Agent...⁹⁸

The RCAP Report states that many Elders and healers were prosecuted under this law.⁹⁹ As a result, Aboriginal peoples were stripped of “self-respect and respect for one another.”¹⁰⁰ These discriminatory laws left a legacy that damaged the essence of Aboriginal communities—the Elders, healers, families, and generations of Aboriginal people. Declining health has been one of the inevitable outcomes.

⁹⁶ *An Act further to Amend “The Indian Act 1880”*, Ch. 27. April 19, 1884.

⁹⁷ *An Act further to Amend The Indian Act*, Ch. 35. July 22, 1895.

⁹⁸ *An Act further to Amend The Indian Act*, Ch. 35, s. 8. June 12, 1914.

⁹⁹ RCAP, *supra* note 95 at 113.

¹⁰⁰ RCAP, *ibid.*

ii) Membership

*The rights and interests of Non-Status Indians are the same as their status Indian brothers. They have the same ancestors, history, cultures and traditions. Instead of seeing ourselves as citizens of our Nations, we are labelled, divided and sorted by our gender, age, marital status, family status, race, birth/descent and blood quantum as if we were dogs trying to prove our pedigrees.*¹⁰¹

In 1857, *An Act to Encourage the Gradual Civilization of Indian Tribes in the Province and to amend the Laws respecting Indians*¹⁰² framed Indian enfranchisement¹⁰³ as an “honour” and tied it to the acquisition of private property.¹⁰⁴ Private land holdings were granted to Indians who were enfranchised as Canadians and abandoned their Indian status. This included relinquishing their right to live on reserve, to receive health services, and to exercise hunting benefits. An Indian who had good moral character, who was free of debts, who could read and write English, and who could pass a three-year probationary period would receive a life estate allotment of up to 50 acres. He or she thus became a “Canadian citizen.” Heirs could inherit interest in the life-estate allotment of Indian people in fee simple. These allotments, however, were taken from the reserve land base.¹⁰⁵

For women in particular, the effects of forced enfranchisement have been devastating. Federal legislation from 1869 to 1985 determined a person’s *Indian Act* status as well as band membership and determined who would or would not live on reserve. When a woman married a man from another band, she automatically transferred to her husband’s band. Additionally,

[A]fter 1876 and the passage of the Indian Act, Indian women were denied the right to vote in band elections or to participate in reserve land-surrender decisions, and, where their husbands died without leaving a will, they were

¹⁰¹ Non-status Indians, online: <http://nonstatusindian.blogspot.com/2010/05/bill-c-3-debates-of-may-25-2010.html> (accessed October 25, 2010).

¹⁰² *An Act to Encourage the Gradual Civilization of Indian Tribes in the Province and to amend the Laws respecting Indians*, S. Prov. C. 1857, c. 16.

¹⁰³ Black’s Law Dictionary, 7th ed., Bryan A. Garner ed. (St. Paul, Minn.: West Group, 1999) at 549 s.v. enfranchisement: “the granting of voting rights or other rights of citizenship to a class of persons.”

¹⁰⁴ CP, JLAC (11Vic, 24 June 1847), Report, sec III, pt. III, subsec. I: Title to Lands in Canada, INAC, J. Leslie & R. Maguire eds. “The Historical Development of the Indian Act”, 1978 at 18 [Leslie, Maguire] at 27, 28.

¹⁰⁵ J. Baxter & M. Trebilcock, “Formalizing” Land Tenure in First Nations: Evaluating the Case for Reserve Tenure Reform’ (2009) 7:2 Indigenous L.J. 45 at 72. From 1857 to 1876 only one Indian (Elias Hill, a Mohawk) applied and was granted enfranchisement under this regime. There was Indian opposition and backlash and Hill was given a cash settlement for much less than the value of the land. (J.S. Milloy, “The Era of Civilization – British Policy for the Indians of Canada, 1830 -1869” PhD Thesis, Oxford University, 1978 at 280).

required to be “of good moral character” in order to receive any of their husband’s property.¹⁰⁶

The federal government agent had the sole discretion to decide if an Aboriginal woman had “good moral character.”

Not only did the *Act* identify those who could live on reserves, it also defined an Indian as "a male Indian, the wife of a male Indian or the child of a male Indian." Indian women who married outside of their band were stripped of their status and could not pass it onto their children. Indian men who married gave their status and band membership to their wives, children, and grandchildren. These patrilineal lines of status still have a preference in the current *Indian Act*.

The *Report of the Royal Commission on Aboriginal Peoples in Canada* summarized the number of women who were “enfranchised” and removed from their home communities:

Between 1955 and 1975 (when forced enfranchisement of women stopped), 1,576 men became enfranchised (along with 1090 wives and children), while 8,537 women (as well as 1,974 of their children) were forcibly enfranchised and lost their status. From 1965 to 1975, only five percent of enfranchisements were voluntary; 96 per cent were involuntary and the great majority of these involved women.¹⁰⁷

Since the 1960s, Indian women have been in the public and fighting for fairness to secure equal rights in the Indian registration provisions. Jeanette Corbiere Lavell¹⁰⁸ and Yvonne Bedard challenged section 12(1)(b) of the *Indian Act* as a breach of the 1960 *Canadian Bill of Rights* (sex equality),¹⁰⁹ but they lost their case before the Supreme Court of Canada. The Supreme Court rationalized that equal discrimination against all Indian women amounted to equality

¹⁰⁶ RCAP, *supra* note 95 at vol. 4, ch. 2, section 3.

¹⁰⁷ RCAP, *supra* note 95 at vol. 4, ch. 2, Seven Generations, Record 19116 citing Kathleen Jamieson, *Indian Women and the Law: Citizens Minus* (Ottawa: Supply and Services, 1978).

¹⁰⁸ *A.G. Canada v. Lavell*, [1974] S.C.R. 1349; Kathleen Jamieson, “*Indian Women and Law in Canada: Citizens Minus*.” (Supply and Services Canada, 1978) at 30.

¹⁰⁹ *Canadian Bill of Rights*, S.C. 1960, c. 44, s. 1(b).

under the law. In 1981, Sandra Lovelace¹¹⁰ successfully challenged Canada on section 12(1)(b) for being in violation of the *International Covenant on Civil and Political Rights*.¹¹¹ The United Nations Human Rights Committee found that First Nations women and their children were deprived of the fundamental right to enjoy culture in their communities.

In 1985, an amendment was made to the *Indian Act* through Bill C-31.¹¹² Bill C-31 sustained the Indian status of those already recognized, but relegated and reinstated women who had lost status because of sex discrimination to another class of Indian and second-class status category. As a result of Bill C-31, Indians who never lost status can pass their status to their children and grandchildren, while Indians who have a second class (and diminished) status can pass their status down to their children, but not to their grandchildren.

Sharon McIvor has spent the last twenty-five years arguing that the *Indian Act* violates the equality guarantees in section 15 of the *Canadian Charter of Rights and Freedoms*.¹¹³ She challenged the continuing discrimination that gives preferred Indian status to men who married outside their band as well as to the descendants of male Indians. These provisions diminished the status of women who married outside of their band as well as of those descended from female Indians. Sharon McIvor was successful in arguing her case to the B.C. Supreme Court in 2007 as well as in the B.C. Court of Appeal in 2009. Both courts confirmed that the status provisions of the *Indian Act* violate the equality guarantees of the *Charter*.

Consequently, the federal government is in the process of amending the *Indian Act*, much like it did with Bill C-31—that is, unilaterally and without input from the people whose lives the Bill affects. On March 11, 2010, Bill C-3 *Gender Equity in Indian Registration Act* was introduced to remedy the sex discrimination in the status registration provisions of the *Indian Act*. On May 18, 2010, Sharon McIvor wrote to the House of Commons, stating:

¹¹⁰ *Lovelace v. Canada*, Communication No. R.6/24, U.N. Doc. Supp. No. 40 (A/36/40) (1981) (U.N. Human Rights Committee).

¹¹¹ Adopted December 16, 1966, entry into force March 23, 1976; G.A. Res. 2200A (XXI) (accession by Canada 19 May 1976) Can TS no. 47.

¹¹² *An Act to Amend the Indian Act*, S.C. 1985, c. 27, assented to 28th June, 1985, in effect April 17, 1985.

¹¹³ *Canadian Charter of Rights and Freedoms*, Pt.I of *Constitution Act, 1982*, being Schedule B to the Act, *Canada Act, 1982* (U.K.) 1982, c.11.

Like the 1985 legislation - Bill C-31, Bill C-3 will provide a remedy for some Aboriginal women and their descendants, but continue the discrimination against many more. Bill C-3 will still exclude: 1) grandchildren born prior to September 4, 1951 who are descendants of a status woman who married out; 2) descendants of Indian women who co-parented in common law unions with non-status men; and 3) the illegitimate female children of male Indians. These Aboriginal women and their descendants are only ineligible for registration as Indians because of the entrenched discrimination in the *Indian Act*, which has been fiercely held onto by Canada, despite years of protest and repeated, damning criticisms by United Nations treaty bodies.

Bill C-3 will not even confer equal registration status on those who will be newly eligible. The grandchildren of Indian women who married out will only receive section 6(2) status, and never section 6(1) status. So even those who will be newly entitled to status under Bill C-3 will be treated in a discriminatory way because their Aboriginal ancestor was a woman, not a man. The “second generation cut-off” will apply to the female line descendants a generation earlier than it does to their male line counterparts.¹¹⁴

Bill C-3 will not address all of the inequity in the *Indian Act* or solve all the discrimination problems that women and their families face. It will positively affect the lives of an estimated 45,000 women. On December 15, 2010 Bill C-3 *Gender Equity in Indian Registration Act* received Royal Assent and was proclaimed in force on January 31, 2011. INAC currently has a process in place to receive applications for women who lost their status.¹¹⁵

Laws, legislation, and policies—including how they are enacted and enforced—have a direct impact on the status of women in their communities and the *Indian Act* is a prime example. The aggregate of Canadian laws have contributed to perpetuating the inequality of Aboriginal women, which translates into inequities in the area of health care and health services as well. Harmful health consequences for women negatively affect not only their own personal experiences but also the lives of their children, family, and community members.

¹¹⁴ Sharon McIvor, Letter to Members of Parliament, May 18, 2010, Native Women’s Association of Canada, online: <http://www.nwac.ca/sites/default/files/imce/SharonMay182010MPletterfinal%20%282%29.pdf> (accessed October 25, 2010).

¹¹⁵ Canada, Indian and Northern Affairs, “Gender Equity in Indian Registration Act” May 5, 2010, online: <http://www.ainc-inac.gc.ca/br/is/vor-eng.asp> (accessed October 25, 2010).

iii) Other *Indian Act* Issues Affecting Health

a) Prostitution

Women's inequality in Canadian society was created and reinforced with laws that were enacted to "protect" women. For example, laws regulated prostitution, contraception, abortion, sexual assault, and obscenity. Laws also regulated medical practices and a wide range of health services.¹¹⁶ Some laws were enacted to protect everyone but the Aboriginal woman. For instance, by 1879, a series of provisions relating to prostitution were added to the *Indian Act*. These sections of the *Indian Act* underwent several revisions, each adding more force to the legislation to the detriment of Aboriginal women.

The *Indian Act* of 1879¹¹⁷ focused on punishing individuals who kept houses of prostitution. However, these sections were repealed and replaced in 1880 and again in 1884. The 1880 law prohibited the keeper of any house of prostitution from allowing on their premises any Indian woman who was believed to be a prostitute. The 1884 *Act* extended the prohibition placed on the "keepers of houses of prostitution" to prohibit any Indian woman or *man* from keeping, frequenting, or being found in a "disorderly house or wigwam."¹¹⁸ The law was changed again in 1887, so that keepers, residents, and visitors of houses of prostitution would be equally liable to a fine of \$100 or six months imprisonment. These new provisions were aimed at eliminating intra-racial prostitution only.

The *Indian Act* criminalized Aboriginal women for practicing prostitution and punished Aboriginal men for "pimping" and "purchasing" the services of prostitutes. By contrast, few attempts were made to punish non-Aboriginal men. In 1892, when the *Criminal Code of Canada* was enacted, the federal government removed all of the prostitution sections from the *Indian Act* and inserted them into the *Criminal Code*. Consequently, many Aboriginal women who were arrested for prostitution-related offences were banished from cities and towns and were forced back to their reserves—if, indeed, their communities accepted them back.

¹¹⁶ Sheilah L. Martin, "Legal Controls on Human Reproduction in Canada: A History of Gender biased Laws and the Promise of the Charter" (University of Toronto, 1991) at 375.

¹¹⁷ See National Archives of Canada, RG 10, Reel 10 193c, Volume 3816, File 57,045 for a collection of newspapers detailing prostitution involving Aboriginal women.

¹¹⁸ For a clear discussion of these developments see *The Historical Development of the Indian Act*, 2nd ed., (August 1978). Treaties and Historical Research Centre, P.R.E. Group, Indian and Northern Affairs, especially Chapter 5.

b) Education

The *Indian Act* has been harmful for Aboriginal women and their families in many other ways. For instance, children aged 7 to 16 were forced to attend residential school away from home. The parents were penalized if the child did not attend.¹¹⁹ After 1951¹²⁰ truancy may have resulted in branding an Aboriginal child as a juvenile delinquent, which attracted further punishment. From 1932 on, the RCMP were authorized to act as truant officers to enforce these requirements.¹²¹

c) Medical Doctors

In 1858, the medical profession began to organize a more sturdy resistance to unorthodox practitioners of all kinds. For example, the 1876 *Indian Act* mandated that any Indian who obtained the degree of Doctor of Medicine shall “ipso facto become and be enfranchised.” In other words, he or she would lose his or her Indian status: one could be Indian or be educated but one could not be both:

(1) Any Indian who may be admitted to the degree of Doctor of Medicine, or to any other degree by any University of Learning, or who may be admitted in any Province of the Dominion to practice law, either as an Advocate or as a Barrister, or Counsellor, or Solicitor, or Attorney, or to be a Notary Public, or who may enter Holy Orders, or who may be licensed by any denomination of Christians as a Minister of the Gospel, shall ipso facto become and be enfranchised under this Act.¹²²

This largely consisted in having legislation passed in each colony that regulated the activities of not only the medical profession but of other health occupations as well. As each succeeding piece of legislation passed, the various Acts were strengthened by amendments, until orthodox, allopathic, scientific medicine could lay claim to controlling much of the provision of health.

¹¹⁹ The requirement to attend school and the punishments for parents, as well as the system of truant officers, was placed in the *Indian Act* R.S.C. 1927, c. 98, s. 10.

¹²⁰ S.C. 1951, c. 29, s. 119.

¹²¹ S.C. 1932-33, c. 42, s. 1 enacting s. 10(6) of R.S.C. 1927, c. 98.

¹²² The *Indian Act*, 1876 S.C. 1876, c. 18.

The modern context of Canadian physicians is controlled by legislation and by formal and informal sanctions and institutions. It is a complex regulatory regime. For non-Aboriginal Canadians, issues of health and education are the constitutional responsibilities of each province and territory. Provincial and territorial legislation called the *Medical Acts* or *Medical Profession Acts* or *Medical Practitioner Act* creates the College of Physicians and Surgeons. These Acts delegate to the colleges the authority to prescribe the educational qualifications and licensing regime of practitioners. They define the "practice of medicine" as meaning "the carrying on for hire, gain, or hope of gain or reward, either directly or indirectly, of the healing art or any of its branches." Without restricting the definition of medical practice to a specific field, a person shall be deemed to be practising medicine within the meaning of the Acts who:

- (a) by advertisement, sign, or statement of any kind, written or oral, alleges or implies or states that he is, or holds himself out as being, qualified, able, or willing, to diagnose, prescribe for, prevent, or treat, any human disease, ailment, deformity, defect, or injury, or to perform any operation or surgery to remedy any human disease, ailment, deformity, defect, or injury, or to examine or advise upon the physical or mental condition of any person; or
- (b) diagnoses, or offers to diagnose, or attempts by any means whatsoever to diagnose, any human disease, ailment, deformity, defect, or injury, or who examines or advises upon, or offers to examine or advise upon, the physical or mental condition of any person; or
- (c) prescribes or administers any drugs, serum, medicine, or any substance or remedy, whether for the cure, treatment, or prevention, of any human disease, ailment, deformity, defect, or injury; or
- (d) prescribes or administers any treatment, or performs any operation or manipulation, or applies any apparatus or appliance, for the cure, treatment, or prevention, of any human disease, ailment, deformity, defect, or injury, or acts as a midwife.¹²³

These Acts also impose penalties on those who violate the standards of medical practice, such as practicing medicine without being licensed. The Acts delegate to the provincial elected or appointed college the responsibility of administering the Act's provisions to the licensed practitioners and establishing policy.¹²⁴ The college must maintain a register of all those who

¹²³ *Manitoba Act*, C.C.S.M. c. M90 An unauthorized practice is framed as "No person other than a licensed member or associate member or a medical corporation shall practise medicine in the province, and such a person shall not practise medicine in the province except as permitted by this Act and the person's licence."

¹²⁴ The definition of practice of medicine does not include or apply to the practice of dentistry or pharmacy, or to the vendors of dental or surgical instruments, apparatus, or appliances, or to a podiatrist acting within the scope of *The Podiatrists Act*; to a chiropractor acting within the scope of *The Chiropractic Act*; to a midwife acting within the scope of *The Midwifery Act*; to a naturopath acting within the scope of *The Naturopathic Act*; to a nurse acting

have met the basic requirement for the practice of medicine. They are also vested with the power to prescribe the curriculum of medical schools and professional orientation of their graduates. The justification for these delegated powers is that they protect the general public and the profession.

Aboriginal physicians have additional strenuous requirements to fulfill. The Indigenous Physicians Association of Canada (IPAC) is a collective of Aboriginal physicians:

It is our collective intent as Indigenous people diversely rooted in our ancestry (past and present) and our relationship with the natural world (our homelands) who have also had the privilege of medical training and accept the responsibility of working together to use our skills, abilities and experiences to improve the health (broadly defined) of our nations, communities, families and selves.¹²⁵

Clearly, the IPAC mandate involves blending traditional healing and western science, as expressed in their “Value Statement”:

Traditional knowledge, wisdom and practices – IPAC is committed to respectfully building internal development and external contributions to health improving approaches on strong foundations of traditional knowledge, wisdom and practices.¹²⁶

Legal prohibitions and the genocidal effects of the *Indian Act* regime have reduced the number of people who overtly practice Aboriginal medicine. This is yet another facet of the enormous damage that the *Indian Act* has done to Aboriginal women. The fact that far fewer Aboriginal people practice their own Aboriginal healing ways has had harmful if not devastating effects on personal health as well as on the health of children, families, and communities.

within the scope of *The Registered Nurses Act*, *The Registered Psychiatric Nurses Act* or *The Licensed Practical Nurses Act*; to an optician acting within the scope of *The Opticians Act*; to an optometrist acting within the scope of *The Optometry Act*; to a physiotherapist acting within the scope of *The Physiotherapists Act*; to a person registered under *The Psychologists Registration Act* acting within the scope of that Act.

¹²⁵Indigenous Physicians Association of Canada, 2010, online: <http://www.ipac-amic.org/mission.php> (accessed October 25, 2010).

¹²⁶*Ibid*, online: <http://www.ipac-amic.org/values.php> (accessed October 25, 2010).

6.2.2 The *Criminal Code of Canada*

Under subsection 91(27) of the *Constitution Act, 1867*, the federal government has jurisdiction over "[t]he Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters."¹²⁷ It may seem odd to rely on the criminal law power to support public health, but where public health regulations are concerned, the criminal law power can be useful. The public needs protection against such things as tainted food, advertising tobacco to minors, and false therapeutic claims for medicines.¹²⁸

However, Aboriginal healers could face serious problems in this area. Anyone who provides medical services to individuals in Canada could be exposed to some level of criminal liability for their actions. The legislation does not exempt Aboriginal traditional healers. In fact, because of the nature of Aboriginal traditional medicine—its unwritten traditions and the lack of visible internal or external regulation—traditional healers may find themselves vulnerable to criminal prosecution.

In addition to the liability outlined in existing legislation, such as the *Food and Drugs Act* and the Natural Health Products Regulations,¹²⁹ the Crown may use the following sections of the *Criminal Code* to prosecute traditional healers. Generally, prosecution occurs when one of their patients suffers injury during the course of treatment.

216. Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

217. Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.

219. (1) Every one is criminally negligent who
(a) in doing anything, or
(b) in omitting to do anything that it is his duty to do,
shows wanton or reckless disregard for the lives or safety of other persons.

¹²⁷ *CA, 1867, supra* note 3.

¹²⁸ See, *RJR-MacDonald v. Canada (A.G.)*, [1995] 3 S.C.R. 199, 127 D.L.R. (4th) 1; *R. v. Wetmore*, [1983] 2 S.C.R. 284, 2 D.L.R. (4th) 577 [cited to S.C.R.].

¹²⁹ Canada Gazette, (2003a), *Food and Drugs Act. Natural Health Products Regulations*. (Part II, 137(13). June 18). See also, Canada, Health Canada, Natural Health Products Directorate, 2010, online: <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/nhpd-dpsn/index-eng.php> (accessed October 25, 2010).

220. Every person who by criminal negligence causes death to another person is guilty of an indictable offence ...

221. Every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

245. Every one who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence and liable

(a) to imprisonment for a term not exceeding fourteen years, if he intends thereby to endanger the life of or to cause bodily harm to that person; or

(b) to imprisonment for a term not exceeding two years, if he intends thereby to aggrieve or annoy that person.¹³⁰

In addition to the *Criminal Code*, the *Controlled Drugs and Substances Act*¹³¹ regulates a number of substances that may include those used by traditional healers. The legislation makes it illegal for anyone other than provincially licensed medical practitioners to dispense controlled substances. Again, provincial governments do not have Constitutional jurisdiction to directly regulate Aboriginal traditional healers. Therefore, unless traditional healers also qualify as some other type of medical practitioner licensed provincially, traditional healers are not subject to or nor should they be required to comply with this statute.

The intersection of criminal law and Aboriginal practices raises the possibility that criminal charges could be laid against healers and/or communities. Charges that might arise include:

Criminal negligence: Everyone is criminally negligent who in doing anything or in omitting to do anything that it is his or her duty to do shows wanton or reckless disregard for the lives or safety of other persons (Criminal Code, s. 219(1)(a)-(b)).

Homicide: a person commits culpable homicide when he causes the death of a human being, by criminal negligence (Criminal Code, subpara. 222(5)(a)).

¹³⁰ *Criminal Code*, R.S.C. 1985, c. C-46.

¹³¹ *Controlled Drugs and Substances Act*, S.C. 1996, c-19.

Homicide: death from the treatment of an injury (Criminal Code, s. 225).

Murder: (where a person who causes the death of another human being means to cause their death or means to cause him or her bodily harm that he or she knows is likely to cause his death and is reckless whether death occurs or not), (Criminal Code, s. 229(a)(i)-(ii)).

Murder in the commission of offences – i.e., an “offender willfully stopping, by any means, the breath of a human being and [] death ensues therefrom” (Criminal Code, s. 230).

Accessory after the fact: everyone who is an accessory after the fact to murder is guilty of an indictable offence and liable to imprisonment for life. (Criminal Code, s. 240)

Bodily harm and acts and omissions causing danger to the person: every one who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence. (Criminal Code, s. 245)

Kidnapping: forcible confinement (Criminal Code, s. 279(2)).

Break and enter with intent, committing offence or breaking out: (Criminal Code, s. 348(1)).

Assault: The application of force intentionally to another person, directly or indirectly. Criminal Code s. 265 (1)

In addition to possible offences under the *Criminal Code of Canada*, Aboriginal healers may find themselves in conflict with various provisions of the *Controlled Drugs and Substances Act*,¹³² i.e., trafficking in substance (s. 5) and importing and exporting (s. 6)). The basis for this conflict is that the medicine(s) used in traditional and ceremonial practices may fall within a list(s) of controlled drugs or substances. Traditional healers have reason to be concerned. Among reported cases, Aboriginal people have, in fact, been charged under the *Criminal Code* for a variety of offences that arose in connection with their healing work.

¹³² *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 [Unofficial Chapter No. C-38.8].

Some of the criminal cases deal with consequences of denying Aboriginal healing. In the 1897 decision, *R. v. Machekequonabe*,¹³³ an Indian man killed another man because he believed his victim was a Wendigo.¹³⁴ The victim was actually Machekequonabe's foster father and the accused was mistaken. The accused was subsequently convicted of manslaughter. The case contains a brief discussion of a Wendigo. On appeal, the defence argued that:

J. K. Kerr, Q.C., for the prisoner. The evidence shews the Indian tribe were pagans, and believed in an evil spirit clothed in human form which they called a Wendigo, and which attacked, killed and ate human beings. The man that was shot was thought to be a Wendigo, a spirit as distinguished from a human being. It is true there was [28 OR Page311] a mistake, but there was no intention even to harm a human being much less to kill. The evidence shews the mistake was not unreasonable. At common law the following of a religious belief would be an excuse. The trial Judge wrongly directed the jury to find the prisoner guilty. There should be a new trial at least.¹³⁵

The court refused to entertain the thought that Machekequonabe had a mistaken belief and instead found sufficient evidence to convict him of manslaughter.

Conversely, nearly a hundred years later, in *R. v. Jacko*,¹³⁶ Mr. Jacko used a self-defence argument during his murder trial. Mr. Jacko successfully argued that he killed a man because the man was a bear walker and that he would have caused harm to Mr. Jacko. Mr. Jacko struck at least two blows to the victim's head with a walrus bone, which caused extensive damage to the left side of the skull behind the left ear. Mr. Jacko was small in stature with a diminutive

¹³³ *R. v. Machekequonabe* [1897] O.J. No. 98 (H.C. Just.) [*Machekequonabe*].

¹³⁴ Counsel for the accused in this case described a Wendigo as "an evil spirit clothed in human form" which "attacked, killed and ate human beings." (at para. 12) A Wendigo is also described as a spirit as distinguished from a human being." (at para. 12).

¹³⁵ *Machekequonabe*, *supra* note 133. O.J. No. 2472; 32 O.T.C. 271; [1998] 1 C.N.L.R. 164; 35 W.C.B. (2d) 188.

¹³⁵ *Ibid.*

¹³⁵ NAHO Briefing Note, "Information on Ecuadorian Healers facing criminal charges", Briefing #: 007/02, March 6, 2002. See also, Michael Erskine, Ecuadorian shaman speaks at Laurentian University, April 3, 2002 Manitoulin Expositor, online: <http://www.manitoulin.ca/Expositor/oldfiles/apr3.htm> (accessed October 25, 2010).

¹³⁵ NAHO Briefing Note, "Information on Ecuadorian Healers facing criminal charges", Briefing #: 007/02, March 6, 2002.

¹³⁵ *Ibid.*

¹³⁶ *R. v. Jacko*, [1997] O.J. No. 2472; [32 O.T.C. 271](#); [\[1998\] 1 C.N.L.R. 164](#); [35 W.C.B. \(2d\) 188](#).

disposition. The victim, on the other hand, was a large man and violent and likely the instigator of the fight that caused his death. Counsel offered the following evidence:

The first of the utterances made by the Accused at the Trudeau home were preceded 20 minutes earlier by a bellowing noise like bears fighting, a sound Ronald Roy had never heard from a human. They were followed by human voices cursing and yelling. One of the voices sounded like Tab's, according to Roy. The utterances made to Roy and other Native witnesses, included statements that "I am a warrior." "I got the Bearwalker." "I won the victory." "I cut my wrist by killing a Bearwalker - the bearwalker won't bother us anymore." The Native witnesses described the Accused as crying, dazed, looking like a cornered animal, emotional, and screaming as he uttered the words.

...

His description of himself as a warrior, who killed the Bearwalker, must be understood, not as an act of aggression but as an act of self defence, an act to protect others from an evil spirit.¹³⁷

The court allowed Mr. Jacko's claim of self-defense as defined in s. 34(2) of the Criminal Code. The court did not say—one way or the other—whether the accused was an unsuspecting victim of a Bearwalker. It did, though, allow the self-defense argument because the evidence was not clear and convincing of murder. The Crown could not prove, by a reasonable doubt standard, that Mr. Jacko struck the fatal blow with the intent to murder and not in self-defense under s. 34(2) of the Code.

The following Ecuadorian Healers Case is particularly interesting case for healers visiting from out of the country when something goes awry and the Criminal Code is invoked in accidental death. Two Ecuadorian healers, Juan and Edgar Uyunkar, were invited into Wikwemikong, Ontario territory, by the Naandwedidaa program of the Wikwemikong Health Services Department to perform healing ceremonies for community members.¹³⁸ Mrs. Jean (Jane) Maiangowi, a terminally ill woman, died during one of the healing ceremonies. Initial investigations into her death revealed that she had died due to natural causes. The Uyunkars were told they could return to Ecuador. One month later, after further investigations and

¹³⁷ *Ibid.*

¹³⁸ NAHO Briefing Note, "Information on Ecuadorian Healers facing criminal charges", Briefing #: 007/02, March 6, 2002. See also, Michael Erskine, Ecuadorian shaman speaks at Laurentian University, April 3, 2002 Manitoulin Expositor, online: <http://www.manitoulin.ca/Expositor/oldfiles/apr3.htm> (accessed October 25, 2010).

pressure from the elderly woman's family, the healers were charged with various criminal charges, including criminal negligence causing death, administering a noxious substance, and importing and trafficking in a controlled substance. The Crown alleged that the Uyunkars provided a mixture of water, nicotine, and harmaline known as natem to Mrs. Maiangowi. Mrs. Maiangowi's cause of death was the result of acute nicotine poisoning. Maria Ventura, the healers' interpreter, was also charged with administering a noxious substance and trafficking in a controlled substance.¹³⁹ The Uyunkars were released on bail but were forced to relinquish their passports and were unable to leave the Manitowaning area. They were ordered to report to the Ontario Provincial Police on a regular basis. As a bail condition, the healers were prohibited from possessing the medicines that they used in their healing ceremony.¹⁴⁰

At the trial of the healers and their interpreter, the healers pled guilty to two of the charges: administering a noxious substance and trafficking in a controlled substance. The remaining charges—criminal negligence causing death, importing a controlled substance into Canada, and possession of a controlled substance—were dropped in a negotiated plea. The interpreter, Maria Ventura of Manitowaning, had all charges against her dropped. Juan Uyunkar received a 12-month conditional sentence and a 12-month probation. He was required to serve 150 hours of community service, reside in the area of Wikwemikong, observe a curfew, and not leave Ontario. Edgar Uyunkar received a 12-month conditional sentence and one-day in jail, time served. He was also ordered to return to Ecuador within 14 days of the trial.¹⁴¹

While the Ecuadorian healers and their interpreter are Indigenous people from Ecuador, the Canadian criminal charges laid against them are illustrative of the fact that traditional practitioners are extremely vulnerable to criminal charges. Since it can be generalized that most traditional medicine people and healers have a helper to support them throughout the ceremony, the helper of a medicine person is also vulnerable. In the rare situation where death occurs and the medicine person is charged with murder, it follows that his/her helpers may face charges as

¹³⁹ NAHO Briefing Note, "Information on Ecuadorian Healers facing criminal charges", Briefing #: 007/02, March 6, 2002.

¹⁴⁰ *Ibid.*

¹⁴¹ NAHO Briefing Note, "Implications of Criminal Conviction of Traditional Healers", Briefing # 063/03, April 28, 2003.

accessories to murder. In the Ecuador healers case, the interpreter was charged. The Ecuadorian healers are not considered to fall within the scope of persons possessing existing Aboriginal and treaty rights and thus cannot avail themselves of the protection of section 35 of the *Constitution Act, 1982*. Despite this explanation – this reasoning is itself open to question in light of the global rights of the world’s Indigenous peoples and the application of International laws.

As the Uyunkar situation suggests, specific provisions of the *Criminal Code* may be particularly problematic for Aboriginal healers. In some instances, for example, traditional medicines may be deemed to be “noxious” substances.¹⁴² A person charged and convicted of this offence faces the possibility of a term of imprisonment not to exceed fourteen years. Although it is unlikely that Aboriginal healers will force their practices on others, the issue of forcible confinement may arise. The facts in the *Thomas v. Norris* case suggest that criminal charges for forcible confinement or assault may be laid.

The 1992 decision of the court in *Thomas v. Norris*¹⁴³ is illustrative of the clash of two worldviews. David Thomas was involuntarily removed from his home by a number of defendants, Daniel Norris, William Seymour, Ernie Rice, Leonard Peters, Alfred Joe, Frank Wilson and Robert Harry, for the purpose of being initiated i as a spirit dancer in a First Nation healing ceremony of the Coast Salish peoples. Typically, a member of the family will ask that a participant be initiated because they need to learn some type of “lesson.” David Thomas was creating difficulties for his family through his excessive alcohol consumption, so his future wife asked that he be initiated. This initiation was a common Coast Salish practice. Mr. Thomas was taken by the “spirit dancers” to participate in a sacred ceremony. The Spirit Dancing of the Coast Salish people was the traditional healing practice on trial in this case. Justice Hood described this ceremony as follows:

The initiation process is commenced by the initiate being “grabbed”, by his or her initiators, and taken to a Long House and there detained for a number of days, presumably the time it takes to complete the initiation. It is completed when the initiate has his or her vision experience, which is evidenced by the

¹⁴² Noxious is defined as “harmful to health; injurious” (*Blacks Law Dictionary*, 7th ed., (St. Paul Mn.: West Group, 1999) s.v. “noxious”).

¹⁴³ *Thomas v. Norris*, [1992] 2 C.N.L.R. 139 (B.C.S.C.) [*Thomas v. Norris*].

initiate dancing and singing his or her song. While in the Long House, the initiate undergoes a process which includes being lifted horizontally to shoulder or head height, by eight or so initiators, who, among other things, blow on the body of the initiate “bring out” or sing his or her song. This ritual is repeated daily, four times each morning and four times each afternoon. The initiation is done under the guidance of elders who are in charge of the process, which takes a number of days. During the process the initiate participates in rituals including a ceremonial bath, dressing in clean clothes, fasting and sleeping in a blanket tent set up in the House. The initiate is always accompanied by an attendant who is called his or her “babysitter.”

The initiate is captured or grabbed either with or without his or her consent. The only consent required is that of a senior member of the initiate’s family. Apparently, it is not uncommon for a wife to ask the elders to have her husband initiated by the house dancers. It is said that in the end the initiate sings his or her song while dancing, and the song is said to be proof of a supernatural vision experience.¹⁴⁴

It was suggested in the case that the complainant argued that he was taken against his will. Mr. Thomas sued for assault, battery, and wrongful confinement. At trial, the court found that Mr. Thomas satisfied the burden of proof with respect to these allegations, so he was awarded non-pecuniary and exemplary damages. The court stated that, on the facts of this case, there was insufficient evidence “to prove that spirit dancing is an aboriginal right, or that it was in existence and practiced at all the material times.”¹⁴⁵ In addition, the judge was not satisfied that:

[E]ven an ancient tradition or activity carried on by the defendants and their ancestors, which involves force, assault, injury and confinement, all against the will of the initiate, can be said to be an aboriginal right which survived the introduction of English law into the colonies. In this regard I note that under the Criminal Code both assault and confinement of a person are criminal offences in certain circumstances.¹⁴⁶

The *Thomas v. Norris*¹⁴⁷ decision may be of somewhat less importance than it appeared initially as it can be distinguished having been decided prior to a number of significant

¹⁴⁴*Thomas v. Norris*, *ibid* at Quick Law Reference, at 14 of 22.

¹⁴⁵ *Ibid*.

¹⁴⁶ *Ibid* at 16.

¹⁴⁷ *Thomas v. Norris*, *supra* note 143.

Supreme Court of Canada decisions concerning Aboriginal rights such as *Van der Peet*,¹⁴⁸ *Delgamuukw*,¹⁴⁹ *Marshall*,¹⁵⁰ *Sappier and Grey*¹⁵¹ and *Morris*.¹⁵² However, in the case of *Moulton Contracting Ltd. v. British Columbia*, Hinkston J. commented that “The torts of conspiracy to commit unlawful conduct and unlawful interference with contractual relations, as well as the defences to them, have not been thoroughly fleshed out by Canadian courts”¹⁵³ Hinkston J. adds:

However, in this case, I find that the treaty rights guaranteed by the s. 35 of the Constitution Act, 1982 do not provide for civil immunity for unlawful tortious conduct. Unlike in other cases where treaty rights have been alleged as defences to regulatory prosecutions (see for example, *R. v. Sappier*, [2006 SCC 54](#) and *R. v. Morris*, [\[2006\] 2 S.C.R. 915](#)) the defendants here are not alleging constitutional invalidity of the statutory provisions where the offence is set out. Instead, they are attempting to use treaty rights to justify tortious conduct.¹⁵⁴

The court also held that even if the healing ceremony was an Aboriginal right and protected by section 35 and 52 of the *Constitution Act, 1982*, it still would not justify tortious conduct.¹⁵⁵

As seen in *Thomas v. Norris*¹⁵⁶ even though the defendants were sued for false imprisonment, assault, and battery that occurred in a traditional ceremony that they argued was protected under s. 35 of the *Constitution Act, 1982* Mr. Justice Hood surmised “[p]lacing the Aboriginal right at its highest level it does not include civil immunity for coercion, force, assault, unlawful confinement or any unlawful tortious conduct on the part of the defendants ...”.¹⁵⁷ However, unlike *R. v. Sappier*¹⁵⁸ and *R. v. Morris*¹⁵⁹ where treaty rights have been infringed through a regulatory scheme, the use of Constitutional supremacy framework arguments in *Moulton*

¹⁴⁸ *R. v. Van der Peet*, *infra* note 172.

¹⁴⁹ *Delgamuukw v. British Columbia*, [1998] 1 C.N.L.R. 14.

¹⁵⁰ *R. v. Marshall*, [1999] 4 C.N.L.R. 161.

¹⁵¹ *R. v. Sappier*, [2006 SCC 54](#) [*Sappier*].

¹⁵² *R. v. Morris*, [\[2006\] 2 S.C.R. 915](#) [*Morris*].

¹⁵³ *Moulton Contracting Ltd. v. British Columbia*, [2010] B.C.J. No. 665 at para 82 [*Moulton*], citing Lewis Klar, *Tort Law*, 4th ed. (Toronto: Thomson Canada Ltd., 2008) at 711-12.

¹⁵⁴ *Moulton*, *ibid* at para 82.

¹⁵⁵ *Moulton*, *ibid* at para 83.

¹⁵⁶ *Thomas v. Norris*, *supra* note 143.

¹⁵⁷ *Ibid* at 164.

¹⁵⁸ *Sappier*, *supra* note 151.

¹⁵⁹ *Morris*, *supra* note 152.

could have been argued that the contractual relations were an infringement of their Aboriginal and treaty rights as protected by the *Constitution Act, 1982*.

In the *R. v. Cummings* decision,¹⁶⁰ a case concerning adverse possession,¹⁶¹ the court considered the prior possession of land by an “Indian medicine man” named Klaw Chaw or Dr. Johnson. The court recognized the unique status of a medicine man and his existence on the land prior to the birth of the Canadian colony. The case, however, was reversed a year later.¹⁶² In *R. v. Lafferty*,¹⁶³ the Crown brought an application for change of venue because the jurors might be influenced by the anticipated appearance of a local “medicine man” at the new trial. The court entertained competing affidavits concerning the powers of the medicine man, and Justice de Weerd found that bias was unlikely and dismissed the Crown’s change of venue application. The court accepted that community members understood that the powers of the medicine man were limited and not supernatural. This acceptance was based in large part on the supplementary affidavit sworn by the Grand Chief of the Dogrib Nation, Eddie Erasmus:

Medicine men and women in our culture are authorized to deal only in matters of health and healing. These persons are not priests nor prophets. ... The people in the Rae Edzo community know of the very limited powers of these said powers and specifically that they have no supernatural powers.¹⁶⁴

Traditional healers may be liable for negligence or for other areas of tort law. Issues may arise with respect to tortious liability for malpractice. The law states that a medical practitioner does not guarantee the success of any treatments.¹⁶⁵ The medical practitioner is held to the standard of an average practitioner. Where an individual practices Aboriginal medicine, a problem arises with such uncertainty and ambiguity. Can this individual be employed by a medical doctor and be covered by the doctor’s insurance, or would it be possible for the individual who practices Aboriginal medicine, be insured independently?

¹⁶⁰ *R. v. Cummings* (1925) 1 D.L.R. 642.

¹⁶¹ Adverse possession is a method of acquiring title to real property when there is a non-permissive use of the land that is continuous and exclusive. (*Blacks Law Dictionary*, 7th ed., (St. Paul Mn.: West Group, 1999) s.v. “adverse possession”).

¹⁶² *Canada (ag) v. Cummings*, [1926] 1 D.L.R. 52 CASCC.

¹⁶³ *R. v. Lafferty* [1992] N.W.T.J. No. 151 (S.C.).

¹⁶⁴ *Ibid.*

¹⁶⁵ *Johnston v. Wellesly Hospital*, 1971 2 O.R. 103.

There are serious problems with people claiming to be healers who are not, as in the 2000 case of *R. v. Mianskum*.¹⁶⁶ Jonathan Harold Mianskum was charged with sexual assault and sexual touching contrary to s. 271 and s. 153(1) of the *Criminal Code of Canada*. The young woman was 17 years old and went to Mianskum's home for the purpose of healing her abdominal pains since she found no relief from her medical doctor. She had recently discovered that she had an Aboriginal heritage and had met Mianskum at the local friendship center. While she was receiving her “healing” Mianskum touched various parts of her body, including her breasts with a liquid, sucked out brown liquid from her abdominal area by placing his lips near her navel and inserted a “medical bundle” into her vagina. He also forcibly kissed her. The court relied on the evidentiary procedure in *R v. Mohan*¹⁶⁷ and was able to discern from testimony from a credible and court approved healer Wanda Elizabeth Whitebird that Mianskum was not acting appropriately as an Aboriginal healer. Ms. Whitebird testified that she had never seen a ceremony like this. She testified that she had never heard of stripping naked at a healing ceremony. She testified that, if a man and woman were involved in a process like that, they would be totally clothed and had never heard of anything being placed in the vaginal area. Ms. Whitebird also testified that, if a woman approached her who was complaining of abdominal pain, she would initially take her history then decide upon a healer and the next processes to take. There would always be another person present in the room, and the parties would always be clothed. If the pain was in the abdominal area, pants may be undone or loosened but the underwear would never be removed. She testified that it would be important to know what Nation the healer came from and to learn of his or her credentials.¹⁶⁸ Mianskum was subsequently convicted on both counts.

Similarly, In the case of *R. v. H.G.*¹⁶⁹ an uncle of the 12 year old victim performed smudging ceremonies on his grandniece on three occasions. He claimed to be an Elder and a medicine man. While he was performing two of his ceremonies he made suggestive remarks to the young girl and during the last “ceremony” he told her to take her shorts and underpants off and put his

¹⁶⁶ *R. v. Mianskum*, [2000] O.J. No. 5802 [*Mianskum*].

¹⁶⁷ *R. v. Mohan*, [1994] 2 S.C.R. 9.

¹⁶⁸ *Mianskum supra* note 166 at para 66, 67, 68.

¹⁶⁹ *R. v. H.G.* [2003] S.J. No. 589 S.C.A.

finger in her vagina. He received an eighteen month conditional sentence from which he unsuccessfully appealed.

Aboriginal spirituality has also played a role in the awarding of custody in cases involving Aboriginal children. In *Kudaka v. Kudaka*,¹⁷⁰ for example, the court granted custody to the mother of a young boy because the child's stepfather was against native spirituality and the teaching of spirituality to the child. The child's birth father was a First Nations man and the child's mother wanted her son to know about his cultural heritage.

Generally, Aboriginal healing practices and traditional medicines are not recognized through legislation. The use of the Canadian legal system as a means of regulation traditional healing is generally considered unsatisfactory. Healers, educators and communities have resisted the regulation of traditional practices. This resistance is expected to continue, particularly given that the Canadian legal system has clashed with the systems and beliefs of Aboriginal peoples.

6.3 Legal Issues Affecting Traditional Practices

In general, the various heads of provincial power give the provinces greater jurisdiction over health matters than the federal government. The exception are those areas of health practices that the *Indian Act* specifically suppresses. Each province exercises its own discretion about its own legislation; however, the provinces are generally uniform in their exercise of jurisdiction in a number of areas that have an impact on Aboriginal traditional health and healers. Without going into a province-by-province survey of legislation, this section will review the general nature of provincial legislation and how it might affect traditional medicine and the practice of traditional healers.

i) Tobacco Legislation

The provinces have enacted various statutes that control the use of tobacco in public places. Federal legislation may be seen as failing to accommodate the traditional use of tobacco by Aboriginal people by making it illegal to provide tobacco to a youth under any circumstance.

¹⁷⁰ *Kudaka v. Kudaka*, [2001] O.J. No. 712 (C.J.).

However, most—though not all—provinces accommodate traditional tobacco use specifically in their statutes or legislation by suspending the federal laws in cases of traditional use by Aboriginal people and section 13 of the *Tobacco Control Act, 1994* establishes that provincial and municipal laws and regulations that prohibit smoking do not apply to Aboriginal use of tobacco.¹⁷¹

ii) Collection of Medicines

Just as the federal government can control the collection of medicines within federal jurisdiction, so, too, the provinces have authority to control the collection of flora and fauna within their regions. However, the jurisdictional limits placed upon the provinces by the Constitution would affect whether a restriction on the collection of traditional medicines would apply to Aboriginal healers and their helpers. Thus, if provincial legislation infringed upon the Aboriginal right to harvest traditional medicine, the province would have the burden of proving that the infringement was justified according to the principles set out by the Supreme Court of Canada in *Sparrow* and subsequent decisions.¹⁷²

Exercising its constitutional authority over federal lands and the residual “peace, order and good government” head of power, Parliament has enacted a number of statutes that may restrict the ability of traditional healers to collect or harvest traditional medicines.

Because of its authority over lands held by the federal government, Parliament is able to control the wildlife, including flora and fauna, in national parks. The *Canada National Parks Act*¹⁷³ regulates access to and use of all national parks. Amendments to the Act in 2001 now permit the Governor in Council to protect flora and fauna in national parks, which includes regulating the taking of specimens. Regulations such as the National Parks General Regulations¹⁷⁴ and the

¹⁷¹See for example, *Tobacco Control Act, 1994*, S.O. 1994, c.10, s.13; Alberta Regulation 149/204 “Prevention of Youth Tobacco Use Regulations”, s.4; *The Non-Smokers Health Protection Act*, C.C.S.M., c. S-125, s.7(2); *Smoke-Free Places Act*, S.N.B. 2004, ch. S-9.5, s.2(2).

¹⁷²*R. v. Sparrow*, [1990] 1 S.C.R. 1075, [1990] 3 C.N.L.R. 160 [*Sparrow*], *R. v. Van der Peet*, [1996] 2 S.C.R. 507, [1996] 4 C.N.L.R. 146 [*Van der Peet*].

¹⁷³*Canada National Parks Act*, S.C. 2000, c.32 [Parks].

¹⁷⁴National Parks General Regulations, SOR/78-213.

National Historic Parks General Regulations¹⁷⁵ restrict the removal of any flora or fauna from parks. At the same time, the *Canada National Parks Act* authorizes the Cabinet to permit Aboriginal traditional harvesting activities for the “use or removal of flora and other natural objects, by Aboriginal people for traditional spiritual and ceremonial purposes.”¹⁷⁶

Whereas the *Canada National Parks Act* regulates flora and fauna by virtue of their location in national parks, the *Species at Risk Act*¹⁷⁷ regulates flora and fauna by virtue of their designation as species at risk. Once designated, Parliament can prohibit the collection, possession, and trade of particular species of flora and fauna. Although it is not legally binding, the preamble to this statute states, “the traditional knowledge of the aboriginal peoples of Canada should be considered in the assessment of which species may be at risk and in developing and implementing recovery measures.”

The legislation goes on to create two committees for providing “Aboriginal advice.” First, the Minister is supposed to select six representatives of Aboriginal Peoples to sit on the *National Aboriginal Council on Species at Risk* (NACOSAR) to provide advice on administering the Act (s. 8.1). Second, the Committee on the *Status of Endangered Wildlife in Canada* is to set up a sub-committee specializing in Aboriginal traditional knowledge (s.18(1)).¹⁷⁸ The role of the NACOSAR is to advise the Minister of Environment on administering the Act and to provide advice and recommendations to the Canadian Endangered Species Conservation Council (CESCC) as set out in section 8(1) of the Act. NACOSAR is made up of six representatives of the Aboriginal Peoples of Canada who are appointed by the Minister for two-year terms and may be reappointed.¹⁷⁹

¹⁷⁵National Historic Parks General Regulations, SOR/82-263.

¹⁷⁶*Parks*, *supra* note 173 at ss. 16 and 17.

¹⁷⁷*Species at Risk Act*, S.C. 2002, c.29.

¹⁷⁸This may be a step at trying to justify any infringement on Aboriginal and/or treaty rights. However, it is questionable that those six “Aboriginal representative” seats on the committees would meet the legal requirements of consultation.

¹⁷⁹ National Aboriginal Council on Species at Risk 2010, online: http://www.nacosar-canep.ca/aboutus_en.php (accessed October 25, 2010).

The Courts have issued interlocutory injunctions (i.e., an injunction or court order prior to a trial) in certain cases of plant harvesting. For example, in *Hunt v. Halcan Log Services Ltd.*,¹⁸⁰ a case concerning a land dispute, the right to harvest herbal medicines is mentioned in passing. The parties in this case each sought interlocutory injunctions to prevent the other party from interfering with proprietary and other rights to Deer Island. The Kwakiutl Indian Band (and one of its hereditary chiefs) sought to prevent Halcan Log Services from logging on Deer Island until the trial was over. This argument was advanced on both Aboriginal and treaty rights to the land. In the context of these rights, the Band and their Hereditary Chief asserted claims to, amongst other things, harvest medicines.

For its part, Halcan had recently purchased the land in issue and sought to prevent the Band members from trespassing or obstructing Halcan's access to the land. The firm based its argument on its "ownership" of the land in fee simple as well as on a logging permit issued to the firm by the Ministry of Lands and Forests. Justice Trainor of the British Columbia Supreme Court granted the interlocutory injunction that restrained the company's logging activities.

In *MacMillan Bloedel Ltd. v. Mullin*,¹⁸¹ the court issued an interlocutory injunction that prohibited MacMillan Bloedel from clear-cutting an area of Meares Island claimed by the Clayoquot Island Band. The Court found that the area to be clear-cut would be wholly logged and permanently destroyed as a result. The Court considered the symbolic and cultural importance of the island to the Band, which included harvesting plants.

In British Columbia, the Wet'suwet'en asked for a continuance of a stay to prevent pesticide use on their traditional territories. The Wet'suwet'en submitted that if their lands were subjected to chemical treatment, the land would suffer harm that "is clearly harm of the type that cannot be quantified in monetary terms or otherwise cured." Specifically, the pesticides would destroy the traditional foods, medicines, and cultural resources. They also claimed that the Wet'suwet'en frequently visited the areas proposed for chemical application for the purposes of harvesting food, medicine, and cultural resources. They used approximately 90% of the plants gathered

¹⁸⁰ *Hunt v. Halcan Log Services Ltd.*, [1987] 4 C.N.L.R. 63.

¹⁸¹ *MacMillan Bloedel Ltd. v. Mullin*, [\[1985\] 3 W.W.R. 577](#) (B.C.C.A.).

there. The Wet'suwet'en claimed that applying the herbicide would cause not only the loss of the plants themselves but also the loss of the animals who rely on the plants as well as to the loss of fish and all wildlife.¹⁸² In this case, the Wet'suwet'en were unsuccessful, and the court did not grant a stay.

In *McCrary v. Ontario*,¹⁸³ Theron McCrary, the Chief of Poplar Point Ojibway Nation, asked the court for an injunction to stop the construction of a hydroelectric power dam at High Falls on the Namewaminikan River (the River) near Beardmore in the District of Thunder Bay. Chief McCrary claimed that an environmental assessment should be completed because of the repercussions on "the potential impacts of the project on our Aboriginal food and medicine harvesting rights and on our sacred sites."¹⁸⁴ The Court applauded the Minister for finally doing what it should have done in the beginning:

The willingness of the Minister to abide by the terms of the agreement is a great advance over the deaf ears that were turned to the earlier entreaties by McCrary for an environmental assessment. As a result of the pressure and insistence of the applicants, the Minister has acknowledged that the people closest to the environment affected by the hydro project will have a say in the management of that environment: This is as it should be and as it should have been from the very outset of this project. The peaceful and non-violent conduct of the applicants in protecting their legitimate interests in their environment stands in enviable contrast to many of the protests conducted in this day and age by White Society. The Poplar Point Ojibway Nation has achieved a victory not only for itself but for all of the people of Northwestern Ontario. And the environment will be better and more secure as a result of this victory.

The courts have seen a myriad of applications and motions and injunctions between First Nations and others who seek to exploit property in First Nation territories. There have been difficult proceedings in such cases as *Frontenac*¹⁸⁵ and *Platinex*¹⁸⁶ as well as the Haudenosaunee claims¹⁸⁷ at Caledonia and Brantford, Ontario. These conflicts raise involved

¹⁸² *Wet'suwet'en v. British Columbia (Ministry of Water, Land and Air Protection)*, [2002] B.C.E.A. No. 49.

¹⁸³ *McCrary v. Ontario*, [1991] O.J. No. 1722.

¹⁸⁴ *Ibid.*

¹⁸⁵ *Frontenac Ventures Corp. v. Ardoch Algonquin First Nation*, [2008] OJ No. 1 2651.

¹⁸⁶ *Platinex Inc. v. Kitchenumaykoosib Inninuwig First Nation*, [2008] OJ No. 2650.

¹⁸⁷ *Re Corporation of the City of Brantford v. Montour et al., Ontario Superior Court, CV-08-334, Endorsement of G.E. Taylor J., June 2, 2008* and *Henco Industries Ltd. v. Haudenosaunee Six Nations Confederacy Council*, [2006] OJ 4790.

and complex issues. The process of consultation in these cases is short and somewhat unrealistic, the result is that traditional territories are exploited and medicines are forever destroyed.

6.3.1 Codex Alimentarius and Bill C-36

The Natural Health Product Directorate of Health Canada was established in 1999 in direct response to the House of Commons Standing Committee on Health Recommendations.¹⁸⁸ The resulting Regulations since evolved into Bill C-51, C-52 (both killed at election), C-6 and most recently is Bill C-36.¹⁸⁹ Bill C-36 is a “modernization” of the defeated *Consumer Protection Act* (Bill C-6 and defeated). Bill C-51 did not pass in 2008 due to “enraged vendors of herbs, supplements and other natural remedies.”¹⁹⁰ Lawyer and president of the Natural Health Products Protections Association, Shawn Buckley, states this Act merely re-introduced many of the controls over natural remedies that are imported from Bill C-51.¹⁹¹ For instance, Section 4 (3) exempts natural health products from enforcement provisions, which include allowing Health Canada inspectors to enter private property if there are “reasonable grounds”, carry out inspections, and seize products for testing. Buckley noted that “the state cannot take control over your property and gain ownership of it and destroy it and all of these fun things without involving the courts.” However, he also noted that Section 21 2 (d) of Bill C-36 allows inspectors to “detain for any time that may be necessary” property found on-site, with no warrant needed and the courts not having to be informed.¹⁹² Buckley also wonders if the

¹⁸⁸ James LaMouche, NAHO Briefing Note 042/02, *Natural Health Products Directorate (NHPD) Aboriginal Roundtable* (2002) [unpublished, on file at NAHO]. See also, Natural Health Products, online: http://www.qualityandcompliance.com/pdfs/QuickNote%20-%20NHPD%20Overview_March%202009.pdf (accessed October 25, 2010).

¹⁸⁹ Bill C-36, online:

<http://www2.parl.gc.ca/HousePublications/Publication.aspx?DocId=4606148&Language=e&Mode=1&File=32%20-%201> (accessed October 15, 2010).

¹⁹⁰ Matthew Burrows, Georgia Straight, July 22, 2010 “Health rep Shawn Buckley call Bill C-36 a “Trojan horse” online: <http://www.straight.com/article-334721/vancouver/health-rep-calls-bill-c36-trojan-horse> [Burrows] (accessed October 15, 2010).

¹⁹¹ Bill C-51 was introduced on April 8th, 2008, and it proposes sweeping changes to *Canada’s Food and Drugs Act* that would impact the health products industry and in particular the collection and use of traditional medicines. Terminology would be changed, including replacing the word “drug” with “therapeutic product” throughout the Act, which would give the government broad powers to regulate the sale of all vitamins, supplements and other items including all plant-derived substances. (The Best of Raw Food, “Codex Alimentarius Canada” October 2010, online: <http://www.thebestofrawfood.com/natural-cures-canada.html> (accessed October 15, 2010).

¹⁹² Burrows, *supra* note 190.

conservatives will reintroduce Bill C-51 and apply its provisions once Bill C-36 passes.¹⁹³ In addition to the threats posed by the implementation of Canadian legislation and regulations that give sweeping government powers, the Codex Alimentarius is the grandfather of menaces to Aboriginal healers and all Aboriginal people who use natural medicines.

Codex Alimentarius is a subcommittee of the United Nations that is mandated to establish guidelines on food trade issues. Although these guidelines themselves are not legally binding, countries that are part of the World Trade Organization (WTO) may be severely penalized for not following the Codex (the implementation of Bill C-51 would effectively implement the Codex in Canada).

The Codex Alimentarius Commission, formally established in 1962, is a subsidiary of a joint program of the Food and Agriculture Organization of the United Nations and the World Health Organization's Food Standards Program. The Commission, composed of member governments including Canada, is mandated to set international reference standards for trade in all kinds of food products. In the early 1990s Codex began harmonizing standards for food supplements. By 2002 the guidelines prevented the sale of all vitamins, minerals, enzymes and most other essential nutrients as food supplements and treated them as pharmaceutical drugs. This meant that only pharmacists could dispense them.¹⁹⁴ The materials were to be only manufactured by pharmaceutical companies and only made from synthetic materials, including genetically engineered substances.¹⁹⁵

Most of the information available regarding Codex Alimentarius refers to its role in the USA, but it is not a US-specific body. Codex is involved in every national or international body concerned with public health. Currently, Canada is the North American representative on the

¹⁹³ Burrows, *ibid*. See also, Shawn Buckley, "Draft Discussion Paper on Bill C-36 the Canada Consumer Product Safety Act" June 17, 2010, online: <http://nhppa.org/?p=1079> (accessed October 15, 2010).

¹⁹⁴ On November 4-8, 2002, the Codex committee on Nutrition and Foods for Special Dietary Uses (NFSDU) met in Germany to develop guidelines which will result in binding new global trade rules for health supplements. Food and drug laws of all member countries will be "harmonized" to emerging international standards. (Consumer Health, "Why are your Natural Health Products under attack?" October 2003, online: <http://www.consumerhealth.org/articles/display.cfm?ID=20060225185041>(accessed October 15, 2010).

¹⁹⁵ Helke Ferris, *On Codex*, Vitality Magazine, February 2005.

Codex Executive Committee that meets annually. Canada is also the host country for the Codex Committee on Food Labelling (CCFL) and the Codex Committee on Vegetable Proteins. Canada hosts the Codex Regional Co-ordinating Committee for North America and Southwest Pacific on a rotational basis, sharing the hosting responsibilities with Australia, New Zealand and the United States.¹⁹⁶

The Codex program in Canada is managed by an Interdepartmental Committee for Codex consisting of senior officials from Health Canada, the Canadian Food Inspection Agency, the Department of Foreign Affairs and International Trade, Industry Canada, and Agriculture and Agri-Food Canada. The designated Codex Contact Point for Canada is located in the Food Directorate of Health Canada's Health Protection Branch. The key activities of the Office of the Codex Contact Point for Canada are:

1. Co-ordination of the consultative process involved in developing Canadian positions for various Codex Committees.
2. The organization and conduct of, and the logistical and secretariat support to all Codex meetings hosted by Canada.
3. Ensuring the timely circulation of all working papers, discussion papers and information received from the Codex Secretariat in Rome.
4. Serving as the primary contact point for all matters related to the Codex program in Canada.
5. Liaison between Canada, the Joint FAO/WHO Codex Secretariat in Rome, and the Codex Contact Point in other countries.
6. Maintenance of the Codex Canada website.¹⁹⁷

The key issue is that the Codex will move all natural products into the drug category. In Canada this will be accomplished through Bill C-51 which will move natural products into the drug category. If Canada defined natural products as food by law then the Codex would have no jurisdiction in Canada. With natural medicines being categorized as drugs, it will prove difficult for Aboriginal healers to practice medicine without being criminalized, since drugs may only be dispensed by pharmacists.

¹⁹⁶ Ontario, Ministry of Agriculture, CODEX Alimentarius and CODEX Commission, 2010, online: <http://www.omafra.gov.on.ca/english/food/inspection/codex.htm#can> (accessed October 25, 2010).

¹⁹⁷ *Ibid.*

6.3.2 Regulation of Health Professions

Provincial legislatures probably have the greatest power to affect the practice of traditional medicine, because they regulate health care professionals. Of course, no provincial legislation would attempt directly to regulate Aboriginal traditional healers. It would be *ultra vires*¹⁹⁸ for the provinces to do so, as it would single out First Nation (and arguably Inuit healers) healers.

For instance, when the Supreme Court of Canada rejected the Manitoba legislature's attempt to specifically exclude Indians from hunting in designated areas of the province,¹⁹⁹ it clarified when provincial laws apply:

While provincial law may apply to Indians, it can only do so "... as long as such laws do not single out Indians nor purport to regulate them qua Indians ...". *Four B Manufacturing Ltd. v. United Garment Workers et al.* [[1980] 1 S.C.R. 1031.] [The *Wildlife Act*] is clearly "in relation to" one class of citizens in object and purpose and is, therefore, in constitutional derogation of the right of the federal power to legislate in respect of Indians and lands reserved for the Indians under Head 24 of s. 91 of the British North America Act [the *Constitution Act, 1867*].²⁰⁰

Later, in the case of *Kitkatla Band v. British Columbia (Minister of Small Business, Tourism and Culture)*,²⁰¹ the Supreme Court states unequivocally, "it is clear that legislation which singles out aboriginal people for special treatment is *ultra vires* the province."²⁰²

However, in exercising their power to define activities that are subject to regulation and to restrict the practice of certain health services to provincially licensed persons, the provinces have generally captured the activities of traditional healers. In some cases, they have made Aboriginal conduct illegal because of provincial licensing requirements. They have classified individuals as "practicing medicine" through a broad definition of "practicing medicine" that

¹⁹⁸“Unauthorized; beyond the scope of power allowed or granted by a corporate charter or by law.” (*Blacks Law Dictionary*, 7th ed., (St. Paul Mn.: West Group, 1999) s.v. “ultra vires”).

¹⁹⁹*Wildlife Act*, R.S.M. 1970, c. W140, s. 49.

²⁰⁰*R. v. Sutherland*, [1980] 2 S.C.R. 451 at 455 [*Sutherland*].

²⁰¹*Kitkatla Band v. British Columbia (Minister of Small Business, Tourism and Culture)* [2002] S.C.J. No. 33; [2002] A.C.S. no 33; 2002 SCC 31; 2002 CSC 31; [2002] 2 S.C.R. 146; [2002] 2 R.C.S. 146; 210 D.L.R. (4th) 577; 286 N.R. 131; [2002] 6 W.W.R. 1; J.E. 2002-605; 165 B.C.A.C. 1; 1 B.C.L.R. (4th) 1; [2002] 2 C.N.L.R. 143; 112 A.C.W.S. (3d) 808 [*Kitkala*].

²⁰²*Kitkala*, *ibid* at 67. See also, *Canadian Western Bank v. Alberta* [2003] A.J. No. 1166; *Laboucane v. Brooks* [2003] B.C.J. No. 1886; *Muskwachees Ambulance Authority Ltd. (Re)* [2006] Alta. L.R.B.R. 243.

would include the activities of traditional healers.²⁰³ The provincial Acts have then prohibited Aboriginal healers from practicing their medicine because they are not registered or licensed with the province. Again, the Aboriginal practice of midwifery, as we discussed earlier, has suffered as a result.

The courts have struggled with how to define “practicing medicine.” So far, provincial courts have relied on the very early 1907 Ontario Court of Appeal case of *R. v. Hill*²⁰⁴ to claim that provincial medical licensing legislation applies to Indians. In that case, the defendant Hill was convicted of unlawfully practicing medicine contrary to the Ontario *Medical Act*.²⁰⁵ In the *Hill* case, the patient was non-Indian, and the services were provided on off-reserve territory. Would the same result have followed if the services had been provided on a reserve territory to an Aboriginal person?

Unfortunately, the case as reported lacks some important factual details. For example, was Hill charged for practicing traditional Aboriginal medicine? This fact is probably absent because it did not matter for Hill’s defense. The defence submitted that Hill was an Indian and, therefore, not a person. As a result, all provincial legislation was *ultra vires*, since only Parliament has jurisdiction over Indians. The court found that the law was *infra vires* the province, which meant that it did apply to Hill. Since Hill admitted that he was practicing medicine, he was convicted, fined, and imprisoned.²⁰⁶

The *Hill* case was decided at a time when Indians were considered Crown wards and not eligible to vote and before Aboriginal and treaty rights were recognized and affirmed in the *Constitution Act, 1982*. Due to these factors and the absence of any evidence that Hill was practicing traditional medicine, the decision in *Hill* must be limited to cases where an Aboriginal person is practicing western medicine. In other words, *Hill* gives no guidance whatsoever that the provincial licensing legislation is *infra vires* the provinces in cases

²⁰³The definition is so broad that it may even include a parent administering cough medicine to a child: James C. Robb, “Legal Impediments to Traditional Indian Medicine”, in *Health Care Issues in the Canadian North*, D.E. Young ed. (Edmonton: University of Alberta: Boreal Institute for Northern Studies, 1988) at 136.

²⁰⁴*R. v. Hill* (1907), 15 O.L.R. 406 (Ont. C.A.) [*Hill*].

²⁰⁵*Medical Act*. R.S.O. 1897, ch. 176, s. 49.

²⁰⁶*Hill*, *supra* note 204 at 407.

involving Aboriginal traditional healers. The cases following *Hill* do clarify and confirm that provincial Legislatures have the power to apply their laws on reserves, so long as the laws are connected to an issue that falls under a provincial head of power.²⁰⁷

Professor Peter Hogg articulates five exceptions to the general rule that provincial laws apply to Indians and lands reserved for the Indians. Those exceptions are known as: (1) the singling out rule; (2) the "Indianness" rule; (3) paramountcy; (4) natural resources agreements; and (5) section 35 of the Charter of Rights.²⁰⁸ For instance, provincial laws of general applicability do not apply to Indians and Lands reserved for the Indians when such laws affect the core of "Indianness." In the case of health and health practices, it may be argued that provincial laws do not apply to traditional healers because their work does go to the core of their Indianness. Similarly, provincial laws do not apply when the doctrine of federal paramountcy holds, that is, when a provincial law is inconsistent with a federal law. Section 91(24) of the *Constitution Act, 1867*, could mean, therefore, that federal laws protecting Aboriginal rights trump any provincial laws dealing with or regulating traditional healers.

Moreover, the provincial legislatures cannot single out Aboriginal people for special treatment or *because* they are Aboriginal.²⁰⁹ Based on this restriction, we can conclude that provinces have no jurisdiction to regulate, license, or register traditional healers. Yet, provincial legislation makes it illegal for anyone to practice medicine of any kind unless the province licenses him or her. Thus, provincial legislation claiming that traditional healers must be licensed by provinces conflicts with the *Constitution Act, 1867*, which states that the provinces have no jurisdiction to license traditional healers. In other words, conflicts between federal and provincial legislation over traditional healers can be examined in various ways, all leading to the same result.

All such conflicts may therefore be resolved by a more precise interpretation of the statute. Given that provinces cannot license traditional healers, any legislation pertaining to the practice

²⁰⁷ *Four B Manufacturing v. United Garment Workers*, [1980] 1 S.C.R. 1031. *Paul v. British Columbia*, [2003] 1 S.C.R. 585.

²⁰⁸ Hogg, *supra*, note 8.

²⁰⁹ See *Sutherland*, *supra* note 200 and *Kitkatla*, *supra* note 201.

of medicine cannot be intended to apply to the activities of traditional healers under the meaning of “practicing medicine.” Thus, there is no conflict. The statute does not apply to traditional healers, because it was never intended to apply to them. However, from a practical perspective, such issues persist.

6.4 Summary

This chapter has reviewed the law as a determinant of health by reviewing two large intersecting bodies of Canadian law: the Constitution and legislation. The law has a direct link to many social and societal factors that affect Aboriginal health, not just in the public health context but in many areas where the heads of power are delineated that affects Aboriginal health and traditional healers such as the criminal law, peace order and good government and Indians and lands reserved for Indians. The Constitution does not specifically address health, but through these heads of power it does affect health of Aboriginal people, though not directly but inadvertently. The courts and legislature continues to define what this means. The *Charter* has been explored as to what benefit it might be to advance Aboriginal health. It may be used in combination with additional arguments either found in the *Constitution Act, 1982* or in common law.

Jurisdiction is a large and looming problem for First Nation Métis and Inuit peoples; it has caused internal strife among the federal and provincial governments and has resulted in a jumble of programs and inequities for on reserve residents and Inuit in the north and the urban Métis.

The second category of law as a determinant of health is legislation. The prohibitive laws found in the *Indian Act* from 1850 on have been reviewed as to their potential harmful effects on the health of Aboriginal people and in particular First Nations women. The impacts of provincial laws applicable to health have also been reviewed and categorized as to their impacts on traditional healers, patients and to the *Indian Act*. Finally an examination of the *Criminal Code* and its application on traditional healers and people who claim to be traditional healers is offered which provides a critical analysis of the dangers of not only practicing traditional medicine but accessing traditional medicine from someone who is not qualified.

The following section delves further into the Constitution and Aboriginal and treaty rights and provides an analysis that solidifies Aboriginal and treaty rights to health within the structure of the *Constitution Act, 1982*.

7. Aboriginal and Treaty Rights to Health

In Chapter 3, the current state of Aboriginal health was presented that showed a large disparity between Aboriginal and non-Aboriginal health in general. Health determinants and historical health influences were also introduced that were shown to have an effect on the general health of Aboriginal people today. Included in these influences was the application of government policies and laws which left a legacy that has determined the poor state of Aboriginal health today. Chapter 4 reviewed the health practices of early Aboriginal society, showing historically Aboriginal people enjoyed a relatively disease free society and practiced medical and health ceremonies with a detailed and self sustaining pharmacopeia of medicines and herbs and treatments for prevention of disease and treatment of medical conditions. Beginning at European contact there was a degradation of the state of health we are experiencing today which is indicative of an overwhelming disparity between Aboriginal and non-Aboriginal health in general.

For clarity, it is important to define what is meant by “health” particularly in relation to the current Chapter. When discussing the treaty right to health we are looking at the oral and written clauses of the treaties which are closely aligned with medicine and medical care as well as the provision of services and access to those services, so the term “health” refers to these terms.

Even though not all people who possess Aboriginal rights also possess treaty rights, the *Constitution Act, 1982* confirms that anyone who possesses treaty rights also possesses Aboriginal rights (if these rights were not extinguished or modified by treaties). Aboriginal rights are inherent to all Aboriginal people in Canada and are passed down from generation to generation. They are derived from Aboriginal knowledge, heritage, and law.¹ Traditional healing and health practices, medicines and medical applications for the prevention and

¹ M. Battiste & J.Y. Henderson, *Protecting Indigenous Knowledge and Heritage: A Global Challenge* (Saskatoon: Purich, 2000), [Battiste and Henderson]. See also *R. v. Van der Peet*, [1996] 2 S.C.R. 507, [1996] 4 C.N.L.R. 146 [*Van der Peet* cited to S.C.R.] [*Van der Peet*]; *Delgamuukw v. British Columbia*, [1997] 3 S.C.R. 1010, [1998] 1 C.N.L.R. 14, reversing in part (1993), 10 D.L.R. (4th) 470, [1993] 5 C.N.L.R. 1 (B.C.C.A.), varying in part [1991] 3 W.W.R. 97, [1991] 5 C.N.L.R. 1 (B.C.S.C.) [*Delgamuukw*].

promotion of good health are ways through which Aboriginal people manifest or express an inherent right to health. The term “health” is defined in this broad manner when referring to Aboriginal rights.

In addition to defining the term of “health” it may be helpful to define the application of western law in relation to those rights. Jurisdiction over health and health matters for First Nations, Métis and Inuit may be seen as law making powers that affect Aboriginal health; the provision of medical care by the federal government (that is intertwined with jurisdiction); the ability to practice and maintain traditional health care free from Canadian interferences (meaning legal sanctions); and the ability to seek and maintain good health within all the realms noted here. The objective of this Chapter is to consider how the law can be used to bring the health status closer together – to help close the gap by discovering the reasons that there are gaps and to identify if any legal breaches are the cause. To achieve this objective, the rights that Aboriginal people possess will be examined to highlight any breaches of the government’s constitutional obligations towards Aboriginal peoples that may have contributed to the poor health outcomes. This involves first establishing that health is an Aboriginal and/or treaty right (that has constitutional protection) and determining if there have been breaches (through a comparison of Aboriginal and non-Aboriginal health determinants) that are justified in law. If no justification can be found then the government must be held accountable for the result of a health system that has resulted in an echelon of a two or three tiered health system, with Aboriginal people at the lowest rung. While accountability is important, so are solutions and recommendations for change and working towards new ways to deal with old problems.

Aboriginal and treaty rights are confirmed in Canadian law through s. 35 of the *Constitution Act, 1982*: “existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.”² These ‘existing’ rights are affirmed at face value without definition or providing a reference to the sources of the rights. It is important to note that in addition, section 25 requires that *Charter* rights,

² *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

...shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada including

(a) any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and

(b) any rights or freedoms that now exist by way of land claims agreements or may be so acquired.³

Charter rights were examined in Chapter 6 in relation to Aboriginal health and in particular s. 7 which states, “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”⁴

Aboriginal rights are inherent to Aboriginal people in Canada and are derived from Aboriginal knowledge, heritage and law.⁵ These rights have been practiced since time immemorial and are evident in the practices of Aboriginal people and Aboriginal society. As identified in Chapter 4, by virtue of the evidence produced through recordings and historical documents of Elders, historians, early explorers, traders and Jesuit priests show that early measures were in place that exemplified how Aboriginal people treated disease and maintained good health in their respective societies. They developed highly evolved pharmacopeias and formularies and plant and food sources to prevent disease and maintain good health.⁶ It may be then said that the practice of medicine, healing and preventative health measures comprised a *vital facet* or *integral part of a distinctive culture* or *of central significance* of Aboriginal society, which has passed from *generation to generation* in various forms and are *still in existence* today in modified forms.⁷ Because these are core underpinnings of Aboriginal society they have manifested into Aboriginal and treaty rights that have evolved into the modern equivalent of traditional health and health care and fill the requirements of the common law tests the courts have set out to prove an Aboriginal right.

³ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11 s. 25.

⁴ *Ibid* at s. 7.

⁵ Battiste and Henderson, *supra* note 1 at 205. *Van der Peet*, *supra* note 1 at para. 31, *Delgamuukw*, *supra* note 1.

⁶ J. Waldrum, D.A. Herring, & T.K. Young, *Aboriginal Health in Canada. Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995)[Waldrum, Herring & Young] at 103.

⁷ Waldrum, Herring & Young *ibid* at Chapter 5.

In addition to Aboriginal rights, some Aboriginal peoples also possess treaty rights. A treaty is an agreement and an exchange of promises between two sovereign nations.⁸ In this case, the promises were between the Crown and these Indian Nations who signed the treaties. Treaties are legal instruments of Canadian law, International law, and also the law of the Indian signatories.⁹ The purpose of the treaties was to ensure peaceful relations, military alliances, trade and mandated the British sovereign and Canadian government to provide protection and services for treaty signatories.¹⁰ Some treaties supplement the Aboriginal right to health care such as the medicine chest clause and the pestilence and famine clause of Treaty 6. Other treaties contain references to medicine, health care and protection - these and Treaty 6 medicine clause will be examined later in this Chapter. These protections continue to exist today in modern forms as the First Nations did not relinquish their sovereignty to the Crown, nor did they relinquish their health care systems to the Crown when signing the treaties. Evidence simply does not exist to support relinquishment. There is however, a presumption that if the Crown did intend to limit any Aboriginal rights to health care it would violate the Crown's promises of protection found in the treaties and the *Royal Proclamation, 1763*. Thus, it may be said that treaty rights have evolved and manifested themselves into the modern existence of the provision of health care which will be explored throughout this Chapter.

7.1 Aboriginal Rights to Health

The existence of Aboriginal rights originates from two important understandings. The first is that before European contact, Aboriginal societies were self-sustaining Nations. The Supreme Court is clear:

In my view, the doctrine of aboriginal rights exists, and is recognized and affirmed by s. 35(1), because of one simple fact: when Europeans arrived in North America, aboriginal peoples were already here, living in communities on the land, and participating in distinctive cultures, as they had done for centuries. It is this fact, and this fact above all others, which separates

⁸ *R. v. Badger*, [1996] 1 S.C.R. 771 at para. 41, [1996] 2 C.N.L.R. 77 [*Badger* cited to S.C.R.][*Badger*]. See also James Sákéj Youngblood Henderson, "Interpreting Sui Generis Treaties" (1997) 36 Alta. L. Rev. (No. 1) 46 [Sui Generis].

⁹ James Sákéj Youngblood Henderson, "Treaty Rights in the Constitution of Canada" (Carswell: 2007).

¹⁰ J.Y. Henderson, "Treaty Rights to Health" (2002) [unpublished, Native Law Centre, University of Saskatchewan] at 15 [Treaty Rights to Health]. See also H. Cardinal & W. Hildebrandt, *Treaty Elders of Saskatchewan* (Calgary: University of Calgary Press, 2001) at 31–38.

aboriginal peoples from all other minority groups in Canadian society and which mandates their special legal, and now constitutional, status.¹¹

The Supreme Court further clarified that Aboriginal societies consisted of practices, traditions and cultures which manifestly were comprised of evolved institutions such as health, policing, education and law:

More specifically, what s. 35(1) does is provide the constitutional framework through which the fact that aboriginals lived on the land in distinctive societies, with their own practices, traditions and cultures, is acknowledged and reconciled with the sovereignty of the Crown. The substantive rights which fall within the provision must be defined in light of this purpose; the aboriginal rights recognized and affirmed by s. 35(1) must be directed towards the reconciliation of the pre-existence of aboriginal societies with the sovereignty of the Crown.¹²

The second key understanding is that Aboriginal people generally have not ceded any rights to be sovereign either individually or collectively. This is important as it illustrates that Aboriginal people have a different viewpoint of social or state control than that of non-Aboriginal Canadians who accept the Eurocentric concepts that social control is state imposed and outside the individual's control that results in the relinquishment of their individual freedoms.¹³ It is also important because a sovereign nation is recognized as such because of their inherent rights to govern themselves. This chapter deals with the existence of Aboriginal rights that protect essential aspects of Aboriginal health. The common law view of Aboriginal rights is based on pre-contact views and practices of Aboriginal knowledge and heritage, culture and traditions of health care (sectors of Aboriginal law) but also exists in contemporary forms through practices that currently guide the lives of Aboriginal people in their individual and collective health. This will be shown through an analysis of common law tests as applied to Aboriginal health.

The Supreme Court of Canada has dealt extensively with the meaning of Aboriginal rights in s. 35 of the *Constitution Act, 1982* through case law addressing various matters before the Court.

¹¹ *Van der Peet*, *supra* note 1 at para 30.

¹² *Van der Peet*, *supra* note 1 at para 31.

¹³ P. Monture-Okanee. "Alternative Dispute Resolution: A Bridge to Aboriginal Experience?" in C. Morris & A. Pirie, eds., *Qualifications For Dispute Resolution: Perspectives on the Debate* (Victoria, B.C.: UVic Institute for Dispute Resolution, 1994) 131 at 137–138.

In 1990, the Supreme Court of Canada decided *R. v. Sparrow*,¹⁴ and then followed with a 1996 trilogy of *Van der Peet*,¹⁵ *Gladstone*,¹⁶ and *NTC Smokehouse*.¹⁷ The Court continues to refine the meaning through more recent decisions such as *Sappier and Gray*,¹⁸ and *Bernard and Marshall*.¹⁹ The following section will review the tests and approaches that the Court has used and will assess its applicability to Aboriginal health.

The Supreme Court of Canada addressed the meaning of 'existing' Aboriginal rights in *R. v. Sparrow*,

The word "existing" makes it clear that the rights to which s. 35(1) applies are those that were in existence when the Constitution Act, 1982 came into effect. This means that extinguished rights are not revived by the Constitution Act, 1982. ...The phrase "existing aboriginal rights" must be interpreted flexibly so as to permit their evolution over time. To use Professor Slattery's expression, in "Understanding Aboriginal Rights," the word "existing" suggests that those rights are "affirmed in a contemporary form rather than in their primeval simplicity and vigour." Clearly, then, an approach to the constitutional guarantee embodied in s. 35(1) which would incorporate "frozen rights" must be rejected.²⁰

The Court also held that only imperial statutes can extinguish Aboriginal rights and these rights cannot be altered or extinguished by federal policy or law and only imperial statutes can extinguish those rights.²¹ They, however, may be infringed by federal law or policy as per the justification test that was developed in *Sparrow*. The Crown must prove that the infringing measures serve a "valid legislative objective"; that they are in keeping with the special trust relationship and responsibility of the government; that the infringement has been minimal; whether fair compensation has been available in a context of expropriation; and whether the affected Aboriginal group has been consulted.

¹⁴ *R. v. Sparrow*, [1990] 1 S.C.R. 1075, [1990] 3 C.N.L.R. 160 [*Sparrow* cited to S.C.R.] [*Sparrow*].

¹⁵ *VanderPeet*, *supra* note 1.

¹⁶ *R. v. Gladstone*, [1996] 2 S.C.R. 723, [1996] 4 C.N.L.R. 65 [Gladstone].

¹⁷ *R. v. N.T.C. Smokehouse Ltd.*, [1996] 2 S.C.R. 672[Smokehouse].

¹⁸ *R. v. Sappier; R. v. Gray* [2006] S.C.C. 54 [*Sappier and Gray*].

¹⁹ *R. v. Marshall; R. v. Bernard* [2005] 2. S.C.R. 220 at para 48 [*Marshall and Bernard*].

²⁰ *Sparrow*, *supra* note 14 at 1091-1093 (footnotes omitted).

²¹ *Sparrow*, *supra* note 14.

The *Sparrow* decision was an important step forward for Aboriginal people in defining what an Aboriginal right is and is not in the Court's view. A good example is the Aboriginal or treaty right to hunt. Traditionally, Aboriginal people used to hunt with a bow and arrow. The frozen rights approach would force Aboriginal people to continue to hunt with a bow and arrow. The Supreme Court of Canada rejected this approach and, as a result, when examining the nature of Aboriginal or treaty rights it was held that these rights must be considered in a contemporary manner. As such, Aboriginal people may use any modern instrument (i.e. rifle, shotgun, etc.) in exercising their Aboriginal or treaty rights. Additionally, in *R. v. Badger*²² it was held that the *Natural Resources Transfer Agreement* (NRTA) did not alter any existing treaty rights to hunt held by Treaty 8 peoples but in effect expanded it while extinguishing treaty protection of the right to hunt commercially. Therefore one must read the NRTA in light of the fact that this treaty right continues in force and effect.²³

In *Sparrow* the Court did not have to address the full scope of Aboriginal rights protected by s. 35(1); however, the Court did identify the Musqueam right to fish for food (social and ceremonial purposes) in the fact that:

The anthropological evidence relied on to establish the existence of the right suggests that, for the Musqueam, the salmon fishery has always constituted an *integral part of their distinctive culture*. Its significant role involved not only consumption for subsistence purposes, but also consumption of salmon on ceremonial and social occasions. The Musqueam have always fished for reasons connected to their cultural and physical survival. [Emphasis added.]²⁴

The suggestion of this passage is that participation in the salmon fishery is an Aboriginal right because it is an "integral part" of the "distinctive culture" of the Musqueam. This is consistent with the position adopted by the courts; identifying those practices, customs and traditions that are integral to distinctive Aboriginal cultures will serve to identify the crucial elements of the distinctive Aboriginal societies that occupied North America prior to the arrival of Europeans.

²²*Badger*, *supra* note 8.

²³ *Badger*, *supra* note 8 at para 47.

²⁴ *Sparrow*, *supra* note 14 at 1100.

In 1996, the Supreme Court of Canada further articulated the concept of distinctive cultures in *R. v. Van der Peet*:

When Europeans arrived in North America, aboriginal peoples were already here, living in communities on the land, and participating in *distinctive cultures*, as they had done for centuries.²⁵

The Court developed a test to be used to further identify an existing Aboriginal right. The activity must not only be integral to the distinctive culture, it must have been of “central significance” to the society in issue and must be a “defining characteristic” and “one of the things that made the culture of the society distinctive.”²⁶ The activity that is claimed to be an Aboriginal right must have developed before “contact.”²⁷ Practices that developed “solely as a response to European influences” do not qualify as an Aboriginal right.²⁸

In order to fulfill the purpose underlying s. 35(1) -- i.e., the protection and reconciliation of the interests which arise from the fact that prior to the arrival of Europeans in North America aboriginal peoples lived on the land in distinctive societies, with their own practices, customs and traditions -- the test for identifying the aboriginal rights recognized and affirmed by s. 35(1) must be directed at identifying the crucial elements of those pre-existing distinctive societies. It must, in other words, aim at identifying the practices, traditions and customs central to the aboriginal societies that existed in North America prior to contact with the Europeans.²⁹

The Supreme Court in *Van der Peet* and subsequent cases has articulated that the test for the existence of an Aboriginal right is specific to a definable Aboriginal group and that the right in issue must be distinctive to that society.

²⁵ *Van der Peet*, *supra* note 1 at para 30.

²⁶ *Van der Peet*, *ibid* at para 55.

²⁷ *Ibid*, at paras. 60-62.

²⁸ *Van der Peet*, *ibid* at para. 73.

²⁹ *Van der Peet*, *ibid* at para. 44.

In *R. v. Powley*,³⁰ the Supreme Court of Canada wrestled with citizenship issues and attempted to establish a definition of who the Métis are through its consideration of a hunting case outside of Sault Ste. Marie. The Court said Métis did have constitutionally protected rights:

The inclusion of the Métis in s. 35 is based on a commitment to recognizing the Métis and enhancing their survival as distinctive communities ... the inclusion of the Métis in s. 35 is not traceable to their pre-contact occupation ... s.35 as it relates to the Métis is therefore different from ... Indians or the Inuit. The constitutionally significant feature of the Métis is their special status as peoples that emerged between first contact and the effective imposition of European control.³¹

The Court had previously developed a pre-contact test in *Van der Peet* for First Nations based on the constitutional premise that Aboriginal communities are entitled to continue those practices, customs and traditions that are integral to their distinctive existence or relationship to the land. Comparing the core purpose of this test for Métis practices should focus on identifying those practices, customs and traditions that are integral to the Métis community's distinctive existence and relationship to the land. The Court stated:

This unique history can most appropriately be accommodated by a post contact but pre-control test that identifies the time when Europeans effectively established political and legal control in a particular area. The focus should be on the period after a particular Métis community arose and before it came under the effective control of European laws and customs. This pre-control test enables us to identify those practices, customs and traditions that predate the imposition of European laws and customs on the Métis.³²

The Court rejected the argument that Métis rights must find their origin in the pre-contact practices of the Métis' Aboriginal ancestors. To do so would deny the Métis their full status as distinctive rights-bearing peoples whose own practices are entitled to constitutional protection under s. 35(1) as the right claimed was a practice of both the Ojibway and the Métis.³³

³⁰ *R. v. Powley*, [2003] 2 S.C.R. 207, [2003] 4 C.N.L.R. 321 [*Powley*]. See also: Larry Chartrand, "A Commentary on Métis Identity and Citizenship from an International Law Perspective," Native Law Centre, *Justice as Healing*, 2001 Vol. 6., No.2; For *Powley* and the history of Métis case law development see: Jean Teillet, "Métis Law Summary" online: http://www.metisnation.org/Harvesting/Powley_Case/assets/docs/MLS-2004.pdf, (accessed March 3, 2009).

³¹ *Powley*, *ibid* at para. 13 and 17.

³² *Powley*, *ibid* at para. 37.

³³ *Powley*, *ibid* at para. 37.

The Supreme Court has been faced with Aboriginal and treaty rights issues through *Marshall and Bernard*,³⁴ *Morris*,³⁵ *Mitchell*,³⁶ *Haida Nation*,³⁷ *Taku River*³⁸ and *Mikisew Cree*³⁹ amongst others. In *Marshall* and *Bernard* the Court upheld the trial judge's rulings that Aboriginal title to cutting sites had not been proven and held that the Mi'kmaq do not have a treaty right to harvest wood for sale on Crown land without a permit. The Court did not find any basis for finding title in these cases through the *Royal Proclamation* or *Belcher's Proclamation*.⁴⁰ The appeal at the Supreme Court dealt with the two cases together. In *Marshall*, thirty five Mi'kmaq Indians were charged with harvesting timber for sale on Crown lands without a permit. In *Bernard*, a Mi'kmaq Indian was charged with possession of spruce logs he cut while bringing them to the local saw mill. The logs had been cut on Crown lands in New Brunswick. In both cases, the accused claimed they were not required to obtain provincial permits to log because they have a right to log on Crown lands for commercial purposes pursuant to their treaty rights or Aboriginal title. The trial Courts entered convictions which were upheld by the summary conviction Courts. The Courts of Appeal set aside the convictions. A new trial was ordered in *Marshall* and an acquittal entered in *Bernard*. The Supreme Court of Canada upheld the appeals and restored the convictions. There are many benefits (or at least no harms done) to be gained by this decision, claiming the Court resolved some ambiguities in several aspects of the *Delgamuukw* test for Aboriginal title, and expanded

³⁴ *Bernard*, *supra* note 42.

³⁵ *R. v. Morris*, [2006] 2 S.C.R. 915, 2006 SCC 59.

³⁶ *Mitchell v. Peguis Indian Band*, [1990] 2 S.C.R. 85.

³⁷ *Haida Nation v. B.C. and Weyerhaeuser* (2002), 99 B.C.L.R. (3d) 209, [2002] 2 C.N.L.R. 121 at paras. 33–36 (C.A.); additional reasons, (2002), 5 B.C.L.R. (4th) 33, [2002] 4 C.N.L.R. 117 (C.A.) [*Haida Nation*].

³⁸ *Taku River Tlingit First Nation v. Ringstad et al.* (2002), 98 B.C.L.R. (3d) 16, [2002] 2 C.N.L.R. 312 (C.A.) [*Taku River*].

³⁹ There are a number of cases that have dealt with Aboriginal rights and the duty to consult in 2008 and 2009, *Little Salmon/Carmacks v. Yukon (Minister of Energy and Mines)*(2008 YKCA) 13; *Klahoose First Nation v. Sunshine Coast Forest District (District Manager)*, 2008 BCSC 1642; *Carrier Sekani Tribal Council v. British Columbia (Utilities Commission)*, 2009 BCCA 67; *Kwitkwetlem First Nation v. British Columbia (Utilities Commission)*, 2009 BCCA 68; *Wii'litswx v. British Columbia (Minister of Forests)*, 2008 BCSC 1139; *Ke-Kin-Is-Uqs v. British Columbia (Minister of Forests)*, 2008 BCSC 1505; *Tsuu T'ina Nation v. Alberta (Environment)*, 4 CNLR 259; *Tzeachten First Nation v. Canada (Attorney General)* [2008] 4 CNLR 293 [FCTD].

⁴⁰ These two Proclamations were signed in order to maintain peace and to forbid the Crown or its subjects any interference with the Indian people or lands thereof. *Belcher's Proclamation* was signed on May 4 1762 and the *Royal Proclamation* was signed in 1763.

some components of the test.⁴¹ The Court, however, called for an assessment of Aboriginal rights:

The Court's task in evaluating a claim for an aboriginal right is to examine the pre-sovereignty aboriginal practice and translate that practice, as faithfully and objectively as it can, into a modern legal right.⁴²

Bernard also switched from *Delgamuukw* recognition of Aboriginal law into "Aboriginal perspectives" and made it more difficult to prove title,

The Court must give equal consideration to the aboriginal and common law perspectives. An analysis which seeks to reconcile aboriginal and European perspectives may not draw a distinction between nomadic and sedentary modes of use or of occupation. Both modes would suffice to create the connection between the land and the First Nations which forms the core of aboriginal title.⁴³

However, the minority of the *Bernard* Court had concerns with the equal consideration perspective,

The common law notion that "physical occupation is proof of possession" remains but is not the governing criterion: the nature of the occupation is shaped by the aboriginal perspective, which includes a history of nomadic or semi-nomadic modes of occupation.⁴⁴

In 2006 the Supreme Court of Canada confirmed the existing rights test in *Morris* where two members of the Tsartlip band in B.C. were charged with night hunting under the British Columbia *Wildlife Act*. The Court analyzed the treaty right to hunt and whether provincial laws of general application could infringe the band's treaty right to hunt and whether or not the *Wildlife Act* was applicable to the band by virtue of S. 88 of the *Indian Act*. Although the *Wildlife Act* is directly within British Columbia's purview, it is directed at safety, a matter within provincial power. It does not go to the core of "Indianness" and does not conflict with

⁴¹ Kathryn Deo, Woodward and Company, *Why the Bernard and Marshall Case Doesn't Hurt Aboriginal Title Claims in British Columbia*, online: http://www.woodwardandcompany.com/pdfs/Bernard_and_Marshall.pdf (accessed September 13, 2010). See also, Grand Chief Edward John, of the First Nations Summit, in a Press Release issued by the First Nations Leadership Council on July 20, 2005, was quoted as saying that "Today's Marshall and Bernard decisions will not affect political or legal issues," online: http://www.ubcic.bc.ca/News_Releases/UBCICNews07200501.htm (accessed September 8, 2010).

⁴² *Marshall and Bernard*, *supra* note 18 at para 48.

⁴³ *Marshall and Bernard*, *ibid* at para 129.

⁴⁴ *Marshall and Bernard*, *ibid*.

federal legislation (therefore the doctrine of paramountcy does not apply). Because the *Wildlife Act* is directed at safety, it does not affect a treaty right then the law applies *ex proprio vigore*, without recourse to s. 88 of the *Indian Act*. The Court held that the overriding intent of the *North Saanich Treaty of 1852* was to preserve the traditional way of hunting for the Saanich Nation. The fact that they were using nightlights to hunt was simply an evolved form of the ancient methods of illuminating the night through torches.⁴⁵ How these rights “translate” into rights already recognized in law has come under scrutiny by a number of legal scholars.⁴⁶ Moreover, the fact that Aboriginal rights must be molded into something that is recognizable in Canadian law is an affront to these rights and the right to health for Aboriginal people is no exception while the courts modify the tests to determine an Aboriginal right.

The Supreme Court adopted a broader approach to Aboriginal rights than the tests found in *Van der Peet* through *R. v. Sappier* and *R. v. Gray*⁴⁷ which were also log harvesting cases. The Court focused on seeking the significance of a resource to the Aboriginal lifestyle thus creating a restriction on the exercise of these rights. They recognized the Aboriginal right to harvest for domestic uses and rejected any “commercial dimension” to harvest. The Court made some very important findings and held that the Aboriginal right must be protected to preserve Aboriginal society. While the Court accepted the evidence of a Mi’kmaq historian, they also recognized the importance of recognizing harvesting as an Aboriginal right – although in this case there was no evidence of it being a pre-contact practice. In *Bernard*, the Supreme Court held that logging for sale or trade was not a traditional practice but actually interfered with the traditional practice of fishing:

The experts agreed that it was probably in the 1780s before the Mi’kmaq became involved in logging and then only in a limited fashion as part of British operations. Logging was not a traditional Mi’kmaq activity. Rather, it was a European activity, in which the Mi’kmaq began to participate only decades after the treaties of 1760-61. If anything, the evidence suggests that logging was

⁴⁵ *Morris*, *supra* note 35 at paras 82, 87, 92.

⁴⁶ See Kent McNeil, “Aboriginal Title and the Supreme Court: What’s Happening?” (2006) 69 Sask. L. Rev 679; Mark Walters, “The Morality of Aboriginal Law” (2006) 31 Queen’s L.J 470; Paul Chartrand, “*R. v. Marshal*; *R. v. Bernard*: the Return of the Native” (2006) 55 U.N.B.L.J. 135.

⁴⁷ *Sappier and Gray*, *supra* note 18.

inimical to the Mi'kmaq's traditional way of life, interfering with fishing which, as found in *Marshall 1*, was a traditional activity.⁴⁸

The *Sappier* and *Gray* decision also addressed some of the problems that have arisen since the 1996 “integral to a distinctive culture” test found in *Van der Peet*. The problems encountered were such that there was some thought that the distinctness had to be different from other cultures (that is not practiced by other people). Because many societies historically harvested wood, the central issue is whether or not the harvesting of wood for survival purposes (to provide shelter) is central to the Mi'kmaq's distinctive cultures. If it is central then it is an Aboriginal right. The Court notes the differences in the terms “distinctive” versus “distinct”.⁴⁹ To be considered *distinct*, harvesting timber would have to be seen as is unique to that aboriginal community (as compared to other communities) whereas *distinctive* would mean that harvesting wood must be of “central significance” to the community culture (regardless of whether other communities do the same). The Mi'kmaq “culture” focuses on the pre-contact way of life which includes their “means of survival, their socialization methods, their legal systems and, potentially, their trading habits.”⁵⁰ The Court also confirmed the *Sparrow* requirement that the right (as in not commercial) may be carried out in a modern form and not frozen in time. The historical fact that wood was used in pre-contact days to create temporary structures “must be allowed to evolve into one to harvest wood by modern means to be used in the construction of a modern dwelling.”⁵¹

The Court also reviewed the site-specific requirement of this Aboriginal right and acknowledged that the evidence showed that the harvesting of wood was within the traditional territories of the Mi'kmaq and Maliseet Peoples and found that the site specific test did not apply but did say that harvesting should be within traditional territory.⁵² The majority of the Court in *Sappier* held that the right had no commercial aspects to it. They held that the harvested wood could not be sold or traded for any reason even if it was to construct a new

⁴⁸ *Marshall and Bernard*, *supra* note 19 at para 34.

⁴⁹ *Marshall and Bernard*, *ibid* at para 36.

⁵⁰ *Marshall and Bernard*, *ibid* at para 45.

⁵¹ *Sappier and Gray*, *supra* note 18.

⁵² *Sappier and Gray*, *ibid*.

home. Mr. Justice Binnie disagreed on this point and said that the wood could be traded, sold or bartered if it was for domestic purposes and done within the reserve or local Aboriginal community.⁵³

Applying the tests found in *Sappier* and *Gray* to Aboriginal health, one might first characterize the practice of preventative care, healing and the maintenance of good health in relation to the tests found in *Van der Peet*. The following table is an illustrative summary of the *Van der Peet* tests as applied to Aboriginal health evidentiary facts (as documented in Chapter 4).

Table 1

***Van Der Peet* Test to Determine an Aboriginal Right to Health**

Van der Peet	Aboriginal Facts
Is the activity integral to the distinctive culture?	Yes. Health is undeniably integral to any culture, and in Aboriginal cultures – it is shown that there were highly evolved health practices
Is the activity of “central significance” to the society in issue?	Yes. The practice of specific health practices were at the center of the sphere of Aboriginal society.
Is it a “defining characteristic” and “one of the things that made the culture of the society distinctive”? (and as modified by <i>Sappier</i>).	Yes. Evidence of highly evolved medical knowledge through plants, herbs and nutrition. practiced preventative health, healing, disease treatments and the maintenance of good health.
Did it develop before “contact.”	Yes. Evidence through oral history, missionaries, traders, whalers, explorers
Did it develop not “solely as a response to European influences”?	Yes. Although evolved with the advent of disease brought by the Europeans, evidence to prove it was in place pre-contact
Were the Aboriginal rights to health infringed?	Yes, by racist, cruel and inhumane laws and policies
Were the Aboriginal rights to health extinguished at any time?	No evidence exists to corroborate this statement.

Were the infringements on the Aboriginal rights to health justified as per the *Sparrow* test?

⁵³ *Sappier and Gray, ibid.*

The Crown must prove that the infringing measures serve a “valid legislative objective”	There is contention in that the <i>Indian Act</i> and health policies, laws and legislation show that from an Aboriginal perspective the legislative objectives were racist, cruel and inhumane. The Crown has not been able to prove otherwise since.
That they are in keeping with the special trust relationship and responsibility of the government	No
Has the infringement been minimal?	No - extensive
Whether fair compensation has been available in a context of expropriation?	Forced into residential school claims, debatable. Does this mean expropriation? Not likely.
Has the affected Aboriginal group been consulted?	No
Has the infringement been justified?	No

The above tests will now be analyzed.

The first step is to identify the exact nature of the claim asserting that Aboriginal health is an Aboriginal right and the practice that is used to establish this right. In this case Aboriginal health is generally at a disadvantage compared to non-Aboriginal Canadians. Aboriginal people suffer from among others, higher rates of diabetes, heart problems, tuberculosis, and beyond comparison are the horrid social factors that keep children killing themselves and adults and children sniffing gas and solvents into self-destruction.⁵⁴ However, incredibly so, Aboriginal and treaty rights to be healthy are entrenched in the Constitution but these vast inequalities still exist. Policies and laws were enacted by the government that had a detrimental effect on Aboriginal health and may be considered breaches of Aboriginal and treaty rights as Aboriginal people had highly evolved medical knowledge through plants, herbs and nutrition, practiced preventative health, healing, disease treatments and the maintenance of good health. Chapter 4 clearly substantiated this.

⁵⁴CBC News, In Depth: Aboriginal Canadians, *Sheshatshiu: An Innu community's battle with addiction*, December 14, 2004, online: <http://www.cbc.ca/news/background/aboriginals/sheshatshiu.html> (accessed August 1, 2010); KNet Media, Aboriginal health programs developed and delivered without local support are failing, *Helping the Innu help themselves*, Nov. 18, 2006, online: <http://media.knet.ca/node/2350> (accessed August 1, 2010); Denis Calnan, This Magazine, *Innu village of Sheshatshiu out of crisis, into the classroom*, online: <http://this.org/magazine/2010/01/20/sheshatshiu-innu-school/> (accessed August 1, 2010).

In *Sappier* and *Gray* the court sought to understand how the logs were harvested, extracted and utilized as they were the practices that are integral to their culture – these are considered the “Aboriginal component”. Although the court found that it was not necessary to recognize harvesting as a pre-contact practice, they still found the Aboriginal component in the fact that ancestors of *Sappier* and *Gray* historically had harvested logs which thereby created an Aboriginal right. In either version – pre-contact or not – Aboriginal people clearly practiced good health care – or they would not have survived as thriving peoples and societies. Aboriginal health passes the first leg of the *Van der Peet* test as the court could clearly identify the specific *practices* of Aboriginal health that helps to define the distinctive way of life as an Aboriginal community. The court in *Sappier* and *Gray* stated:

The importance of leading evidence about the pre-contact practice upon which the right is claimed should not be understated. In the absence of such evidence, courts will find it difficult to relate the claimed right to the pre-contact way of life of the specific aboriginal people, so as to trigger s. 35 protection.⁵⁵

As also noted in Chapter 4, health practices are varied and distinctive to each culture, dependant on where they were located geographically in North America; they ranged from sweat lodges to the Grand Medicine Society. Arguably, this more than satisfies the evidentiary burden of proving the pre and post-contact practices of Aboriginal health and healing.

The second arm of the test is to identify the pre-contact practices that have evolved into present day form. In Chapter 4 it was shown that health and healing were practiced since time immemorial and continued, albeit often underground, because Canadian policies and laws attempted to destroy the ceremonies, languages and healing practices. The mere fact that healing practices evolved through the underground is achievement enough to satisfy this test. Akin to harvesting wood for a communal purpose, the right to practice Aboriginal health and healing assists the society in maintaining its distinctive character. It also should be noted that

⁵⁵ *Sappier and Gray*, *supra* note 18 at 22.

the Supreme Court has referenced the principle that an interruption in the continuity of the use of the use will not prejudice the claimants.⁵⁶

The Court differentiated between “distinctiveness” and “distinctness” and claimed that the proper test requirement is that the practice only be distinctive.⁵⁷ This means that the practice does not have to be a unique practice only done by the group claiming the right. In the context of Aboriginal health this is useful as all Aboriginal societies practiced some form of health care and provided protection for survival of the Aboriginal community thus garnering s. 35 protection.

Additionally, in relation to the distinctive culture test, Henderson and Barsh argue that culture has been taken to mean a “fixed inventory of traits or characteristics” which is inappropriate because “culture” is a moving process, not an actual thing that can be permanently described. The Supreme Court in *Sappier* explained what is meant by culture in relation to *Van der Peet*:

What is meant by “culture” is really an inquiry into the pre-contact way of life of a particular aboriginal community, including their means of survival, their socialization methods, their legal systems, and, potentially, their trading habits.⁵⁸

When the Courts looked at the term “distinctive” they qualified that it did not mean distinct and the notions of being Aboriginal cannot be reduced to racialized stereotypes of Aboriginal people. Chapter 4 provided a variety of documented evidence from Elders, historians, Jesuits, traders, explorers and fur traders that showed the colorful and diverse healing and health practices from various Aboriginal communities across Canada in different time spans and geographical regions, thereby showing that the practices of Aboriginal health and healing were integral to pre and post-contact distinctive cultures of Aboriginal people in Canada.

The nature of the right must be considered in the context of the pre-contact distinctive culture of the particular Aboriginal community and must be determined in light of the present day

⁵⁶ *Delgamuukw*, *supra* note 1 at para 198, See also *Van der Peet*, *supra* note 1 at para 65.

⁵⁷ *Van der Peet*, *supra* note 1 at para 254.

⁵⁸ *Sappier and Gray*, *supra* note 18 at para 45.

circumstances.⁵⁹ There are hundreds of instances of the modernization of Aboriginal healing practices. For instance, among many others, the Fort Qu'Appelle Hospital, Sioux Lookout Meno-Ya-Win Health Centre, the Nisga'a Valley Health Board and Weeneebayko Health Ahtushkaywin, Muskeg Lake Cree Nation, and Sturgeon Lake Cree Nation all practice modern forms of ancient Aboriginal health practices.⁶⁰ It appears then that that the continuity of this right may be confirmed as a modern form of a distinctive ancient practice(s).

The next requirement is the "site specific" requirement. In *Sappier and Gray*, this issue was not required to be addressed. However in *Marshall* and *Bernard* there was a site specific requirement and "[o]ccasional forays for hunting, fishing and gathering are not sufficient to establish Aboriginal title in the land.⁶¹ In relation to Aboriginal health, a site specific requirement would not be applicable as Aboriginal health was practiced throughout Canada and North America.

It is clear that Aboriginal health and health practices have been compromised. The evidence lays in the statistics noted earlier in the stark discrepancies of Aboriginal health and non-Aboriginal health: the infringement continues. It would be untenable to assume that this right was extinguished by treaty, statute or any laws as there has never been any clear intention to do so nor has it been implicitly extinguished. Additionally, through the examination of the legal history of health care in Canada, as applied to Aboriginal people, one is able to conclude that Aboriginal rights and treaty rights have been largely ignored by the federal government when passing laws and implementing health policies.⁶²

⁵⁹ *Van der Peet*, *supra* note 1 at para 48.

⁶⁰ Assembly of First Nations Health Secretariat, *Treaty Right to Health approved as major focus of CCOH Strategic Plan* (2005), online at <http://www.afn.ca/cmslib/general/HB04-SM-e.pdf> (accessed September 9, 2010).

⁶¹ *Marshall and Bernard*, *supra* note 19 at para 107.

⁶² Specific infringements are discussed in Chapter 6 where traditional healing practices were banned and criminalized such as the Potlach ceremony.

7.1.1 Aboriginal and Treaty Rights Tests as Applied to Aboriginal Health

When the principles emanating from the Supreme Court of Canada in *Sparrow*, *Van der Peet* and *Sappier and Gray* are applied to health and healing of Aboriginal people, it appears that there may be an Aboriginal right to practice Aboriginal health. However, the tests the Supreme Court of Canada has laid out are stringent. Under the *Sparrow* test the activity had to be a practice that was never properly extinguished. *Van der Peet* added that the activity had to be central to the pre-colonial Aboriginal culture, thereby creating another hurdle in that it had to be compatible with Canadian law as a whole. The Court in *Sappier and Gray* modified the tests somewhat by holding that a practice can be an Aboriginal right even if it is related to survival or a practice that is engaged in by other Aboriginal people.

Law Professors Barsh and Henderson question the logic of the Supreme Court in *Van der Peet* of the requirement to tie certain activities to a culture in order for it to be recognized as an Aboriginal right.⁶³ The Court reasons that the purpose of referring to Aboriginal rights in the *Constitution* was to reconcile pre-existing Aboriginal societies with the sovereignty of the Crown.⁶⁴ To qualify for s. 35 protection the practice must be “a central and significant part of society’s distinctive culture,”⁶⁵ must not have existed in the past “simply as an incident” to other cultural elements⁶⁶ or as a response to European influences.⁶⁷ The Court proposed a two stage decision making process involving the concept of “reconciliation” which “takes into account the Aboriginal perspective while at the same time taking into account the perspective of the common law,” and that “true reconciliation will, equally, place weight on each.”⁶⁸ These Aboriginal perspectives must then be rendered “cognizable to the non-Aboriginal legal system”⁶⁹ through a process of judicial adaptation. Even the Court in *Sappier and Gray*, determined that in order for a practice to receive s. 35 protection, it must pass the *Van der Peet* test:

⁶³ James (Sakej) Youngblood Henderson & Russel Barsh “The Supreme Court’s Van der Peet Trilogy: Naïve Imperialism and Ropes of Sand” (1997) 42 McGill L.J. 993 [Henderson Barsh].

⁶⁴ *Van der Peet*, *supra* note 1 at 539.

⁶⁵ *Van der Peet*, *ibid* at 539, 553, 564.

⁶⁶ *Van der Peet*, *ibid* at 539, 560.

⁶⁷ *Van der Peet*, *ibid* at 539, 554.

⁶⁸ *Van der Peet*, *ibid*.

⁶⁹ *Van der Peet*, *ibid*.

- Examination of the historical roots of the practice to determine its centrality to the pre-colonial Aboriginal culture.
- If it passes, the practice then should be adapted to make it recognizable to the western legal system.

Barsh and Henderson argue that the requirement to view the centrality of a practice or a custom as an object is problematic as the practice may be overlooked or regarded as incidental by some to either accept cultural testimony or reject it. The determination of centrality is left to the judges who wrongly apply centrality to all the rights of Aboriginal people. This process also cannot distinguish between the cultural elements that exist independently, so the loss of one element does not compromise the perpetuation of the others. The presumption of independence is completely incompatible with Aboriginal thought (all human activity is interdependent). Barsh and Henderson dismiss this notion of centrality in human society as absurd as “arguing that an ecosystem remains the same after the removal of a few incidental species” calling it a “judicial fiction.”⁷⁰ They argue that the term “culture” in *Van der Peet* means a fixed inventory of traits or characteristics which leads judges to presume they understand what a certain Aboriginal society once believed or valued at a certain point in time. This subjective viewpoint solidifies European paternalism when determining if a practice is an Aboriginal right. An excellent concrete example of evolving Aboriginal culture is found in the Haudenosaunee concept of “adding to the rafters” which allows for new laws to be added to the Great Law of Peace, just as new rafters would be added to the longhouses in which they lived. Future generations would be able to adapt to the natural changes in their lives and society through this concept.⁷¹

From the mere fact that the Supreme Court of Canada assessed Aboriginal practices in *Marshall* and *Bernard* and insisted on the ‘translation’ of the practice into a modern legal right is very problematic and is akin to saying that if it isn’t compatible with Canadian law then it may be deemed to be extinguished at law or at least unprotected by s. 35 and unenforceable.

⁷⁰ Henderson Barsh, *supra* note 63 at 6,

⁷¹ Johanna Lazore, “Indigenous Strategies to Protect Traditional Health Knowledge”. Unpublished on file with the author at 10. See also, Donald S. Lutz, “The Iroquois Confederation Constitution: An Analysis,” [Publius](#), Volume 28, Issue 2, 99-127, 1998, (CSF Associates, Easton, PA).

Although the Court in *Sappier* and *Gray* somewhat modified this requirement when they held that a practice can be an Aboriginal right even if it is related to survival or a practice that is engaged in by other Aboriginal people, yet the most stringent tests from *Van der Peet* must still be met.

The question arises whether the specific nature test (or centrality) developed by the Supreme Court of Canada in *Van der Peet* is appropriate in relation to Aboriginal people in the context of health and health-related activities. The practice of healing in accordance with their own customs and would apply to all traditional societies everywhere, for example, was not unique to a specific group of Aboriginal people – rather, practices will vary but remain integral to all Aboriginal people as part of collective societies. This regime established persistent and connected traditions. In *Sappier* the Court found that a practice can be an Aboriginal right if it is related to survival even if practiced by others. Thus a general rather than a specific type of test appears more applicable.⁷²

Legal Scholar Brian Slattery supports the specific right test and explains that the Aboriginal rights that the Court in *Van der Peet* recognizes is in a category called “specific rights,”

[R]ights that are specific to a particular Aboriginal group and whose dimensions are established by reference to the distinctive historical practices of that group.

Slattery contrasts *Delgamuukw* where “generic rights” are defined as “rights of a standardized character held by all Aboriginal groups that meet certain basic criteria.” In *Delgamuukw*, Aboriginal title gave the Aboriginal group the right to exclusive use and possession of the lands that they were exclusively using at the time of Crown sovereignty. The use in present day is not limited to the same use in effect at sovereignty; the use can evolve over time. Slattery explains:

⁷² For a discussion on generic Aboriginal rights, see B. Slattery, “New Developments on the Enforcement of Treaty Rights” (Paper presented to the Canadian Aboriginal Law Conference, Vancouver, Pacific Business & Law institute, December 2002) and Brian Slattery, [Aboriginal and Treaty Rights] [unpublished, on file with the author].

Although the Court maintains somewhat half heartedly that Aboriginal title fits into the broad category of Aboriginal rights recognized in *Van der Peet*, it is clear that in fact the Court is recognizing a quite different category of Aboriginal rights – what may be called generic rights. ...The basic contours of a generic right are determined by the common law rather than aboriginal practices, customs and traditions. So the abstract dimensions of the right are identical in all groups where the right arises, even if it may take somewhat different concrete forms in practice.⁷³

Slattery further dismisses the requirement in *Van der Peet* that the activity that is claimed to be an Aboriginal right must have developed before “contact.”⁷⁴ He states:

All land based Aboriginal rights need to be measured against a uniform threshold date if conflicts are to be avoided. The date of contact is not suited for this role. It does not provide a solid basis for distinguishing between aspects of aboriginal society that are worthy of constitutional protection and those that are not. It is both over-inclusive and under-inclusive. The most appropriate threshold date is the time of sovereignty, that is, the time the Crown actually assumed governmental authority over a particular territory and responsibility for its aboriginal inhabitants.⁷⁵

When looking closer at *Van der Peet*, Slattery states that what the Supreme Court recognized is actually a generic right at the abstract level that “gives birth to a series of specific rights that must be proved individually and that differ from group to group” (Slattery calls these “umbrella rights”). The generic right itself is a right of uniform dimensions that is held by all Aboriginal groups. However, McEachern C.J. for the court in *Delgamuukw* stated “that aboriginal rights are not proprietary in nature, but rather “personal and usufructuary”, and dependent upon the good will of the Sovereign.”⁷⁶ Whereas the court in *Powley* found that the pre-contact test might not be so useful to prove the varied range of “Métis customs, practices or traditions that are entitled to protection, since Métis cultures by definition post-date European contact.”⁷⁷

⁷³ Aboriginal and Treaty Rights, *ibid.*

⁷⁴ Aboriginal and Treaty Rights, *ibid* at 60-62.

⁷⁵ Aboriginal and Treaty Rights, *ibid.*

⁷⁶ *Delgamuukw*, *supra* note 1 at para 17.

⁷⁷ *Powley*, *supra* note 30 at para 16

In the Supreme Court of Canada decision of *R. v. Marshall*⁷⁸ it was held that when Aboriginal people pass under the protection of the Crown, they then have the right to sustain themselves in the manner they had prior to sovereignty. Although *Marshall* is specifically about the interpretation of a treaty – it goes about this task against a background of generic rights – what Slattery calls generic rights of sustenance.⁷⁹

In *Sappier* and *Gray* the Court supported the notion that Aboriginal rights did not have to be proven pre-contact but could assume this when it is obvious for survival (for instance Inuit would not have to prove they were “loggers” pre-contact and similarly Mi’kmaq would not have to prove their proficiency in snow hut building). The practice can be then seen as an Aboriginal right even if it is related to survival or a practice that is engaged in by other Aboriginal people thereby fulfilling the requirements for classification as a generic right (which may be in direct contradiction to *Sparrow* that said the activity had to a practice that was never properly extinguished). Accordingly, in general, when Aboriginal people came under the sovereignty of the Crown a standard array of generic rights was recognized by virtue of the common law Doctrine of Aboriginal Rights. Some examples of generic rights are:

- Right of self-government;⁸⁰
- The right to conclude treaties;⁸¹
- The right to an autonomous legal system;⁸²
- The right to Aboriginal title;⁸³
- The right of sustenance;⁸⁴
- The right to cultural integrity.⁸⁵

⁷⁸ *R. v. Marshall*, [1999] 3 S.C.R. 456, [1999] 4 C.N.L.R. 161 [*Marshall*].

⁷⁹ *Marshall*, *ibid*.

⁸⁰ The utility of self government being a generic right is arguable. *Campbell v. British Columbia (Attorney General)* (2000) BCSC 1123, 79 B.C.L.R. (3d) 122 (S.C.) [*Campbell*].

⁸¹ *Marshall*, *supra* note 78.

⁸² *Casimel v. Insurance Corp. of British Columbia* (1993), [1994] 2 C.N.L.R. 22, 82 B.C.L.R. (2d) 387, 30 B.C.A.C. 279, 49 W.A.C. 279, 18 C.C.L.I. (2d) 161, 106 D.L.R. (4th) 720 (C.A.) [*Casimel*]. *Van der Peet*, *supra* note 1, *Delgamuukw*, *supra* note 1, *Campbell*, *supra* note 80.

⁸³ *Delgamuukw*, *supra* note 1.

⁸⁴ *R. v. Adams*, [1996] 3 S.C.R. 101, [1996] 4 C.N.L.R. 1, *R. v. Cote*, [1994] C.N.L.R. 98, [1993] R.J.Q. 1350, 107 D.L.R. (4th) 28 (Que. C.A.) leave to appeal refused (1994), 63 Q.A.C. 142 (note), 109 D.L.R. (4th) vii (note), 172 N.R. 90 (note) (S.C.C.) [*Cote*]; *Marshall*, *supra* note 78.

⁸⁵ *Van der Peet*, *supra* note 1.

Although, the Aboriginal right to health may fall in every category listed by Slattery, it particularly falls in closely with a set of generic rights in cultural integrity (and may be seen to stand on its own as a generic cultural Aboriginal right to health),

The right to cultural integrity gives rise to a range of distinct specific rights to engage in particular activities, whose nature and scope are established by reference to the practices, customs and traditions of the group at time of contact.⁸⁶

When generic status is applied to the Aboriginal right that includes health and healing, at the abstract level, the rights are uniform. As discussed, all Aboriginal groups were practicing some type of health based practices or ceremonies to maintain good health and to prevent ill health at the time of Crown sovereignty and pre-contact. However, at the concrete level this generic right assumed a variety of particular forms that were distinctive to each Aboriginal group (specific rights from umbrella rights). For instance the methods used were designed specifically to suit local needs (culturally, linguistically, geographical, environmentally ie: what medicines are available and otherwise). The different forms found in practices are specific rights. In health matters, the practice of health generally (generic rights) may be broken down into sub-rights by putting into practice the application of health measures (specific rights).

Using Slattery's generic rights analysis while interpreting *Van der Peet* in that the existence of an Aboriginal right must be specific to a definable group and the right must be distinct to that group is not useful (and according to Slattery – not correct) when recognizing a general or generic right to health. Rather, analyzing *Van der Peet* as being reflective of a generic right with distinctive specific rights may be more appropriate to establish Aboriginal health (which traditionally consisted of methods (specific rights) to create a good state of health).

Certainly, *Sappier* and *Gray* illustrates that a practice can be an Aboriginal right even if it is related to survival, into which clearly health falls. Additional case law illustrates that an

⁸⁶ *Van der Peet* cited by Slattery, *Aboriginal and Treaty Rights*, *supra* note 72.

Aboriginal right to health has been accepted as a generic right. The courts have stepped out of the *Van der Peet* framework and recognized rights (specific rights) outside of the basic (generic) Aboriginal rights and recognized “incidental” rights as the ability to pass the accompanying knowledge of the use of the Aboriginal right to a succeeding generation. In *R. v. Cote*⁸⁷ the issue was that of an Algonquin fisher being charged with not obtaining provincial licenses to fish as well as not paying the fee to enter the provincial park. The Supreme Court of Canada held that freshwater fishing had been an important source of sustenance thereby obliterating the requirement to obtain provincial fishing licenses, however the defendant had not been fishing for himself but to teach a younger generation how to fish. The Court confirmed incidental rights when “a substantive Aboriginal right will normally include the incidental right to teach a practice, custom and tradition to a younger generation” but may convict on other grounds.⁸⁸

While the Courts recognize incidental rights to Aboriginal rights, it is reasonable to assume that Aboriginal rights then are not static but generic to a genus of Aboriginal rights that can change with cultures and environments and specific rights are integral and a sub category to Aboriginal rights. Cultural elements are interdependent and the courts struggle with the concepts of recognizing these rights as being in constant change. The centrality of cultural elements cannot be tied to a specific culture (knowledge, heritage and traditions of health care). Therefore it may be said that the right to health and the practice of these rights are integral to all human beings but for Aboriginal people the specialized practices (as illustrated earlier) were/are integral to their distinctive cultures pre-contact and pre-sovereignty by Aboriginal nations in general.

⁸⁷ *Cote, supra* note 84.

⁸⁸ The court said:

In the aboriginal tradition, societal practices and customs are passed from one generation to the next by means of oral description and actual demonstration. As such, to ensure the continuity of aboriginal practices, customs and traditions, a substantive aboriginal right will normally include the incidental right to teach such a practice, custom and tradition to a younger generation. Thus, looking behind the immediate context of the appellant Côté’s actions, the actual substantive claim in this instance should still be viewed as a right to fish for food. *Côté, supra* note 84 at 176.

7.2 Treaty Rights to Health and Healing

*The three purposes for entering into treaties or ‘covenant’ with the British sovereign was to ensure that future generations would continue to govern themselves and their territories according to Aboriginal teachings and law; (2) would make a living (pimachihowin), providing for both spiritual and material needs; (3) would live harmoniously (witaskewin) and respectfully with treaty settlers.*⁸⁹

The treaties entrenched legally binding relationships between the Crown and Indian nations with the intent to create obligations. The Supreme Court of Canada has confirmed that a treaty is an exchange of solemn promises from formal negotiations between two sovereign nations: the Crown and Indian nations, whose nature is sacred.⁹⁰ Obligations between the parties are derived from the intent and context of the treaty negotiations.

Treaties are legal instruments of Canadian law. A critical purpose of the treaties was to ensure that the British sovereign and Canadian governments would provide protection for Aboriginal people. Some First Nations, through conveying territory to the sovereign, understood that the sovereign could use the lands to generate beneficial revenue for government services, services that would include Aboriginal people. The government stance that no one deserves to benefit from “free” medical services certainly rings true for Aboriginal people – as within the treaties and within inherent Aboriginal rights the costs of these services have been dear and were paid for through the exchange of land for government services. Interestingly, in 1970 in a congressional address, American President Nixon stated, “to the extent that the government has provided health services for Indians in conjunction with treaties in which land was ceded, Indian health care represents a prepaid health plan – quite likely the first example of such a concept.”⁹¹

First Nations have retained their treaty rights regarding matters relating to jurisdiction over internal health matters, unless specific treaties contained terms to the contrary that were clearly

⁸⁹ Treaty Rights to Health, *supra* note 10. See also H. Cardinal & W. Hildebrandt, *Treaty Elders of Saskatchewan* (Calgary: University of Calgary Press, 2001) at 31-38 [Cardinal and Hildebrandt].

⁹⁰ *Badger*, *supra* note 8.

⁹¹ Pfefferbaum R, Pfefferbaum B, Rhades E, and Rennard J. “Providing for the Health Care Needs of Native American: Policy, Programs, Procedures, and Practices” 21(1) *American Indian Law Review* pp 211-258 at 219.

understood by both parties as diminishing the sovereign authority of the First Nation concerned. This is clearly not the case.

In the early 1600s French settlers in North America negotiated the first treaties with the Indians, the British Crown followed by negotiating treaties with First Nations from 1725 to 1930.⁹² Treaty-making was the primary route chosen to establish significant relationships by both the Crown and First Nations in most of Canada. From their beginning, treaties have played an important role in the relationship between the Crown and First Nations in Canada. The purposes of the treaties have varied. At first they were intended to encourage trade and military alliances versus the common enemy and to establish peace and friendship, but later treaties were designed to acquire land controlled by First Nations. In all cases there was an exchange of promises. The spirit and intent of the treaties between the Crown and First Nations are based on harmony, peace, respect, good relations and honour.⁹³ Treaties have been negotiated in Canada between First Nations and the Crown in both the pre and post-Confederation eras.⁹⁴ The numbered treaties were negotiated after Confederation to allow the influx of European settlers and to industrialize the country⁹⁵ from Treaty 1 in 1871 to the final adhesions to Treaty 9 in 1930.⁹⁶

It is proposed that the Chiefs and Headmen who were responsible for negotiating the numbered treaties were shrewd and savvy than the history books suggest - having benefited from two

⁹² Canada in the Making, "Aboriginal, Treaties and Relations", 2005 online:

http://www.canadiana.org/citm/themes/aboriginals/aboriginals2_e.html (accessed October 17, 2009).

⁹³ Office of the Treaty Commissioner, *Treaty Implementation: Fulfilling the Covenant* (Office of the Treaty Commissioner: Saskatoon) 2007 at xiv [OTC].

⁹⁴ Pre-Confederation Treaties include the Peace and Friendship Treaties on the East Coast, the Treaty of Swegatchy (Southern Quebec), the Murray Treaty of 1760 (Quebec), the Upper Canada Treaties (Southern Ontario), the Robinson- Huron Treaties (Ontario), the Douglas Treaties (Vancouver Island), the Selkirk Treaty (Manitoba) and the Manitoulin Island Treaties (Ontario) (OTC, *ibid*).

⁹⁵ OTC, *supra* note 93.

⁹⁶ The first post-Confederation Treaty was Treaty 1, which was concluded on August 3, 1871 at the Hudson's Bay Company post, Lower Fort Garry. Treaty 2 was signed on August 21, 1871 at the Manitoba House Post and Treaty 3, or the North-West Angle Treaty, was concluded on October 3, 1873, near Lake of the Woods. The first of the Saskatchewan Treaties was Treaty 4, concluded on September 14, 1875 at the Qu'Appelle Lakes. Treaty 5 was signed in 1875. Treaty 6 was negotiated in 1876 (the same year that the first *Indian Act* was passed, although 'pre-Indian Act' legislation had been passed as early as 1868), Treaty 7 passed in 1877, from 1899 to 1922 Treaties 8 to 11 were concluded; the Williams Treaty was passed in 1923 and finally adhesions to Treaty 9 in 1930 (OTC, *ibid*).

centuries of fur trade with Europeans.⁹⁷ They also had experience with the already concluded treaties in Upper Canada and the United States. One might argue that the signing of the treaties was a need born from disease, the extinction of the buffalo, the incoming railway, the influx of white settlers and a looming civil war. However when reviewing the history of the fur trade in North America it may be argued that the Chief and Headmen were somewhat effective in substituting the benefits that accrued to them while they were dealing with the Northwest Company (NWC) and the Hudson's Bay Company (HBC) (which transferred its territory to Canada in 1870) to the inclusion of the treaties.⁹⁸

English and French explorers arrived in the late 15th and early 16th century marking the start of a long period of colonization and competition. In 1604 [Samuel de Champlain](#) created the first settlement at the Bay of Fundy (Acadia). In the early 1600s, treaties were negotiated by the Crown (which would eventually be the United States), and the (then) five -nation [Iroquois Confederacy](#). Trade markets began booming in North America with all parties benefiting from trade: the Europeans wanted the furs and the First Nations wanted goods that the Europeans possessed. Through the trade system “both societies exchanged technologies and material goods that made their lives easier in their common environment.”⁹⁹ In 1668 the fur trade erupted, resulting in huge European financial gains for beaver pelts and as a result the British Crown granted a Charter to the Hudson's Bay Company (HBC) which granted HBC the title to all the lands that drained into the Hudson's Bay (later called Rupert's Land). Rupert's Land was an area roughly one-third the size of Canada and was comprised of what is now parts of Alberta, Saskatchewan, Manitoba, Northwest Territories, Nunavut, Quebec and Ontario. The French and the HBC fought bitterly over fur trade supremacy until 1760 when the French trading company collapsed and was overtaken by the Northwest Company (Montreal based Scottish and British traders). The year 1821 marked the merger between the HBC and NWC, the competition between the two companies ended.¹⁰⁰

⁹⁷ Arthur Ray, Jim Miller, Frank Tough, “Bounty and Benevolence: A History of Saskatchewan Treaties” (McGill-Queen's University Press, 2000) [Bounty].

⁹⁸ Bounty, *ibid.*

⁹⁹ Royal Commission on Aboriginal Peoples. *Volume 1: Looking Forward, Looking Back*. (Ottawa: Minister of Supply and Services, 1996) 101.

¹⁰⁰ Sarah Carter, *Aboriginal People and the Colonizers of Western Canada*. (Toronto: University of Toronto Press, 1999) at 48.

It was clear early on that the fur traders understood that they required permission from the Aboriginal people to travel, trade and build forts and posts in Canada.¹⁰¹ As early as 1680 the HBC instructed its men:

Wee judge [it] would be much for the interest and safety of the Company, That...In severall places where you are, or shall settle, you contrive to make compact with. The [Native] capt. Or chiefs of the respective Rivers and places, whereby it might be understood by them that you had purchased both the land & rivers of them, and that they transferred the absolute propriety to you, or at least the only freedom of trade.¹⁰²

The HBC incorporated First Nation practices into the trade, as they needed the allies. For instance they participated in ceremonies such as the pipe ceremony and exchanged gifts.¹⁰³ The pipe ceremony was undertaken with great seriousness before trading. At times the First Nation would leave the pipe with the trading partners and take it back if the relationship ended or was compromised.¹⁰⁴ The parties also exchanged gifts in a Cree ceremony called *Puc ci tin ash a win* in which good will and spiritual blessings were received in exchange for gifts from the First Nations. Medicines and (disease ridden) uniforms were also given to the Aboriginal people to assist them in combating the diseases to which they had no immunity.¹⁰⁵

In the 1800s as the buffalo died and disease decimated Aboriginal peoples, the HBC tried to protect its interests through administering vaccines against smallpox and assisting the frail and elderly. The HBC tried to conform to the principles of good relations.¹⁰⁶ By engaging in ceremonies and assisting in times of need they garnered the good will of the Aboriginal people and they required a measure of good will to gain access to their lands. This was extended by the Crown during the treaty-making period. The fur trade was very important to the treaty-making because it set the standard for negotiations which were adopted during the treaty negotiations such as the provisions of rations and medicines. The terms and protocols of the treaties were concretely developed during the fur trade which began two hundred years before.

¹⁰¹ Arthur Ray, *I Have Lived Here Since the World Began: An Illustrated History of Canada's Native People*: (Toronto: Lester Publishing, 1996) at 69 [Ray].

¹⁰² Ray, *ibid* at 70.

¹⁰³ Bounty, *supra* 97 at 10.

¹⁰⁴ *Ibid*, at 17.

¹⁰⁵ *Ibid*, at 16.

¹⁰⁶ Cardinal and Hildebrand, *supra* note 89 at 19-21.

It is contended that the protocols and behaviours of the treaty parties were an extension of the fur trade practices. As the buffalo disappeared and disease swept through the lands, the Chief and Headmen were shrewd in their negotiations for the continuance of the medicines and provisions in hard times (pestilence and famine clause); they negotiated for a new way of life that would be compatible with the settlement and agriculture that was clearly upon them. First Nation leaders exerted a powerful influence on treaty-making, an influence that the official historical records failed to acknowledge. Indeed, the text of the numbered treaties should be considered incomplete and inaccurate without evidence of these negotiations and this critical Aboriginal perspective. These misunderstandings and omissions have led to many problems that contribute to the interpretation of treaties¹⁰⁷ and ultimately to the poor state of Aboriginal health today. Evidence does not exist to support the notion that jurisdiction over internal health matters was ever relinquished as no terms to the contrary were brought forward by either party that would remove health jurisdiction that could diminish the sovereign authority of the First Nation concerned.

The written treaty provisions carry verbal and written promises of medicines and protection and a new way of life. For the purposes of reviewing health and healing we are focusing primarily on the post confederation treaties and the settlement in the western provinces where promises and undertakings were made specifically in relation to health with no relinquishment of First Nation jurisdiction in this area.

¹⁰⁷ An example of this is in Treaty 8: The Treaty Commissioners, in their report on negotiations promised that Indian people would be exempt from military service and taxation; however, the pledge was not included in the actual provisions of the treaty. In 2002, the Federal Court of Canada ruled in the case *Benoit v. Canada*, [2002] 2 C.N.L.R. 1) that Indians in northern Saskatchewan, northeastern British Columbia, and the Northwest Territories were exempt from all forms of taxation because of the promise made by the commissioners in 1899. During the trial, the oral testimony of Elders was admitted as evidence, and this information provided vital context to the Indian understanding of the promise of tax exemption. In reacting to the decision, the Canadian Taxpayers Federation and many media commentators wrongly viewed the decision as one based on race, not on an historic treaty obligation. This was overturned on appeal (*Benoit v. Canada*, 2003 FCA 236, [2003] 3 F.C. D-35). There were other problems. Since numbered Treaties 4, 5, and 6 predated the first consolidated *Indian Act* of 1876, many contemporary Indian leaders traced their relationship with the Crown and new colonists to the treaties, not to the *Indian Act*. The treaties were forward looking documents designed as a framework for future relations. The *Indian Act*, on the other hand, emphasized assimilation. This outcome was not part of the original spirit and intent of the treaties.

Contrary to some government views, treaties are not simple business contracts.¹⁰⁸ The English words in the treaties encompass British legal traditions but they do not encompass ways of knowing through Aboriginal legal traditions. The traditions inform the parties' respective historical lineages, however these are found behind the text and function within the treaty text. For Aboriginal people the best sources of information from an Aboriginal perspective are the oral traditions of those who were present at the signing of the treaties or accounts transmitted orally or by legal traditions.¹⁰⁹ Thus, while being sensitive to the unique cultural and linguistic differences between the parties,¹¹⁰ construing the English words generously, and resolving all doubts in favor of the Indians, Courts cannot alter the terms of the treaty by exceeding what "is possible on the language" or realistic in Court's terms.¹¹¹

Outside of the written text of Treaty 6 that refers to the medicine chest, there is documentary evidence that health was discussed in the negotiations of other treaties. Historian René Fumoleau provided considerable information on the actual negotiation of the treaties and their terms (as distinguished from the written versions) such as details on epidemic diseases and failure to provide medical care as promised in the treaties. Fumoleau presented a great number of quotations from archival, published and interview material regarding the history of the treaties from the varied perspectives of the Aboriginal people, traders, police, commissioners and government employees, Métis and other observers, translators, and missionaries. In brief, this material provided considerable support for the view that the treaties are not accurately represented by the written treaty documents.¹¹² For instance, in 1887 Thomas White (Superintendent of Indian Affairs) recorded that the Indians of the Peace River district were very sick and that they had little food and were suffering from the croup and measles. White reported that the Hudson's Bay Company stated that the government should be responsible for the sick and destitute as their protectors and the Hudson's Bay Company should not be

¹⁰⁸ *Badger*, *supra* note 8. *R. v. Horseman*, [1990] 1 S.C.R. 901, [1990] 3 C.N.L.R. 95 at 908 [Horseman].

¹⁰⁹ Waldrum, Herring & T.K. Young, *supra* note 6 at 142.

¹¹⁰ *Van der Peet*, *supra* note 1 at paras. 52-54.

¹¹¹ *Badger*, *supra* note 8 at para. 76; *R. v. Sioui*, [1990] 1 S.C.R. 1025, [1990] 3 C.N.L.R. 127 [*Sioui*] at p. 1069; *Horseman*, *supra* note 108.

¹¹² Rene Fumoleau, 1973 *As Long as this Land Shall Last A History of Treaty 8 und Treaty 11, 1870-1939*. McClelland and Stewart, Toronto [Fumoleau].

responsible.¹¹³ Fumoleau also reported that an article described “Starving Indians” where it was suggested that the destitute Indians needed a treaty to alleviate their poor conditions.¹¹⁴

Fumoleau also reports that the negotiations of Treaty 8 included medicines and medical care¹¹⁵ and relied on a report by D. McLean (Assistant Deputy of Indian Affairs) in 1919 that the Indians were “assured ... the Government would always be ready to avail itself of any opportunity of affording medical service.”¹¹⁶ Additionally, the report of the treaty commissioners also stated that Indian requested assistance in seasons of distress and the “old and indigent who were no longer able to hunt and trap and who were consequently often in distress should be cared for by the government.”¹¹⁷ The Treaty Commissioners also promised that supplies of medicines would be put at various points by the government and distributed free of charge to those that require them. They also explained that it was impossible for the government to arrange regular medical care to all Indians as they were so spread out, but they did say that the government would avail itself of every opportunity to provide medical services by way of the physician who traveled with the commissioners.¹¹⁸ As for Treaty 11, the stories are similar as the destitute and sick Indian asked to be in the treaty to alleviate their suffering.¹¹⁹ Treaty 5 Indians were furious in 1915 when a physician did pay his annual visit as they had expected him to.¹²⁰ A Treaty 7 Elder commented that the “only two promises they kept were with regard to medicine and education.”¹²¹ The provision of medicines and medical care were linked to the treaties themselves because the medical doctor accompanied the treaty parties after the treaties were signed and on all subsequent treaty annuity days. The link between treaty and medicines and medical care was clear as well as oral terms of the negotiations formed the whole of the treaty.¹²²

¹¹³ Fumoleau, *ibid* at 36.

¹¹⁴ Fumoleau, *ibid* at 37.

¹¹⁵ Fumoleau, *ibid* at 114.

¹¹⁶ Fumoleau, *ibid*.

¹¹⁷ R. Daniel, 1987 “The Spirit and Terms of Treaty Eight “ in Richard Price, ed. *The Spirit of the Alberta Indian Treaties*, 47-100. Montreal: Institute for Research on Public Policy at 98 [Daniel].

¹¹⁸ Daniel, *ibid* at 98.

¹¹⁹ Fumoleau, *supra* note 112 at 114.

¹²⁰ W. Morrison, *Showing the Flag: The Mounted Police and Canadian Sovereignty in the North, 1894 – 1925*. Vancouver: University of British Columbia Press , 1985 at 149.

¹²¹ Daniel, *supra* note 117 at 142.

¹²² Fumoleau, *supra* note 112 at 114.

7.2.1 Interpretative Principles

Because treaties attract special principles of interpretation, the Supreme Court of Canada has laid out guiding principles.¹²³

- The spirit and intent, outside of the written word, must be interpreted fully. Treaties should be liberally construed and ambiguities or doubtful expressions should be resolved in favour of the Aboriginal signatories.¹²⁴
- Any limitations that restrict the rights of Indian signatories must be narrowly construed.¹²⁵ Treaties made with Aboriginal people were written in the English language. The words of the treaty must be given the sense which they would naturally have held for the parties at the time.¹²⁶
- A technical or contractual interpretation of treaty wording should be avoided.¹²⁷
- Where a treaty was concluded orally and transcribed by the Crown's agents afterwards, the Crown cannot ignore the oral terms¹²⁸ thereby requiring the Court to supply any deficiencies in the written document.¹²⁹
- When the Courts have been faced with various interpretations of the treaties judges are directed to choose the mutual intent that best reconciles the shared interests of the treaty parties.¹³⁰
- A reasonable person's standard must be used to determine incidental treaty rights,¹³¹ and used an "ubiquitous officious bystander's" perspective to understand the intent and context of the treaties.¹³²
- The Courts must interpret the treaties in a way that does not bring dishonour to the Crown;¹³³ they must assume the integrity of the Crown and the desire of the Crown to

¹²³ *R. v. Sundown*, [1999] 1 S.C.R. 393, at para. 24; *Badger*, *supra* note 8. at para. 78; *Sioui*, *supra* note 112 at para. 1043; *Simon v. The Queen*, [1985] 2 S.C.R. 387, at p. 404 [Simon]. See also: Sui Generis, *supra* note 8; L. I. Rotman, "Defining Parameters: Aboriginal Rights, Treaty Rights, and the Sparrow Justificatory Test" (1997), 36 *Alta. Law Rev.* 149.

¹²⁴ *Nowegijick v. The Queen* [1983] 1 S.C.R. 29 at 36; *Simon*, *ibid*, at p. 402; *Sioui*, *supra* 119, at p. 1035; *Badger*, *supra* note 8.

¹²⁵ *Badger*, *ibid*.

¹²⁶ *Badger*, *ibid*, at para. 53 et seq.; *Nowegijick v. The Queen*, [1983] 1 S.C.R. 29, at 36.

¹²⁷ *Badger*, *ibid*; *Horseman*, *supra* note 108; *Nowegijick*, *ibid*.

¹²⁸ *Marshall*, *supra* note 78.

¹²⁹ *Ibid*, at 43-44.

¹³⁰ *Van der Peet*, *supra* note 1 at para. 45.

¹³¹ *Sundown*, *supra* note 123 at para 41.

¹³² Treaty Rights to Health, *supra* note 10.

¹³³ See, for example, *R. v. White* (1965), 52 D.L.R. (2d) 481 (S.C.C.), affirming (1964), 52 W.W.R. 193 (B.C.C.A.), per Norris J.A.; *R. v. Taylor* (1981), 34 O.R. (2d) 360 (C.A.); *R. v. George*,

fulfill its promises;¹³⁴ they must be vigilant to ensure any hidden intent of the Crown to be deceitful, commit fraud or to use sharp practices is not validated.¹³⁵

- Treaty rights, like Aboriginal rights, are not frozen in time, but rather¹³⁶ must be interpreted in meaningful present day language that is sensitive to the evolution of change in normal practice that recognizes “continuing obligations.”¹³⁷

Under the interpretative principles of treaties, these oral and written statements of the Treaty Commissioners would create a treaty right to Aboriginal health (meaning full health services on par with other Canadians in a modern context). The following sections review specific promises made.

7.2.2 Protection and Non-interference

In 1871, Treaty Commissioner Archibald opened the negotiation of the numbered treaties by stating that the “Great Mother” Queen Victoria wished the Indian people to be “happy and content and live in comfort...to make them safer from famine and distress...to live and prosper.”¹³⁸ The Great Mother “has no idea of compelling you to do so,” but left the lifestyle decision to their own “choice” and “free will.”¹³⁹

In the 1874 Treaty 4, the Qu’Appelle Treaty, Commissioner Archibald reaffirmed the Queen’s wishes:

[t]he Queen cares for you and for your children, and she cares for the children that are yet to be born... The Queen has to think of what will come long after today. Therefore the promises we have to make to you are not for today only but for tomorrow, not only for you but for your children born and unborn, and the promises we make will be carried out as long as the sun shines above and water flows in the ocean.¹⁴⁰

[1966] S.C.R. 267 (Cartwright J. dissenting); *R. v. Wesley*, [1932] 4 D.L.R. 774 at 788 (Alta. C.A.); *R. v. Cooper*; *R. v. George* (1968), 1 D.L.R. (3d) 113 (B.C.S.C.).

¹³⁴ *Van der Peet*, *supra* note 1 at para 42.

¹³⁵ *Badger*, *supra* note 8.

¹³⁶ *Ibid.*

¹³⁷ See discussion of *Sioui*, *supra* note 118 and *Sundown*, *supra* note 123 in *Marshall*, *supra* note 78 at para 53.

¹³⁸ Chiefs of Treaty 6, 7, 8, *Declaration of Treaty 6, 7 and 7 First Nations: Treaty Right to Health* (2005) online: http://www.treatycouncil.org/PDFs/Treaty_Rights_and_Health_Resolution.pdf (accessed August 1, 2010).

[Declaration].

¹³⁹ Reported by A. Morris, *The Treaties of Canada with the Indians of Manitoba and the North West Territories, Including the Negotiations on Which They Were Based and Other Information Relating Thereto* (Toronto: Belfords, Clarke, 1880) commencing at 28 [Morris].

¹⁴⁰ Morris, *ibid* at 92.

In 1876 during the Treaty 6 negotiations, the Treaty Commissioner “fully explained” to the Cree that they (the treaty makers) “would not interfere with their present mode of living,”¹⁴¹ and that what was being offered by the Treaty Commissioner “does not take away your living, you will have it then as you have now, and what I offer you is put on top of it.”¹⁴² Additionally, “we have not come here to take away anything that belongs to you.”¹⁴³ In Treaty 7 of 1872, the Treaty Commissioner told the Blackfoot that the purpose of the treaty was so that the Great Mother “would hold them in the palm of her hand and protect them and look after them just like a child, as long as the sun, rivers and mountains last... [The Queen] will take the best care of you. Whatever you ask for will be given to you.”¹⁴⁴

Again in 1899, the Treaty 8 Chiefs and Headmen stressed the importance of maintaining their way of life and livelihood during the negotiations.¹⁴⁵ The Treaty Commissioners made it clear that the intent of the treaties was not to interfere with their traditional way of life.¹⁴⁶ The spirit and intent of the treaties that Indians were promised that their traditional way of life would not be interfered with and that they would receive benevolence from the ‘Great Mother’/Queen of England.

The treaty negotiations also contain many references to the protection and non-interference with Aboriginal ways of life. As being vital to life, these references naturally apply to Aboriginal people’s health and well being. From 1837 to 1901, under the Treaties, for example, the ‘Great Mother’ was obliged to “create an enriched way of life for treaty beneficiaries and their ancestors.”¹⁴⁷ In Treaties 6, 8, 9, and 10 there is explicit reference to medicine in either the wording of the treaties or in records of the oral negotiations surrounding the Treaties. Treaty 7 Elders confirm the treaty right to medicines, medical care and indeed health was negotiated. In none of the numbered treaties is there any reference to the relinquishment of

¹⁴¹ Morris, *ibid* at 184.

¹⁴² Morris, *ibid* at 211.

¹⁴³ Morris, *ibid* at 212.

¹⁴⁴ Morris, *ibid* at 132.

¹⁴⁵ Treaty Rights to Health, *supra* note 10 at 15.

¹⁴⁶ Treaty Rights to Health, *ibid*.

¹⁴⁷ Treaty Rights to Health, *ibid*.

jurisdiction over health by any First Nations; logically then the First Nation retained this jurisdiction as it had before the treaties were negotiated.

7.2.3 Medicine and Medical Care

Treaty 6 specifically included a medicine chest clause in the written text of the treaty:

A medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent.¹⁴⁸

The Indian people told Treaty Commissioner Alexander Morris that they required ‘provisions for the poor, unfortunate, blind and the lame,’ ‘the exclusion of fire water in the whole Saskatchewan [district], and a free supply of medicines.’¹⁴⁹ Morris’s report did not include a reply to the medicine request.¹⁵⁰ However, the records of Dr. A.G. Jackes, M.D., acting as the Secretary of the Treaty Commission, provide insight into the issue of medical services. Jackes recorded the Indians’ request that medicine be provided free of charge and Morris’s response as: “[a] medicine chest will be kept at the house of each Indian agent, in case of sickness amongst you.”¹⁵¹

Numerous promises were made by the Treaty 7 commissioners during negotiations of Treaty 7. There is a unanimous opinion by the Treaty 7 Elders that there were prominent and repeated promises of medical assistance. The five Treaty 7 nations were to give commitments to peace and access to land in exchange for the government’s many “sweet promises.” The Elders recalled that what they had agreed to was virtually unrecorded and what emerged was far different than what was agreed to. They all agreed that they were supposed to be taken care of by the government of Canada and this included the treaty right to health care.¹⁵²

Treaty 8 of the First Nations of Alberta state that among other guarantees, there is a definite guarantee to health care for the signatory Nations. The following was recorded:

¹⁴⁸ Morris, *supra* note 134.

¹⁴⁹ Morris, *ibid* at 185.

¹⁵⁰ Morris, *ibid* at 186.

¹⁵¹ Morris, *ibid* at 218.

¹⁵² Walter Hildbrandt, Dorothy First Rider, Sarah Carter “The True Spirit and Original intent of Treaty 7 (McGill-Queen's Press - MQUP, 1996) at 120. See also Declaration, *supra* note 138.

We promised that supplies of medicines would be put in the charge of persons selected by the Government at different points, and would be distributed free to those of the Indians who might require them. We explained that it would be practically impossible for the Government to arrange for regular medical attendance upon Indians so widely scattered over such an extensive territory. We assured them, however, that the Government would always be ready to avail itself of any opportunity of affording medical service just as it provided that the physician attached to the Commission should give free attendance to all Indians whom he might find in need of treatment as he passed through the country.¹⁵³

In Treaty 9 the commissioners report that medical care was provided during negotiations for the treaty:

Dr. Goldie had been giving the Indians free medical attendance as far as the medicine he had with him permitted, and he also offered his services in association with Dr. Meindl during our stay at the post.¹⁵⁴

Additional promises were made in Treaty 10:

I promised that medicines would be placed at different points in the charge of persons to be selected by the government, and would be distributed to those of the Indians who might require them. I showed them that it would be practically impossible for the government to arrange for a resident doctor owing to the Indians being so widely scattered over such an extensive territory; but I assured them that the government would always be ready to avail itself of any opportunity of affording medical service just as it provided that the physician attached to the commission should give free attendance to all Indians whom he might find in need of treatment.¹⁵⁵

Additionally:

This meant that the federal government would move very slowly in extending its obligations to the Native Peoples covered by Treaty Ten. Most essential demands were met: assistance was forthcoming in times of severe hardship, financial support was offered for mission schools, medical aid was provided when illness or disease struck, and efforts were made to protect the Natives' special rights to hunt and trap, subject to conservation regulations.¹⁵⁶

¹⁵³ Canada, Indian and Northern Affairs, *Treaty No. 8 Made June 21, 1899 and Adhesions, Reports, Etc.* (2008), online: <http://www.ainc-inac.gc.ca/al/hts/tgu/pubs/t8/trty8-eng.asp> (accessed September 8, 2010).

¹⁵⁴ Canada, Indian and Northern Affairs, *The James Bay Treaty - Treaty No. 9 (Made in 1905 and 1906) and Adhesions Made in 1929 and 1930* (2008) online at <http://www.ainc-inac.gc.ca/al/hts/tgu/pubs/t9/trty9-eng.asp> (accessed September 8, 2010).

¹⁵⁵ Canada, Indian and Northern Affairs, *Treaty No. 10 and Reports of Commissioners* (2008), online at <http://www.ainc-inac.gc.ca/al/hts/tgu/pubs/t10/trty10-eng.asp> (accessed September 8, 2010).

¹⁵⁶ *Ibid.*

Fumoleau notes a 1919 report by Assistant Deputy Minister and Secretary of Indian Affairs, D. McLean, stating that Indians were ‘assured that the government would always be ready to avail itself of any opportunity of affording medical service’.¹⁵⁷

Considering the oral and documentary evidence and under Treaty interpretive principles it is proposed then that the treaty rights to medicines and medical care exists in at least Treaties 6, 7, 8, 10 and 11.

7.2.4 Pestilence and Famine, Sickness and Disease

It was noted in Treaty 3 by Treaty Commissioner Simpson that due to an outbreak of disease and the worry that Scarletina would spread, the Indians dispersed during the negotiations.¹⁵⁸

There is ample evidence that sickness and diseases brought to North America played an important part of the decision making to enter into treaties and this was recognized in the treaty text. For instance, Treaty 6 contains a pestilence or famine clause:

In the event hereafter of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents, will grant to the Indians assistance of such a character and to such extent as Her Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians from the calamity that shall have befallen them.¹⁵⁹

When Treaty Commissioner Morris negotiated Treaty 6, he wrote in the official texts that:

[t]he Indians were apprehensive about their future. ... Small pox had destroyed them by hundreds a few years before, and they dreaded pestilence and famine.¹⁶⁰

In 1887, Thomas White, Superintendent of Indian Affairs, described repeated verbal and written requests by the Indians for protection and linked diseases with famine:

[Q]uite recently the Hudson’s Bay company has renewed its solicitations in the same behalf, alleging that serious sickness is now prevalent among the Indians of the Peace River District and there is apprehension of there being an

¹⁵⁷ Waldrum, Herring & Young, *supra* note 6 at 134 and 144.

¹⁵⁸ PAC, RG10, Vol. 1864, file 375, Commissioner Simpson to Secretary of State, Howe, 11 July 1871.

¹⁵⁹ Treaty No. 6. “Between Her Majesty the Queen and the Plains and Wood Cree Indians and Other Tribes of Indians at Fort Carlton, Fort Pitt and Battle River” (Ottawa: Queen’s Printer).

¹⁶⁰ *Ibid* at 177.

insufficiency of food during the winter ...The diseases they are stated to be suffering from are measles and the croup.¹⁶¹

According to Superintendent White, the Hudson's Bay Company took the position that "the expense of providing and caring for the sick and destitute Indians should be the government's responsibility as their natural protectors."¹⁶² Fumoleau cited an 1887 *Calgary Tribune* article titled 'Starving Indians' where it was suggested that the destitute Indians needed a treaty in order to alleviate suffering.¹⁶³

Treaty 11 documents a similar story in that the Dene Indians were suffering from sickness and starvation. Tuberculosis, dysentery, whooping cough, measles and Spanish influenza were taking their tolls. The intent of the Dene in making the treaty was a means of alleviating their suffering.¹⁶⁴

As noted earlier, medical doctors generally accompanied treaty parties dispensing medicine and providing medical care.¹⁶⁵ This demonstration of medical care was important to the Aboriginal people, since their knowledge system is built on demonstrations and words. The providing of medicine and medical care at this critical time created a reasonable expectation of medical care among the First Nation parties. The promises and the provision of medical services should be linked to the justification of Chiefs and Headmen entering the treaties to help ameliorate the suffering of their respective people. The Treaty Commissioners indicated to the Indians that medicine and the provision of medical services would be available at subsequent treaty annuity ceremonies. Physicians attended these ceremonies, examined and treated patients at no cost. It is possible that the demonstration of providing medical care influenced the Chiefs to enter in to the treaty – a connection and an expectation was thereby created between the two – medical care and treaty.

¹⁶¹ Fumoleau, *supra* note 112 at 36.

¹⁶² *Ibid.*

¹⁶³ *Ibid* at 37.

¹⁶⁴ Waldrum, Herring, & Young, *supra* note 6 at 145.

¹⁶⁵ Waldrum, Herring & Young, *ibid* at 145.

7.2.5 Judicial Interpretations of the Treaty Right to Medicine and Health Care

In 1935, the federal Court in *Dreaver* established that the medicine chest clause meant that all medicines, drugs, or medical supplies were to be supplied free of charge to treaty Indians.¹⁶⁶ Dreaver, Chief of the Mistawasis Band in Saskatchewan, had been present at the signing of Treaty 6. Dreaver launched a lawsuit against the federal government to recover money he had spent on medical supplies between 1919 and 1935 arguing that all medicines were guaranteed at no cost to Indians under the medicine chest clause in Treaty 6. He further supplied evidence that medicines had been provided free of charge from the time of the Treaty in 1876 to 1919. The trial judge agreed. To date, *Dreaver* has never been overruled. Angers, J. ruled that:

The clause might unquestionably be more explicit but, as I have said, I take it to mean that all medicines, drugs or medical supplies which might be required by the Indians of the Mistawasis Band were to be supplied free of charge.¹⁶⁷

With the creation of provincial medical care, the Court has dealt with the issue of payment of health taxes. In 1965 in *R. v. Johnston*, an off-reserve Treaty 6 Indian was charged with failing to pay tax under the *Saskatchewan Hospitalization Act* R.S.S. 1953, c. 232 (Act).¹⁶⁸ Mr. Johnson, claimed that the provisions of Treaty 6 gave him tax-exempt status under the Regulation 23(1)(v) of the *Act*. The trial judge followed the *Dreaver* decision and found,

Referring to the medicine chest clause of Treaty No. 6, it is common knowledge that the provisions for caring for the sick and injured in areas inhabited by the Indians in 1876 were somewhat primitive compared to present day standards. It can be safely assumed that the Indians had limited knowledge of what provisions were available and it is obvious that they were concerned that their people be adequately cared for. With that in view, and possibly carrying the opinion of Angers, J., a step farther, I can only conclude that the “medicine chest” clause and the “pestilence” clause in Treaty No. 6 should be properly interpreted to mean that the Indians are entitled to receive all medical services, including medicine, drugs, medical supplies and hospital care free of charge.¹⁶⁹

¹⁶⁶ *Dreaver et al v. The King* (1935), 5 C.N.L.C. 92 Ex. Ct. Canada, online:

<http://library.usask.ca/native/cnlc/vol05/092.html> (accessed September 8, 2010) [previously unreported].

¹⁶⁷ *R. v. Johnston* (1966), 56 D.L.R. (2d) 749 (Sask. C.A.) at 754 [*Johnston*].

¹⁶⁸ No information is reported for the decision of the Magistrate’s Court in *Johnston* (i.e., date of decision, citation information or name of the judge). This decision would have occurred sometime after the date of the information laid in relation to the charge against Johnston (22 March 1965) and the date of the appellate Court decision in *Johnston* (17 March 1966). The appellate Court decision is reported at *Johnston, ibid.*

¹⁶⁹ *Johnston, ibid* at 751

The 1965 decision was ultimately overturned by the Saskatchewan Court of Appeal that relied on a literal interpretation of the Treaty and, as such, held that only a “first aid” kit was required to be provided. The Court further ruled that the provincial government did not have to provide comprehensive and free medical services to Indians. In addition, it was held that the provision of medicine was at the discretion of the Indian agent on the reserve. Similar literal interpretation methodology was used by the courts in the 1969 *Klein*¹⁷⁰ decision and again by the Appellant Court in the 1970 *Swimmer* decision.¹⁷¹

In *Klein and Spence*,¹⁷² a member of Peguis band was involved in a motor vehicle accident. Mrs. Spence recovered her expenses from the Unsatisfied Judgment Fund and the Manitoba Hospital Commission acted to recover their expenses from Mrs. Spence. Mrs. Spence claimed that as a treaty Indian she was entitled to free medical care and the Commission’s claim was void. The court ruled in favor of the Commission and stated that Treaty 1 and 2 had no provisions for medical care and although Treaty 6 had the medicine chest clause it was not valid in Manitoba for two reasons: Alexander Morris signed Treaty 6 in his capacity as Lieutenant Governor of the Northwest Territories and not in his capacity as Lieutenant Governor of Manitoba; secondly the Court decided to follow the plain reading of the medicine chest clause found in *Johnson*.

In 1969, the trial judge found that Andrew Swimmer,¹⁷³ another Treaty 6 Indian, who also did not reside on a reserve, was wrongfully charged for not paying a tax under *the Hospital Services Insurance Act*¹⁷⁴ and *Saskatchewan Medical Care Insurance Act*.¹⁷⁵ The federal government had an arrangement with the Saskatchewan government to pay for the hospitalization tax for reserve Indians, and Indian residing outside a reserve for less than twelve months. Swimmer had not lived on a reserve since 1958.

¹⁷⁰ *Manitoba Hospital Commission v. Klein and Spence* (1969), 67 W.W.R. 440 (Man. Q.B.) [*Klein*].

¹⁷¹ Since the Saskatchewan Court of Appeal’s comments concerning the interpretation of the medicine chest clause were *obiter*, the decision of the appellate Court in *Swimmer* should have become the leading case for interpreting treaty rights to free medical services and was binding on lower Courts. Interestingly, however, it is the *Johnson* case that is referenced and not the *Swimmer* decision. (*R. v. Swimmer* (1970), [1971] 1 W.W.R. 756 (Sask. C.A.)).

¹⁷² *Klein*, *supra* note 170.

¹⁷³ *Andrew Swimmer v. The Queen*, (1971) W.W.R. 756 (Sask. C.A.)

¹⁷⁴ *The Hospital Services Insurance Act*, S.M. 1962, c. 30.

¹⁷⁵ *Saskatchewan Medical Care Insurance Act*, R.S.S. 1965, c. 255.

The justice of the Magistrate's Court accepted that the medicine clause entitled Indians to free medical care, and that Swimmer was exempt from the tax. The Crown appealed and the Court of Appeal interpreted the medicine chest clause to not entitle off-reserve treaty Indians to free medical services under the *Hospital Services Insurance Act* and *Saskatchewan Medical Care Insurance Act*. As in *Klein and Spence* the Court of Appeal also overruled an affirmative ruling from the trial court. The Court of Appeal interpretation of the treaty rights is inconsistent with current treaty interpretive principles. The refusal of the court to give a fair, large and liberal interpretation in favor of the Indians to the concept of medicine chest clause at the time of the treaty cannot be relied upon in modern interpretative principles of *sui generis* treaty rights.

Dreaver was correctly decided. However, the decisions in *Klein*, *Swimmer* and *Johnston* likely would not be upheld in the Courts today. All three cases following *Dreaver* were decided before 1982 and prior to Supreme Court of Canada decisions setting out the principles of treaty interpretation and will be assessed in the following section). These decisions predate the coming into force of ss. 35 and 52 of the *Constitution Act, 1982* as well as the *Canadian Charter of Rights and Freedoms*¹⁷⁶ and the Constitutional entrenchment of Aboriginal and treaty rights in the Canadian Constitution.

In 1999, *Wuskwi Sipiik Cree Nation v. Canada (Minister of National Health and Welfare)*¹⁷⁷ was heard in the Federal Court on the interpretation of the medicine chest clause in Treaty 6. Prothonotary Hargrave briefly addressed the issue of "jurisdiction over health care to First Nations:"¹⁷⁸

Mr. Justice Angers took a proper approach in his 1935 decision *Dreaver*, reading the Treaty No. 6 medicine chest clause in a contemporary manner to mean a supply of all medicines, drugs and medical supplies. Certainly, it is clear that the Saskatchewan Court of Appeal took what is now a wrong approach in its literal and restrictive reading of the medicine chest clause in the 1966 decision

¹⁷⁶ *Canadian Charter of Rights and Freedoms*, *supra* note 3.

¹⁷⁷ *Wuskwi Sipiik Cree Nation v. Canada (Minister of National Health and Welfare)* [1999] F.C.J. No. 82 (T.D.) [*Wuskwi Sipiik*].

¹⁷⁸ *Wuskwi Sipiik*, *ibid* at para 9.

in Johnston. In a current context, the clause may well require a full range of contemporary medical services.¹⁷⁹

Prothonotary Hargrave referred to the Supreme Court of Canada decision in *Nowegijick v. The Queen* as authority for treaties (and statutes) being "liberally construed and doubtful expressions resolved in favour of the Indians."¹⁸⁰ He also referred to the Supreme Court of Canada's decision in *Sparrow* as authority for interpreting rights in a flexible manner "in order to permit their evolution" as opposed to adopting a 'frozen rights' approach where the right in issue is interpreted rigidly within the confines of that concept at the time the treaty was signed.¹⁸¹

In *Duke v. Puts*,¹⁸² the Court referred to the medicine chest clause and observed that appellate courts in Saskatchewan had been critical of lower courts that gave a broad interpretation to the medicine chest clause. Mr. Justice Kyle observed that following the introduction of the *Canadian Charter of Rights and Freedoms* in 1982, government policy had favoured "the generous provision of ... medicines, drugs and medical supplies free of charge".¹⁸³ These comments do reflect the interpretive principles for treaty interpretation, in particular the medicine chest clause and the observations in the *Wuskwi Cree Nation* case.¹⁸⁴ The 1935 decision of Justice Angers in *Dreaver* appears to be the precedent on the federal obligation to provide Treaty Indians with medicine.

¹⁷⁹ *Wuskwi Sipihk*, *ibid.* at para 14.

¹⁸⁰ *Nowegijick v. The Queen* [1983] 1 S.C.R. 29 at 36, cited in *Wuskwi Sipihk*, *ibid* at para 13. *Simon*, *supra* note 123 at para 41.

¹⁸¹ *Sparrow*, *supra* note 14 at 1093 and 1099, cited in *Wuskwi Sipihk Cree Nation*, *supra* note 177 at paras 12 and 13.

¹⁸² *Duke v. Puts* (2001), 204 Sask. R. 130 (Q.B.).

¹⁸³ *Ibid* at para 2.

¹⁸⁴ S. Haslip & V. Edwards, 2002, "Does a Contemporary Interpretation of the Medicine Chest Clause in Treaty No. 6 Include a Right to Sport?" [unpublished, on file with the author].

7.2.6 Interpretation of Treaties

i) Canada, Health Canada

The Government of Canada has always maintained that the provision of health services to First Nations and Inuit Peoples is done as a matter of policy and not through any legal obligation. In 1957 the government insisted that a treaty obligation existed only under Treaty 6.¹⁸⁵ Canada, however, did not implement any special programs for the beneficiaries of Treaty 6 so its beneficiaries were caught in a quagmire of bickering and buck-passing of responsibilities between government departments. For instance, Medical Services Branch (of the National Health and Welfare Department) claimed that the responsibility for discussing treaties on behalf of Canada resided with the Department of Indian Affairs. Although, the Medical Services Branch maintained that it was prepared to participate in discussions of a treaty matter involving health, the Department of Indian Affairs, on the other hand, adopted the position that discussion of a treaty right to health was not their responsibility as the Medical Services Branch was responsible for health. As a result no one took responsibility.¹⁸⁶

In 1964, the government announced that it had “never accepted the position that Indians are entitled to free medical services by treaty rights.”¹⁸⁷ This position was reiterated again in 1968,¹⁸⁸ 1969¹⁸⁹ and 1970:

Despite popular misconceptions of the situation and vigorous assertions to the contrary, neither the federal nor any other government has any formal obligations to Indians or anyone else, with free medical services.¹⁹⁰

¹⁸⁵Canada, Department of National Health and Welfare, 1958. *Annual Report, 1957* Ottawa: Queen’s Printer at 76. See also Treaty No. 6. The treaties are reproduced in R.A. Reiter, *The Law of Canadian Indian Treaties* (Edmonton: Juris Analytica, 1995) at Part III.

¹⁸⁶Sákéj Youngblood Henderson reflects: “There has been no documented case where the two departments have ever agreed to a joint process to address the treaty right to health issue.” See, Treaty Rights to Health, *supra* note 10.

¹⁸⁷Canada, Department of National Health and Welfare, 1965 *Annual Report, 1964* (Ottawa: Queen’s Printer) at 95.

¹⁸⁸Canada, Department of National Health and Welfare, 1968 *Annual Report, 1968* (Ottawa: Queen’s Printer) at 102.

¹⁸⁹Canada, Department of National Health and Welfare, 1969 *Annual Report, 1969* (Ottawa: Queen’s Printer) at 117.

¹⁹⁰Canada, Department of National Health and Welfare, 1971 *Annual Report, 1971* (Ottawa: Queen’s Printer) at 105.

In 1974, the Minister of National Health and Welfare tabled the *Policy of the Federal Government concerning Indian Health Services* which reiterated that no statutory or treaty obligations exist to provide health services to Indians. However, the federal government wanted to ensure "the availability of services by providing it directly where normal provincial services (were) not available, and giving financial assistance to indigent Indians to pay for necessary services when the assistance (was) not otherwise provided".¹⁹¹

In 1995 the government reported in an internal document that "undertakings" for health care were made in relation to other treaties besides Treaty 6,

For example, Treaty 6 (1876) contains a medicine chest clause which stipulates that '...a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the discretion of such agent.' Similar verbal undertakings were made by treaty commissioners when negotiating Treaties 7, 8, 10 and 11."¹⁹²

In 1999, the federal government participated in a Exploratory Treaty Table discussion with First Nations in Saskatchewan, where they reiterated their social policy perspective on the treaties:

... the Government of Canada, as a matter of public policy, seeks to provide a basic level of health care, access to education, economic opportunities, and the like to all citizens, regardless of treaty status.¹⁹³

The government has remained steadfast in its position that there is no treaty obligation to provide health care. The 2002 Romanow report on *The Future of Health Care in Canada* notes,

[a]ccording to the federal government, however, there is no constitutional obligation or treaty that requires the Canadian government to offer health programs or services to Aboriginal Peoples.¹⁹⁴

¹⁹¹ Canada, Health Canada, *History of Providing Health Services to First Nations People and Inuit* (2007), online at <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fmhb-dgspni/services-eng.php> (accessed September 8, 2010).

¹⁹² Canada, Report of an Interdepartmental Working Group to the Committee of Deputy Ministers on Justice and Legal Affairs, *Fiduciary Relationship of the Crown with Aboriginal Peoples: Implementation and Management Issues – A Guide for Managers* (Ottawa: n.p., 1995) at 13.

¹⁹³ Office of the Treaty Commissioner, *Statement of Treaty Issues*, (1998), online at http://www.otc.ca/pdfs/OTC_STI.pdf (accessed September 8, 2010) at 36.

¹⁹⁴ Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Ottawa: Canadian Government Publishing, 2002) [Romanow], online: Health Canada

Although the government has denied a treaty right to medical care, medicine and health services, some common understandings between the government and First Nations have been measured through the Saskatchewan Office of the Treaty Commissioner where both the federal government and the Saskatchewan First Nations recognized that the treaties are a foundation for future relations through ongoing treaty discussions.

ii) First Nation Organizations

The Federation of Saskatchewan Indian Nations expressed their views on the importance of the treaties:

[T]hey granted some of their powers to the Crown in exchange for certain benefits and rights... Indian people entered into a political arrangement with the Crown so that they could live as Indian people forever... By signing the treaties, the Indian nations created an ongoing relationship with the Crown in Indian social and economic development in exchange for lands surrendered.¹⁹⁵

In 2007 the Federation of Saskatchewan Indian Nations passed a resolution to accept a set of important *Treaty Implementation Principles*.¹⁹⁶ This document outlines the responsibilities of the Crown in implementing treaty promises in, among other areas, health and through the medicine chest clause in Treaty 6,

Our Elders also tell us that we did not agree to give up the land. The written text contains the words “cede, release, surrender and yield up ... all their rights, titles and privileges, whatsoever to the lands...” These words are contrary to what actually took place in the negotiations. First Nations intended to share the land. The word *witaskiwin* was used in the negotiations when describing the accord relating to land. *Witaskiwin* means sharing or living together on the land. More particularly, First Nations only intended to share the topsoil to the depth of a plough. According to our Elders, this was because the white man asked us if they could use this soil for farming and we agreed.

In return the Crown undertook to provide assistance in a number of areas including: education, *health* and medicine, economic independence, hunting,

<http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html> at 212 (accessed September 8, 2010).

¹⁹⁵ Delia Opekokew, *The First Nations: Indian Government and the Canadian Confederation*, Federation of Saskatchewan Indians, 1979 at 10.

¹⁹⁶ Federation of Saskatchewan Indian Nations, Statement of Treaty Principles (2007), online at <http://www.fsin.com/treatygovernance/downloads/TreatyImplementationPrinciples.pdf> (accessed September 8, 2010) [FSIN treaty].

fishing, trapping, gathering, annuities, agriculture, prohibition of liquor, exemption from taxes and conscription (emphasis added).¹⁹⁷

Further:

The *spirit and intent* of the Treaty also means that the written terms must be interpreted to reflect changes with the progression of time. The medicine chest clause means a comprehensive type of health and medical coverage to supplement First Nations health and medicine.¹⁹⁸

In relation to the pestilence and famine clause:

The pestilence and famine clause in the modern day context would mean assistance in times of extraordinary circumstances such as diseases, pandemic and floods.¹⁹⁹

In 2008 Treaty 6 Nations across Alberta, Saskatchewan, and Manitoba met at the Thunderchild First Nation to propose a health system that is autonomous from the federal government. They proposed First Nation run hospitals where patients can access western and First Nation medicine based on treaty promises for full health care coverage.²⁰⁰

In the view of the Assembly of First Nations, the Assembly of First Nations Chiefs Committee on Health have approved the Treaty Right to Health as a part of their overall Strategic Plan as a means of ensuring and improving health services,

Elder Helen Gladue, who spoke on the second day of the meeting, reminded the Chiefs that they should concentrate on the Treaty Right to Health. “Being a direct descendant of a signatory of Treaty Six, it goes without saying that the Treaty right is a sacred belief,” she said. “We have had equal rights right from the beginning. We have a bundle of rights. And those are sacred rights.”²⁰¹

The Health and Social Secretariat of the Assembly of First Nations has a mandate and a role to ensure that all First Nations citizens, regardless of residence, have access to quality health

¹⁹⁷ FSIN treaty, *ibid.*

¹⁹⁸ FSIN treaty, *ibid.*

¹⁹⁹ FSIN treaty, *ibid.*

²⁰⁰ Darren Bernhardt, Saskatoon Star Phoenix, *Treaty Six chiefs promote Native health-care system* (2008), online at

<http://www.canada.com/saskatoonstarphoenix/news/local/story.html?id=9b26cd92-f104-4953-a367-00a743e106e1>, (accessed September 8, 2010).

²⁰¹ Assembly of First Nations Health and Social Secretariat, *Treaty Right to Health approved as major focus of CCOH Strategic Plan* (2005), online: <http://www.afn.ca/cmslib/general/HB04-SM-e.pdf> (accessed September 8, 2010).

services funded by the First Nations and Inuit Health Branch (FNIHB) of Health Canada. The AFN further asserts that health benefits are,

[A]n Inherent Aboriginal and Treaty Right and are constitutionally protected. Health services are to be comprehensive, accessible, fully portable, and provided as needed on a timely basis without regard to a person’s financial status, residence, or the cost of benefit.²⁰²

The following chart indicates how First Nations and the Federal Government maintain their differences in how they view Treaties:

Figure 1

First Nations	Federal Government
Sacred promises	Contracts
Land sharing agreements between two sovereign nations that established a permanent relationship	Land surrender agreements whereby First Nations ceded their territories to the Crown
The spirit and intent of the treaties are what is most important, including all the oral commitments and not necessarily in the English language	Written contractual text is what is most important

A core disagreement has been the reading of the medicine chest clause in Treaty 6. First Nations interpret it as a promise for health care and medicines. The federal government has interpreted it more along the lines of a literal box for medicines. This policy disagreement has never been fully resolved, either by court rulings, or by substantive realignment in federal and provincial health policies so a “treaty right to health” is given a new, modern meaning in keeping with the original intent. The Government of Canada, the Province of Saskatchewan and the Federation of Saskatchewan Indian Nations were able to make some progress on this issue, through the Office of the Treaty Commissioner (OTC) located in Saskatoon, Saskatchewan, that assisted to outline the respective parties’ understanding of “treaty rights to health” in the modern context and understanding of the treaties.

²⁰² Assembly of First Nations, Health and Social Secretariat, Your Health Benefits: A Guide to Accessing your Non-Insured Health Benefits, online: http://www.afn.ca/cmslib/general/AFN_NIHB_Handbook.pdf (accessed September 8, 2010).

Although it seems as if the Government of Canada and First Nation organizations are miles apart with their views on treaty obligations, in 1997 and 1998 the Office of the Treaty Commissioner brought the parties together and created some common understandings of the treaties as a foundational key for future relations and discussions on treaty obligations. The federal government entered into exploratory discussions for the first time in over a hundred years. The Federation of Saskatchewan Indian Nations as leaders in this area expressed:

Treaties provided us with a shared future, treaties prevented war and guaranteed peace, treaties defined and shaped relations between nations through enduring relations of mutual respect, and treaties guaranteed the shared economic bounty of one of the planet's richest and most productive lands.²⁰³

The federal government expressed similar views,

The federal government understands that the treaties between Canada and First Nations were intended by the parties to endure into the future. It recognizes that treaties define fundamental aspects of the continuing relationship between Canada and Treaty First Nations and that they are important instruments guiding the way to a shared future for First Nations and other Canadians. The federal government recognizes that, by doing justice to the treaties, it may honour the past and enrich the future.²⁰⁴

It has been well over ten years since the Exploratory Treaty Table was initiated in Saskatchewan, the Office of the Treaty Commissioner has worked tirelessly to advance treaty issues in schools, the public forum for broad based outreach, research and facilitating discussions. The Treaty Table functions as a neutral meeting ground where Elders are listened to and the treaty parties openly explore treaty issues. The mandate of the Office of the Treaty Commissioner is to advocate on behalf of the treaty relationship and not on behalf of either party. Although initially the mandate was for a ten year period, the Office has recently been extended to 2011 to continue this important work advancing the spirit and intent of the treaties in a modern relevant context.

²⁰³ Office of the Treaty Commissioner, *Statement of Treaty Issues*, (1998), online at http://www.otc.ca/pdfs/OTC_STI.pdf (accessed September 8, 2010) at 33 [*Statement of Treaty Issues*].

²⁰⁴ *Statement of Treaty Issues*, *ibid.*

7.3 Analysis Summary

Treaties are legal instruments of Canadian law. The purpose of the treaties was to ensure that the British sovereign and Canadian governments would provide protection for First Nations. By conveying territory to the sovereign it was understood that the sovereign could use the lands to generate beneficial revenue for government services, services that would include First Nations. The government stance is that no one deserves to benefit from “free” medical services certainly rings true for First Nations – as within the treaties and within inherent Aboriginal rights the costs of these services have been dear and were paid for through the exchange of land for government services. It is clear that First Nations have retained their treaty rights regarding jurisdiction over internal health matters, unless specific treaties contained terms to the contrary that were clearly understood by both parties as diminishing the sovereign authority of the First Nation concerned. This is clearly not the case.

Treaties must be considered within the context of the historical ceremonies and the assurances of friendship and brotherhood and the Queen's concern for her Indian subjects which were such a prominent feature of the historical treaty negotiations. The treaties must be interpreted not only in cultural and historical terms, but within the context of a modern and ever changing Canada.

The Report of the Royal Commission on Aboriginal People stated that it is “indisputable, however, those existing treaties have been honoured by governments more in the breach than in the observance.”²⁰⁵ The Report concluded that the treaty relationship between the Treaty Nations and Canadian government are “mired in ignorance, mistrust and prejudice. Indeed, this has been the case for generations.”²⁰⁶ The dishonoured treaties are part of the negative “ghosts” of Canadian history.²⁰⁷ Although small steps have occurred, Treaty obligations and rights of Aboriginal people remain unfulfilled while Aboriginal health continues to suffer.

²⁰⁵ Canada, *Report of the Royal Commission on Aboriginal Peoples* (Ottawa: Communication Group, 1996) at vol. 2(1) at 3 [RCAP].

²⁰⁶ *Ibid* at vol. 2(1) at 38.

²⁰⁷ RCAP, *supra* note 205 See, *People to People, Nation to Nation, Highlights from the report of the Royal Commission on Aboriginal Peoples* (Ottawa: Minister of Supply and Services Canada 1996) at 5.

In summary, the existence of Aboriginal rights as we know them today stems from two key understandings. First, prior to contact and at the time of contact, Aboriginal societies were self-sustaining nations with evolved institutions such as law, policing, education, and health.²⁰⁸ Second, Aboriginal Peoples “have not deferred either our individual or collective right(s) to be sovereign.”²⁰⁹ This latter understanding is significant as it illustrates that Aboriginal Peoples have a different understanding of social or state control from that of non-Aboriginal Canadians who accept that social control is state imposed and, therefore, outside the individual’s control. Implicit in this acceptance is the relinquishment of individual freedoms and control.²¹⁰ Aboriginal rights are designed to protect integral aspects of collective Aboriginal health, they are inherent in the continuity of practices that govern the daily lives of individual Aboriginal people within (the bundles of) Aboriginal rights and a critical component of Aboriginal sovereignty (indeed, without Aboriginal rights there would be no sovereignty). These Aboriginal rights are based on pre-contact views and practices of Aboriginal knowledge, heritage, law, culture, and traditions of health and healing but also are inherent in the continuity of practices that govern the daily lives of Aboriginal people. This Chapter provided the common law tests of determining an Aboriginal right as applied to Aboriginal health to those tests. *Sparrow* tests require that the right be existing – Chapter 4 provided documented evidence from the Jesuits, whalers, traders and explorers who confirmed that before contact, Aboriginal people enjoyed a good health status and employed methods to ensure the status of this Aboriginal right to health. These rights were not frozen in time and have evolved into contemporary Aboriginal health care as seen through institutions such as the Whitehorse General Hospital and Sturgeon Lake First Nation. The right to health has not been extinguished by the *Indian Act* or any other federal legislation. Finally the question of infringement has been answered through Chapter 6 (*Law is a Determinant of Health*) whereby there has been a horrendous amount of infringement on the Aboriginal right to health, seen through laws and policies and continuing through regulation and laws such as Bill C-51. The required *Sparrow* justification by the government is not clear or evident as only a crass government would justify the desperate state of Aboriginal health today or the justification of

²⁰⁸ *Van der Peet*, *supra* note 1 at para 30.

²⁰⁹ Alternative Dispute Resolution, *supra* note 13 at 137–138.

²¹⁰ *Ibid.*

the government sponsored events that have produced it. The only conclusion can be that there has been a breach of the inherent Aboriginal right to health.

Further, a treaty right to health is provided for in the written and verbal texts of Treaty 6, 7, 8, 10 and 11 and accrues to those First Nations who were signatories, or are descendants of those who were signatories, to these treaties. According to the spirit and intent of the treaties, treaty provisions promised that signatories to those treaties and their descendants would receive benevolence from the Great Mother.

In spite of possessing the identical rights to health care that all Canadians possess by virtue of being Canadians – Aboriginal people possess *in addition* Aboriginal and treaty rights to health that are protected by the *Constitution Act, 1982* and yet Aboriginal health is in crisis. The government has not fulfilled its obligations in relation to Aboriginal rights to health or treaty promises relating to health. In light of any disparities in outcomes in standards of health, it is clear that past and present government legislation, policies, actions and inaction have adversely impacted upon Aboriginal people with devastating results. It is untenable to think that Aboriginal people have either agreed to accept this, or that the Canadian government is removed from its constitutional obligations with respect to Aboriginal and treaty rights. Therefore in light of the constitutional obligation and judicial interpretations surrounding Aboriginal and treaty rights, lawmakers and policy-makers should be compelled to accept the existence and implementation of Aboriginal and treaty rights to health in Canada and implement them in laws, policies and procedures that will have a positive effect on the outcome of Aboriginal health in Canada. Chapters 9 and 10 provide concrete recommendations and a framework for constitutionalizing Aboriginal health.

The connection between medical care and treaties creates a fiduciary duty provide medical services and medicines as well as²¹¹ a reasonable and legitimate expectation to receive supplemental medicines and health care in its modern form (and at least on par with other

²¹¹ Treaty Rights to Health, *supra* note 10.

Canadians). It also affirms an inherent Aboriginal right (through traditional ways of dealing with health issues in Aboriginal society) and treaty right (through the exchange of promises) to Aboriginal health. The following section will focus on what the “Honour of the Crown” and other principles mean through the examination of any breaches of fiduciary law as applied to Aboriginal health.

8. Fiduciary Law and Aboriginal Health

8.1 Introduction

When the Supreme Court of Canada gave recognition to the fiduciary relationship between the federal government and Aboriginal people, important guiding principles for Crown-Aboriginal relations were placed in Canadian law.¹ What the scope of this relationship and the ensuing responsibilities entail are at the source of debate among the courts, governments, First Nations, Métis and Inuit people.² The federal government does recognize the Crown Aboriginal

¹*Guerin v. R.*, [1984] 2 S.C.R. 335, [1985] 1 C.N.L.R. 120 [*Guerin*].

² L.I. Rotman, *Parallel Paths: Fiduciary Doctrine and the Crown-Native Relationship in Canada* (Toronto: University of Toronto Press, 1996) at 3 [Rotman]. Scholars have struggled to “pin down the fiduciary principle”, see for example: L.I. Rotman, “The Fiduciary Concept, Contract Law, and Unjust Enrichment: A Functional Comparison,” in P. Giliker, ed., *Comparative Perspectives on Contract and Unjust Enrichment/Restitution*, (Leiden: Martinus Nijhoff, 2007) 87-108; “Developments in Aboriginal Law: The 2005-06 Term,” (2006) 35 *S.C.L.R.* (2d) 1-16; “Developments in Aboriginal Law: The 2004-05 Term,” (2005) 30 *S.C.L.R.* (2d) 1-41; “The Perception of Justice in Canadian Aboriginal and Treaty Rights Jurisprudence,” (2004) 53 *U.N.B.L.J.* 221-39; “*Wewaykum*: A New Spin on the Crown’s Fiduciary Obligations to Aboriginal Peoples?” (2004) 37 *U.B.C. L. Rev.* 219-58; “Let Us Face It, We Are All Here to Stay” ... But Do We Negotiate or Litigate?” in K. Wilkins, ed., *Advancing Aboriginal Claims: Visions/Strategies/Directions*, (Saskatoon: Centre for Constitutional Studies, University of Alberta and Purich Publishing, 2004) 202-40; “Developments in Aboriginal Law: The 2003-04 Term,” (2004) 26 *S.C.L.R.* (2d) 1-30; “Crown-Native Relations as Fiduciary: Reflections Almost Twenty Years After *Guerin*,” (2003) 22 *Windsor Y.B. Access Just: Symposium on Aboriginal Rights Issues* 363-96; Editor-in-Chief’s Preface, (2003) 22 *Windsor Y.B. Access Just: Symposium on Aboriginal Legal Issues* 251-2; “The Application of Crown Fiduciary Duty to Off-Reserve, Non-status, and Métis Peoples,” in J.E. Magnet and D.A. Dorey, eds., *Aboriginal Rights Litigation*, (Toronto: Butterworths, 2003) 363-86; “Developments in Aboriginal Law: The 2002-03 Term,” (2003) 21 *S.C.L.R.* (2d) 1-21; “Conceptualizing Crown-Aboriginal Fiduciary Relations,” in Law Commission of Canada, *In Whom We Trust: A Forum on Fiduciary Relationships*, (Toronto: Irwin, 2002) 25-56; “Developments in Aboriginal Law: The 2001-02 Term,” (2002) 18 *S.C.L.R.* (2d) 1-40; “Developments in Aboriginal Law: The 2000-01 Term,” (2001) 15 *S.C.L.R.* (2d) 1-29; “Developments in Aboriginal Law: The 1999-2000 Term,” (2001) 13 *S.C.L.R.* (2d) 1-44; “Developments in Fiduciary and Trust Law: The 1998-99 Term,” (2000) 11 *S.C.L.R.* (2d) 483-515; “Balancing the ‘Scales of Justice’: Fiduciary Obligations and *Stewart v. CBC*,” (1999) 76 *Can. Bar Rev.* 445-85; “Fiduciary Doctrine: A Concept in Need of Understanding,” (1996) 34 *Alta. L. Rev.* 821-52; “The Vulnerable Position of Fiduciary Doctrine in the Supreme Court of Canada,” (1996) 24 *Man. L.J.* 60-91; “Provincial Fiduciary Obligations to First Nations: The Nexus Between Governmental Power and Responsibility,” (1994) 32 *Osgoode Hall L.J.* 735-83; B. Slattery, “First Nations and the Constitution: A Question of Trust” (1992) 71 *Can. Bar Rev.* 261; W.R. McMurtry & A. Pratt, “Indians and the Fiduciary Concept, Self-Government and the Constitution: *Guerin* in Perspective” [1986] 3 *C.N.L.R.* 19; R.H. Bartlett, “The Fiduciary Obligation of the Crown to the Indians” (1989) 53 *Sask. L. Rev.* 301; K. McNeil, *Emerging Justice: Essays on Indigenous Rights in Canada and Australia* (Saskatoon: University of Saskatchewan, 2001) [McNeil]; K. McNeil, “Fiduciary Obligations and Aboriginal Peoples”, in Mark Gillen and Faye Woodman, eds., *The Law of Trusts: A Contextual Approach*, 2nd ed. (Toronto: Emond Montgomery, 2008), 907-76; K. McNeil, *Canada’s Fiduciary Obligation to Aboriginal Peoples in the Context of Accession to Sovereignty by Quebec, Vol. 2, Domestic Dimensions*, with Renée Dupuis. Ottawa: Royal Commission on Aboriginal Peoples, 1995; Sakej Youngblood Henderson, “Fiduciary Obligations and Honour of the Crown to Aboriginal peoples of Canada” In whom we Trust. A Forum on Fiduciary Obligations, Law Commission of Canada (Toronto: Irwin Law, 2002) at 81-112; M. Stevenson and A. Peeling, “Probing the Parameters of Canada’s Crown – Aboriginal Fiduciary Relationship” in Law Commission of Canada, Association of Iroquois and Allied Indians, *In Whom We Trust: A Forum on Fiduciary Relationships* (London: Irwin 2002) [*In Whom we Trust*].

fiduciary relationship and the ensuing fiduciary obligations.³ The federal government, however, takes the position that the provision of health services to First Nations and the Inuit is done as a matter of policy only and not because of any fiduciary obligation or Aboriginal or treaty right.⁴ Judicial interpretation of the Constitution has determined that the Inuit are a federal responsibility.⁵ As for the Métis, the provinces have primary responsibility for health care delivery for Métis⁶ and non-status Indians (which is no different than their responsibility to non-Aboriginal Canadians). Since the Yukon, Nunavut and the Northwest Territories are under federal jurisdiction each territory is responsible for delivering health care services to all of their respective residents, including non-Aboriginal people living within their jurisdictions. The following chapter will focus on Crown/Aboriginal fiduciary relationships between the Crown and Aboriginal people and the ensuing set of obligations in relation to Aboriginal health.

Through the lens of Aboriginal health policy and legal history, it is judicially and legislatively clear that fiduciary relationships exist between Aboriginal people and the Crown and there are obligations which flow from the relationships. These obligations, coupled with the recognition of the meaning of Aboriginal and treaty rights that First Nation, Métis and Inuit peoples⁷

³See for instance, INAC refers to the fiduciary obligations:

In these decisions (*Haida, Taku River, Mikisew Cree*), the SCC also determined that the legal duty to consult stems from the Crown's unique relationship with Aboriginal peoples and must be discharged in a manner that upholds the honour of the Crown and promotes reconciliation of Aboriginal and non-Aboriginal interests. The SCC is looking at how the Crown manages its relationships with Aboriginal groups and how it conducts itself when faced with constitutionally protected Aboriginal and treaty rights. Crown decisions can be subject to review by a court prior to the final definition of an established right or the resolution of an outstanding claim. (Indian and Northern Affairs Canada, "Aboriginal Consultation and Accommodation - Interim Guidelines for Federal Officials to Fulfill the Legal Duty to Consult (February 2008)" online: <http://www.ainc-inac.gc.ca/ai/arp/cnl/intgui-eng.asp> [Guidelines] [Action Plan] (accessed October 20, 2010)).

⁴ Canada, First Nations and Inuit Health Branch, "First Nations and Inuit Control – Historical Perspective" *Handbook for Pilot Projects* (October 29, 2001) [*Handbook*] online: Health Canada http://www.hc.sc.gc.ca/fnihb/nihb/publications/pilot_projects_handbook/part_a_overview.htm.

See also, Auditor General, Report of the Auditor General of Canada, October 2000 at 15:15:

...[the federal government maintains that it provides health services to status Indians and recognized Inuit as a matter of policy and not under treaty or other legal obligations. However most First Nations generally consider that all necessary health services must be provided to them under Aboriginal and treaty rights and, as such represent a fiduciary obligation owed to them by the Crown.

⁵ *Re: Eskimos*, [1939] S.C.R. 104, [1939] 2 D.L.R. 417 [*Eskimos*].

⁶Although the Métis have a legal status for health care which is no different than that of non-Aboriginal Peoples in Canada, the *Powley* decision may have future impacts on the present Métis exclusion from services and programs (*R. v. Powley*, [2003] 2 S.C.R. 207, [2003] 4 C.N.L.R. 321)[*Powley*].

⁷Modern land claims are treaties and include Inuit and Métis, see Chapter 7. Historically, the inclusiveness of Métis in the treaties has been a contentious issue, although some say that only First Nations could sign a treaty but

possess, have largely been ignored by the federal government when implementing its health care policies. Additionally, the gender equality rights found in section 35(4) of the *Constitution Act, 1982* qualify the fiduciary obligations resulting from the *Constitution* and have not been applied in this area – leading to even larger gaps between Aboriginal women’s health and the health of the Canadian population.

This chapter suggests that Canada should continue to acknowledge the legally enforceable fiduciary obligations the Crown owes to Aboriginal people in all areas but particularly regarding health and health care, which also includes the obligation to act (government inaction does not relieve the government of its responsibilities). In accordance with these fiduciary responsibilities, Canada must review its policies in relation to health services and the resulting differential outcomes of those health services (including provision of and access to those services) and guarantee that all Aboriginal people are provided with the same level and quality of health care that all Canadians enjoy. Further, to fulfill their duty, Canada must move forward with principles articulated by the Supreme Court of Canada through adequate and meaningful consultations to carry out these important responsibilities.

8.2 What is Fiduciary Law?

Fiduciary law traces its origins to the Court of Chancery which governed several issues including trusts and confidences and dealt with the faithfulness of the person in whom a confidence (or trust) has been entrusted. It makes the expectations of loyalty arising from these relationships enforceable.⁸

This area of law governs relationships between ‘fiduciaries’ and ‘beneficiaries’. In particular, it deals with the duties and obligations of the fiduciary and the resulting benefits owing to the beneficiaries of that relationship.⁹ It deals with the conduct of people in these positions. One of

there certain instances that Métis were included in the treaties, such as through and adhesion to [Treaty 3](#) as well as 84 Métis in the [Robinson Superior Treaty](#) of 1850. While many Métis claim that the *Manitoba Act, 1870* was a treaty, many more Métis were initially included in a number of other treaties and then excluded under later amendments to the [Indian Act](#). (McNab, David, and Ute Lischke, *The Long Journey of a Forgotten People Métis Identities and Family Histories*, Waterloo, Ont: Wilfrid Laurier University Press, 2007).

⁸ Michael NG, *Fiduciary Duties: Obligations of Loyalty and Faithfulness* (Canada Law Book: Aurora) 2005 at 1-1 [NG].

⁹ Rotman, *supra* note 2 at 151.

the earliest recorded fiduciary cases is *Keech v. Sandford* (1726)¹⁰ where a child (Keech) had inherited a lease on a market near London. Sandford was entrusted to look after the property until the child matured. Before the child grew up the lease expired. Sandford did not renew the lease for the child's benefit but instead the landlord renewed the lease in Sandford's name (as the landlord refused to renew the lease in the child's name). When Keech grew up, he sued Sandford for the profit that he had been making from the market's lease. Confirming that the fiduciary cannot reap a benefit from the relationship, the court stated:

A person being possessed of a lease of ... a market, devised his estate to trustee in trust for the infant; before the expiration of the term the trustee applied to the lessor for a renewal for the benefit of the infant, which he refused, ... there was clear proof of the refusal to renew for the benefit of the infant, on which the trustee sets a lease made to himself.¹¹

In 1913, in *Complin v. Beggs*, it was said "The relation existing between a principal reposes trust and confidence in the person whom he selects as his agent."¹² Further, fiduciary law is also an important tool for the control and regulation of socially valuable relationships. It shapes the perimeters of the beneficiaries' reliance on the fiduciary's discretion and has been described as "the law's blunt tool for the control of the fiduciaries discretion."¹³

Uberrima fides is a Latin term which is the foundation of fiduciary law and the cornerstone of the fiduciary relationship. All fiduciaries must act with *uberrima fides* or "utmost good faith"¹⁴ toward their beneficiaries. If fiduciaries do not uphold this strict standard of *uberrima fides*, they are *prima facie* in breach of their duties. Fiduciary law is not interested with "why" or "how" the breach occurred, but only that the breach happened. Circumstances of the event causing a breach of fiduciary duties come into play only when determining remedies. The courts have described three general characteristics that are at the core of every fiduciary relationship:

- The fiduciary has scope for the exercise of some discretion or power;

¹⁰ *Keech v. Sandford* (1726), 25 E.R. 223 (Ch.).

¹¹ *Keech and Sandford*, *ibid.*

¹² *Complin v. Beggs*, (1913), 13 D.L.R. 27 (Man. K.B.), at p. 32.

¹³ E. Weinrib, "The Fiduciary Obligation" (1975) 25 U.T.L.J. 1 at 4.

¹⁴ *Uberrima fides* is a Latin term meaning "utmost good faith", Black's Law Dictionary, 7th ed., (St. Paul Mn.: West Group, 1999) s.v. "utmost good faith".

- The fiduciary can unilaterally exercise that power of discretion so as to affect the beneficiary's legal or practical interests;
- The beneficiary is particularly vulnerable to or at mercy of the fiduciary holding the discretion or power.¹⁵

Not all relationships are classed as fiduciary, but only the ones where a fiduciary is in a legal position to affect the practical interests of the beneficiary. There are many types of relationships that are fiduciary in nature, for instance a doctor and a patient, director and officers, as well as parents and their children are classes of fiduciaries. Whether a person occupies a fiduciary position depends on certain circumstances¹⁶ as well as the nature of the relationship. The Supreme Court of Canada clarified:

It is sometimes said that the nature of the fiduciary relationship is both established and exhausted by the standard categories of agent, trustee, partner, director, and the like. I do not agree. It is the *nature* of the relationship, not the specific category of actor involved that gives rise to the fiduciary duty. The categories of fiduciary, like those of negligence, should not be considered closed.¹⁷

The Federal Court of Appeal in *Semiahmoo* commented on the specificness of the relationship:

The authorities on fiduciary duties establish that courts must assess the specific relationship between the parties in order to determine whether or not it gives rise to a fiduciary duty and, if yes, to determine the nature and scope of that duty. This approach applies equally in the context of the fiduciary duty owed to Indian Bands when they surrender reserve land. In my view, while the statutory surrender requirement triggers the Crown's fiduciary obligation, the Court must examine the specific relationship between the Crown and the Indian Band in question in order to define the nature and scope of that obligation.¹⁸

A fiduciary is someone who must act in the best interests of the beneficiary and the fiduciary must be faithful to this trust or confidence bestowed upon him or her. The fiduciary role must be fulfilled with fidelity by meeting the terms of the trust that is imposed – the terms being defined from the nature of the trust. Fiduciaries owe a duty to refrain from acting in a way that will interfere with their abilities to perform their fiduciary duties. Similarly,

¹⁵ *Frame v. Smith* [1987] 2 S.C.R. 99, at 136 [*Frame*].

¹⁶ NG, *supra* note 8 at 1-2 and 1-3.

¹⁷ *Guerin*, *supra* note 1.

¹⁸ *Semiahmoo Indian Band v. Canada*, (1997), 148 D.L.R. (4th) 523 (F.C.A.), at 536.

The fiduciary may be involved in matters which, while of interest to his principal, are irrelevant to and do not conflict with, his duty to him.¹⁹

A fiduciary must also act within a prescribed set of principles in matters impacting, either directly or indirectly, upon its beneficiary. There are a number of positive duties that are imposed upon a fiduciary:

- A fiduciary must not act in a conflict of interest situation;²⁰
- Must not benefit from their position;²¹
- Must provide full disclosure of their actions;²²
- May not compromise their beneficiary's interests;²³
- A fiduciary may delegate their authority, provided absolute responsibility remains with the fiduciary;²⁴
- A fiduciary is personally liable for the direct breach of their duties or the wrongful actions of its delegates that results in a breach.²⁵

Correspondingly, in a fiduciary relationship, the beneficiary acquires a number of benefits, including:

- the ability to commence legal action for any breach of fiduciary duty once the cause of action is exposed;²⁶
- alleging a breach is sufficient – the onus of discharging the allegation of breach rests with the fiduciary;²⁷ and
- the ability to seek remedial aid upon tracing and finding the breach.²⁸

¹⁹ *Two Brothers (Kingston) Ltd. v. Zakos* (1985), 28 D.L.R. (4th) 541 (Ont. H.C.J.), at 549.

²⁰ Rotman, *supra* note 2 at 180.

²¹ *Ibid.*

²² *Ibid.*

²³ *Ibid.*

²⁴ *Ibid* at 181.

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ *Ibid.*

²⁸ *Ibid.*

A claim of breach of fiduciary duties occurs when certain conditions are met: i) a fiduciary relationship must be established; ii) the applicable standard of conduct must be identified with the breach and iii) an established equitable remedy must be found.²⁹ An examination of a fiduciary's conduct is crucial and relevant when determining whether a breach of duty has occurred with any possible mitigating factors noted. In this case, the health of Aboriginal people, including the health policies, laws and legislation is examined to determine if there are breaches. The Supreme Court of Canada has stated when the fiduciary duty is breached; the court is not only concerned with equity between the parties but also with the larger public interest in maintaining the integrity of fiduciary relationships.³⁰ The courts consider breach of a fiduciary duty seriously and a variety of penalties may flow from the finding of a breach, which may include the imposition of punitive damages.³¹

The following section of this paper will review the Crown/Aboriginal relationship and the obligations flowing from that relationship. The principles underlying this general analysis will be applied specifically to the Crown's fiduciary duties in relation to Aboriginal health.

8.3 Crown-Aboriginal Fiduciary Relationship

Although fiduciary principles have been in existence for a long period, some confusion prevails about the application to the Crown/Aboriginal relationship. This uncertainty however, has not slowed down or impeded the use of fiduciary arguments by Aboriginal organizations, individuals, communities and the courts. To be certain, fiduciary obligations flow from the fiduciary relationship.

Legal scholar Leonard Rotman comments that unlike other areas of law such as contracts, "...the fiduciary relation – and its concomitant duties, obligations, rights and benefits – is not well understood."³² Author Paul Desmond Finn concurs:

²⁹ *Canadian Aero Service Ltd. v. O'Malley* [1974] S.C.R. 592 at para 21.

³⁰ *Soulos v. Korkontzilas*, [1997] 2 S.C.R. 217, 146 D.L.R. (4th) 214 [*Soulos*]. See also, *Osoyoos Indian Band v. Oliver (Town)*, [2001] 3 S.C.R. 746, [2002] 1 C.N.L.R. 271 [*Osoyoos*]; *Opetchesah Indian Band v. Canada*, [1997] 2 S.C.R. 119, [1998] 1 C.N.L.R. 134.

³¹ *Ibid.*

³² Rotman *supra* note 2at 3.

Depending on the context, the judiciary might simply require the fiduciary to consult, act in good faith or provide relevant information to a beneficiary. Since fiduciary duties vary so significantly from context to context and from relationship to relationship, their content cannot be pinned down with any degree of precision. This conceptual uncertainty has led P.D.Finn to remark that ‘fiduciary’ is one of the most ill defined, if not altogether misleading, terms in our law.³³

The Crown’s fiduciary relationship with Aboriginal people has been described as *sui generis* or of its “own kind or class.”³⁴ Rotman explains that the Crown/Aboriginal relationship is “rooted in the historical, political, social and legal interaction of the groups from time of contact.”³⁵ Accordingly, the unique character of this relationship gives rise to the Crown being regarded as a fiduciary. Dickson J. stated “in this *sui generis* relationship, it is not improper to regard the Crown as a fiduciary.”³⁶ Fiduciary law, as part of the common law, is also part of the *sui generis* relationship and is therefore applied when determining if the Crown has breached its obligations to Aboriginal people.³⁷ The Federal Court in *Squamish Indian Band v. Canada* clarified:

[A]ll parties agreed that "*sui generis*" meant "unique". In my view, there are two aspects to the uniqueness of the fiduciary duty identified in *Guerin*. Firstly, the fiduciary duty is unique because it arises outside its traditional private law context. Secondly, it is unique because it is more flexible in its requirements than the traditional Private Law Fiduciary Duty. The content of the *sui generis* fiduciary duty may vary depending on the circumstances of the case.³⁸

Since the beginning of the British assertion of sovereignty, the guiding principles of fiduciary law have governed Crown/Aboriginal relations.³⁹ It was clarified in the *Sparrow* decision that “[T]he *sui generis* nature of Indian title, and the *historic powers and responsibility assumed by*

³³ P.D. Finn, *Fiduciary Obligations* (Sydney: The Law Book Company, 1977) at para 1 in Patrick Maclem, *Indigenous Difference and the Constitution of Canada* (University of Toronto Press: Toronto, 2002) at 253.

³⁴ *Sui generis* is a Latin term meaning “of its own kind”, “unique or peculiar”. *Blacks Law Dictionary*, 7th ed., (St. Paul Mn.: West Group, 1999) s.v. “sui generis”. Rights that are *sui generis* do not fit into categories of French or English law (*R. v. Guerin supra* note 1 cited in J. Woodward, *Native Law* (Toronto: Carswell, 2002) at 5-7.

³⁵ Rotman, *supra* note 2.

³⁶ *Ibid* at 387.

³⁷ Rotman, *supra* note 2 at 14. See also *Guerin, supra* note 1.

³⁸ *Squamish Indian Band v. Canada*, [2000] F.C.J. No. 1568; 2001 FCT 480 at para 473.

³⁹ Rotman, *supra* note 2 at 4.

the Crown constituted the source of such a fiduciary obligation.”⁴⁰ The fiduciary relationship exists through the historic responsibilities found in the language of the early treaties, the *Royal Proclamation of 1763*;⁴¹ judicial affirmation through case law; and the entrenchment of Aboriginal and treaty rights in the *Constitution Act, 1982* has solidified the Crown’s fiduciary obligations into the supreme law of Canada.

8.4 Sources of the Fiduciary Obligation

8.4.1 Early Treaties

The manifestation of the benefits of the fiduciary relationship is found in the early treaties through protections that are noted as early as in 1664 in the Treaty of Albany, “The Indians at Wamping and Espachomy and all below the Manhatans, as also all those that have submitted themselves under the protection of His Ma(tie) are included in these Articles of Agreements and Peace.”⁴² In 1701 Britain and the (then) Five Nations of the Iroquois Confederacy entered into a treaty in which the Iroquois were promised that “wee [the Five Nations] are to have free hunting for us and the heires and descendants from us the Five nations forever and that free of all disturbances expecting to be protected therein by the Crown of England.”⁴³

The early treaties were entered into as early as the 1600s in Boston.⁴⁴ Peace and Friendship treaties were negotiated to establish partners in trade between the Indian Nations and Britain and they were subsequently supplied with political and military allies, mutual protection,

⁴⁰ *R. v. Sparrow*, [1990] 1 S.C.R. 1075, [1990] 3 C.N.L.R. 160 [Sparrow cited to S.C.R.] at 180 [Sparrow].

⁴¹ *Royal Proclamation of 1763*, R.S.C. 1985, App. II, No. 1 [Royal Proclamation]. See also, *Sparrow*, *ibid* at 177, *Delgamuukw v. British Columbia*, 1997] 3 S.C.R. 1010, [1998] 1 C.N.L.R. 14 [Delgamuukw] at para. 200 per La Forest, J. The legal rights deriving from the 1763 Proclamation are specifically guaranteed to Aboriginal Peoples in s. 25 of the *Charter of Rights and Freedoms*, against all individuals:

The guarantee in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada including

(a) any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and

(b) any rights or freedoms that may be acquired by the aboriginal peoples of Canada by way of land claims settlement. (*Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.)

⁴² Rotman, *supra* note 2 at 311.

⁴³ “Deed of the Beaver Hunting Ground,” E.B. O’Callaghan ed. *Documents Relative to the Colonial History of the State of New York*, vol. 9 (Albany: Weed, Parsons and Company, 1853-1887) at 908-910.

⁴⁴ B. Wildsmith, “Pre-Confederation Treaties,” in B.Morse, ed. *Aboriginal Peoples and the Law* (Ottawa: Carleton University Press, 1991) at 122.

military and economic support in war times and a detriment to their enemies in times of peace.⁴⁵ Before and after 1760, the relationships between Britain and Aboriginal nations were structured more around principles of alliance rather than conquest.⁴⁶

Besides military alliances, the treaties ensured that the British sovereign, and later the Canadian governments, would provide protection for Aboriginal people. The need to protect Aboriginal people to ease their transition into assimilation was a fundamental element of early British Indian policy. The 1752 Treaty with the Mi'kmaq, promised that the Mi'kmaw "shall have all favor, Friendship and Protection shewn them from this His Majesty's Government."⁴⁷ These principles of protection were also reflected in other treaties such as the Treaty of Utrecht, 1713,⁴⁸ the Articles of Capitulation at Montreal of September 8, 1760,⁴⁹ and the *Royal Proclamation of 1763*.⁵⁰

8.4.2 Royal Proclamation of 1763

Building on the protectionist policies from the Treaty of Utrecht and the Articles of Capitulation, King George III issued the Royal Proclamation in 1763 to organize Britain's government administration and to stabilize relations with Aboriginal nations through regulation of colonies, trade, settlement, and land purchases. It also established the constitutional framework for the negotiation of Indian treaties with the Aboriginal inhabitants of large sections of Canada. It became a key legal instrument for the establishment of colonial governments in Quebec, E. Florida, W. Florida and Grenada. It further defined the legal status of a large area in the North American interior as a very large Indian reserve,

⁴⁵ Rotman, *supra* note 2 at 31.

⁴⁶ Royal Commission on Aboriginal Peoples, *Treaty Making in the Spirit of Co-existence: An Alternative to Extinguishment* (Ottawa: Minister of Supply and Services, 1995) at 23.

⁴⁷ The Mikmaq district chiefs ratified the Wabanaki Compact in 1726 and 1749. These treaties were reaffirmed as part of the Mikmaq Compact in 1752. W.E. Daugherty, *Maritime Indian Treaties in Historical Perspective*. (Ottawa: INAC, Treaties and Historical Research Centre, 1983) at 84-85.

⁴⁸ Article 15 held provisions for the protection of Native allies of Britain and France in North America: The subjects of France inhabiting Canada and others, shall hereafter give no hindrance or molestation to five Nations or Cantons of Indians, subject to the Dominion of Great Britain, not to the Natives of America, who are friends to the same. In like manner, the Subjects of great Britain shall behave themselves peaceably towards the Americans who are Subjects or Friends to France. Rotman, *supra* note 2 at 27.

⁴⁹ Article 40 details the surrender of France at its North American outpost and also made provisions for France's Indian Allies to be maintained in the lands they inhabited and unmolested by the British. (Rotman, *supra* note 2 at 27).

⁵⁰ Rotman, *supra* note 2 at 26.

The eastern boundary of this territory, which explicitly excluded the colony of Québec and the lands of the Hudson's Bay Co, was set along the heights of the Appalachian mountain range. The western border was not specifically described. These special provisions to acknowledge and protect some rights of the native peoples in the N American interior were made in recognition of the fighting power they collectively represented.⁵¹

When King George III directed his Governors on the implementation of the *Royal Proclamation* he instructed:

[Y]et His Majesty's Justice & Moderation inclines Him to adopt the more eligible Method of conciliating the Minds of the Indians by the Mildness of His Government, by protecting their Persons & Property & securing to them all the Possessions, Rights and Priviledges they have hitherto enjoyed, & are entitled to
...⁵²

The King further directed Governor James Murray to “assemble, and treat with the said Indians, promising and assuring them of Protection and Friendship on Our Part, and delivering them such Presents, as shall be sent to you for that purpose.”⁵³ The Governors were “strictly forbid, on pain of Our Displeasure, all our Subjects from making any purchases or settlements ... or taking Possession of any of the Lands reserved to the several Nations of Indians, with whom We are connected, and who live under our Protection ...”⁵⁴ They were further commanded to “by all ways seek fairly to oblige them” and to “carefully protect and defend” Aboriginal nations from adversaries.⁵⁵ Governors were also instructed to “especially take care that none of our own subjects, nor any of their servants do in any way harm them.”⁵⁶

⁵¹ The Canadian Encyclopedia, online:

<http://www.thecanadianencyclopedia.com/index.cfm?PgNm=TCE&Params=A1ARTA0006990> (accessed October 20, 2010).

⁵² Documents relating to the constitutional history of Canada, 1759 – 1791, Gage’s enclosure No. 38 March 20, 1762 in Amheart’s to Egremont of 12 May, 1762 A. & W. I. Vol. 97. Shortt, Adam, 1859 – 1931 Doughty, Arthur G., 1860 – 1936 Public Archives of Canada Historical documents Publication Board (Ottawa: J. de L. Tache, 1918) at 128-129.

⁵³ Documents relating to the constitutional history of Canada, 1759 – 1791, Shortt, Adam, 1859 – 1931 Doughty, Arthur G., 1860 – 1936 Public Archives of Canada Historical documents Publication Board (Ottawa: J. de L. Tache, 1918) at 199.

⁵⁴ *Ibid* at 200.

⁵⁵ Treaties and Historical Research Centre, *The Historical Development of the Indian Act* (2d ed.) (Ottawa: Indian and Northern Affairs, 1978) at 2.

⁵⁶ *Ibid*.

The *Royal Proclamation* affirmed rights that were already in existence before 1763, it merely formalized an enduring relationship between Aboriginal nations and the Crown. The *Royal Proclamation* affirmed the fiduciary responsibilities flowing from their relationship.⁵⁷

The language and promises of protection found in the *Royal Proclamation* directly links the fiduciary relationship and duties of the Crown and its agents to the Aboriginal inhabitants as beneficiaries.⁵⁸ *St Catherine's Milling and Lumber Co. v. the Queen* held that Aboriginal rights were derived from the *Royal Proclamation of 1763*⁵⁹ and modern Canadian courts have articulated that that the Proclamation did not create any rights which were not already in existence.⁶⁰

The English Court of Appeal⁶¹ and the Supreme Court of Canada⁶² have directed that, as successor to the British sovereign, the Crown in right of Canada became charged with these same obligations to Aboriginal people as a result of the *Royal Proclamation of 1763*. The applicable text reads:

And whereas it will greatly contribute to the speedy settling of our said new Governments, that our loving Subjects should be informed of our Paternal care, for the security of the Liberties and Properties of those who are and shall become Inhabitants thereof. ...

... Such Regulations and restrictions are used in other Colonies; and in the mean Time, and until such Assemblies can be called as aforesaid, all Persons Inhabiting in or resorting to our Said Colonies may confide in our Royal Protection for the Enjoyment of the Benefit of the Laws of our Realm of England.

⁵⁷ Rotman, *supra* note 2 at 39.

⁵⁸ *In Whom We Trust*, *supra* note 2 at 12.

⁵⁹ *St Catherine's Milling and Lumber Co. v. the Queen* (1888), 14 App. Cas. 46 (P.C.) [*St Catherine's Milling*].

⁶⁰ See, for example, *R v. Koonungnak*, [1963] 45 W.W.R 282 at 302 (N-W-T. Ten. Ct.): 'This proclamation has been spoken of as the "Charter of Indian Rights-" Like so many great charters in English history, it does not create rights but rather old rights. The Indians and the Eskimos had their aboriginal rights and English law has always recognized these rights.'; *Calder v. British Columbia (Attorney General)*, [1973] S.C.R. 313, [1973] 4 W.W.R. 1, 34 D.L.R. (3d) 145, 7 C.N.L.C. 91 at 150 [cited to C.N.L.R.] [*Calder*] per Hall J.; *Hamlet of Baker Lake v. Minister of Indian Affairs and Northern Development* (1979), 107 D.L.R (3d) 5 13 at 54 1 (F.C.T.D.); Guerin, *supra* note 1 at 335 (SCC.) per Dickson J.

⁶¹ *The Queen v. Secretary of State for Foreign and Commonwealth Affairs, Ex Parte Indian Association of Alberta*, [1982] Q.B. 892, [1981] 4 C.N.L.R. 86 (Engl. C.A.) at 99.

⁶² *Ibid.*

And whereas it is just and reasonable, and essential to our Interest, and the Security of our Colonies, that the several Nations or Tribes of Indians with whom We are connected, and who live under our Protection, should not be molested or disturbed in the Possession of such Parts of Our Dominions and Territories as, not having been ceded to or purchased by Us, are reserved to them, or any of them, as their Hunting Grounds.⁶³

In *The Queen v. Secretary of State for Foreign and Commonwealth Affairs, Ex Parte Indian Association of Alberta*,⁶⁴ Lord Denning M.R. interpreted the promises made to Aboriginal peoples as being rights and freedoms that are guarantees made by the Crown and that “[n]o parliament should do anything to lessen the worth of these guarantees.”⁶⁵ Lord Denning clarified, that while the promises contained in the *Royal Proclamation* were made originally by the British Crown, but that these promises “should be honoured by the Crown in respect of Canada ‘so long as the sun rises and [the] river flows.’ That promise must never be broken.”⁶⁶

Lord Denning further stated the Court of Appeal’s “interpretation would strengthen their [the Indians’] hand so as to enable them to withstand any onslaught [by the Government of Canada]” and that “[n]o parliament should do anything to lessen the worth of these guarantees.”⁶⁷ Because of this, the *Royal Proclamation* limits the activity of the government authorities over the Indian nations and is analogous to an ‘Indian Bill of Rights’ and an ‘Indian Magna Carta’ because it recognized and affirmed the pre-existing sovereign relationship between the Crown and Aboriginal people.⁶⁸ The Courts in *Delgamuukw* have also used the *Royal Proclamation* to advance the doctrine that legally recognizes Aboriginal title to land in situations in which Indians never surrendered land through a treaty. Aboriginal nations are able to refer to the *Royal Proclamation* as the confirmation that they possessed land and other rights that the provincial and federal governments must recognize. For the Inuit, the Royal

⁶³ *Royal Proclamation*, *supra* note 41.

⁶⁴ *The Queen v. Secretary of State for Foreign and Commonwealth Affairs, Ex Parte Indian Association of Alberta*, [1982] Q.B. 892, [1981] 4 C.N.L.R. 86 (Engl. C.A.) at 99.

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*

⁶⁷ *Ibid.*

⁶⁸ *Calder*, *supra* note 60. See also, J. Bird, L. Land & M. MacAdam, “Land Claims: Stuck in Never-never Land” in J. Bird, L. Land and M. MacAdam, eds., *Nation to Nation: Aboriginal Sovereignty and the Future of Canada* (Toronto: Irwin Publishing, 2001) 53 at 54 [*Nation to Nation*].

Proclamation has been called the “Eskimo Magna Carta” as it is considered one source of the Crown/Inuit fiduciary relationship.⁶⁹

Mr. Justice Hall, dissenting in *Calder v. British Columbia (Attorney General)* described the *Royal Proclamation* as “a fundamental document upon which any just determination of original rights rests:”

A line of policy begotten of prudence, humanity and justice adopted by the British Crown to be observed in all future dealings with the Indians in respect of such rights as they might suppose themselves to possess was outlined in the Royal Proclamation of 1763 erecting, after the Treaty of Paris in that year, amongst others, a separate government for Quebec, ceded by that treaty to the British Crown.

That policy adhered to thenceforward, by those responsible for the honour of the Crown led to many treaties whereby Indians agreed to surrender such rights as they were supposed to have in areas respectively specified in such treaties.

In these surrendering treaties there generally were reserves provided for Indians making such surrenders to enter into or be confined to for purposes of residence.⁷⁰

In 1984, the Supreme Court of Canada in *R. v. Guerin* agreed with the analysis provided by the earlier courts and affirmed “the historic responsibility...to act on behalf of the Indians so as to protect their interests in transactions with third parties.”⁷¹ The Supreme Court held that the *sui generis* nature of Aboriginal title imposed a positive fiduciary duty on the Crown. This right existed prior to the [Royal Proclamation](#) and is founded in historical occupation of the Aboriginal nations and concludes that title to Aboriginal lands can only be alienable to the Crown and the Crown can only use it in the interests of the Aboriginal people.

The Supreme Court in *R. v. Sioui*, was also clear on the protective purposes of the *Royal Proclamation*:

The very wording of the Royal Proclamation clearly shows that its objective, so far as the Indians were concerned, was to provide a solution to the problems

⁶⁹*Regina v. Kogokolak*, (1959), 31 C.R. 12; 28 W.W.R. 376 at preamble.

⁷⁰*Calder*, *supra* note 60 at 150-151.

⁷¹*Province of Ontario v. Dominion of Canada* (1909), 42 S.C.R. 1 at pp. 103-4 [affd [1910] A.C. 637]in *Guerin*, *supra* note 1 at 383.

created by the greed which hitherto some of the English had all too often demonstrated in buying up Indian land at low prices. The situation was causing dangerous trouble among the Indians and the Royal Proclamation was meant to remedy this...⁷²

It is recognized that through the *Royal Proclamation* the Crown's fiduciary duty continues to be operational in its fulfillment of the terms of treaties:

The Proclamation confers rights on the Indians without necessarily thereby extinguishing any other right conferred on them by the British Crown under a treaty.⁷³

Law professor Sákéj Youngblood Henderson not only clarifies that these historical obligations created a political trust of protection, but confirms that Canada cannot hold parliamentary sovereignty over Aboriginal people:

The purpose of the Indian Act was to implement the obligations of treaties, royal instructions, and the Royal Proclamation into federal law in order to clarify national obligations. After 1930 this authority was considered legislative power under the pretence of Parliamentary sovereignty. No legislative body in Canada was ever sovereign in the sense of the imperial Parliament: a unitary legislature that was able to make or unmake any law whatsoever. Still, the federal Parliament increasingly took a broad view of being able to legislate for the "Indians" on matters not delegated to it by the treaties and, therefore, outside its competence. Yet, contemporary courts have held that the historical obligations, codified in the Indian Act, created a political trust of the highest obligation and a Constitutional, protective, fiduciary obligation.⁷⁴

The following section examines the roots of the political trust cases.

8.4.3 Judicial Recognition of Fiduciary Obligations

Prior to the 1984 *Guerin* decision, the Crown/Aboriginal relationship was understood to be that of 'guardian and ward'. This characterization dates back to an American case, *Cherokee Nation*

⁷² *R. v. Sioui*, [1990] 1 S.C.R. 1025, [1990] 3 C.N.L.R. 127 (cited to C.N.L.R.) [*Sioui*].

⁷³ *Sioui*, *ibid* at 153.

⁷⁴ J.Y. Henderson, "Treaty Rights to Health" (2002) [unpublished, Native Law Centre, University of Saskatchewan] at 19 [Treaty Rights to Health]. See also, J. Y. Henderson, (1994), "Empowering Treaty Federalism," *Saskatchewan Law Review*, vol. 58, no. 2, pp. 241-329.

v. State of Georgia (1831) where the United States Supreme Court stated that the Cherokee Nation's relationship to the United States "resembles that of a ward to his guardian".⁷⁵

They look to our government for protection; rely upon its kindness and its power; appeal to it for relief to their wants; and address the President as their Great Father. They and their country are considered by foreign nations, as well as by ourselves, as being so completely under the sovereignty and dominion of the United States that any attempt to acquire their lands, or to form a political connexion with them, would be considered by all as an invasion of our territory and an act of hostility.⁷⁶

This early characterization may be critical for several reasons: it assumed that Aboriginal peoples – as wards – were incapable of looking after themselves and it followed then that the Crown, as guardian, must make decisions for Aboriginal people.⁷⁷ It further followed that a guardian-ward relationship meant that, under Canadian law, the Crown acted out of a moral rather than any legal obligation and was therefore not administratively responsible for its actions. The Supreme Court of Canada in *St. Catherine's Milling and Lumber Co. v. The Queen* (1885), characterized this obligation as being "a sacred political obligation" and *not* a "legal obligation:"

The Indians must in the future, every one concedes it, be treated with the same consideration for their just claims and demands that they have received in the past, but, as in the past, it will not be because of any legal obligation to do so, but as a sacred political obligation, in the execution of which the state must be free from judicial control.⁷⁸

In light of this "sacred political obligation" noted in *St. Catherine's Milling*, the cases following became known as the "political trust" cases.⁷⁹ In the political trust cases, the party claiming to be a beneficiary under such a trust was dependent entirely upon statute, ordinance or foreign treaty as the basis for its claim to an interest in the funds in question. This distinction was recognized in two English cases dealing with the position of the Crown as trustee in other

⁷⁵ *Cherokee Nation v. Georgia*, 30 U.S. (Pet.) 1 (1831), 8 L. Ed. 25 (1831) [*Cherokee Nation*].

⁷⁶ *Ibid* at 18.

⁷⁷ Rotman, *supra* note 2 at 20.

⁷⁸ *St. Catherine's Milling*, *supra* note 59 at 513.

⁷⁹ *Guerin*, *supra* note 1 at 379.

colonies: *Tito v. Waddell*⁸⁰ and *Kinloch v. Secretary of State for India in Council*.⁸¹ In *Guerin*, the Court stated “In *Kinloch*, Lord Selbourn L.C. said:

Now the words "in trust for" are quite consistent with, and indeed are the proper manner of expressing, every species of trust —a trust not only as regards those matters which are the proper subjects for an equitable jurisdiction to administer, but as respects higher matters, such as might take place between the Crown and public officers discharging, under the directions of the Crown, duties or functions belonging to the prerogative and to the authority of the Crown. In the lower sense they are matters within the jurisdiction of, and to be administered by, the ordinary Courts of Equity; in the higher sense they are not. What their sense is here, is the question to be determined, looking at the whole instrument and at its nature and effect.”⁸²

The "political trust" cases involved the distribution of public funds or other property held by the government, rather than government services. In these cases the party claiming to be a beneficiary under such a trust depended entirely on statute, ordinance or foreign treaty as the basis for its claim to an interest in the funds in question. In 1983, the earlier Federal Court of Appeal case in *Guerin* validated this interpretation and stated that the "extent to which the Government assumes an administrative or management responsibility for the reserves ... is a matter of governmental discretion, not legal or equitable obligation".⁸³ In 1984, the Supreme Court of Canada overturned this decision, its theory of political trust, and its no-fault administrative responsibility.⁸⁴ It replaced political trust theory with a legally enforceable and compensable statutory fiduciary obligation, stating the inherent rights arising under *sui generis* legal regime of Aboriginal law and title⁸⁵ make the "political" trust decisions or public law duty inapplicable. The Supreme Court in *Guerin* rejected Canada's characterizing the trust relationship as a non-enforceable political trust, rather than an enforceable Constitutional or statutory right. Instead, the court held that the relationship was fiduciary in nature and the Crown has fiduciary duties and responsibilities towards Aboriginal people because of it.

⁸⁰ *Tito v. Waddell* (No. 2), [1977] 3 All E.R. 129 (Ch.)

⁸¹ *Kinloch v. Secretary of State for India in Council* (1882), 7 App. Cas. 619 (H.L.) [Kinloch].

⁸² *Guerin*, *supra* note 1 at 371 quoting *Kinloch*, *ibid* at pp.625-26.

⁸³ *Guerin v. R.* [1983] 2W.W.R. 750 (Federal Court of Appeal speaking through Le Dain J.) In his view, this discretion in section 18(1) of the *Indian Act* indicated it was for the government, not the courts, to determine what was for the use and benefit of the band. The Crown had argued that if there was a trust it was, at best, a "political trust", enforceable only in Parliament and not a private "true trust", enforceable in the courts.

⁸⁴ *Guerin v. R.* [1984] 2 S.C.R. 335, reversing [1983] 2 F.C. 656.

⁸⁵ Since Aboriginal title is an independent or *sui generis* legal regime, their protected interest in their lands under British law is a pre-existing legal right not created by *Royal Proclamation*, or by s.18(1) of the *Indian Act*, or by any other executive order or legislative provision.

The significance of the Supreme Court's rejection of the political trust characterization of Canada's relationship with Aboriginal people along with its no-fault administrative responsibility in favour of a fiduciary relationship cannot be underestimated: the fiduciary obligation is a legally enforceable and compensable obligation. The *Guerin* Court also stated that, additionally, the inherent rights arising under the *sui generis* legal regime of Aboriginal law and title make the political trust decisions inapplicable. Although, the fiduciary obligation in *Guerin* arose in the context of a reserve land surrender, the case laid the foundation for applying fiduciary law to other aspects of the Crown/Aboriginal relationship through Aboriginal reliance on the Crown's discretionary power and the Crown's obligation to act in their best interests. However the 2002 *Wewaykum*⁸⁶ case clarifies that this duty is not always an attribute of the Crown-Aboriginal relationship, but actually places reasonable limits on the fiduciary duty akin to the same standards found in fiduciary law.

Because the Supreme Court established that these fiduciary rights are *sui generis* to Aboriginal relations with the British sovereign and Canada, this relationship and its obligations are based on distinguishing between the common and civil law traditions. As noted in *Guerin* the private law⁸⁷ concept of a trust was rejected as applying to an action of an *Indian Act* band's transfer of reserve land "in trust for lease" to Canada because of this *sui generis* relationship.⁸⁸ This judicially imposed standard of conduct which the *sui generis* fiduciary obligation imports is

⁸⁶ *Wewaykum Indian Band v. Canada*, 2002 SCC 79 (S.C.C.) aff'g (1999), 247 N.R. 350, [1999] F.C.J. No. 1529, [2000] 3 C.N.L.R. 303 (Fed. C.A.), aff'g in result (1995), 99 F.T.R. 1 (F.C.T.D.) [*sub nom. Roberts v. Canada*] [*Wewaykum*].

⁸⁷ Fiduciary duties generally arise only with regard to obligations originating in a private law context of the common law. The Court held at page 384 "while it is not a private law duty in the strict sense either, [the *sui generis* duty] is nonetheless in the nature of a private law duty." The law of trusts is a highly developed, specialized branch of British private law, which requires a settlor, a beneficiary, a trust corpus, words of settlement, certainty of object and certainty of obligation. Nor does surrender give rise to a constructive trust.

⁸⁸ The Court at 385 stated when an Indian band surrenders its interest to the federal Crown, "a fiduciary obligation takes hold to regulate the manner in which the Crown exercises its discretion in dealing with the land on the Indians' behalf". To the majority at page 379 it did not matter that the case was concerned with the interest of an Indian band in a reserve rather than with unrecognized Aboriginal title in traditional tribal lands. The Indian interest in the land is the same in both cases, relying on *A.G. Que. v. A.G. Can.*, [1921] 1 A.C. 401 at 410-11 (P.C.) (the "Star Chrome" case). They saw the reserve in question was created out of the ancient tribal territory of the Musqueam band by the unilateral action of the colony of British Columbia, prior to Confederation. Additionally at page 381: "In 1938 the title to all Indian reserves in British Columbia was transferred by the provincial government to the Crown in right of Canada."

more general and more exacting than the terms of any particular surrender.⁸⁹ In spite of the words chosen by Canada (in trust for lease), the of the Court split but stated that the Crown's obligations vis-à-vis the surrendered lands in a Indian reserve cannot be defined as a private law trust,⁹⁰ a constructive trust,⁹¹ or agency.⁹² Aboriginal lands, on and off a reserve, are held under Aboriginal law and tenure or title; this distinct tenure is not part of the British law, but recognized by it.⁹³ A change in sovereignty over a particular territory does not in general affect the presumptive title of the Aboriginal inhabitants.⁹⁴ The Supreme Court in *Calder* implicitly applied this principle to affirm the principle that Aboriginal title is an independent legal right which, although recognized by the *Royal Proclamation of 1763*, nonetheless predates it.⁹⁵ Thus categories and operation of Aboriginal law is beyond the British common law, and cannot be validly conceptualized by it or its *sui generis* nature.⁹⁶

⁸⁹ *Guerin*, *supra* note 1 at 390 relying on *Central London Property Trust Ltd. v. High Trees House Ltd.*, [1947] 1 K.B. 130, [1956] 1 All E.R. 256n; *Robertson v. Min. of Pensions*, [1949] 1 K.B. 227, [1948] 2 All E.R. 767 (C.A.). The majority viewed the action of the federal Crown after the surrender to the band as equitable fraud. Equitable fraud is defined in *Kitchen v. Royal Air Force Assn.*, [1958] 1 W.L.R. 563, [1958] 3 All E.R. 241 (C.A.), as [p.573] "conduct which, having regard to some special relationship between the two parties concerned, is an unconscionable thing for the one to do towards the other".

⁹⁰ *Guerin supra* note 1 at 386.

⁹¹ *Guerin, ibid.*

Nor does surrender give rise to a constructive trust. As was said by this court in *Pettkus v. Becker*, [1980] 2 S.C.R. 834 at 847, 19, "The principle of unjust enrichment lies at the heart of the constructive trust". See also *Rathwell v. Rathwell*, [1978] 2 S.C.R. 436. Any similarity between a constructive trust and the Crown's fiduciary obligation to the Indians is limited to the fact that both arise by operation of law; the former is an essentially restitutionary remedy, while the latter is not. In the present case, for example, the Crown has in no way been enriched by the surrender transaction, whether unjustly or otherwise, but the fact that this is so cannot alter either the existence or the nature of the obligation which the Crown owes.

⁹² The majority in *Guerin, supra* note 1 at 387 argued that:

[W]hile the fiduciary relationship between the Crown and the Indians also bears a certain resemblance to agency, since the obligation can be characterized as a duty to act on behalf of the Indian bands who have surrendered lands, by negotiating for the sale or lease of the land to third parties. However, the federal Crown relations is not their agent in British law, since its authority to act on the band's behalf lack a basis in contract and the band is not a party to the ultimate sale or lease, as it would be if it were the Crown's principal. Estey J. in his concurring opinion argued to dispose the case on the bases of the law of agency. He argued the Band did not release their interest in the surrendered lands, it appointed the Crown in the right of Canada to carry out the commercial exploitation of the Indian interest.

⁹³ *Delgamuukw*, *supra* note 41 at paras 133-34.

⁹⁴ *Ibid.*

⁹⁵ *Amodu Tijani v. Southern Nigeria (Secretary)*, [1921] 2 A.C. 399 in *Calder, supra* note 60 at 26.

⁹⁶ *Ibid.*

Through the surrender of Aboriginal tenure in trust for lease to Canada,⁹⁷ Canada acquired this *sui generis* “fiduciary duty” and obligation that are analogous or “trust-like” in character.⁹⁸ If the Crown breaches this duty “it will be liable to the Indians in the same way and to the same extent as if such a trust were in effect.”⁹⁹ The relevant aspect of the required standard of conduct is defined by a principle analogous to the basis of the common law doctrine of promissory or equitable estoppel, or fiduciary duty or private trust law.

i) *Sui Generis* Fiduciary Obligations extend to the Constitution

In *Sparrow*, the Court extended this statutory enforceable obligation to a comprehensive Constitutional fiduciary obligation that applies to the Crown-Aboriginal relationship. It stated the “general guiding principle” for s. 35(1) is:

[T]he government has the responsibility to act in a fiduciary capacity with respect to aboriginal peoples. The relationship . . . is trust-like, rather than adversarial and contemporary recognition and affirmation of aboriginal rights must be defined in light of these historic relations.¹⁰⁰

The *sui generis* fiduciary duties of Constitutional supremacy are designed to terminate the legal fictions of political trust, bureaucratic absolutism, and parliamentary sovereignty. The Court emphasized that the *Sparrow* analysis should not be applied mechanically to all cases but challenging future courts to mould the analysis to particular cases to give real meaning to Constitutional rights of Aboriginal peoples.

⁹⁷ *Guerin, supra* note 1 at 388-389: In the view of the majority, the federal Crown was not “empowered by the surrender document to ignore the oral terms which the band understood would be embodied in the lease. The oral representations form the backdrop against which the Crown's conduct in discharging its fiduciary obligation must be measured. They inform and confine the field of discretion within which the Crown was free to act. After the Crown's agents had induced the band to surrender its land on the understanding that the land would be leased on certain terms, it would be unconscionable to permit the Crown simply to ignore those terms. When the promised lease proved impossible to obtain, the Crown, instead of proceeding to lease the land on different, unfavourable terms, should have returned to the band to explain what had occurred and seek the band's counsel on how to proceed. The existence of such unconscionability is the key to a conclusion that the Crown breached its fiduciary duty. Equity will not countenance unconscionable behaviour in a fiduciary, whose duty is that of utmost loyalty to his principal.”

⁹⁸ *Guerin, supra* note 1 at 376.

⁹⁹ *Guerin, supra* note 1 at 387: “As would be the case with a trust, the Crown must hold surrendered land for the use and benefit of the surrendering band. The obligation is thus subject to principles very similar to those which govern the law of trusts concerning, for example, the measure of damages for breach.”

¹⁰⁰ *Sparrow, supra* note 40 at 180.

Much of the jurisdictional understanding of health care is based on the decisions of the Supreme Court of Canada. It would be a violation of Constitutional supremacy and the rule of law to ignore the Court decisions on fiduciary relationship between Canada and the provinces toward Aboriginal peoples. The Supreme Court has affirmed that a legally enforceable but reasonable fiduciary obligation exists and limits the activities and policies of the federal or provincial Crown toward Aboriginal peoples. It casts their discussion of the Constitutional fiduciary obligation of the Crown to Aboriginal people against the backdrop of the Canadian law's failure to recognize Aboriginal claims to land and, indeed, the law's general failure to acknowledge or uphold Aboriginal and treaty rights.¹⁰¹ The Court has held that "historical policy on the part of the Crown is ... incapable of, in itself, delineating" aboriginal and treaty rights and "[t]he nature of government regulations cannot be determinative of the content and scope of an existing" aboriginal or treaty right.¹⁰² It concludes that s. 35(1) of the *Constitution Act, 1982* is the "culmination of a long and difficult struggle in both the political forum and the courts for the Constitutional recognition" of Aboriginal and treaty rights.¹⁰³

Although the *Guerin* decision was the first time that a Canadian court recognized the existence of a fiduciary relationship that was owed to Aboriginal peoples by the Crown, the scope of this relationship was further defined in *Kruger v. R.*¹⁰⁴ *Kruger* determined that the Crown's fiduciary obligations not only were applicable outside of the context of surrender of Indian lands but were also a fundamental part of the *sui generis* relationship between the Crown and Aboriginal people. The *Sioui* case was also important since, in a context other than the surrender of territorial lands, the Court established that both the federal and provincial Crown owed a fiduciary obligation to Aboriginal Peoples when exercising their legislative authority.¹⁰⁵

¹⁰¹ *Sparrow, ibid.*

¹⁰² *Ibid* at 3.

¹⁰³ *Ibid.*

¹⁰⁴ *Kruger v. R.* (1985), 17 D.L.R. (4th) 591, [1985] 3 C.N.L.R. 15 (F.C.A.), aff'g (1981), 125 D.L.R. (3d) 513, [1982] 1 C.N.L.R. 50 (F.C.T.D.).

¹⁰⁵ McNeil, *supra* note 2 at 315. The Commissioners of the Aboriginal Justice Inquiry of Manitoba have also taken the position that the fiduciary obligation applies not only to the federal government, but is also a responsibility of the provincial Crowns:

Our courts have established an entirely new approach toward the examination of aboriginal legal issues, which includes the fiduciary obligation, the content of Aboriginal title, and the scope of Aboriginal and treaty rights. This approach applies

In *Apsassin v. Canada (Department of Indian Affairs and Northern Development)*, McLachlin J. submitted that a fiduciary obligation will arise where the Crown has power and control, and therefore discretion, over Aboriginal interests:

Where a party is granted power over another's interests, and where the other party is correspondingly deprived of power over them, or is "vulnerable", then the party possessing the power is under a fiduciary obligation to exercise it in the best interests of the other.¹⁰⁶

The courts generally continue to uphold the principle of fiduciary obligations based on the establishment of a fiduciary relationship between the Crown and Aboriginal people. However in *Wewaykum Indian Band v. Canada*¹⁰⁷ the Supreme Court confirmed the existence of a fiduciary duty but clarified that there are reasonable limits on the fiduciary doctrine and decided that the fiduciary obligations must be determined on a case by case basis.¹⁰⁸

8.5 Nature and Scope of the Crown/Aboriginal Fiduciary Duty in Relation to Aboriginal Health

As noted, it is well established that fiduciary relationships give rise to fiduciary obligations. The Supreme Court in *Wewaykum Indian Band v. Canada* confirmed these ensuing fiduciary duties through the words of Professor Brian Slattery:

The fiduciary duty, where it exists, is called into existence to facilitate supervision of the high degree of discretionary control gradually assumed by the Crown over the lives of aboriginal peoples. As Professor Slattery commented:

The sources of the general fiduciary duty do not lie, then, in a paternalistic concern to protect a "weaker" or "primitive" people, as has sometimes been suggested, but rather in the necessity of persuading native peoples, at a time

to all legislation, whether or not Aboriginal peoples or their unique legal rights are mentioned. The broad thrust of the law covers both federal and provincial legislation because both levels of government owe a fiduciary duty to all Indian, Inuit and Métis people. "Report of the Aboriginal Justice Inquiry of Manitoba: The Justice System and Aboriginal People (Winnipeg: Queen's Printer, 12 August 1991) at 160-161).

¹⁰⁶ *Blueberry River Indian Band v. Canada (Department of Indian Affairs and Northern Development)*, [1995] 4 S.C.R. 344, [1996] 2 S.C.R. 25 at para. 115.

¹⁰⁷ *Wewaykum*, *supra* note 86.

¹⁰⁸ *Ibid.*

when they still had considerable military capabilities, that their rights would be better protected by reliance on the Crown than by self help.¹⁰⁹

The Crown's discretionary control over the daily lives of Aboriginal people is a factor that establishes the nature of the fiduciary obligation, the control has been present in the early policies that has affected Aboriginal health as noted in Chapter 5.2 (residential schools, sterilization, experiments) and through laws that affected not only Aboriginal health but the social fibre of their existence such as the *Indian Act*, provincial and federal laws as discussed in Chapter 6. Additionally the transition from the political trust theories that formed the basis for the early health policies have been replaced with a fully enforceable fiduciary duty that result from the Crown/Aboriginal relationships.¹¹⁰

Most of the cases concerning fiduciary duties deals with First Nations claims. There are no court decisions on the Crown/Inuit fiduciary relationship or ensuing duties and the only application to Métis claims is in the context of the *Sparrow* justification test on the infringement of harvesting rights.¹¹¹

The Supreme Court has directed that fiduciary obligations arise in certain contexts. To be clear:

There must be a legal interest that the Crown is in a position to exercise its discretion and the Aboriginal group must be vulnerable as a result of the Crown discretion.¹¹²

It is obvious that fiduciary obligations would arise in aspects of the *Indian Act* as the Crown assumes discretionary control over bands, lands¹¹³ and their funds¹¹⁴ and in particular in some instances over the estates under the *Indian Act*.¹¹⁵

¹⁰⁹ *Ibid* at para. 79 citing B. Slattery, "Understanding Aboriginal rights" (1987), 66 *Can. Bar Rev.* 727, at 753.

¹¹⁰ *Guerin*, *supra* note 1.

¹¹¹ *Powley*, *supra* note 6.

¹¹² *Frame*, *supra* note 15; *Hodgkinson v. Simms*, [1994] 3 S.C.R. 377; *Blueberry River*, *supra* note 106; *Wewaykum*, *supra* note 86.

¹¹³ *Wewaykum*, *supra* note 86; *Guerin*, *supra* note 1; *Osoyoos*, *supra* note 30.

¹¹⁴ In relation to the negotiation of legal settlements that deal with reserve lands (*Fairford First Nation v. Canada (Attorney General)* (1998), 1998 CarswellNat 2900, [1999] 2 C.N.L.R. 60 (Fed. T.C.)). Also for the management of royalties that the Crown holds in trust (*Ermineskin Indian Band & Nation v. Canada*, 2009 SCC 9, 2009 CarswellNat 203 (S.C.C.)).

¹¹⁵ *Morin v. Canada* (2000), 2000 CarswellNat 1390, [2000] 4 C.N.L.R. 218 (Fed. T.D.).

The Crown also has an obligation to protect Aboriginal and treaty rights. As noted in Chapter 7, in order to justify any type of infringement on Aboriginal of treaty rights protected under s. 35 of the *Constitution Act, 1982*, the Crown must satisfy the *Sparrow* infringement test in manner that is consistent with its fiduciary obligations. The federal government has responsibility exclusively for their fiduciary obligations in relation to the *Indian Act*, but the provincial governments also have fiduciary obligations that flow from the *Sparrow* justification test.¹¹⁶

Crown conduct is examined in relation to the interests of its Aboriginal beneficiaries. As noted in the *Wewaykum* case, the standard will vary depending on what interests are at risk.¹¹⁷ The Crown must also show good faith and full disclosure¹¹⁸ In relation to Aboriginal health the Crown has a fiduciary obligation to protect s. 35 rights when it is seeking to infringe those rights. Chapter 4 provided an examination of early healing practices that were recorded by the Jesuits, missionaries, whalers, traders and at times by the Aboriginal peoples themselves through oral history. Chapter 7 provided an analysis of Aboriginal and treaty rights to health and showed that not only is there a treaty right to health but there are Aboriginal rights to health as well. The scope of the fiduciary duty would naturally flow to any infringements the government has undertaken that affect Aboriginal health. It is also noted that while s. 35 rights do attract fiduciary obligations, unproven rights do not.¹¹⁹ However, it is also noted that the Crown has no obligation to continue funding a program that benefits Aboriginal people as long as this funding cut does not breach s. 35 of the *Constitution Act, 1982*.¹²⁰ Conversely then, a breach of fiduciary duty would occur if the funding was cut, or not funded adequately to begin with. Such is the case of Aboriginal health.¹²¹

¹¹⁶ *Chippewas of Mnjikaning First Nation v. Chiefs of Ontario* (2010), 2010 ONCA 47, 2010 CarswellOnt 273. See also, *R. v. Badger*, [1996] 1 S.C.R. 771, [1996] 2 C.N.L.R. 77; *R. v. Côté*, [1996] 3 S.C.R. 139, [1996] 4 C.N.L.R. 26.

¹¹⁷ *Wewaykum*, *supra* note 86 at para 86.

¹¹⁸ *Wewaykum*, *supra* note 86 at para 97; *Guerin*, *supra* note 1 at 388-389.

¹¹⁹ *Haida Nation v. B.C. and Weyerhaeuser* (2002), 99 B.C.L.R. (3d) 209, [2002] 2 C.N.L.R. 121 (C.A.); additional reasons, (2002), 5 B.C.L.R. (4th) 33, [2002] 4 C.N.L.R. 117 (C.A.) at para 18 [*Haida Nation*].

¹²⁰ *Winnipeg Child and Family Services (Southeast Area) v. Canada (Attorney General)* (1997), 1997 CarswellMan 370, [1997] 9 W.W.R. 236 (Man Q.B.) at paras 22 and 23, affirmed (21998), 1998 CarswellMan 236, [1998] 9 W.W.R. 583 (Man. C.A.).

¹²¹ As far as remedies for a breach of fiduciary duty in relation to Aboriginal health are concerned, in fiduciary law generally the beneficiary who suffered a breach is entitled to be returned to the state they were before the breach occurred. (*Guerin*, *supra* note 1 at 357) In the case of Aboriginal health, this is not likely possible. Chapter 4.1 provided a snapshot of Aboriginal society and good health pre-contact, the return being unlikely, nor would equitable compensation be appropriate. Equitable compensation being the payment of damages to compensate the

8.6 Elements of Fiduciary Obligations

8.6.1 Discretion is an Important Aspect of Fiduciary Obligations

Fiduciary law and the courts are clear that when a beneficiary relies on a fiduciary, the fiduciary carries a certain amount of discretion while discharging its duties. As noted, there are strict guidelines that govern the behavior of the fiduciary. The Crown must act according to these guidelines in its dealings with Aboriginal people. In the absence of guidelines or criteria on how the Crown's discretion may be exercised, statutes and regulations may be found to infringe upon Aboriginal or treaty rights. Chief Justice Lamer of the Supreme Court of Canada explained the need for the Crown to guard against an unstructured discretionary administrative regime when dealing with Aboriginal rights:

[I]n light of the Crown's unique fiduciary obligations towards Aboriginal peoples, Parliament may not simply adopt an unstructured discretionary administrative regime which risks infringing aboriginal rights in a substantive number of applications in the absence of some explicit guidance. If a statute confers an administrative discretion which may carry significant consequences for the exercise of an Aboriginal right, the statute or its delegate regulations must outline specific criteria for the granting of refusal of that discretion which seek to accommodate the existence of Aboriginal rights. In the absence of such specific guidance, the statute will fail to provide representatives of the Crown with sufficient directives to fulfill their fiduciary duties, and the statute will be found to represent an infringement of Aboriginal rights under the Sparrow test.¹²²

The test of outcomes may be applied when examining the discretionary aspect of the Crown's fiduciary obligations. To determine how well a policy or law has been applied one has to look at the result. In the case of Aboriginal health, when applying a test of outcomes to the discretionary aspect of the Crown's fiduciary obligations, one has to look at the unequal health status to witness how unequally government discretion has been exercised. It is clear that the outcome or result of the discretion of the Crown, when dealing with Aboriginal health, is very poor. There is ample evidence to prove that the health status of Aboriginal people in Canada falls well below that of non-Aboriginal Canadians. These outcomes reveal the magnitude of the

beneficiary for the loss (*Guerin, supra* note 1 at 357, 362 and 391), however a concrete plan to address health inequities may be logical. See Chapter 10 for a suggested framework to address health inequities.

¹²² *R. v. Adams*, [1996] 3 S.C.R. 101, [1996] 4 C.N.L.R. 1 (S.C.C.) at para. 54.

government's overall failure to discharge its discretionary powers in relation to the fiduciary obligation it has towards Aboriginal peoples. Can the government simply provide the level of services it wants or must the government seek to achieve a certain level of health to effectively discharge its obligation? Given the equality provisions of the *Charter of Rights and Freedoms*, one must surely expect that Aboriginal Peoples are entitled to the same standards of health as Canadians in accessing services, quality of health services, culturally appropriate health services and holistic health services which leads to a healthy state.

8.6.2 The Duty to Consult is an Element of Fiduciary Obligations

The terms "consultation" and the "duty to consult" are significantly misinterpreted and misused. Such terminology is frequently erroneously believed to include information sessions, telephone calls and Internet postings. Current jurisprudence is clear that certain criteria must be met to effectively discharge the duty to consult or the government risks the very real possibility that its decision (made in the absence of adequate consultation) will be overturned by the courts.

Upholding the honour of the Crown is an established principle and includes consultation before Aboriginal or treaty rights are infringed. Deputy Grand Chief Roseanne Archibald of the Nishnawbe Aski Nation spoke to the Standing Committee on Aboriginal Affairs and Northern Development on two way communication as a specific issue of consultation:

In terms of consultation, for us in the Nishnawbe Aski Nation it does come back to the issue of jurisdiction and self-government, in that when you're talking about consulting, you're still talking about the old paradigm of bringing legislation forward to us and asking "Will this work for you?" That, to me, is not really a part of the broader solution that first nations really need, which is a respect for the fact that for thousands of years prior to the establishment of this government, we had our own processes in place that worked for us. And those things can still work today in some way where we could coexist, because it's not necessarily talking about removing all things that are Canadian legislation but really figuring out how we balance those things.

So consultation becomes not so much what you're talking about, which is how do we consult with you, but how do we have meaningful dialogue so that the whole issue of human rights really is addressed in a meaningful way.¹²³

While the development of case law in Canada has focused on elements of the duty to consult and accommodate, they also show that the duty to consult and accommodate is not even close to adequately resolving or even addressing the years and generations of trampling of Aboriginal rights in Canada.

The duty to consult originates from the fiduciary duty imposed on the Crown under its responsibility for Aboriginal peoples, as discussed by the Supreme Court of Canada in *Guerin*. However, when the Supreme Court of Canada applied s. 35 of the *Constitution Act, 1982* in *Sparrow* and considered when the Crown's interference with an Aboriginal or treaty right can be justified they created a 'justification test' to determine this and added the element of consultation:

[T]he Crown's fiduciary duty to Aboriginal Peoples would require the Court to ask, at the justification stage, such further questions as: ... whether there has been as little infringement as possible in order to effect the desired result; whether, in a situation of expropriation, fair compensation is available; and, *whether the aboriginal group in question has been consulted* with respect to the conservation measures being implemented.¹²⁴ (emphasis added)

It was not until *Delgamuukw*¹²⁵ that the duty to consult was described as involving the intention of substantially addressing the Aboriginal concerns. Although later on, the Supreme Court in *Haida Nation* referred to a number of decisions with respect to consultation, it specifically relied on the "seminal decision in *Delgamuukw*" as confirming and expanding on "the duty to

¹²³ Standing Committee on Aboriginal Affairs and Northern Development number 050, 1st Session, 9th Parliament, May 8, 2007. It is also noted that in *Williams Lake Indian Band v. Abbey* [1992] 4 C.N.L.R. 21 at 23, the British Columbia Supreme Court held that a duly-elected Chief and Council as well as members of a band council are fiduciaries as far as other members of the Band are concerned, since "The members of the band are vulnerable to abuse by the fiduciary of his or her position and a fiduciary undertakes not to allow his or her interest to conflict with the duty that he or she has undertaken."

¹²⁴ *R. v. Gladstone*, [1996] 2 S.C.R. 723, [1996] 4 C.N.L.R. 65 at para. 55 citing *Sparrow*, *supra* note 40. The facts in *Gladstone* were similar to those in *Sparrow* – i.e., the alleged infringement of federal *Fisheries Act* and its regulations. For instance: the government must prove a valid legislative objective for the interference; the interference must be minimal; the affected Aboriginal group(s) must be consulted and fair compensation must be paid.

¹²⁵ *Delgamuukw*, *supra* note 41.

consult.” Since *Sparrow* and *Delgamuukw*, there have been numerous cases also dealing with certain aspects of the Crown’s obligation to consult, however it was not until *Haida Nation* that the issue was squarely in front of the court.

The Government of British Columbia held title to the Queen Charlotte Islands, *Haida Gwaii*. British Columbia granted Weyerhaeuser Company a Tree Farm Licence to harvest trees on a large block of land in *Haida Gwaii*. The *Haida Nation* had asserted a claim to its traditional lands. British Columbia took the position that until the Haida formally prove their claim, they have no legal right to be consulted or to have their needs and interests accommodated. The licences to cut timber were issued without consultation and over the objections of the Haida. Chief Justice McLachlin concluded,

I conclude that the government has a legal duty to consult with the Haida people about the harvest of timber from Block 6, including decisions to transfer or replace Tree Farm Licences. Good faith consultation may in turn lead to an obligation to accommodate Haida concerns in the harvesting of timber, although what accommodation if any may be required cannot at this time be ascertained. Consultation must be meaningful. There is no duty to reach agreement. The duty to consult and, if appropriate, accommodate cannot be discharged by delegation to Weyerhaeuser. Nor does Weyerhaeuser owe any independent duty to consult with or accommodate the Haida people's concerns.¹²⁶

Haida established a general framework for the duty to consult and accommodate, which is in the process of developing as courts apply the general framework in other cases. The future application of the duty to consult and accommodate is assisted by the Court’s discussion in *Haida* of the principles for the duty, such as being grounded in the honour of the Crown.

The honour of the Crown is a central core principle which is always at stake in the Crown’s dealing with Aboriginal peoples. In *Taku River* the Court clarified that this is derived from the Crown’s assertion of sovereignty in the face of prior Aboriginal occupation, and is enshrined in section 35(1) of the *Constitution Act, 1982*. The Courts stated that the honour of the Crown cannot be interpreted narrowly or technically, but must be given full effect in order to promote the process of reconciliation mandated by s.35(1).

¹²⁶ *Haida Nation supra* note 119 at para 10.

The Crown must act honourably in all of its dealing with Aboriginal people. What is required of the Crown in order to discharge the requirement to act honourably will vary with the circumstances. For instance, where the Crown has assumed discretionary control over specific Aboriginal interests, the honour of the Crown gives rise to a fiduciary duty, and a concomitant requirement to act (and not simply “not act” or forget to act or omit to act) in the best interests of the Aboriginal group. In the processes of treaty making, application and interpretation, the Crown must act with honour and integrity, avoiding even the appearance of “sharp dealing”. Where treaties remain to be concluded, the honour of the Crown requires negotiations leading to a just settlement of Aboriginal claims. The following are cases which continue to define what this duty means. For instance, the Supreme Court of Canada clarified the duty in *Mikisew Cree*:

The duty to consult is grounded in the honour of the Crown, and it is not necessary for present purposes to invoke fiduciary duties. The honour of the Crown is itself a fundamental concept governing treaty interpretation and application that was referred to by Gwynne J. of this Court *as a treaty obligation* as far back as 1895, four years before Treaty 8 was concluded: *Province of Ontario v. Dominion of Canada* (1895), 25 S.C.R. 434, at pp. 511-12 *per* Gwynne J. (dissenting). While he was in the minority in his view that the treaty obligation to pay Indian annuities imposed a trust on provincial lands, nothing was said by the majority in that case to doubt that the honour of the Crown was pledged to the fulfilment of its obligations to the Indians. This had been the Crown's policy as far back as the *Royal Proclamation of 1763*, and is manifest in the promises recorded in the report of the Commissioners. The honour of the Crown exists as a source of obligation independently of treaties as well, of course. In *Sparrow, Delgamuukw v. British Columbia* [1997] 3 S.C.R. 1010, *Haida Nation* and *Taku River*, the “honour of the Crown” was invoked as a central principle in resolving aboriginal claims to consultation despite the absence of any treaty.¹²⁷

Mikisew Cree also notes that another foundation of the duty to consult and accommodate is the goal of reconciliation and consultation must occur “early in the planning stages” of a project and not at a point where a decision in relation to a project has “essentially been made.”¹²⁸ Binnie J. clarifies that the alternative to reconciliation is confrontation. Treaties serve to

¹²⁷ [Mikisew Cree First Nation v. Canada \(Minister of Canadian Heritage\)](#), [2005] 3 S.C.R. 388 [Mikisew Cree, SCC].

¹²⁸ *Mikisew Cree SCC*, *ibid* at para 67.

reconcile pre-existing Aboriginal sovereignty with assumed Crown sovereignty, and to define Aboriginal rights guaranteed by section 35 of the *Constitution Act, 1982*.

In the *Corbiere*¹²⁹ decision the Supreme Court looked at equality rights of non-resident band members and commented that consultation is a principle of democracy:

Because the regime affects band members most directly, the best remedy is one that will encourage and allow Parliament to consult with and listen to the opinions of Aboriginal people affected by it. The link between public discussion and consultation and the principles of democracy was recently reiterated by this Court in *Reference re Secession of Quebec*, [1998] 2 S.C.R. 217, at para. 68: “a functioning democracy requires a continuous process of discussion”. The principle of democracy underlies the Constitution and the Charter, and is one of the important factors guiding the exercise of a court’s remedial discretion. It encourages remedies that allow the democratic process of consultation and dialogue to occur.¹³⁰

The Supreme Court of Canada in *Delgamuukw* addressed the requirement and depth of consent:

There is always a duty of consultation...The nature and scope of the duty of consultation will vary with the circumstances. In occasional cases, when the breach is less serious or relatively minor, it will be no more than a duty to discuss important decisions that will be taken with respect to lands held pursuant to Aboriginal title. Of course, even in these rare cases when the minimum acceptable standard is consultation, this consultation must be in good faith, and with the intention of substantially addressing the concerns of the Aboriginal peoples whose lands are at issue. In most cases, it will be significantly deeper than mere consultation. Some cases may even require the full consent of an Aboriginal nation, particularly when provinces enact hunting and fishing regulations in relation to Aboriginal lands.¹³¹ [Emphasis added]

There are a number of recent cases following *Haida Nation*, *Taku River* and *Mikisew Cree* decisions which help to further define what the duty to consult and accommodate means. A brief snapshot follows.

¹²⁹*Corbiere v. Canada* [1999] 2 S.C. R. 203, [1999] 3 C.N.L.R. 19.

¹³⁰*Ibid* at para 16 as cited in Peggy J. Blair and Bradford Morse, *A Review of the Social Union Framework and its Implications on the Métis* (Métis National Council: March, 2002).

¹³¹*Delgamuukw*, *supra* note 41 at para 168.

The *Little Salmon/Carmacks*¹³² case looked at the issue of whether or not the duty to consult would apply to a “modern” final agreement between the Crown and Little Salmon/Carmacks. At issue in this case was a final self-government agreement with Canada and the Yukon signed in 1997. Under the agreement all members of Little Salmon had a right of access for subsistence harvesting except where the Crown land was subject to an agreement for sale. An application was made for a grant of Crown land that was within a trap line of a Little Salmon member. Little Salmon objected and claimed that they needed to be consulted and accommodated, as it would impact on their rights to hunt. The chambers judge agreed and relied on *Mikisew Cree* that said that the objective of the modern law on Aboriginal and treaty rights is the reconciliation of Aboriginal and non-aboriginal peoples and their claims.¹³³ He also held that the duty to consult was not met. On appeal, the unanimous Yukon Court of Appeal relied on the honour of the Crown in the earlier case law and drew the “inescapable conclusion that the duty to consult would apply independent of any treaty obligation,¹³⁴ clearly a constitutional duty¹³⁵ and not possible to differentiate between a historic and a modern treaty.”¹³⁶ The court held that the duty to consult in this case was comparable to the facts in *Mikisew* in that it was on the low end of the spectrum and Yukon had carried out its duty to consult obligations effectively.¹³⁷

The scope of the duty to consult was at issue in *Klahoose First Nation v. Sunshine Coast Forest District (District Manager)*.¹³⁸ Tree farm licenses were issued to a Forest Service over land to which the *Klahoose* asserted Aboriginal title and claimed that the duty to consult with them had not been met. The respondents claimed they had “bent over backwards” to consult and

¹³² *Little Salmon/Carmacks v. Yukon (Minister of Energy and Mines)* (2008 YKCA) 13 [*Little Salmon*]. An appeal from the Yukon Court of Appeal decision in *Little Salmon/Carmacks First Nation* was heard by the Supreme Court of Canada on November 12, 2009. The Supreme Court agreed with the Court of Appeal and held the duty of consultation was discharged. The Supreme Court restated the Little Salmon/Carmacks’ acknowledged that it had received appropriate notice, and that the Director weighed their concerns and the response of those who attended the meeting when he approved the application. The Supreme Court felt nothing more was required.

¹³³ *Mikisew Cree First Nation v. Canada*, 214 F.T.R. 48, [2002] 1 C.N.L.R. 169 (F.C.T.D.) at para 1 [*Mikisew Cree*].

¹³⁴ *Little Salmon*, *supra* note 132 at para 67.

¹³⁵ *Little Salmon*, *ibid* at para 88, although not clearly stated as a constitutional right see para 84 and 89.

¹³⁶ *Little Salmon*, *ibid* at para 69.

¹³⁷ *Little Salmon*, *ibid* at para 115-117.

¹³⁸ *Klahoose First Nation v. Sunshine Coast Forest District (District Manager)*, 2008 BCSC 1642 [*Klahoose*].

accommodate *Klahoose*.¹³⁹ The court found that the duty to consult was at the high end of the spectrum for consultation as in *Haida Nation* and the obligation to consult and accommodate had not been met. The court further differentiated *Taku River* as well and found that a separate test was necessary to assess accommodation as a separate and necessary branch of the duty to consult. The *Wii'litswx v. British Columbia (Minister of Forests)*¹⁴⁰ case is an example of the test articulated in *Klahoose*:

1. Did the Crown reasonably assess the scope of its duty to consult?
2. Was the consultation process reasonable?
3. Did meaningful consultation produce reasonable accommodation?¹⁴¹

The *Wii'litswx* case was decided on the third point:

The Crown's obligation to reasonably consult is not fulfilled simply by providing a process within which to exchange and discuss information. The consultation must be meaningful...An assessment of whether consultation was meaningful inevitably leads to an examination of what accommodations were reached.¹⁴²

The implications of this case may be critical in that even if consultation was adequate, a lack of accommodation may lead to an order for declaratory relief.

The *Tzeachten First Nation v. Canada (Attorney General)*¹⁴³ also looked at the scope of the duty to consult as set out in *Haida Nation* and *Taku River*. After reviewing the framework on the strength of the claim and the potential adverse effects, the court decided that there was not a strong prima facie claim of Aboriginal title, but only a moderate one¹⁴⁴ and found that the Crown had sufficiently discharged its duty to consult and accommodate in light of the facts of the case.¹⁴⁵

¹³⁹ *Klahoose*, *ibid* at para 2 and 4.

¹⁴⁰ *Wii'litswx v. British Columbia (Minister of Forests)*, 2008 BCSC 1139 [*Wii'litswx*].

¹⁴¹ *Wii'litswx*, *ibid* at para 143-146.

¹⁴² *Wii'litswx*, *ibid* at para 178-179.

¹⁴³ *Tzeachten First Nation v. Canada (Attorney General)* [2008] 4 CNLR 293 [FCTD] [*Tzeachten*].

¹⁴⁴ *Tzeachten*, *ibid* at para 39-40.

¹⁴⁵ *Tzeachten*, *ibid* at para 72. For further discussion on the duty to consult and accommodate, See also *Carrier Sekani Tribal Council v. British Columbia (Utilities Commission)*, 2009 BCCA 67; *Kwitkwetlem First Nation v.*

Although the courts have been active on ruling on narrowing and defining what the duty to consult and accommodate means, the historical framework has not been addressed and there remains a high level of uncertainty by the governments, Aboriginal peoples and the courts. The federal government through Indian and Northern Affairs Canada has taken heed to the Supreme Court of Canada rulings in *Mikisew Cree, Taku River and Haida Nation* and has developed an *Action Plan and Guidelines*¹⁴⁶ for implementation. If developed and implemented properly the prospect for creating a uniform standard for consultation and accommodation may prove useful.

In the 2010 case, *Tsuu T'ina Nation v. Alberta*,¹⁴⁷ the Alberta Court of Appeal held that the province's duty to consult and accommodate the Tsuu T'ina and Samson Cree was met in relation to the adequacy of consultation and accommodation with respect to Alberta's Water Management Plan for the South Saskatchewan River Basin. The Alberta environment minister requested that a water management plan be implemented for the South Saskatchewan River Basin. The Tsuu T'ina and Samson Cree Nations filed applications for a judicial review of the order in council that approved the plan claiming that the province did not discharge its duty to consult and to accommodate them. They relied on the Supreme Court of Canada decision in *Haida*.

The application for judicial review was dismissed by the lower court that stated that although a duty to consult existed, the duty to consult was at the very low end of the spectrum since the plan in question did not adversely affect the Appellants' water use and that sufficient consultation had taken place. The Alberta Court of Appeal affirmed the judgment of the lower court and dismissed the appeal.

British Columbia (Utilities Commission), 2009 BCCA 68; *Ke-Kin-Is-Uqs v. British Columbia (Minister of Forests)*, 2008 BCSC 1505; *Tsuu T'ina Nation v. Alberta (Environment)*, 2008, 4 CNLR 259.

¹⁴⁶ See, Canada, Indian And Northern Affairs Canada "Government of Canada Moves Ahead with Action Plan to Consult First Nation, Métis and Inuit Groups: Ottawa (November 1, 2007) News Release, online: <http://www.ainc-inac.gc.ca/ai/mr/nr/s-d2007/2-2948-eng.asp> (accessed October 20, 2010); Canada, Indian and Northern Affairs Canada, "Background - Action Plan on Consultation and Accommodation", online: <http://www.ainc-inac.gc.ca/ai/mr/nr/s-d2007/2-2948-bk-eng.asp> (accessed October 20, 2010); Canada, Indian and Northern Affairs Canada, "Understanding the Federal Action Plan on Aboriginal Consultation and Accommodation - Consultation Accommodation Presentation" online: <http://www.ainc-inac.gc.ca/ai/mr/is/acp/acp-eng.pdf> (accessed October 20, 2010); Guidelines, *supra* note 3.

¹⁴⁷ *Tsuu T'ina Nation v. Alberta*, 2010 ABCA 137.

Lawyers, Osler, Harkin and Harcourt comment on another action the Tsuu T'ina and Samson Cree have commenced:

[C]oncerning the nature and extent of their Treaty and Aboriginal rights as they pertain to water rights and water management. These actions are still in their early stages and, among other things, the First Nations are seeking declarations that they possess Treaty and Aboriginal rights to water; a property interest in the water resources, beds and foreshores of water courses and water bodies within and adjacent to their reserve lands; and that the *Water Act* constitutes an unjustified infringement of their Treaty water rights and right to self-government because it vests all water in the Crown.¹⁴⁸

The duty to consult and accommodate is an evolving area of law particularly in relation to natural resources. It is therefore critical that First Nations, Métis and Inuit pay close attention to these court decisions develop.

8.6.3 Indian Affairs Response to the Duty to Consult and Accommodate

In response to the specific direction from the Supreme Court of Canada, Indian and Northern Affairs Canada (INAC) have produced two documents, the *Federal Action Plan on Aboriginal Consultation and Accommodation (Action Plan)*¹⁴⁹ and *Aboriginal Consultation and Accommodation, Interim Guidelines for Federal Officials to Fulfill the Legal Duty to Consult (Guidelines)*¹⁵⁰ that form the policy framework and are informed by, and inform, the legal positions of the government of Canada in this area.

The critical elements of the Action Plan are:

- 1) Creating a Repository for information relating to location and nature of all established Aboriginal and treaty rights;
- 2) Establishing a federal interdepartmental mechanism to improve and monitor coordination of consultation;
- 3) Developing a Federal Policy on Consultation and Accommodation;

¹⁴⁸ Shawn Denstedt, Terri-Lee V. Leniuk and Jessica Ng, "Canada: Provincial Government Wins Prelude to the Fight for Aboriginal Water Rights" May 10, 2010, online:

<http://www.mondaq.com/canada/article.asp?articleid=99832> (accessed October 20, 2010).

¹⁴⁹ See, Action Plan *supra* note 3.

¹⁵⁰ *Ibid.*

- 4) Developing an Engagement Strategy on a Federal Policy;
- 5) Developing and Distributing Interim Consultation Guidelines; and
- 6) Creating a Federal Government Interdepartmental Team.¹⁵¹

The objective of the Action Plan is to establish a government coordinated approach for government to fulfill its legal duties. The result is intended to be a sustainable coordinated approach and the reconciliation of Aboriginal and Treaty rights with other societal interests. The Action Plan further states that the outcome will be that all federal departments will “possess the tools they require to discharge their legal duties; consistency among federal departments; creation of a federal policy that reflects the participation of the people to whom it affects; and improved coordination with related provincial and territorial activities.”¹⁵²

The stated purpose of *Interim Guidelines* is to “provide practical advice and direction to federal departments and agencies regarding the legal requirement for the Crown to consult with Aboriginal groups and, where appropriate, accommodate their interests.” These Legal and Practice Principles have been gleaned from case law and from federal government practice in consultation over the years.

The Guidelines mention the fiduciary principle in the context of the *Sparrow* case:

The Court also found that there is a fiduciary relationship between the Crown and Aboriginal peoples based on the need for the Crown to act honourably. Therefore, section 35 must be interpreted in a manner consistent with this relationship. The Court placed a high burden on the Crown to justify any infringement with the enjoyment of Aboriginal rights protected by s. 35.¹⁵³

They are careful not to actually say that there is a positive fiduciary duty between the Crown and Aboriginal people. They do however mention a “unique” relationship and the duty to consult and accommodate results from this relationship:

A common law duty now underlies Crown consultation in some particular circumstances. Such a duty where it arises is based on the Haida, Taku River and Mikisew Cree decisions, where the Supreme Court of Canada (SCC) held that the Crown has a legal duty to consult and, if appropriate, accommodate, when the Crown contemplates conduct that might adversely impact section 35 rights (established or potential). This duty has been applied to an array of Crown

¹⁵¹ *Ibid.*

¹⁵² *Ibid.*

¹⁵³ *Ibid* at 34.

actions and in relation to a variety of potential and established Aboriginal and treaty rights.

In these decisions, the SCC also determined that the legal duty to consult stems from the Crown's unique relationship with Aboriginal peoples and must be discharged in a manner that upholds the honour of the Crown and promotes reconciliation of Aboriginal and non-Aboriginal interests. The SCC is looking at how the Crown manages its relationships with Aboriginal groups and how it conducts itself when faced with constitutionally protected Aboriginal and treaty rights. Crown decisions can be subject to review by a court prior to the final definition of an established right or the resolution of an outstanding claim. The scope and content of consultation will be proportionate to the strength of the potential right and the seriousness of the potential adverse effect of the contemplated activity. Consultation may reveal a need to accommodate.¹⁵⁴

The legal duty is the responsibility of all departments/agencies and each one must manage the duty to consult triggered by its own activities. However, no one department or agency has been responsible for coordinating a federal approach which may result in lack of coherence and consistency

8.6.4 Summary

The duty to consult arises when the Crown has knowledge of the potential existence of an Aboriginal right and considers any type of conduct that might affect it. This means that consultation will be required where Aboriginal interests are adversely affected. As such, Aboriginal peoples must have a direct and effective role in the planning and delivery of programs and services that affect them. This requires the capacity to engage in consultation activities at the international, national, regional and local levels, depending on the nature of the right in question. There are legal obligations but there are also important policy reasons to engage in consultation and accommodation measures to ensure Aboriginal participation in planning, budgeting and delivery of services and programs.

The following principles are clarified by the Supreme Court:

¹⁵⁴ *Ibid* at 5.

- The duty to consult includes not only the federal Crown but includes a similar duty for the provincial Crown.¹⁵⁵
- The Crown carries the burden of proving meaningful consultation.¹⁵⁶
- A standard public consultation/information session does not entirely satisfy the test for adequate consultation with Aboriginal people.¹⁵⁷
- A distinct consultation with the rights' holders is required.¹⁵⁸
- The Crown cannot delegate its duty to consult to an “interested third party”,¹⁵⁹ but this does not mean that a fiduciary duty cannot be transferred to a third party.¹⁶⁰
- Consultation must be “adequate” and “meaningful”¹⁶¹ and must “substantially address” the concerns of the First Nation,¹⁶² and in some instances, the full consent of a Nation may be required to fulfill the duty to consult.¹⁶³
- The Crown must “fully inform itself of the practices and views of the First Nation affected.”¹⁶⁴

¹⁵⁵See generally, *Halfway River First Nation v. British Columbia (Minister of Forests)* (1999), 178 D.L.R. (4th) 666, [1999] 4 C.N.L.R. 1 (B.C.C.A.) where it was held that British Columbia Ministry of Forests, did not adequately discharge their obligations of meaningful and adequate consultation.

¹⁵⁶See especially Justice Hansen in *Mikisew Cree*, *supra* note 133 at para. 156.

¹⁵⁷*Ibid* at para 156. The fact that the *Mikisew Cree* did not participate in a public consultation process was described as “not constitut[ing] First Nations consultation as required [by] s. 35(1) of the *Constitution Act, 1982*.” In *Halfway River*, *supra* note 155 at para 49, it was noted that the Crown provided fourteen letters to the First Nation, held three meetings, held five telephone calls and gave the First Nation an opportunity to provide feedback. The Court found that there was not adequate consultation because the First Nation was not invited to attend the meeting where the permit was approved, was not provided with the report on the impacts until close to the approval date, did not provide the First Nation an opportunity to participate in the Assessment and did not provide the First Nation with the permit application until the permit was issued. The Court found that in general that information was not provided on a timely basis.

¹⁵⁸*Gitksan First Nation v. British Columbia (Minister of Forests)*, [2003] 2 C.N.L.R. 142 at para 89. In terms of consultation – *Delgamuukw* *supra* note 41 refers to the importance, at minimum, of consultation and notes that it will generally “be significantly deeper than mere consultation.” (at para. 168) and *Mikisew Cree*, *supra* note 133 at para 153.

¹⁵⁹*Mikisew Cree*, *supra* note 133 at para. 156.

¹⁶⁰*Haida Nation*, *supra* note 111 at paras 100, 101. In the *Haida Nation* case, the B.C.C.A. was of the opinion that not only did the Crown owe a fiduciary obligation to consult with First Nations but that such an obligation was also owed by private corporations.

¹⁶¹*Halfway River*, *supra* note 155 at para 160.

¹⁶²*Delgamuukw*, *supra* note 41 at para 168.

¹⁶³*Ibid* at para 168.

¹⁶⁴*Halfway River*, *supra* note 155 at para 160.

- The Crown must ensure that the group affected is provided with full information with respect to the proposed legislation or decision and its potential impact on Aboriginal rights.¹⁶⁵
- The Crown must ensure that the substance of the First Nation’s concerns are addressed or face the very real possibility that the courts will overturn the decision.¹⁶⁶
- The Crown must take the views of the First Nation seriously.¹⁶⁷
- The Crown’s obligation to consult is “continuing and ever present” and does not end if the Crown breaches its duty.¹⁶⁸
- Even if Aboriginal or treaty rights are not proven *prima facie*, the Crown is not relieved of its duty to consult.¹⁶⁹ Section 35 of the *Constitution Act, 1982* protects those existing rights at common law.¹⁷⁰
- The Crown’s duty extends beyond the signing of a final agreement and there is not differentiation between a historic and a modern agreement as far as the duty to consult goes as it is a constitutional duty.¹⁷¹
- A separate test was necessary to assess accommodation as a separate and necessary branch of the duty to consult.¹⁷²

8.7 Constitutional Supremacy, Equality Rights and the Fiduciary Obligation

Section 35 (1) of the *Constitution Act, 1982* constitutionalized the Crown fiduciary obligation through the entrenchment of Aboriginal and treaty rights. Constitutional law dictates the

¹⁶⁵ *Ibid* at para 82.

¹⁶⁶ *Taku River Tlingit First Nation v. Ringstad et al.* (2002), 98 B.C.L.R. (3d) 16, [2002] 2 C.N.L.R. 312 (C.A.) [*Taku River*].

¹⁶⁷ *R. v. Noel*, [1995] 4 C.N.L.R. 78 at 93 (N.W.T.T.C.).

¹⁶⁸ *Haida Nation*, *supra* note 127 at para 64.

¹⁶⁹ *Haida Nation*, *ibid* at para 76. However, in *Ontario (Minister of Municipal Affairs and Housing) v. TransCanada Pipelines Ltd.* (2000), 186 D.L.R. (4th) 403, [2000] 3 C.N.L.R. 153) the Ontario Court of Appeal held that it was only after a First Nation had established an infringement of an existing aboriginal treaty right through an appropriate hearing that the duty of the Crown to consult with First Nations was a factor for the court to consider in the justificatory phase of the proceeding.

¹⁷⁰ *Ibid*.

¹⁷¹ *Little Salmon* *supra* note 132.

¹⁷² *Klahoose*, *supra* note 138; *Wii'litswx*, *supra* note 140.

exercise of governmental power. Professor Peter Hogg iterates the importance of the *Constitution* :

A Constitution has been described as “a mirror reflecting the national soul”: it must recognize and protect the values of a nation.¹⁷³

Constitutional supremacy is reflected in s. 52:

The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.¹⁷⁴

Through the *Constitution Act, 1982*, s.35(1) Constitutional status was accorded to "existing" Aboriginal and treaty rights:

The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.¹⁷⁵

For the purpose of s.35(1) these rights are those that were not extinguished before April 17, 1982. Prior to 1982, Aboriginal rights did exist and were recognized under the common law but did not have Constitutional status and Parliament could extinguish or regulate those rights at any time.¹⁷⁶ However, the Supreme Court has confirmed that the regulation of an Aboriginal activity by specific imperial treaty, act, or legislation does not amount to its extinguishment but affirms the continuity of an Aboriginal right.¹⁷⁷

The entrenchment of Aboriginal and treaty rights in the *Constitution Act, 1982* further placed restraints on the exercise of governmental power in relation to these rights. The *Sparrow* decision is one of the most important cases dealing with the restriction of Crown interference on Aboriginal and treaty rights.¹⁷⁸ As noted, in *Sparrow*, the court rejected the political trust arguments and extended the concept of an enforceable statutory fiduciary obligation to a

¹⁷³ P.W. Hogg, *Constitutional Law of Canada*, 4th ed. (Scarborough: Carswell, 2002) at 1-1 [Hogg].

¹⁷⁴ *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11. at s.52(1)

¹⁷⁵ *Ibid* at s.35(1).

¹⁷⁶ As a side note and interestingly in Form B1 – “North-West Half Breed Claims Commission, 1901” Question 17 states “Has claimant ever received or applied, to your knowledge, for land or scrip in extinguishment of an aboriginal right?” This may signify that the federal government acknowledged the existence of Aboriginal rights in 1901.

¹⁷⁷ *R. v. Gladstone*, [1996] 2 S.C.R. 723, [1996] 4 C.N.L.R. 65 at 80.

¹⁷⁸ See also, *Blueberry River, supra* note 106; *Canadian Pacific Ltd. v. Paul*, [1988] 2 S.C.R. 654, [1989] 1 C.N.L.R. 47.

comprehensive Constitutional fiduciary obligation that applies to virtually every facet of the Crown-Aboriginal relationship. The Court found that a) the source of the fiduciary obligation stemmed from the rights identified in section 35 through the Crown's unilateral acts of claiming sovereignty, and b) the words "recognition and affirmation" used in section 35 "incorporate the fiduciary relationship and import some restraint on the exercise of sovereign power." They added:

Rights that are recognized and affirmed are not absolute. Federal legislative powers continue, including, of course, the right to legislate with respect to Indians pursuant to s.91(24) of the Constitution Act, 1867. These powers must, however, now be read together with s.35(1). Federal legislative powers, such as those found in s.91(24) of the Constitution Act, 1867, must now be read together with s.35(1). Federal power must be reconciled with federal duty by demanding the justification of any government regulation that infringes upon or denies aboriginal rights.¹⁷⁹

The Supreme Court of Canada has made it clear that not only must the federal government reconcile its power with its duties to Aboriginal people but also all government action must comply with the *Constitution* and must be justified before the government infringes or denies an Aboriginal right. The courts must balance the Crown's Constitutional fiduciary obligations with the Crown's justification for the infringement. In this sense, the fiduciary obligation concept polices the line between respect for Aboriginal and treaty rights and the government's exercise of its powers.

Further, the Court is adamant that any limits placed on section 35 rights must arise only when absolutely necessary, with as little infringement as possible.

[T]he Government has the responsibility to act in a fiduciary capacity with respect to aboriginal peoples. The relationship between the Government and aboriginals is trust-like, rather than adversarial, and contemporary recognition and affirmation of aboriginal rights must be defined in light of this historic relationship.¹⁸⁰

¹⁷⁹ *Sparrow*, *supra* note 40 at 181.

¹⁸⁰ *Sparrow*, *ibid.*

The Crown/Aboriginal fiduciary relationship is defined by strict principles and elements of interaction and ensuing obligations. The gender equality provisions in section 35(4) are also a source of fiduciary obligations by virtue of pre-existing rights and recognition of these rights in the *Constitution Act, 1982*. These are examined in the following section.

i) Section 35(4)

Equality is a human right – every person has equal rights regardless of their gender. Section 35(4) reads:

(4) Notwithstanding any other provision of this Act, the aboriginal and treaty rights referred to in subsection (1) are guaranteed equally to male and female persons.¹⁸¹

Through various sources examined in this paper thus far, it has been established that the Crown has a fiduciary obligation to Aboriginal people through historic relationships, laws, legislation, policy and jurisprudence. Author Donna Greschner reviews the purpose of s. 35(4):

It aims to erase the destructive and continuing effects of Anglo-European patriarchy on aboriginal cultures and prevent imposition of Anglo-European patriarchy in the future. It is not about applying non-aboriginal views of sex equality to aboriginal women and men. One reason for the inclusion of s. 35 was to ensure the elimination of s. 12(1)(b) of the Indian Act, a notorious, if not paradigmatic, example of racist patriarchy inflicted upon aboriginal peoples by the Canadian government. The promise of ss. 25 and 35 is Constitutional space for aboriginal peoples to be aboriginal; the necessarily complementary promise of s. 35(4) is the revitalization of gender egalitarianism as understood and practised by aboriginal peoples.¹⁸²

Aboriginal women not only possess section 35 rights individually and collectively but they also possess the individual-based rights identified in the *Charter*. Section 35(4) simply guarantees these rights equally to men and women. The equality provisions in section 15 of the *Charter* do not invalidate Aboriginal or treaty rights. Professor Peter Hogg explains the advantages that s.35 rights possess being situated outside of *Charter* rights. For instance, s.35 is not subject to

¹⁸¹ *Constitution Act, 1982*, *supra* note 174 at s. 35(4).

¹⁸² Donna Greschner, “Special Edition: Aboriginal Justice Aboriginal Women, The Constitution and Criminal Justice” (1992) U.B.C.L. Rev. 338-366 at para. 11 (footnotes omitted).

s.1 of the *Charter* “such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society”; they are not subject to legislative override through s.33 nor are the rights effective only against government action through s.32. Because s.35 is outside of the *Charter* provisions, these rights are not enforceable through s.24 of the *Charter*. Section 25 further provides that the *Charter* must not “derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada.”

The *Royal Commission on Aboriginal Peoples* comments on *Charter* rights:

The Canadian Charter of Rights and Freedoms applies to Aboriginal governments and regulates relations with individuals falling within their jurisdiction. However, under section 25, the Charter must be given a flexible interpretation that takes account of the distinctive philosophies, traditions and cultural practices of Aboriginal peoples.

Moreover, under section 33, Aboriginal nations can pass notwithstanding clauses that suspend the operation of certain Charter sections for a period. Nevertheless, by virtue of sections 28 and 35(4) of the Constitution Act, 1982, Aboriginal women and men are in all cases guaranteed equal access to the inherent right of self-government and are entitled to equal treatment by their governments.¹⁸³

Section 35(4) has rarely been used to advance the equality rights of Aboriginal women and certainly not used in a fiduciary context. It appears that often the rights that Aboriginal people collectively possess to gender equality/balance are non-existent, created by statute or “given” to Aboriginal women post-contact. This analysis transforms the issue into one of strictly a *Charter* application and displaces it from an Aboriginal context with the underlying message that Aboriginal women do not have Aboriginal rights to equal treatment that ultimately could produce equal results in health status. It is strictly a Eurocentric approach that does not consider Aboriginal women’s historical place of balance in society and it is not correct or useful when examining the section 35(4) rights.

Unfortunately, an examination of the case law underscores that a gendered understanding of section 35(4) has yet to be reached as noted by the Native Women’s Association of Canada:

¹⁸³ Canada, Royal Commission on Aboriginal Peoples, Report of the Royal Commission on Aboriginal Peoples: Gathering Strength (Ottawa: Supply and Services Canada, 1996), Vol. 4, “Historical Position and Role of Aboriginal Women: A Brief Overview,” quoting Osennotion (Marlyn Kane), online: <http://www.ainc-inac.gc.ca/ch/rcap/sg/sjm2_e.html> (accessed March 5, 2009) [RCAP].

While the Court has articulated general principles for addressing Aboriginal and Treaty Rights, absent from this articulation by the Courts is the meaning of section 35(4), which provides that the Aboriginal and Treaty rights are guaranteed equally to men and women. Patricia A. Monture argues, in her article “The Right of Inclusion: Aboriginal Rights and/or Aboriginal Women?” (2004), that an analysis of gender has been absent from the discussion on what Aboriginal rights mean. She argues that the litigation strategies and court decisions have given legal prominence to the experience and responsibilities of First Nations men, while women’s pursuits have remained invisible and unconsidered as legal rights.¹⁸⁴

Professor Monture provides a critique of the lack of construction of gender in section 35 case law, citing *Delgamuukw* as an example where gender is not visible. In a further example in the same paper, Professor Monture notes:

There is a plethora of cases on matters involving hunting and fishing rights. These are generally reactive decisions brought to defend against individual charges laid under provincial or federal wildlife or fishing regimes. However, the category “hunting and fishing” is incomplete. Gathering and agriculture were also central components of First Nations’ ‘sustenance’ practices (to borrow a phrase from the courts), even before contact. Contrary to popular belief, agriculture is not something the white man brought. In many nations, it was women who possessed the authority to gather and grow...

Women’s responsibilities were essential for the prairie nations’ survival; these contributions must be taken into account in the rights that First Nations try to protect today. In reclaiming legal recognition of the centrality of hunting and fishing practices, our view must be extended to include all ‘sustenance’ practices of the First Nations, including those responsibilities belonging to the women. It must not be only the women, but also our men, who bring forward this knowledge. Political organizations representing First Nations must also do their part in acknowledging the importance of women’s responsibility to community sustenance. The inclusive phrase we must embrace is the right to hunt, fish, gather and grow.¹⁸⁵

¹⁸⁴ Patricia A. Monture, “The Right of Inclusion: Aboriginal Rights and/or Aboriginal Women?” (2004) at 4, unpublished, on file with NWAC at 20 in NWAC, *Background Document on Aboriginal Women and Negotiations For the Canada-Aboriginal Peoples Roundtable Sectoral Follow-up Session on Negotiations* January 2005, online: http://www.aboriginalroundtable.ca/sect/ngot/bckpr/NWAC_BgPaper_e.pdf (accessed August 7, 2010).

¹⁸⁵ *Ibid* at 19-20.

The focus of section 35(4) is the application of Aboriginal and treaty rights pertaining equally to both males and females. These rights are collective and were specifically and thoughtfully enacted to address the collectivity of Aboriginal and treaty rights noted in section 35. They are part and parcel of the fiduciary duties owed by the governments to Aboriginal people and specifically to Aboriginal women.

When assessing whether an activity is an Aboriginal or treaty right the courts will use certain criteria and principles of interpretation. As noted, Aboriginal rights are *sui generis* in nature. The Supreme Court of Canada has long since recognized the unique nature of Aboriginal rights as not being recognizable within the common law and therefore has described them as a unique class of rights.

The tests articulated by the Supreme Court in *R. v. Sparrow* indirectly supports the existence of gender equality within the bundle of Aboriginal rights. In *Sparrow*, the Supreme Court of Canada stated that the interpretation of Aboriginal cultures must be done in a sensitive manner, respecting the way that Aboriginal peoples view their rights.¹⁸⁶ As noted earlier, the evidence concerning women's roles in ceremonies and healing practices demonstrates that such ceremonies, practices and rites of passage were integral to the existence of Aboriginal society. Similarly as noted earlier, the status that women held within these societies was also integral to the existence of the Aboriginal society and supports the existence of an Aboriginal right to equality for males and females within the bundle of Aboriginal rights as constitutionalized in section 35(4)).

In fact, the rights captured within section 35 and read through a Constitution supremacy framework provide an important structure to understand equality rights for Aboriginal women not only both within section 35(4) but also in the *Charter* context. In addition to the protection of individual equality rights in the *Charter*, the rights referred to in section 35(4) encompass the collective rights of Aboriginal society as a whole within the bundle of Aboriginal rights. All Aboriginal people possess constitutionally protected Aboriginal rights through section 35 of the *Constitution Act, 1982*: in addition to these rights Aboriginal women possess equality rights

¹⁸⁶ *Sparrow*, *supra* note 40

found in the *Charter* and in s. 35(4) which differentiates them and places them above s. 35 rights.

8.8 Summary

The federal government recognizes the existence of their fiduciary relationships and acknowledges that fiduciary duties flow from the relationship. INAC has created a separate branch¹⁸⁷ to deal with the duty to consult and accommodate and they have developed an Action Plan and Guidelines to standardize the practices for the federal government when they deal with Aboriginal communities.¹⁸⁸ The precise “nature and scope of this fiduciary relationship” along with the political, legal and financial implications¹⁸⁹ remain undefined. Both the federal (and provincial) governments have clear fiduciary obligations toward Aboriginal people. The source of these obligations arise from the early treaties, from the *Royal Proclamation*, from the *Constitution Act, 1982* and from the trust-like relationship between the British Crown (and its successors) and Aboriginal peoples. Certain positive duties are imposed upon the federal government because of this fiduciary relationship. Core elements include the Crown’s duty to provide full disclosure of its actions so as not to compromise Aboriginal or treaty rights and the requirements that the Crown refrain from acting in conflict of interest situations or benefits from its role as fiduciary. Case law provides that if there is any possibility of infringement on Aboriginal or treaty rights, meaningful consultation is required, and justification must be advanced to account for such infringement. Consultation does not merely mean a standard public information/consultation process or session.

Any government action or legislation that has the potential to impact upon Aboriginal Peoples and their respective rights requires meaningful consultation before there is infringement of

¹⁸⁷ Action Plan, *supra* note 3.

¹⁸⁸ The purpose:

[D]evelop a federal policy on consultation and accommodation that will address outstanding legal and policy matters including the scope of the duty, who is the Crown, the nature and scope of accommodation, capacity of government and Aboriginal groups to engage in consultation, and the reconciliation of the evolving legal duty with statutory and other legally based obligations to consult (e.g. comprehensive land claim agreements). It is expected that such a policy, to be informed by engagement with First Nations, Inuit and Métis groups, will enable the legal duty to be fulfilled in a more consistent, coherent, and efficient way across the federal government. Guidelines, *supra* note 3 at 6.

¹⁸⁹ Rotman, *supra* note 2 at 4.

rights. Consultation necessarily must apply to government legislation, policies, inactions and actions that impact on Aboriginal and treaty rights. In light of the disparity in outcomes in standards of health, it is clear that past and present government legislation, policies, actions and inaction have adversely impacted upon Aboriginal peoples. It is untenable to think that Aboriginal Peoples have either agreed to accept this, or that the Canadian government is removed from its fiduciary obligations to consult, to act honourably to ‘avoid sharp dealing’ and/or abide by the terms of the treaties and agreements it entered into.

The Supreme Court of Canada has affirmed that the fiduciary obligation limits the activities and policies of the federal or provincial Crown toward Aboriginal peoples.¹⁹⁰ It has cast a discussion of the Crown’s Constitutional fiduciary obligations to Aboriginal people against the backdrop of the Canadian law’s failure to recognize Aboriginal claims to land and, indeed, the law’s general failure to acknowledge or uphold Aboriginal and treaty rights.¹⁹¹ The Court has held that “historical policy on the part of the Crown is ... incapable of, in itself, delineating” Aboriginal and treaty rights and “[t]he nature of government regulations cannot be determinative of the content and scope of an existing Aboriginal right.”¹⁹² Despite these clear directives, the federal government continues to determine the scope of Aboriginal and treaty rights to health through its policy development without the meaningful participation of Aboriginal peoples.

The federal government, under the auspices of Health Canada, cannot reasonably maintain that health services provided to First Nations and Inuit Peoples are “voluntary” and not required by law but simply a matter of policy.¹⁹³ What this means in light of the Federal Guidelines on the Duty to Consult and Accommodate is uncertain. However, the characterization is a discriminatory reading of Canada’s commitments to provide the highest attainable standard of

¹⁹⁰See for instance, L. I. Rotman, “Provincial Fiduciary Obligations to First Nations: The Nexus Between Governmental Power and Responsibility” (1994) 32 Osgoode Hall L.R. 735.

¹⁹¹*Sparrow*, *supra* note 40 at 177.

¹⁹²*Ibid* at 176.

¹⁹³Handbook, *supra* note 4.

physical and mental health to *all* residents of Canada¹⁹⁴ and to facilitate reasonable access to health services without financial or other barriers based on need.¹⁹⁵

Ironically, the federal government's policy recognizes and affirms the government's unique constitutional obligations to Aboriginal Peoples but fails to implement these obligations to certain existing Aboriginal and treaty rights – including access to health and health care (as noted in Chapter 7). Instead, Canada's health policies and guidelines affecting Aboriginal Peoples' health should be examined to ensure that they no longer reflect the outdated wardship model of Crown/Aboriginal relations but instead reflect the fiduciary relationship that the Supreme Court of Canada has stated properly characterizes Crown/Aboriginal relations.

In addition to the positive duty to act as a fiduciary, there logically may be obligations that would result from inaction as well. There is not only a duty that flows but a fiduciary duty may be found in the situations of inaction or omissions to act. Ignoring the fiduciary duty may give rise to a breach in law as well. In other areas of law omissions are recognized breaches, for instance a criminal offence may consist of a failing to act when there is a duty; or the tort law of negligence recognizes that the failure to act may be seen as a breach of this lawful duty. The concept of fiduciary duty and the duty to consult and accommodate should also be extended to omissions and applied in the case of the government not providing adequate health care to Aboriginal people in Canada.

In light of the government's fiduciary obligation that necessarily includes the obligation to consult, Aboriginal organizations may wish to develop/modify guidelines that take these requirements into account. These guidelines may be based upon the direction provided by the courts and implemented for use when discussing potential infringements of Aboriginal or treaty rights by respective governments. Arguments may be developed as to the omission of the government to provide adequate health care is a breach of their fiduciary obligations.

To determine whether the Crown's actions are consistent with its fiduciary duty and to determine if the Crown has acted in good faith, the following principles are re-iterated:

¹⁹⁴Treaty Rights to Health, *supra* note 74.

¹⁹⁵ *Ibid.*

- “[T]he honour of the Crown is always involved” and “No appearance of ‘sharp dealing’ will be sanctioned.”¹⁹⁶
- In exercising its Constitutional powers, the Crown must uphold its Constitutional duty to act in a “trust-like” - rather than “adversarial” - manner.¹⁹⁷
- The Crown has a duty to provide full disclosure of its actions so as not to compromise Aboriginal or treaty rights.¹⁹⁸
- The Crown must refrain from acting in conflict of interest situations or benefit from its role as fiduciary.¹⁹⁹
- If there is any possibility of infringement on Aboriginal or treaty rights, meaningful consultation is required, and the justification test must be met to account for such infringement.²⁰⁰
- The Crown must use its fiduciary discretion to act in the best interests of Aboriginal people.²⁰¹

Methods of developing and implementing consultation, accommodation and engagement processes, must acknowledge Aboriginal knowledge and historical practices. A worthwhile solution would be through supporting Aboriginal Peoples in determining how their own consultation processes should evolve. In other words, whatever strategy is employed to determine what meaningful consultation and accommodation must be based or built upon Aboriginal knowledge and historical practices.

¹⁹⁶ *Sparrow*, *supra* note 40 at 181 and at 187, *Haida Nation*, *supra* note 111.

¹⁹⁷ *Sparrow*, *supra* note 40 at 180.

¹⁹⁸ Rotman, *supra* note 2 at 180.

¹⁹⁹ Rotman, *supra* note 2 at 180.

²⁰⁰ *Sparrow*, *supra* note 40.

²⁰¹ *Blueberry River*, *supra* note 106.

9. Reconciliation of Aboriginal Health and Healing Practices and Canadian Law and Policy

Professor Sákéj Youngblood Henderson describes the “Aboriginal Renaissance” as rising from Aboriginal students and faculty from various departments within university settings (such as law, humanities, sciences and education) creating new and holistic types of study that breeds the development of new research and knowledge formation, development and implementation:

Aboriginal renaissance has shifted the agenda from recrimination to rebirth, from conflict to collaboration, from perceived deficiency to capacity. It has also shifted university thinking from a defensive/assimilative narrative to a receptive/transformational narrative that accepts that benefits to Aboriginal peoples is a benefit to the whole academic community and the multiple publics who look to elite institutions to lead and to listen. As such, innovation from diverse sources can lead to beneficial change for all.¹

The Aboriginal Renaissance sets a perfect stage for applying a combination of knowledge identified in this thesis – from health to law to science and humanities – new theories can be crafted which bring new perspectives and new solutions in a receptive/transformational setting. This chapter attempts to utilize and provide this combined narrative approach to addressing issues outlined thus far.

Coupled with Henderson’s Aboriginal renaissance tools, an approach is crafted that gives meaning to the recommendations provided at the conclusion that meshes law with health and science using a comparison with Canada (as discussed) and the Indigenous Peoples from New Zealand, Australia and the United States. Although they share much of the same colonial history their populations are not directly comparable but it is their differences that show the gaps and produce some interesting analysis.

Finally the Chapter concludes with recommendations gleaned from all Chapters of the thesis and in particular the ideas that have flowed from Chapter 8 itself (Reconciliation). These

¹ Sákéj Youngblood Henderson, “Centennial Theme: Highlighting And Animating The Aboriginal Renaissance Created By The University Of Saskatchewan” presentation to the College of Law, University of Saskatchewan, 2009, on file with the author.

recommendations provide the fodder for further research into Aboriginal health and the law and sciences.

9.1 Influencing Policy Development

New government health policies must address the causes of ill health and be based upon a revamped fair and rational economic and social order and an analysis that implements constitutionally protected rights. This must be outside the realm and structure of other parties (i.e. federal government) directing what is best for Aboriginal people (and outside of the old guardian and ward theory).

The legal background for the common practice of the government “knowing” what is best for Aboriginal people stems from the basic legal premise of the guardian and ward theory. This is the premise on which health policies were crafted. The guardian and ward theory was the common legal basis for dealing with Aboriginal people prior to the 1984 *Guerin* decision, as the Crown-Aboriginal relationship was understood to be that of ‘guardian and ward’.² This characterization was significant for several reasons. First, it assumed that Aboriginal Peoples – as wards – were incapable of looking after their own best interests. Second, it followed that the Crown – as guardian – would make decisions for Aboriginal Peoples.³ Third, a guardian-ward relationship meant that, under Canadian law, the Crown acted out of a moral rather than any legal obligation and was therefore not administratively responsible for its actions. In the 1887 *St. Catherine’s Milling and Lumber Company*⁴ case, the Supreme Court of Canada characterized this obligation as being “a sacred political obligation” and *not* a “legal obligation”. In 1984, the Supreme Court found that the Crown/Aboriginal relationship was fiduciary in nature and the Crown has fiduciary duties and responsibilities towards Aboriginal Peoples.⁵ The significance of the Supreme Court of Canada’s rejection of the political trust

² This characterization dates back to a trilogy of American case law, particularly the 1831 case of *Cherokee Nation v. State of Georgia* where the United States Supreme Court stated that the Cherokee Nation’s relationship to the United States “resembles that of a ward to his guardian”. *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1, 8 L. Ed. 25 (1831).

³ L.I. Rotman, *Parallel Paths: Fiduciary Doctrine and the Crown-Native Relationship in Canada* (Toronto: University of Toronto Press, 1996) at 20 [Rotman].

⁴ *St. Catherine’s Milling and Lumber Co. v. The Queen* (1887), 13 S.C.R. 577; aff’d (1888), 14 App. Cas. 46 (P.C.).

⁵ *Guerin v. R.*, [1984] 2 S.C.R. 335, [1985] 1 C.N.L.R. 120 at 376.

characterization of Canada's relationship with Aboriginal Peoples along with its no-fault administrative responsibility in favour of a fiduciary relationship cannot be under-estimated: the fiduciary obligation is a legally enforceable and compensable obligation. In short, *Guerin* established that the Crown's fiduciary obligations extends to Aboriginal interests, carries a significant discretionary element, and is a broad encompassing duty. Although, the fiduciary obligation in *Guerin* arose in the context of a land surrender, the case did lay the foundation for applying the fiduciary obligation to other aspects of the Crown/Aboriginal relationship.⁶

Although entrenched in the *Constitution Act, 1982*, Aboriginal and treaty rights have not been the guiding principles of the government when developing health policies. As a result, Aboriginal health policies continue to reflect the political trust theory long rejected by the courts. Such policies were developed pre-*Guerin* but continue today despite constitutional Aboriginal rights entrenchment and reform. The age-old approaches still relied upon in developing new policies have not helped in equalizing Aboriginal health in Canada. In fact, they have been the overarching source of Aboriginal health problems.

<p style="text-align: center;">APPLY PRINCIPLES IN POLICY DEVELOPMENT THAT INCLUDE THE CONSTITUTIONAL SUPREMACY OF ABORIGINAL AND TREATY RIGHTS</p>
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To initiate new government health policies certain principles must be acknowledged and discussed. National linkages must be created that bridge the divide between government and Aboriginal people. An example may be found in the *Blueprint on Aboriginal Health (Blueprint)*⁷ that was created in 2005 to improve access and quality of health services for all Aboriginal people through a collaborative approach that included the Canadian governments and the National Aboriginal Organizations (representing their constituents). The key principles noted were:

- Health is holistic in nature;
- Recognize the distinctiveness of the constitutionally recognized aboriginal groups with partnerships built on inclusion;

⁶ *Ibid.* Rotman, *supra* note 3 at 110; B. Slattery, "Understanding Aboriginal Rights" (1987) 66 Can. Bar Rev. 727 at 737-738 at 754.

⁷ Canada, Health Canada, *Blueprint on Aboriginal health: A Ten Year Plan 2005*, online: <http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2005-blueprint-plan-abor-auto/index-eng.php> (accessed July 26, 2010).

- Recognition that a funding source is required and that the blueprint must be reviewed in a timely manner to ensure accountability and goal attainment.

Integral to the framework are several approaches that were fundamental to the Blueprint such as building on Indigenous knowledge; women’s participation; determinants of health; engagement and inclusivity; sustainability and accountability and description of current mandates.

To put the frameworks into action, a distinction based approach was implemented that addressed the specific needs of First Nations, Métis and Inuit respectively. The 2005 *Blueprint* called for a 10 year transformative plan (the federal self-government agreements were cognizant of the timelines) and called for the recognition of the constitutionally protected rights of Aboriginal peoples in Canada. The *Blueprint* did not confine itself to health necessities but looked at policy developments from a collaborative, holistic perspective – confirming that there are no “quick fixes.”

Using a “WHOLE APPROACH” (whole of Aboriginal and non-Aboriginal government approach), collaborative efforts must address the needs of both Aboriginal people and government in order to move forward.

Certain key principles must be reflected and adhered to while developing, changing and influencing policy. They are:

- Every Aboriginal person born in Canada has a powerful set of constitutionally protected rights through Section 35 of the *Constitution Act, 1982*.
- Health care policies must reflect the constitutional rights as expressed in s. 35.
- These constitutional rights include (among others) the inherent right to self-determination, self-government, to control one’s own living circumstances and quality of life.⁸
- Root causes of ill health (colonization, historical policies, legislative policies, guardian and ward theories etc.) must be addressed, rejected and replaced with policies that

⁸ Asch, Michael, “Aboriginal Self-Government and the Construction of Canadian Constitutional Identity” (1992) 30 *Alberta Law Review* 465.

reflect the fiduciary relationship between the federal and provincial and territorial governments and Aboriginal people.⁹

- A collaborative approach which includes: i) the whole of government, federally, provincially, municipalities, and/or Aboriginal governments ii) all three constitutionally recognized Aboriginal groups and a recognition of the distinctions within each group and/or iii) the National Aboriginal Organizations (Native Women's Association of Canada, Métis Nation of Canada, Congress of Aboriginal People, Assembly of First Nations, Inuit Tapiriit Kanatami). This approach is required to establish the political will to effect change and implement policy reform and constitutionalized Aboriginal health care.
- A holistic approach must be engaged that considers all determinants of health and all aspects of health that connects every person to their family, community and nation through a cycle of interdependence and that is cognizant of the requirement that self-determination includes the ability to determine timelines.
- An evidence based approach must be utilized to advance Aboriginal health.

Examples of evidence gathering may include (but not limited to):

- a) Examine and research Aboriginal developed and controlled knowledge networks;
- b) Discuss and research national linkages and how they can bridge the divide between government and Aboriginal people;
- c) Examine other organizations in the health realm and others that are working in various capacities, for instance (but not limited to) Federal, Provincial and Territorial Health Disparities Task Group, Regional Health Survey Institute on Aboriginal Peoples Health (CIHR) Canadian Institute of Health Information, National Collaborating Centre for Aboriginal Health and National Aboriginal Organizations;
- d) Consider non-Aboriginal approaches and their usefulness for Aboriginal people in Canada or Indigenous people globally.
- e) Research and analyze other international Indigenous approaches;
- f) An analysis may be useful that determines if the health outcomes of the communities that were parties to self-government or health transfer agreements have had a positive improvement in the overall health status of those parties (test of outcomes);
- f) Compile research and produce an evidence based document;

⁹ Rotman, *supra* note 3.

g) Determine next steps.

GATHER EVIDENCE – CREATE EVIDENCE BASED DOCUMENTS, TO INCREASE CREDIBILITY AND ACCOUNTABILITY
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In 2005, the First Nations and Inuit Health Branch of Health Canada (FNIHB) produced a manual for the Aboriginal Head Start Program that addressed the needs of children with disabilities.¹⁰ The manual was produced based on the following perspectives:

- Treaty rights;
- Fiduciary obligations;
- Constitutional rights;
- The United Nations Convention on the Rights of the Child via “Canada’s Fit for Children”;
- Canada’s Current and Past initiatives via “Canada’s Fit for Children”; and
- Federal Government Programs and Initiatives.

The mandate of FNIHB is to:

Assist First Nations and Inuit communities and people to address health inequities and disease threats through health surveillance and population health interventions. Ensure the availability of, or access to, health services for First Nations and Inuit people. Devolve control and management of community-based health services to First Nations and Inuit communities and organizations.¹¹

To accomplish their goal of understanding the rights of an Aboriginal child with special needs, a table was created that compared Aboriginal and treaty rights to health with selected articles from the *United Nations Convention on the Rights of the Child*. The table also includes past and current initiative that Canada has done to respect these Aboriginal and treaty rights, the complete table is attached as Appendix “A”:

¹⁰ Canada, First Nation and Inuit Health Branch, Specific Policy Development, “Aboriginal Child Rights: Special Needs Focus”, Aboriginal Head Start, 2005-2006 (on file with the author) [Special Needs]. Dawn Walker, First Nations and Inuit Health Branch, Health Canada, *Aboriginal Child’s Rights Special Needs Focus*, (Ottawa: 2005-06) [Work in Progress, unpublished on file with the author] for a discussion on Aboriginal children with special needs and how the identification of Aboriginal and treaty rights (and their Constitutional status) will advance these rights.

¹¹ Special Needs, *ibid* at Intro.

This project is interesting in that the constitutional obligations of the federal government are listed and implemented in relation to children's rights. It is a starting point for the correct development of policies relating to Aboriginal health and constitutionalization of Aboriginal health care.

Using the federal government document “*Aboriginal Child’s Rights Special Needs Focus*”; Expand and develop these ideas for future implementation in all Health Canada’s policies that affect Aboriginal Peoples in Canada.

Health Impact Assessments are important tools to safeguard health. For instance, Leah Bitternose aptly coined “The Land is Us – We are the Land”¹² which succinctly reveals the intricate connection between Aboriginal people and the land.

Environmental and human health are inextricably interlinked and therefore, a Health impact Assessment (HIA) is an integral part of an Environmental Impact Assessment (EIA). A cornerstone of HIA is the recognition of the need for public participation in the definition and scoping of human health concerns, and in decision-making. Environmental assessments have been in existence since the 1970s,

EA involves determining any changes or impacts that a project or action will have on our surroundings be it positive or negative effects – before that project is carried out in order to prevent irrevocable damage from occurring.

A set of criteria is used to determine possible impacts on human and environmental health and it is graded according to its significant and degree of impact... . The final step in an EA is to decide whether or not the project should be allowed to proceed, and if so, what conditions should be attached to the approval.¹³

Government led policies, laws and legislation have had enormous negative impacts on Aboriginal Peoples.¹⁴ First Nations have questioned the government-led processes and have

¹² Leah M. Bitternose , “The Law Of Duty and Consultation” prepared for The National Aboriginal Land Managers Association, National Fall Assembly 2007, Dakota Dunes Conference Center, Saskatoon, Saskatchewan.

¹³ Canada, Health Canada, “Canadian Handbook on Health Impact Assessment: the Basics, online: “<http://dsp-psd.pwgsc.gc.ca/Collection/H46-2-99-235E-1.pdf> (accessed July 22, 2010).

¹⁴ See for instance: Wanda D. McCaslin ed. *Justice As Healing: Indigenous Ways Writings on Community Peacemaking and Restorative Justice* (Purich: Saskatoon) (April 2005); Assembly of First Nations (1994) [*Breaking the Silence: An Interpretive Study of Residential School Impact and Healing as Illustrated by the Stories of First Nations Individuals*](#). Ottawa: Assembly of First Nations; Von Puttkamer, Peter (1992) [*Beyond the*](#)

called for more community-driven and culturally relevant health models specifically in relation to environmental issues. In response, the Human Environmental Health Impact Assessment was created to assess the potential risks and benefits of proposed developments and natural resource management within their communities.¹⁵

The World Health Organization describes the Health Impact Assessment as,

HIA is a practical approach used to judge the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. Recommendations are produced for decision-makers and stakeholders, with the aim of maximising the proposal's positive health effects and minimising its negative health effects.¹⁶

Health Impact Assessment is based on values that link it to the policy environment in which it is being undertaken.

- Democracy – allowing people to participate in the development and implementation of policies, programmes or projects that may impact on their lives.
- Equity – HIA assesses the distribution of impacts from a proposal on the whole population, with a particular reference to how the proposal will affect vulnerable people (in terms of age, gender, ethnic background and socio-economic status).¹⁷

Shadows [videorecording] Vancouver, B.C.: Gryphon Productions Ltd.; Chrisjohn, Roland. (1991) "Faith Misplaced: " Lasting Effects of Abuse in a First Nations Community" in *Canadian Journal of Native Education*. Vol. 18, No. 2. Vancouver: University of British Columbia Press, 1991. p. 161 – 197; Chrisjohn, Roland, Sherri Young and Michael Maraun (1997) *The Circle Game: Shadows and Substance in the Indian Residential School Experience in Canada*. Penticton: Thytus Books Furniss, Elizabeth. *Victims of Benevolence: Discipline and Death at the Williams Lake Indian Residential School, 1891 - 1920*. (1992) Williams Lake: Cariboo Tribal Council; Haig-Brown, Celia (1988). *Resistance and Renewal: Surviving the Indian Residential School*. Vancouver: Tillicum Library Kuper Island: Return to the Healing Circle; Miller, J. R. (1996), *Shingwauk's Vision: A History of Native Residential Schools*. Toronto: University of Toronto Press, online: <http://resolve.library.ubc.ca/cgi-bin/catsearch?isbn=0802078583> (accessed September 1. 2010); Report of the Nuu-Chah-Nulth Tribal Council (1996) *Indian Residential Schools: The Nuu-chah-nulth Experience*. Port Alberni: Nuu-chah-nulth Tribal Council; Report of the Royal Commission on Aboriginal Peoples. (1996) "Residential Schools" in *Looking Forward, Looking Back*. Vol. 1. Ottawa: Canada Communications Group Publishing. Chapter 10, p. 333 – 409; Sterling, Shirley (1993) *My Name is Seepeetza*. Vancouver: Douglas & McIntyre; Aboriginal Justice Inquiry of Manitoba (1991) "Aboriginal Women" in *The Justice System and Aboriginal People, Volume 1* Manitoba: Province of Manitoba. p. 475 – 507; Faith, Karlene (1993) "Aboriginal Women" in *Unruly Women: The Politics of Confinement and Resistance*. Vancouver: Press Gang Publishers. p. 186 – 203; La Prairie, Carol (1987) "Native Women and Crime in Canada: A Theoretical Model" in Ellen Adelberg and Claudia Currie (Eds.) *Too Few to Count: Canadian Women in Conflict with the Law*. Vancouver: Press Gang Publishers. p. 103 – 112.

¹⁵First Nations Health Environmental Framework, online:

http://www.fnehin.ca/site.php/sitenews/human_environmental_health_impact_assessment_a_framework_for_indigenous_com/ (accessed July 28, 2010).

¹⁶ World Health Organization, "Health Impact Assessments", online: <http://www.who.int/hia/about/en/> (accessed July 22, 2010) [WHO].

¹⁷ WHO, *ibid*.

One of the reasons WHO uses HIA is that it has proven to improve health and reduce inequalities:

Addressing inequalities and improving health is a goal for many organisations and all governments. One way of contributing to the health and inequalities agenda is through the use of HIA. At the very least, HIA ensures that proposals do not inadvertently damage health or reinforce inequalities. HIA uses a wide model of health and works across sectors to provide a systematic approach for assessing how the proposal affects a population, with particular emphasis on the distribution of effects between different subgroups within the population. Recommendations can specifically target the improvement of health for vulnerable groups.¹⁸

It is possible to apply these same principles to programs, policies, laws, legislations and projects that affect Aboriginal health. At the very least, there is great value to be gained through its application within the most dire health circumstances. For example, a screening could occur with a checklist on how far ranging the impacts are, what Aboriginal and treaty rights are affected and what the long term impacts could be. This may include the Haudenosaunee principles of “the effect of their decision on peace; the effect on the natural world; and the effect on seven generations in the future.”¹⁹

REVIEW THE HEALTH IMPACT ASSESSMENT SYSTEM FOR CONSIDERATION TO APPLICATION TO ABORIGINAL HEALTH IN GENERAL
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9.2 Health Delivery Systems for Indigenous Population in Canada, the United States, Australia and New Zealand

In spite of the geographical, political and cultural distances between the Indigenous populations in Canada, the United States, Australia and New Zealand, their poor health status and causes are remarkably similar.²⁰ Each country possesses a distinct political culture in that the general health systems, the legal status of Indigenous peoples and the historical evolution of Indigenous health policy have created four completely different health delivery systems. A quick perusal of

¹⁸ World Health Organization, “Health Impact Assessments, Reasons to Use HIA”, online: <http://www.who.int/hia/about/why/en/index1.html> (accessed July 22, 2010).

¹⁹ The Six Nations: Oldest Living Participatory Democracy on Earth, online: http://www.ratical.org/many_worlds/6Nations/ (accessed July 28, 2010) [Six Nations].

²⁰ Portions of the research for this section originated from “Health Delivery Systems for Indigenous Populations” (Draft, August, 2003) prepared for the National Aboriginal Health Organization by Yvonne Boyer, Crystal Hulley and Trina Wall.

the most basic health statistics shows that the Indigenous peoples located within vastly different countries are closer in health status to each other than to their general population counterparts. There is also a clear consensus in all four countries that the reasons for these appalling health disparities lay in the similar social, cultural and economic crisis that colonization has created within these populations. The following issues will be reviewed:

- Differences and similarities in health status among the four Indigenous populations²¹ in order to establish the comparability of their situations;
- Brief descriptions of historical contexts and description of the evolution of health delivery systems followed by their current status within each country with an examination of the similarities and differences;
- Provide recommendations and analysis that may be useful for future research and follow up.

i) Differences and Similarities in Health Status Among Indigenous Populations

Based on the 2006 Census, the population of Aboriginal and Torres Strait Islanders in Australia is 517, 200 or 2.5 % of the total population.²² There are 565,329 people usually living in New Zealand who are of Māori descent.²³ In the United States, the 2000 Census reports that there are 4,315,865 American Indian/Alaska Native peoples or 1.53% of the total population.²⁴ The United States sector of the Indigenous population represents a large number of people who have serious health issues. However, the Aboriginal and Torres Strait Islander population face a health status that is remarkably lower than that held by Aboriginal Peoples in Canada,

²¹ Canada: First Nations, Métis and Inuit, United States; American Indian and Alaskan Native (AI/AN) Members of federally recognized tribes; Australia: Aboriginal and Torres Strait Islander (ATSI); New Zealand: Maori Self-identifications (due to their history of equal citizenship, definition has never been required for eligibility to basic human rights, and therefore is not as heavily regulated by the government).

²² Australian Bureau of Statistics, “Aboriginal and Torres Strait Islander population tops half a million: ABS,” online:

<http://www.abs.gov.au/Ausstats/abs@.nsf/Latestproducts/4705.0Media%20Release12006?opendocument&tabname=Summary&prodno=4705.0&issue=2006&num=&view=> (accessed April 28, 2011).

²³ Statistics, New Zealand, online: <http://search.stats.govt.nz/search?w=maori&af=ctype%3Astatistics> (accessed July 22, 2010) [Statistics NZ]. “Māori are counted in two ways in the census: through ethnicity and through descent. *QuickStats About Māori* covers both of these measures. Māori ethnicity and Māori descent are different concepts – the former refers to cultural affiliation, while the latter is about ancestry. In 2006, there were 565,329 people who identified with the Māori ethnic group, and 643,977 (17.7 percent) people who were of Māori descent.”

²⁴ Stella U. Ogunwole for the U.S. Department of Commerce Economics and Statistics Administration, February 2006, *Helping You Make Informed Decisions*, We the People: American Indians and Alaska Natives in the United States, online: <http://www.census.gov/population/www/socdemo/race/censr-28.pdf> (accessed July 22, 2010).

American Indian and Alaskan Native (AI/AN) and Maori.²⁵ A quick glance at the causes mortality rate shows that it is twice as high for Aboriginal and Torres Strait Islander (ATSI) population as it is for Maori and 2.3 times as high as the American Indian and Alaskan Native rate.²⁶

The life expectancy gap between Indigenous and non-Indigenous populations is estimated to be 19-21 years in Australia, 8 years in New Zealand, 5-7 years in Canada, and 4-5 years in the United States.²⁷ Indigenous peoples have a higher mortality rate across the spectrum of disease with much of the excess arising from chronic conditions. In all four countries, circulatory conditions, respiratory disease, diabetes, and neoplasms account for most of the excess deaths among Indigenous people. These conditions collectively account for 70 percent or more of excess mortality in Indigenous people.²⁸ There are also differences in the particular health problems that affect each Indigenous population with specific problems originating from a particular geographical concentration.

Although the specific life expectancy rates for each Indigenous population are not exactly the same, they each represent an important gap between Indigenous people and the non-Indigenous population. It is this gap, and not the exact figures, which make these populations comparable.

In addition to these health disparities, another indication that the problems faced by these four Indigenous populations are common ones relates to disease trends. In all four Indigenous groups, the evolution of disease trends within the Indigenous populations has been strikingly different from that of the non-Indigenous population.

²⁵ Australian National Audit Office. & Paul Nicoll. 2002 *The Aboriginal and Torres Strait Islander Health Program : follow-up audit : Department of Health and Ageing / the Auditor-General* Australian National Audit Office, Canberra, online : <http://www.anao.gov.au/WebSite.nsf/Publications/23817F9E309B2FB54A256C6100254991> at 17.

²⁶ *Ibid* at 18.

²⁷ Australian Bureau of Statistics, *Deaths 2001*, Canberra: ABS, 2002. (Catalogue No 3302.0.); Ministry of Health, New Zealand. Our health, our future—Hauora Pakari, Koiora Roa—the health of New Zealanders 1999, online: www.moh.govt.nz/moh.nsf/wpg_Index/Publications-Index (accessed July 22, 2010); Health Canada, First Nations and Inuit Health Branch, online: <http://www.hc-sc.gc.ca/fniah-spnia/index-eng.php> (accessed July 22, 2010); US Department of Health and Human Services, Indian Health Service. Trends in Indian health 1998-99, online: www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp (accessed July 22, 2010).

²⁸ Australian Bureau of Statistics, Australian Institute of Health and Welfare. *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*. Canberra: ABS; 2008 (Catalogue No 4704.0.).

During contact, these trends involved the prevalence of European diseases, such as smallpox and tuberculosis, which ravaged all four Indigenous populations. Today, these trends have moved towards chronic diseases like diabetes and heart disease. Although there are differences in the rates, this does not mean that all four Indigenous populations are affected by the exact same diseases at exactly the same rate that Indigenous people have been affected. What makes their situation a common one is the general trend towards most of the same diseases to a rate that is high relative to the non-Indigenous population. Again, it is the gap, and not the particulars, which links the health problems of these four Indigenous populations. These similarities may also be linked to the fact that each population faces a set of remarkably similar health determinants (colonization, poverty etc.) that shape this health status. It follows then that there may be common solutions, ones that can be exported between countries and recognized and adapted to the particular historical context of each.

ii) The Historical Contexts

Aboriginal people in Canada, Aboriginal and Torres Strait Islanders, American Indian and the Alaskan Native and Maori all share a health status that falls far below that of the non-Indigenous populations. The exact shape of these health disparities, as well as the policies used to address them is contingent upon the unique national contexts in which they have developed. It is also within these national contexts that any new solutions will have to be formed and implemented. As such, to understand the provision of health services to Indigenous populations today, as well as determine new directions which might be transferable, it is essential to understand the commonalities of their individual historical contexts.

The Indigenous population of each of the four countries discussed in this study shares a common origin in British colonial policy. Beginning with the *Royal Proclamation of 1763*²⁹ and reiterated in the *Report of the Parliamentary Select Committee on Aboriginal Tribes*,³⁰ (besides Australia) British policy focused on the ‘legal’ acquisition of land and the ‘legitimate’

²⁹ *Royal Proclamation of 1763*, R.S.C. 1985, App. II, No. 1.

³⁰ [Great Britain. Parliament. House of Commons. Select Committee on Aboriginal Tribes; Aborigines Protection Society, Report of the Parliamentary Select Committee on Aboriginal Tribes, \(British settlements.\) \(1837\) \(London: Pub. for the Society by W. Ball \[etc.\].](#)

imposition of British rule through negotiations of some type with the Indigenous populations. As the negative impacts of colonization on Indigenous populations was repeated in each successive colony, the policy focused on protecting the Indigenous populations from exploitation and extinction. This ‘civilized’ policy of colonization, however, was shaped primarily by a culture which viewed all Indigenous populations as barbarians and without government, culture or society.

Moreover, the extent to which this policy was followed, and the implications for Indigenous populations, varied between the four countries examined and were dependant upon various individual factors. These factors include the existence of other European powers in the area, the timing of contact and the legal tenets applied, and the ability of the Colonial Office to implement its colonial tools. As a result, the historical contexts within which health services for Indigenous populations developed within each country, although they share common origins, differ considerably.

Given the different historical contexts, it is not surprising that the health delivery systems for Indigenous peoples in Canada, the United States, Australia and New Zealand vary just as widely.³¹

United States

The first health services offered to American Indian/Alaska Native people (AI/AN) were delivered by the U.S. Army. Although, in some cases, medical services were provided in compliance with a specific treaty,³² often it was in order to prevent the spread of infectious

³¹ It should be emphasized again, however, that because of the numerous levels of government, status of Aboriginal peoples, and definitions of ‘health’ services, this discussion is meant to be a general overview only.

³² “Of about 400 treaties made between 1776 and 1858, only about 30 provided for either a physician or medical facility. About the same number carried general clauses promising such provisions as ‘the support of poor, infirm persons’, or ‘the support and comfort of the aged and infirm, and the helpless orphans of said Indians.’ See , Todd, John. “Implications of Policy and Management Decisions for Native Americans” at 259-268 at 261[Todd] in *Raffel, Marshall and Norma (1987) Perspectives on Health Policy: Australia, New Zealand, United State: Proceedings of an International Conference held by the Australian Studies Center of the Pennsylvania State University, 27-29 May 1986. Special Issue of the International Journal of Health Planning and Management New York: John Wiley & Sons.*

diseases to the non-Indigenous population. In essence, as Nixon³³ stated, “to the extent that the government has provided health services for Indians in conjunction with treaties in which land was ceded, Indian health care represents a prepaid health plan – quite likely the first example of such a concept.”³⁴ In his Special Message to the Congress on Indian Affairs, President Nixon stated:

[T]he Indians have often surrendered claims to vast tracks of land and have accepted life on government reservations. In exchange, the government has agreed to provide community services such as health, education and public safety, services which would presumably allow Indian communities to enjoy a standard of living comparable to that of other Americans.³⁵

In relation to health care specifically, policy expert Abraham Bergman stated:

Nixon’s Indian policy statement turned Federal/Indian relations on its head. At one fell swoop a colonial system was brought into the modern world. His concept of a business deal, i.e. land from the Indians in exchange for federal services, gave credibility to our position that the tribes had purchased a prepaid health care plan in perpetuity.³⁶

While the first congressional appropriation of Indian health care occurred in 1832,³⁷ the real system did not begin until the passage of the *Snyder Act* in 1921, which allocated funds for the “benefit, care, and assistance of Indians throughout the United States”.³⁸

Once responsibility for AI/AN health was taken by the federal government, control over the provision of these health services were lobbied between organizations, based on the dominant

³³ See also President Obama on Native Health in the US, online: <http://www.reznetnews.org/blogs/red-clout/tribal-advocates-tout-obamas-health-plan-22700> (accessed July 26, 2010).

³⁴ R. Pfefferbaum, B. Pfefferbaum, E. Rhades E, and J. Rennard, “Providing for the Health Care Needs of Native American: Policy, Programs, Procedures, and Practices” 21(1) *American Indian Law Review* pp 211-258 at 219 [Pfefferbaum].

³⁵ President Richard Nixon, Special Message to the Congress on Indian Affairs (July 8, 1970), online: http://www.nixonfoundation.org/Research_Center/1970_pdf_files/1970_0213.pdf (accessed July 22, 2010).

³⁶ See also, A. Bergman et al., *A Political History of the Indian Health Service* (Seattle: Harbourview Medical Centre, 1993), online: <http://www.milbank.org/770406.html> (accessed July 22, 2010).

³⁷ Brett Lee Shelton, “Legal and Historical Basis of Indian Health Care” in Dixon, Mim and Yvette Roubideaux, (2001). *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century*: American Public Health Association pp 1-28 at 10 [Roubideaux].

³⁸ Hall, Gilbert L. (1979) *Duty of Protection: The Federal-Indian Trust Relationship* Washington, DC: Institute for the Development of Indian Law at 29 [Hall]. As Hall points out, this wording “suggests that Congress intended such services to be provided to Indians regardless of their membership in a ‘federally-recognized’ tribe, degree of Indian blood, residency on a reservation, or any other requirement of the Department of the Interior which artificially restricts eligibility for government programs.”

conception of Aboriginal people at the time. The Bureau of Indian Affairs, which began as an office of the War Department, moved in 1849 to the Department of the Interior, as a prelude to the shift in Indigenous policy from that of nation to nation to a more protectionist, individualistic notion.³⁹ The *Transfer Act* of 1954 transferred Indian health to the Public Health Service, with creation of a sub-office entitled the Indian Health Service (IHS) in 1955.⁴⁰ This shift signalled the move towards the provision of health services to AI/AN as separate from Indigenous policy and a real public health focus. This had a very positive impact on AI/AN health, as “there is general agreement that Indian people have experienced substantial improvement in health status since transfer of Indian health services from BIA to IPHS in 1955.”⁴¹

As the health services policy progressed, there was a shift away from federal government involvement in the provision of these services while the increased role for tribal governments was set by the passage of the *Johnson-O’Malley Act*⁴² of 1934 which granted greater control to tribes over their own services and allowed the Secretary of the Interior to contract with the states and territories to provide Indian services. This Act would later be used as a blueprint for the provision of health care. An important development was the passage of the 1975 *Indian Self-Determination and Education Assistance Act*⁴³ which allowed tribal control over health and education programs. This tribal control was further reinforced in 1976 by *The Indian Health Care Improvement Act* (IHCIA)⁴⁴ which appropriated specific funds and allowed IHS hospitals and facilities to be eligible for Medicare/Medicaid reimbursements, which had a critical impact on the contracting/compacting abilities of tribes.⁴⁵ This control was offered only on a trial basis until the *Indian Tribal Self-Government Amendments Act* (2000) made ‘self governance in Indian health permanent.’⁴⁶ This Act continued the discretionary nature of IHS

³⁹ Todd, *supra* note 32 at 262.

⁴⁰ Association of American Indian Physicians, *AAIP Legislative/Health Policy Page*, online: <http://www.aaip.org/?page=Leadership0910> (accessed July 22, 2010) at 6 [Indian Physicians].

⁴¹ Pfefferbaum, *supra* note 34 at 217.

⁴² *Johnson-O’Malley Act* (25 U.S.C. 452).

⁴³ *Indian Self-Determination and Education Assistance Act*, [25 U.S.C. 450 et seq.].

⁴⁴ *The Indian Health Care Improvement Act*, P.L. 94-437 [*The Indian Health Care Improvement Act*].

⁴⁵ Judith K. Bush, (1996) *Legal, Historical and Political Context in which Tribes Make Health Care Decisions* Denver: National Indian Health Board National Indian Health Board Briefing paper on IHCIA at 1.

⁴⁶ Ben Nighthorse Campbell, (2003) “Senator Campbell: Charting a new course in Indian Health Care” *Indian Country Today* January 24, 2003, online:

funding established in the *Snyder Act*, meaning that the program is still funded a certain amount rather than based on need.⁴⁷

The *Indian Health Care Improvement Act*⁴⁸ (IHCA), Public Law 94-437, expired on September 30, 2000, but was extended to 2001 in anticipation that Congress would consider the reauthorization proposals. Although the government has been working on a reauthorization of the Act, the Bill has yet to pass. As a result, IHS is currently officially without a Congressional mandate and remains operative based solely through the *Snyder Act*.⁴⁹

The United States, Current

Funding and the provision of health services to AI/AN in the United States is a responsibility that has been claimed by Congress as one belonging to the federal government. It is implemented by the Indian Health Services Branch of the Department of Public Health in one of four different types of services.

The first is directly through Indian Health Services themselves, where members of federally recognized tribes, “can access this system of hospitals, clinics and health programs on or near reservations for direct health care services, and may be referred to other providers if they meet contract health eligibility requirements.”⁵⁰

The same services can also be provided by tribes, through contracting or compacting agreements. Through the 1975 *Self-Determination and Educational Assistance Act* services can be delegated to Tribal Health Services through a contract “to take over the management of all or part of their healthcare programs (Title 1)” or, since 1988, a compact “to obtain more power and independence in the management of their health programs (Title III).”⁵¹ A contract means that the tribe contracts to provide the IHS designed programs just as the IHS would have done. Compacting, however, (which is open only to tribes which have successfully contracted for at

www.indiancountry.com/?1043423222&style=printable at 2 of 2 (accessed July 22, 2010).

⁴⁷ Pfefferbaum, *supra* note 34 at 216.

⁴⁸ *Indian Health Care Improvement Act*, *supra* note 43.

⁴⁹ Indian Health Service, *Indian Health Care Improvement Act*, online: <http://info.ihs.gov/HlthImprvAct.asp> (accessed July 22, 2010).

⁵⁰ Indian Physicians, *supra* note 40 at 2.

⁵¹ *Ibid.*

least 3 years) involves the transfer of a certain set of funds, with which tribes can determine their own priorities and deliver the programs they want.⁵²

These programs are largely based on or near reservations and service those who live there. IHS is the primary source of health services for 55 percent of Indian people and acts both as direct provider and as funder of tribally run centers. Their services includes 550 health care delivery facilities operated both by the Indian Health Services and tribes, with 44% of the Agency's \$2.6 billion budget transferred to tribes; "[t]here is no standard or minimum benefits package for Indian health."⁵³ Each tribe decides which services are included. Recently, there has been a move to provide services to those living away from reserves through Urban Health Programs through the use of Title V of the IHCA.⁵⁴

In Alaska, there is a unique regional organization of the tribally run medical services. "In Alaska, which is widely regarded as having one of the nation's best and most efficient Native health care systems, all Native medical facilities are either contracted or compacted"⁵⁵ through the Alaska Native Tribal Health Consortium (ANTHC). Originally created in 1990 to run the Alaska Native Medical Center (hospital) the Consortium creates a tier in the system with community and IHS levels augmented by Regional Health Organizations and the Alaska Native Medical Center in Anchorage.⁵⁶

The Alaska Native Tribal Health Consortium (ANTHC) provides statewide services in: specialty medical care; construction of water and sanitation and health facilities; community health and research; information technology; and professional recruiting.⁵⁷

⁵² Pfefferbaum, *supra* note 34 at 237.

⁵³ Indian Physicians, *supra* note 40 at 2.

⁵⁴ Indian Physicians, *ibid* at 2.

⁵⁵ Alaska Native Tribal Health Consortium, online: <http://www.anthc.org/> (accessed September 1, 2010).

⁵⁶ United States General Accounting Office (1998) *Indian Self-Determination Contracting: Effects of Individual Community Contracting for Health Services in Alaska* GAO/HEHS-98-134, online: www.gao.gov (accessed July 22, 2010).

⁵⁷ *Ibid.*

IHS is not the only available source of health services and funding for AI/AN. The government views itself as a funder of last resort, or as responsible only for dealing with the gap between what other programs can pay for and the level of service they want provided:

This means that when Indians qualify for health care from other sources (such as Medicare, Medicaid, and private insurance), these alternative sources are to be utilized first, becoming responsible for payment only after alternate sources have been exhausted.⁵⁸

As a result, other sources of funding, especially state Medicaid and federal Medicare programs, but also private insurance, play an essential part in funding AI/AN health care in the US.⁵⁹ For instance,

Over the past 25 years, Medicare and Medicaid payments have become vital sources of revenue for basic Indian hospital and clinic operations.⁶⁰

As policy scholar Pfefferbaum points out, however, “[u]nfortunately for Indians, although dual entitlement to certain services is established in law, actual receipt of services does not always follow; when it does, it is often only after extensive effort on the part of individuals and agencies.”⁶¹

This complex system means that there are endless variations, and no common methods of accessing health services. However, this service has led to some interesting developments. “In nearly every primary care discipline, the IHS has developed positions and training programs that extend the reach of the limited number of health care professionals and at the same time create employment opportunities for local tribal members.”⁶²

⁵⁸ Pfefferbaum, *ibid* at 225.

⁵⁹ Indian Physicians, *supra* note 40 at 3.

⁶⁰ JT Petherick, (2003) *Briefing Paper: Indian Health Care Improvement Act* National Indian Health Board, online: www.nihb.org (accessed July 28, 2010).

⁶¹ Pfefferbaum, *supra* note 34 at 225.

⁶² Pfefferbaum, *ibid*.

However in March 2010, President Obama signed the bill to make the *Indian Health Care Improvement Act* permanent as part of the *Patient Protection and Affordable Care Act (PPACA)*⁶³ and declared:

Earlier today, I signed into law the Patient Protection and Affordable Care Act, the health insurance reform bill passed by Congress. In addition to reducing our deficit, making health care affordable for tens of millions of Americans, and enacting some of the toughest insurance reforms in history, this bill also permanently reauthorizes the Indian Health Care Improvement Act, which was first approved by Congress in 1976. As a Senator, I co-sponsored this Act back in 2007 because I believe it is unacceptable that Native American communities still face gaping health care disparities. Our responsibility to provide health services to American Indians and Alaska Natives derives from the nation-to-nation relationship between the federal and tribal governments. And today, with this bill, we have taken a critical step in fulfilling that responsibility by modernizing the Indian health care system and improving access to health care for American Indians and Alaska Natives.⁶⁴

The new PPACA is vastly different from the original 1976 version of the IHCIA. It includes many major changes and improvements to facilitate the delivery of Indian health care services, such as:

- Enhancement of the authorities of the IHS Director, including the responsibility to facilitate advocacy and promote consultation on matters relating to Indian health within the Department of Health and Human Services.
- Provides authorization for hospice, assisted living, long-term, and home- and community-based care.
- Extends the ability to recover costs from third parties to tribally operated facilities.
- Updates current law regarding collection of reimbursements from Medicare, Medicaid, and CHIP (Children's Health Insurance Program) by Indian health facilities.
- Allows tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries.
- Authorizes IHS to enter into arrangements with the Departments of Veterans Affairs and Defense to share medical facilities and services.

⁶³*Patient Protection and Affordable Care Act* ([Pub.L. 111-148](#), 124 [Stat.](#) 119, to be codified as amended at scattered sections of [42 U.S.C.](#)).

⁶⁴ United States Department of Health and Human Service, News Release, "Indian Health Care Improvement Act Made Permanent" March 26, 2010, online: <http://www.hhs.gov/news/press/2010pres/03/20100326a.html> (accessed August 14, 2010) [IHCIA].

- Allows a tribe or tribal organization carrying out a program under the Indian Self-Determination and Education Assistance Act and an urban Indian organization carrying out a program under Title V of IHCA to purchase coverage for its employees from the Federal Employees Health Benefits Program.
- Authorizes the establishment of a Community Health Representative program for urban Indian organizations to train and employ Indians to provide health care services.
- Directs the IHS to establish comprehensive behavioral health, prevention, and treatment programs for Indians.
- The IHS provides a comprehensive health service delivery system for approximately 1.9 million of the nation's estimated 3.3 million American Indians and Alaska Natives.⁶⁵

Dr. Yvette Roubideaux, Director of the Indian Health Service, applauded the permanency of the Bill:

Since 2000, tribes and tribal organization have been strongly advocating for the updating and reenacting of the IHCA. The provision of health care services to American Indians and Alaska Natives is a key component of the federal government's trust responsibility, and the updating and permanent authorization of the IHCA helps to fulfill this responsibility.⁶⁶

The actual implementation and provision of services will have to be evaluated for its effectiveness. However the passing of the Bill is a valuable start to address Indian health inequities in the United States.

Australia

The federal government did not play a role in Australian Indigenous policy and the history of health services to Aboriginal and Torres Strait Islanders (ATSI) before the 1967 Australian Referendum⁶⁷ is difficult to delineate. The first government health services were vaguely

⁶⁵ *Ibid.*

⁶⁶ IHCA, *ibid.*

⁶⁷ On 27 May 1967 a Federal referendum was held to determine whether two references in the Australian Constitution, which discriminated against Aboriginal people, should be removed. The sections of the Constitution under scrutiny were:

51. The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:-

(xxvi) The people of any race, other than the aboriginal people in any State, for whom it is necessary to make special laws.

127. In reckoning the numbers of the people of the Commonwealth, or of a State or other part of the Commonwealth, aboriginal natives should not be counted.

The removal of the words '... other than the aboriginal people in any State...' in section 51(xxvi) and the whole of section 127 were considered by many to be representative of the prevailing movement for political change within Indigenous affairs. As a result of the political climate, this referendum saw the highest YES vote ever recorded in a Federal referendum, with 90.77 per cent voting for change. Australian Government, National Archives, online:

offered through a philosophy of offering a ‘pillow for a dying race’ during the late 19th and early 20th century. Following that, each state decided what health services were offered. However, these were most often intimately linked with assimilationist policies.

In 1967 federal responsibility for Indigenous affairs was created and the Commonwealth government began to take an active role in the funding of health services to ATSI, which targeted funding to shape the outcomes of state programs. It was not until 1973 that the government created the National Plan for Aboriginal Health, which aimed to raise health standards of ATSI to the Australian average. In 1979 the House of Representatives Standing Committee on Aboriginal Affairs proclaimed the strategy a failure because in its implementation it failed to take into account the environmental, cultural and social determinants of health.⁶⁸

The first project that the ATSI community created was the 1971 Aboriginal Medical Service, soon followed by the Victoria Health Service. The Auditor General’s report notes, “while in one sense these health services were small medical and dental clinics, they were also early evidence of self-determination among the Aboriginal population. These services became the launching pad for Aboriginal control and participation in both health care policy and service delivery and made strong claims for financial and other government support.”⁶⁹ These community controlled health services banded together to create the National Association of Community Controlled Health Organizations (NACCHO), which proved to have an important lobbying role to play.

The NACCHO⁷⁰ began in 1976 and is the main advocacy group for Australia's 141 community-controlled Aboriginal health services. These services provide primary health care initiated and operated by local Aboriginal communities to provide holistic, comprehensive and culturally appropriate health care to the community which controls it.

<http://www.naa.gov.au/about-us/publications/fact-sheets/fs150.aspx> (accessed July 22, 2010).

⁶⁸ Auditor-General (1998) *Audit Report No 13. The Aboriginal and Torres Strait Islander Health Program* Canberra: Australian National Audit Office (Auditor General (1998) at 68.

⁶⁹ Auditor General (1998), *ibid* at 68.

⁷⁰ National Aboriginal Community Controlled Health Organization, online: www.naccho.org.au (accessed July 26, 2010).

The NACCHO role is to lobby governments, departments and corporate groups to promote positive policy change relating to the health and well-being of Aboriginal communities and to ensure the effectiveness and cultural validity of national policies, programs and initiatives in Aboriginal health. It also seeks to secure adequate resources and funds for its member health services, so that they may fully meet the health needs of their communities.

In 1995 the Department of Human Services and Health took over health policy and services “to ensure that primary health care for Indigenous Australians had a priority position within the mainstream health system, against a background of continuing high rates of Aboriginal and Torres Strait Islander morbidity and mortality.”⁷¹

Since its receipt of the health file, the Department of Health and Aged Care (DHAC) has created the Aboriginal and Torres Strait Islander Health Council (ATSIHC) to be “the primary source of advice to the Minister on matters related to Aboriginal and Torres Strait Islander health and substance misuse”⁷² with 17 members from DHAC, ATSIC, NACCHO, and state/territory Aboriginal Health Units. On 16 March 2005 Parliament passed the ATSIC Amendment Bill repealing provisions of the ATSIC Act, and in particular abolishing ATSIC.

Australia, Current

The Government’s DHAC remains the national policy coordinator on the ATSI health file. Both the mainstream Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) for disadvantaged Australians which ATSI populations are accessible as well the funding for Aboriginal Community Controlled Health Services (ACCHS). The department also has an Office of Aboriginal and Torres Strait Islanders Health (OATSIH) who basically funds “other” associated organizations and their programs (ie: the Commonwealth provides partial funding for “hospital services, mental health and other health services”).⁷³ Despite the Commonwealth’s role as funder, state/local governments still contribute the majority of

⁷¹ Auditor General (1998), *supra* note 69 at 4.

⁷² Auditor General (1998), *ibid* at 45.

⁷³ Auditor General (1998), *ibid* at 18.

expenditure on ATSI health.⁷⁴ Commonwealth provides 80 percent of the funding for Aboriginal health programs but is only directly involved with the provision of services through the Aboriginal Community Controlled Health Services and the MBS and PBS.⁷⁵

The Primary Health Care Access Program (PHCAP) aims to establish a framework for the expansion and regional coordination of comprehensive primary health services for ATSI. In addition, the States and Territories have an important role to play in ATSI health as contractors to provide additional health services.⁷⁶

In 2008, then Prime Minister Kevin Rudd apologized to the Indigenous peoples of Australia and in particular to the Stolen Generations.⁷⁷ In 2010 the Prime Minister reported on the Gaps that were identified between Aboriginal and non-Aboriginal health and reported substantial progress on closing the health gaps.⁷⁸

New Zealand

As early as 1900 the *Maori Councils Act* created public health programs for the Maori population, largely in response to the tireless efforts of the class of young, highly educated Maori which emerged at that time.⁷⁹ Three Maori leaders were prominent in bringing about vast improvements in Maori health and well being. [Apirana Ngata](#) (organising secretary of the Maori Councils), Dr. [Maui Pomare](#), who became the first Maori Health Officer in 1900, and [Peter Buck \(Te Rangihiroa\)](#), also a doctor, became assistant to Maui Pomare.⁸⁰ These three reformers brought about significant improvements in Maori health and life. By 1920, Peter

⁷⁴ Auditor General (1998), *ibid* at 17.

⁷⁵ Auditor General (1998), *ibid* at 17.

⁷⁶ Auditor-General (2002) *Audit Report No 15. The Aboriginal and Torres Strait Islander Health Program Follow-up Audit* Canberra: Australian National Audit Office [Auditor General (2002)] at 22.

⁷⁷ See, Apology to Australia's Indigenous People Speech, online: http://www.aph.gov.au/house/rudd_speech.pdf (accessed July 24, 2010). See also, Reconciliation Network, Stolen Generations Fact Sheet, online: <http://reconciliation.org.au/nsw/education-kit/stolen-generations/> (accessed July 24, 2010).

⁷⁸ See Australian Government, Closing the Gap, 2010, online: <http://www.fahcsia.gov.au/sa/indigenous/pubs/general/Documents/ClosingtheGap2010/closingthegap2010.pdf> (accessed July 24, 2010).

⁷⁹ For a good overview of Maori health history see, Linda Bryder & Derek A. Dow, *Introduction: Maori Health History, Past, Present and Future*, online: <http://www.historycooperative.org/journals/hah/3.1/bryder.pdf> (accessed July 26, 2010).

⁸⁰ Sir Maui Wiremu Piti Naera Pomare (1876-1930) of Ngati Mutunga and Ngati Toa; health reformer, politician, and first Maori doctor, see New Zealand History, online: <http://www.nzhistory.net.nz/media/photo/maui-pomare> (accessed July 26, 2010).

Buck (Te Rangihiroa) had been nominated as the first Director of Maori Hygiene and was successful in making substantial improvements to Maori health.⁸¹

For most of its history, however, Maori health services in New Zealand have been provided almost exclusively as part of the mainstream system, largely due to the Treaty of Waitangi provision for full citizenship privileges for the Maori. It was not until the New Zealand Public Health and Disability Act (NZPHDA) 2000 that “for the first time provides measures in health legislation ‘to recognize and respect the principles of the Treaty of Waitangi.’”⁸²

The Maori and the Treaty of Waitangi

The Treaty of Waitangi, with its different English and Maori versions, has three main sections. Article 1 (Kawanatanga) allows the British government the right of government to govern, “qualified by an obligation to protect Maori interests.” Article 2 (Tino Rangatirantanga) guarantees Maori tribal control over their own affairs, a part of which is iwi (tribal) autonomy. Article 3 (Oritetanga) guarantees the Maori equality with other New Zealanders.⁸³ Its purpose:

The Treaty of Waitangi is a unique document. Unlike the Canadian treaties, it was signed at a time when Maori people held most of the land and were many times more numerous than were the settlers. It recognized the prior existence of Maori title, and it did not restrict the exercise of aboriginal government to reserves.⁸⁴

Rather than restricting the Maoris to isolated reserves, Maori government controlled Maori people, without depending on the land base. Given the various translations of this document and the contrasting interpretations the courts have given it over the years, the extent to which this treaty has been successful as a guarantor of rights is debateable.

⁸¹New Zealand in History: The Maori: Dates marking post-colonial Maori History, online: <http://history-nz.org/maori7.html> (accessed July 23, 2010).

⁸² Waitangi Tribunal (2001) *The Napier Hospital and Health Services Report: Wai 692* Wellington: Legislation Direct, online: <http://www.waitangi-tribunal.govt.nz/reports/nieast/wai692/wai692fullreport.asp> at 44 [Napier Hospital].

⁸³ New Zealand Ministry of Health, *Coordinated Care for Maori – Issues for Development* Wellington: Te Kete Hauora, Ministry of Health, online: <http://www.moh.govt.nz/moh.nsf/pagesmh/336?Open> (accessed September 21, 2010).

⁸⁴ Andrew Armitage, (1995) *Comparing the Policy of Aboriginal Assimilation: Australia, Canada and New Zealand* Vancouver: University of British Columbia Press at 140.

The New Zealand Wars broke out in 1860 between Maori tribes and British forces and continued off and on for 10 years until in 1882 King Tawhiao made a formal act of peace.⁸⁵ The foundations of Maori assimilation were found in the Native Department, established in 1861 to govern the Maori and to undercut the powers of the chiefs; the *Maori Land Act of 1862*, which created a court to decide on land issues that was highly biased against the Maori; the *Native School Act* of 1867, which required English instruction only; and the *Maori Representation Act* of 1867 which reserved four seats in the legislature for Maori (much less than their relative size of the population), with a separate Maori electoral roll.⁸⁶

Much of Indigenous policy after these wars was predicated on the third part of the Treaty that gave the Maori full New Zealand citizenship and was therefore almost completely assimilationist. It was not until the late 1960's that the Treaty resurfaced as an empowerment tool. The *Treaty of Waitangi Act*⁸⁷ of 1975 recognized the treaty and established the Waitangi Tribunal to hear Maori grievances but was amended in 1985 to allow cases dealing with grievances going back to 1840. At the same time, there began "Maori control of the Department of Maori Affairs, language and cultural renaissance and move towards social policy based on partnership."⁸⁸ By 1987, the Maori had won the recognition of a fiduciary relationship with the Crown in the Courts and the Royal Commission on Social Policy was emphasizing the importance of treaty obligations and partnership. The Department of Maori Affairs "no longer has as its objective the governance of the Maori people; instead, it has become a Maori run department, the purpose of which is to assert a Maori presence within the New Zealand government."⁸⁹

New Zealand Current

The Maori population suffers a disproportionately lower health status than non-Maori in New Zealand, which includes evidence from high-level indicators such as life expectancy and infant

⁸⁵ New Zealand History, online: <http://www.nzhistory.net.nz/politics/treaty-events-1850-99-treaty-timeline> (accessed September 1, 2010).

⁸⁶ Armitage, *supra* note 84 at 143.

⁸⁷ *Treaty of Waitangi Act* 1975 No 114 (as at 05 August 2009), Public Act.

⁸⁸ Armitage, *supra* note 84 at 146-148.

⁸⁹ Armitage, *ibid* at 147.

mortality; higher rates of many health conditions and chronic diseases, including cancer, diabetes, cardiovascular disease and asthma.

In New Zealand, all health services are delivered through the Department of Health and its District Health Boards (DHB) who plan and manage health care for the population of their district. This includes providing funding for primary health care, public health services, Elder care, and services provided by other non-government health providers.⁹⁰ Primary Health Organisations (PHOs) deliver Government and community priorities for primary health care at a local level. This includes first-level services such as general practice, mobile nursing and community health services targeted at certain conditions. These services include maternity, family planning and sexual health, mental health and dentistry services, or particular therapies such as physiotherapy, chiropractic and osteopathy services. Chronic diseases, such as diabetes, are best managed by primary health care services so that complications can be prevented or mitigated.⁹¹ Maori health and disability providers play a critical role in developing health services that work for Maori. There are approximately 275 Maori health and disability providers nationwide, providing diverse services and delivering them in ways that empower Maori and their whanau to take control of their health and wellbeing.⁹²

Although the Maori health strategy does not call for a separate role/responsibility for Maori people or communities in the delivery of health services, it instead demands that the three principles of the Treaty of Waitangi are to be recognized in health through “working together with iwi, hapu, whanau and Maori communities to develop strategies for Maori health gain and appropriate health and disability service” (Partnership); “involving Maori at all levels of the sector, in decision-making, planning, development and delivery of health and disability

⁹⁰ For more detailed information about key parts of the New Zealand health and disability system see: New Zealand's health and disability system, online: <http://www.moh.govt.nz/healthsystem> (accessed July 26, 2010).

⁹¹ For more detailed information about primary health care in New Zealand, see: Ministry of Health, Primary Health Care, online: <http://www.moh.govt.nz/primaryhealthcare> (accessed July 26, 2010).

⁹² Tatau Kahukura: Maori Health Chart Book 2010 – 2nd Edition, online: [http://www.moh.govt.nz/moh.nsf/pagesmh/10136/\\$File/maori-hth-cbk-2010.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/10136/$File/maori-hth-cbk-2010.pdf) (accessed July 26, 2010).

services”(Participation); and “working to ensure Maori have at least the same level of health as non-Maori, and safeguarding Maori cultural concepts, values and practices” (Protection).⁹³

ALL POLICIES MUST BE A USEFUL REFLECTION OF CULTURAL CORE VALUES OF THE ABORIGINAL PEOPLE TO WHOM THEY TARGET.

In fact, the *Public Health Act of 2000*, which requires Maori representation on the DHBs, is the only direct inclusion of Maori control or special status. Otherwise, the only requirement is that Regional Health Authorities are mandated to “seek to improve the health status of Maori so that they will enjoy the same level of health as non-Maori.”⁹⁴

iii) Three Areas that Require Further Study

The preceding discussion has provided a general understanding of the health delivery systems for Indigenous populations in all four countries. The uniqueness of each country’s specific circumstances has been highlighted. An obvious conclusion that can be drawn from this review is that the complexities of the situation make direct comparisons impossible, and that further, more in-depth research is essential. It is also evident that there are enough commonalities to justify the extrapolation of best practices and lessons learned from each case that may be adapted to improve conditions elsewhere. Three issues are further examined that it is felt will have the greatest impact. There are numerous examples of more specific programs and services which would provide important direction, however further research is beyond the scope of this paper.

MORE INDEPTH RESEARCH IS REQUIRED TO DRAW COMPARABLES BETWEEN EACH COUNTRY TO IDENTIFY GAPS AND COMPARISONS IN ORDER TO GLEAN BEST PRACTICES

⁹³ He Korowai Oranga, Maori Health Strategy, online: [http://www.moh.govt.nz/moh.nsf/0/8221e7d1c52c9d2ccc256a37007467df/\\$FILE/mhs-english.pdf](http://www.moh.govt.nz/moh.nsf/0/8221e7d1c52c9d2ccc256a37007467df/$FILE/mhs-english.pdf) at 2 (accessed July 22, 2010).

⁹⁴ Maori Health Directorate, Te Kete Hauora, Addressing Maori Health, online: <http://www.maorihealth.govt.nz/moh.nsf/menuma/Addressing+Maori+Health> (accessed July 23, 2010).

a) The Rights Dialogue

One of the most remarkable points uncovered by the comparison of the four countries are the different dialogues surrounding health care for Indigenous populations. For example, in New Zealand, the dialogue is generally one of equal distribution of services, while in the other three countries it is one of special services. Additionally the existence of a rights dialogue concerning the provision of health care is critical. In Australia, the debate on health care is not so much linked with that of Aboriginal rights--to self-government, land, hunting privileges; but in New Zealand, Canada and the United States the rights/health debates are intimately linked, although to different degrees and with different results.

THERE ARE SEVERAL IMPORTANT WAYS IN WHICH THE RIGHTS DIALOGUE HAS INFILTRATED THE DEBATE ON HEALTH CARE, AND DISCUSSING ITS IMPACT COULD LEAD TO IMPORTANT LESSONS FOR CANADA THAT COULD IMPROVE THE HEALTH OF ABORIGINAL PEOPLE.

b) Treaty Rights

One of the most interesting results in this comparison is between Australia and the other three countries. In Australia, the fact that the health status of ATSI remains the lowest of all the countries elicits serious questions and warrants serious responses. Different explanations abound, but the one that is most often cited is that of rights recognition. As Ring and Firman contend, it is “difficult to entirely discount the suggestion that the absence of a treaty is a factor in the relative lack of progress in improving Australian Indigenous health. Treaties have appeared to play a significant role in the development of health services, and in social and economic issues, for the Indigenous people of New Zealand, the United States and Canada.”⁹⁵ The information presented in this thesis is insufficient to establish such a causal relationship, but the possibility presents an important direction for future research.

⁹⁵Ian T. Ring and David Firman, (1998) “Reducing indigenous mortality in Australia: lessons from other countries” *Medical Journal of Australia* 169: 528-533.

c) Fiduciary Obligations

As discussed earlier and through out in this thesis, fiduciary obligations have a critical role in Canada for health care for Aboriginal people. Fiduciary obligations are also important in the United States and play a critical role in the debate around the provision of health care.

In the United States “the indigenous vision of trust authorizes and allows both parties, the United States and the tribe, to do only what is diplomatically agreed or consented to. Any unilateral action that adversely affects either party violates the trust.”⁹⁶ As an example, the Cherokee Nation claims that “rights guaranteed to our people through treaties and compacts with the federal government and our status as a sovereign government must be protected and honoured as we consider changes within our nation’s health care system.”⁹⁷ The government position, however, is much different and decisions are made about health care without Aboriginal input and usually in order to limit the amount of money spent.⁹⁸ The federal government acknowledges that “federal health services to maintain and improve health of the Indians are consonant with and required by the federal government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people.”⁹⁹ The government holds that they owe this responsibility only to federally recognized tribes. However, “at least one court has said that insofar as protection of tribal lands is concerned, almost any Indian tribe is a beneficiary of the federal trusteeship, whether the government recognizes it or not.”¹⁰⁰ A further comparison between the United States and Canada and the fiduciary and trust doctrines may provide more discussion in the debate of the provision of health care in these countries.

iv) Summary

This chapter has analyzed policy development from a constitutional perspective and how this might be accomplished. Examples have been provided of how one federal government department has begun the process. Certain principles and broad recommendations were drawn

⁹⁶ Cherokee Nation position paper submitted to the Senate Committee on Indian Affairs, January 31, 1994 quoted in David E. Wilkins, K. Tsianina Lomawaima “Uneven ground: American Indian sovereignty and federal law” Norman: University of Oklahoma Press 2001 at 96 [Wilkins and Lomawaima].

⁹⁷ Wilkins and Lomawaima, *ibid* at 97.

⁹⁸ Wilkins and Lomawaima, *ibid*.

⁹⁹ Hall, *supra*, note 38 at 11.

¹⁰⁰ Hall, *ibid* at 12.

out that must be reflected and developed when rewriting policy to include this constitutional approach. Environmental Health Impact Assessments were also reviewed for their adaptability and applicability for rewriting policy from this constitutional approach. It has been shown that the Assessments may prove to be a valuable tool in this new approach. Health Delivery systems from Canada, the United States, Australia and New Zealand were reviewed in their historical contexts with their common British origins that have provided the backdrop for their current Indigenous health policies. Although a direct comparison between these populations is not useful, a review of the common gaps and similarities are critical to provide information that may be helpful in assessing what works and what does not to improve the health of these Indigenous populations. Three areas were identified and drawn out for their similarities; Aboriginal rights; treaty rights and fiduciary obligations. It is concluded that all three areas require further research for a more complete analysis, which is outside the scope of this thesis but would provide interesting further research.

The following chapter provides conclusions with recommendations for future work in developing a framework for constitutionalized health care for Aboriginal people.

10. Conclusions and Recommendations for Further Study

Historical documents confirm that Aboriginal people were in good health upon the arrival of the Europeans:

Skeletal remains of unquestionably pre-Columbian date... are, barring a few exceptions, remarkably free from disease. While important scourges [affecting Europeans during the colonial period] were wholly unknown... There was no plague, cholera, typhus, smallpox or measles. Cancer was rare, and even fractures were infrequent... There were, apparently, no nevi [skin tumours]. There were no troubles with the feet, such as fallen arches. And judging from later acquired knowledge, there was a much greater scarcity than in the white population of... most mental disorders, and of other serious conditions.¹

What has happened to the health of Aboriginal people in Canada has been studied from different perspectives throughout this thesis. This chapter highlights the practices, solutions and partial solutions to think about when considering the state of Aboriginal health in Canada and how to improve it. Although the urge to “crisis manage” the specific health problems that plague Aboriginal communities is important, pressing and present, any knee jerk or band aid reactions must be avoided while the current system is restructured to encompass Canada’s responsibilities towards Aboriginal health. Moreover, because the health care system is large and complex, change must come from the coordination and combination of work from the people who understand the specific issues and how the system operates in practice within the health care infrastructure. This holistic approach certainly gives rise to the need for additional development and creative thought. Several recommendations, both Action Recommendations and Research Recommendations are provided to help guide change. The Action Recommendations are concrete suggestions concluded from various sections of this thesis. The Research Recommendations list areas that require further study with a view to informing future policy and law making. This chapter concludes with a suggestion for a broad strategic vision to create a new framework for the future for First Nations, Métis and Inuit peoples – one that uses an interdisciplinary approach with the law to incorporate an everlasting change in Aboriginal health.

¹ Ales Hrdlicka, *Disease, Medicine and Surgery Among the American Aborigines*, Journal of the American Medical Association; Vol. XCIX, No. 20, 1937, pp. 1661- 1662 cited in: Virgil Vogel, *American Indian Medicine*, University of Oklahoma Press, 1970 at 159.

Chapters 1 and 2 provided an explanation of who the Aboriginal people in Canada are and reviewed the factors that have contributed to the decline in Aboriginal health. If there was more parity in access of services, it would be reflected in the health of the population. Aboriginal people have great difficulty accessing health services for many reasons including geographical factors, poverty and disability. Therefore, even though chronic diseases may be controlled and reduced in some Aboriginal communities in a very short period of time through high quality, systematic diagnosis and treatment services. As discussed throughout various barriers preclude this from happening.

ACTION RECOMMENDATION # 1

Adequate primary healthcare service are required for prevention and for early diagnosis and treatment of the high levels of illness and illness precursors that are already present in much of the Aboriginal populations. **Access to quality health care is critical to reduce morbidity and chronic disease levels in Aboriginal communities.**

Therefore, national programs are required to: a) further develop community controlled primary healthcare services at a funding level, that is indexed proportionately to the higher level of need and b) through national training programs to produce Aboriginal health professionals to deliver these services as well as to train culturally competent non-indigenous practitioners.

Chapter 3 reviewed the current state of Aboriginal health and discovered that extreme health disparities exist in Canada between Aboriginal people and the rest of the population. Sky rocketing rates of tuberculosis, chronic diseases and social diseases such as violence and suicide are rampant in Aboriginal communities. Communicable diseases are flourishing in Aboriginal communities and the prison system.

ACTION RECOMMENDATION # 2

Arguably, the simplest way to address the inequities in Aboriginal health may be to **reduce the inequities in the health determinants—the social and economic inequities**. This strategy could catalyze any number of opportunities for improving the grim health outcomes that Aboriginal people face today.

Therefore, a review of the funding allocations in relation to the requirements of the Aboriginal communities must occur at the government level. The political will must be present to develop, implement and sustain any changes in funding standards.

Chapter 3.2 reviews the health statistics of Aboriginal women. The health status of Aboriginal women is crucial in determining the health of a community. Women are most often the center of the household. They are the primary caregivers of children, families, and the elderly, and they most often deliver health care services to family and community members. In spite of these important roles, Aboriginal women experience high rates of suicide, diabetes, obesity and a shorter life span than non-Aboriginal women. The life experience continues to be one of violence, discrimination, inequality, sexual harassment and repression.² In her keynote address, The Honorable L’Heureux-Dubé of the Supreme Court of Canada spoke out about violence against women as an “an assault upon human dignity and a *constitutional denial* of any concept of equality for women”³ (emphasis added); this denial may be seen through the *Charter* lens and the section 35(4) lens of the *Constitution Act, 1982* which, in addition to the Aboriginal and treaty rights that are constitutionally entrenched into s. 35 additional guarantees of equality to both men and women are found in s. 35(4). The *Charter* is discussed in Chapter 6.2 and the equality guarantees of s. 35(4) are discussed in Chapter 8.6.

ACTION RECOMMENDATION # 3

To ensure equality between women and men, all policy and drafting of laws must reflect a culturally relevant gender based analysis at the first planning or developmental stage.

Therefore: government must ensure that these gender principles are met to ensure they are in compliance with the gender equality requirements in the *Charter* and s. 35(4).

Chapter 4 looked at the healing practices that formed early Aboriginal society. Although Aboriginal medical systems have often been misunderstood, disrespected, and undermined, they embody “sets of coherent beliefs and practices that were well integrated within society which served important social, religious as well as medical functions.”⁴ As O’Neil and Postl

² Canadian Association of Elizabeth Fry Societies, “Women Don’t Belong in Cages” *Canadian Association of Elizabeth Fry Societies*, online: Canadian Association of Elizabeth Fry Societies, <http://www.elizabethfry.ca/poster.htm> (accessed September 5, 2009).

³ Honourable Claire L’Heureux-Dubé, “Relationship Recognition: The Search for Equality” *Discussion Forum on Relationships and the Law* (July 7, 2000), online: The Law Reform Commission <http://www.lawlink.nsw.gov.au/lrc.nsf/pages/seminar01.01> (accessed October 15, 2010).

⁴ J. Waldram, D.A. Herring, T.K. Young, *Aboriginal Health in Canada. Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995) at 99.

note, much of what was written by the explorers and missionaries was presented from their vantage point. They did not share the world view of those they observed. As a result, they failed to see Aboriginal medicine in its own terms—as practiced by its own practitioners.⁵

Aboriginal healing practices were comprised of intricate ceremonies, which served to cement these practices into laws of their respective societies. Evidence supports the conclusion that therapeutic ceremonies and healing practices were integral to the existence of Aboriginal society. The Jesuits, the explorers, and the traders who witnessed and wrote about these practices acknowledged their integral importance in the healing practices of Aboriginal people.

ACTION RECOMMENDATION # 4

For a useful and holistic approach to health and healing, it is important that traditional methods be utilized in conjunction with western health care.

Therefore: using practices from established health care models, implement blended models of traditional and western approaches for more effective Aboriginal health care.

Chapter 5 reviewed historical health influences that shaped the health status we see today. Epidemics, nutrition and starvation were reviewed in Chapter 5.1. For Aboriginal people, abandoning a high protein diet and having to adopt a diet of refined foods (and near starvation) has had devastating intergenerational effects that may have long lasting epigenetic effects. Chapter 5.1.3 reviewed genetic changes due to nutritional deficiency and introduced the term “epigenetic” which is used in biology and refers to the inheritable changes in gene function that occur without a change in the DNA structure of a human being:

Epigenetic features are inherited when cells divide despite a lack of change in the DNA sequence itself and, although most of these features are considered dynamic over the course of development in multicellular organisms, some epigenetic features show transgenerational inheritance and are inherited from one generation to the next.⁶

⁵ John D. O’Neil and Brian D. Postl, “Community Healing and Aboriginal Self-Government: Is the Circle Closing?” in John H. Hylton ed. *Aboriginal Self-Government in Canada: Current Trends and Issues* (Saskatoon: Purich Publishing, 1994) at 79-80.

⁶ KG Mathew, Praveen Agarwal, *Medicine: Prep Manual for Undergraduates* 3rd ed. (Elsevier: New Delhi, 2007) at 608.

The *Dutch Hunger Winter Study* was used to compare the effects of starvation on the fetus and the resulting health outcomes. It appears that there may be useful application of those results to the starvation and health outcomes of Aboriginal people, this should be studied further.

RESEARCH RECOMMENDATION # 1

Genetic changes due to starvation and nutritional deficiency may be present in the Aboriginal population.

Therefore: The link between starvation and genetic modification and poor nutrition and genetic modification, should be funded, researched, explored and analyzed.

One approach to disease prevention is through nutrition therapy and control. The simple reduction in high fat, high carbohydrates and refined sugars leads to better health and a reduction in chronic diseases. An increase in physical activity also leads to better health when coupled with this healthier diet.

RESEARCH RECOMMENDATION # 2

Good nutrition and adequate exercise is important for good health. High rates of obesity and diabetes results from poor diet and sedentary lifestyles.

Therefore: The effects of diet and the reduction of chronic disease should continue to be monitored and evaluated and studies funded.

ACTION RECOMMENDATION # 5

Education programs and exercise programs should be implemented at the community level and delivered at the community level. Models that are currently underway should be reviewed and implemented throughout Canada in Aboriginal communities.⁷

⁷ An example of healthy living that promotes exercise with proper nutrition is Cree/Métis Theresa Ducharme who is a certified Personal Trainer Specialist on a mission. Theresa visits various Cree communities and organizes local women to work out with yoga and pilates as well as promoting nutritional counseling and portion control. Theresa motivates the women in the communities to become the trainers of the future for their community. The goal is to have trainers in each Cree Community in Quebec. They are starting a fitness movement in the Cree territory. Because this program is Aboriginal designed and Aboriginal controlled, it is seeing remarkable success in a short period of time. Ducharme's program not only consists of exercises but also incorporates the physical, the mental, the emotional and the spiritual aspects of the individual. See, Nation Magazine, Volume 17, No. 24, October 8, 2010, online: <http://www.nationnews.ca/images/stories/Nation-17-24.pdf> (accessed October 18, 2010).

Chapter 5.1.2, not only discussed illness, but also presented some evidence that indicates that the rations dispersed at Belly Butte and Ghost Coulee during periods of starvation may have been deliberately or inadvertently poisoned.

RESEARCH RECOMMENDATION # 3

Further research and fact finding is warranted and possible archeological research and analysis into the cause of these deaths.

Chapter 5.2 reviewed health services and legislation affecting Aboriginal health and found the midwifery legislation especially conflicting. The devastating effects of lack of maternal and childbirth care in the north cannot be overemphasized. The problems that Inuit mothers encounter from the confusing and discriminatory midwifery legislation have proved devastating to generations of families in the North.

ACTION RECOMMENDATION #6

Competing midwifery legislation in Canada is problematic and requires a thorough examination to determine if the loss of traditional birthing and legal liabilities are s. 35 breaches.

Therefore: an analysis of the current legislation must occur with a view to ensuring Aboriginal and treaty rights are not only respected but implemented in a Canada wide systemic approach encompassing all provinces and territories.

Chapter 5 also presented a snapshot of atrocities hoisted upon children, youth and adults in the residential school system through sterilizations and various non-consensual experiments. Colonization consisted of various government policies and laws that were implemented to assimilate Aboriginal people into the mainstream society that were destructive to their physical and social fibre and certainly a contributing factor to the current poor health status of Aboriginal people.

Residential schools were an ideal tool of colonization. The children were forcibly removed from their parent's home and sent away to residential schools where many endured physical and sexual abuse at the hands of those in charge of the schools. The children were forbidden to

speak their languages or practice their cultures; they were punished for trying to speak to their brothers and sisters. The children forgot how to live in a family. The parents filled with grief at the loss of their children, fell into a dark despair and lost their ability to be a good parent.⁸ The collective nature of the assault on Aboriginal identity and culture has been described as nothing less than cultural genocide. The Aboriginal Justice inquiry noted that now for the **first time in 100 years**, Aboriginal families are experiencing a generation of children who live with their parents until their teens.⁹

Today, the consequences of the policy of forced assimilation are very much alive in Aboriginal communities. As a result of these institutional abuses suffered in the past, Aboriginal people today suffer from the many effects of unresolved trauma, including but not limited to:

- lateral violence (when an oppressed group turns on itself and begins to violate each other;
- suicide;
- depression;
- poverty;
- alcoholism;
- lack of parenting skills;
- lack of capacity to build and sustain healthy families and communities.¹⁰

Thousands of former students have since come forward to claim that physical, emotional, and sexual abuse was rampant in the school system and that little was ever done to stop it or to punish the abusers. Some have described the residential school system as “institutionalized pedophilia” at the hands of priests, nuns, staff, and other children.¹¹

ACTION RECOMMENDATION # 7

There are still a great many misconceptions about the residential school system among the non-Aboriginal population. It is important to dispel the myths that surround residential schools and to educate the general public.

Therefore: Curriculum in all public and private schools across Canada must include a course on Aboriginal people, the beauty of the societies, laws and culture and the ensuing devastation caused by colonialism.

⁸ See, Chapter 5.2.2.

⁹ Aboriginal Healing Foundation, “Misconceptions of Canada’s Indian Residential School System,” online: <http://www.ahf.ca/publications/residential-school-resources> (accessed September 10, 2010).

¹⁰ Aboriginal Healing Foundation, online: <http://www.ahf.ca/faqs> (accessed September 10, 2010).

¹¹ Assembly of First Nations, *Residential School Update* (Ottawa: Assembly of First Nations, 1998).

The indignities suffered through the residential school system were compounded by the forced sterilization of children and young adults certainly added to the poor state of Aboriginal health. Chapter 5.2.3 examined the legislative history of eugenics and how this legislation inadvertently targeted Aboriginal people. Although sterilization legislation may have allowed residential school officials, who stood *in loco parentis* to their charges, to sterilize children, it is unknown at this time how many children were sterilized by virtue of school officials acting in that capacity. Additionally, it is unknown if the Crown ever acted in its capacity as *parens patriae* to exercise its jurisdiction to intervene on behalf of a child or “mentally incompetent person” if they had the requisite knowledge. We do know from the information gleaned from the Access to Information Request of 2007, that sterilization violations have become part of residential school claims.¹²

RESEARCH RECOMMENDATION # 4

Further research should be conducted in this area to determine if any common law torts have been committed and what the extent of section 35 breaches are - to determine if there are any responsibilities of the Crown and if they acted as *parens patriae* and sterilized Aboriginal people under this power.

ACTION RECOMMENDATION #8

To learn lessons from the history of the past.

The discriminatory sterilization of women today who have given birth to babies who suffer from FASD is outdated. Yet there is a call for this by some in the community today. This policy to sterilize “at-risk” women would seem to apply to all mothers equally. In reality, however, Aboriginal mothers would be sterilized in far greater numbers, disproportionate to their percentage of the total population. Addictions are classic symptoms of historical unresolved grief and trauma and ongoing race-based social injustices. To use addictions as a justification for preventing births in a distinct cultural, national group is arguably a form of genocide according to the UN’s definition. Such a policy of sterilization would certainly allow the dominant society to avoid holding itself accountable for the systemic causes of addictions among Aboriginal peoples.

Therefore: Strong opposition must occur to blockade this type of thought and action. Working in unison with Aboriginal people will assist in creating viable solutions.

¹² Document 2-81887, Letter from Susan Ayala, Aboriginal Law Services, Department of Justice Canada to Merchant Law Office: Bruce G. Neill discussing the joinder issue. Access to Information Request of December 2007.

On the issue of murdered and missing women, Aboriginal women, by virtue of being born Aboriginal in Canada, are at a great risk of disappearing or being murdered as noted in Chapter 5.2.5.

RESEARCH RECOMMENDATION # 5

Partnerships between Aboriginal women's organizations and Public Safety Canada should make a concerted effort to identify how to keep Aboriginal women safe. **Therefore:** A research study into how Aboriginal women have managed to stay safe (and resilient) is warranted. Results and tool kits should be made available to every Aboriginal woman in Canada.

Chapter 6 through 8 reviewed laws that have contributed to the state of ill health and reviewed how law and health are interconnected.

Chapter 6.1 reviewed Canadian constitutional governance and how it was established, and how powers were delineated between the federal and the provincial governments. At the time (Confederation), the British Parliament omitted any mention of Canada's legislative power over health and health care. As a result, health does not expressly fall under the ambit of either the federal or the provincial governments. Because the Constitution is silent on health, the courts have defined (and continue to define) how governmental powers should be distributed to meet health needs. Although the Constitutional silence on matters of health and the provision of health care is problematic generally, it has been a colossal jurisdictional problem for Aboriginal people.

Section 91(24) of the *Constitution Act, 1867* provides that the federal government has constitutional authority and responsibility for "Indians, and Lands reserved for the Indians." Judicial interpretation of the Constitution has determined that the Inuit are a federal responsibility.

The provinces have primary responsibility for health care delivery for Métis and non-status Indians, which is no different from their responsibility to non-Aboriginal Canadians. Since the Yukon, Nunavut, and the Northwest Territories are under federal jurisdiction, each territory is responsible for delivering health care services to all of their respective residents, including non-Aboriginal peoples living within their jurisdictions. Within this general framework,

jurisdictional problems, conflicts, and ambiguities of enormous proportions have arisen and have had devastating effects on Aboriginal health, both historically and currently.

Health and health care issues cut across federal, provincial, and territorial jurisdictions and permeate important constitutional law principles. Constitutional law prescribes how the federal and provincial governments exercise their powers (including any limitations) through the legislative, executive, and judicial powers. A country's constitution has been described as reflecting the soul of the nation, because its job is to recognize and protect the nation's values.

While Chapter 6.1 considered how the constitutional division of powers and the ensuing conflicts over jurisdiction has created havoc with Aboriginal health, associated laws and policies and the histories shed light on the present and can be instructive for creating a different legal framework for the future. Without question, Canada's legal framework and its history link directly to the current realities of ill health for Aboriginal people, particularly in relation to jurisdiction realities. Chapter 6.3 reviewed the tragic life circumstances of Jordon River Anderson, who died while the Provincial and Federal governments argued about minutia and who was responsible for paying for Jordan's showerhead.¹³ Jordon never did make it home and neither have many other children who have been excluded from the health care that other Canadian children are entitled to, by virtue of the fact that they live on reserve.¹⁴

¹³ Cindy Blackstock, presentation at University of Ottawa, September 22, 2010.

¹⁴ In the news of September 23, 2010 the CBC reported that "G-20 Costs included 1-day, \$2.2 M car rental bill." The Order to the House of Commons Q-349 also reported that they spent:

- \$1,1097,966.00 on tent rental
- \$11,050.00 on box lunches
- \$85,500.00 on "Bednights at Deerhurst Resort"
- \$491,650.00 on Project Manager Services
- \$282,419.00 on "Geomatics requirement" through a sole source transaction
- \$3.2 million dollars on shuttle busses
- \$68,340.00 on Nikon cameras

CBC News, *G20 Costs included 1-day, \$2.2 M car rental bill*, September 23, 2010, online: <http://www.cbc.ca/canada/story/2010/09/23/g20-g8-summit-costs.html> (accessed September 23, 2010).

ACTION RECOMMENDATION #9

To save the lives of those who cannot speak for themselves and to equalize health care between Aboriginal and non-Aboriginal children, funding must be reallocated.

Therefore: the political will must be present to change the priorities of the government – to re-funnel the appropriate resources to save children’s lives and to prevent women from “disappearing” and when they do – to allocate the resources to find them quickly.

ACTION RECOMMENDATION #9 (A)

The public must be educated about the Jordan Principle and supported by the federal and provincial and territorial governments.

Without naming health specifically, several sections of the Constitution can nonetheless impact Aboriginal health. The *Constitution Act, 1867*, determined that health matters outside of Indian jurisdiction in s. 91(24) may be found in several subsections of s. 92. Chapter 6 also reviewed federal legislation designed to assimilate Aboriginal people into non-Aboriginal society such as the *Indian Act*, including its impacts upon traditional healing practices and its devastating effects on the health and well being of Aboriginal women, families, communities and Nations. Federal legislation from 1869 to 1985 determined a person’s *Indian Act* status as well as band membership and determined who would or would not live on reserve. When a woman married a man from another band, she automatically transferred to her husband’s band. The effects of forced enfranchisement have been devastating. Not only did the Act identify those who could live on reserves, it also defined an Indian as "a male Indian, the wife of a male Indian or the child of a male Indian." Indian women who married outside of their band were stripped of their status and could not pass it onto their children. Indian men who married gave their status and band membership to their wives, children, and grandchildren. These patrilineal lines of status are still entrenched in current *Indian Act*.

Although a 1985 amendment was made to the *Indian Act* through Bill C-31, it did little to ameliorate discrimination. As a result of Bill C-31, Indians who never lost status can pass their status to their children and grandchildren, while Indians who have a second class (and diminished) status can pass their status down to their children, but not to their grandchildren.

Recently, Sharon McIvor was successful in arguing that the *Indian Act* violates the equality guarantees in section 15 of the *Canadian Charter of Rights and Freedoms* she took her case to the B.C. Supreme Court in 2007 and to the B.C. Court of Appeal in 2009. Both courts confirmed that the status provisions of the *Indian Act* violate the equality guarantees of the *Charter*.

Consequently, the federal government is in the process of amending the *Indian Act*, much like it did with Bill C-31—that is, unilaterally and without the input from the people whose lives the Bill affects. On March 11, 2010, Bill C-3 *Gender Equity in Indian Registration Act* was introduced to remedy the sex discrimination in the status registration provisions of the *Indian Act*. If this Bill passes, the discrimination against Aboriginal women will continue.¹⁵

ACTION RECOMMENDATION #10

In order to solve membership problems encountered by the Indian Act, the government must adequately and meaningfully consult with First Nations to provide solutions to these problems.

Chapter 6 also detailed Aboriginal healing practices and how Canadian legislation severely limited the use of these practices and, in some cases, criminalized them. Aboriginal healing practices were labelled “witchcraft and idolatry.” They were ridiculed, denounced, prohibited, suppressed, and invalidated. Western-based health care practices became dominant and Aboriginal healing practices were suppressed. The *Report of Royal Commission on Aboriginal People* describes how this dominance began and then took form in legislation prohibiting Aboriginal health practices. The RCAP Report states that many Elders and healers were prosecuted under this law. As a result, Aboriginal Peoples were stripped of “self-respect and respect for one another.” These discriminatory laws left a legacy that damaged the essence of Aboriginal communities—the Elders, healers, families, and generations of Aboriginal people. Declining health has been a resulting inevitable outcome.

¹⁵ On December 15, 2010 Bill C-3: *Gender Equity in Indian Registration Act* received Royal Assent and came into force on January 31, 2011. See, Canada, INAC, online: <http://www.ainc-inac.gc.ca/br/is/bll/index-eng.asp> (accessed April 23, 2011).

Chapter 6 also described the Codex Alimentarius that is being implemented from an international perspective which will move all natural products in the pharmaceutical category and require pharmacists to dispense all natural health products. Health Canada is regulating natural health products through Bills 51, 52, 6 and now Bill C-36 to accomplish the Codex purpose as well as regulating information, including the authority to collect, use and disclose information. Without adequate consultation, the government may not only breach its fiduciary obligations through their regulatory approach but the regulation may result in the permanent destruction of Indigenous knowledge, traditional practices, and medicines.¹⁶

RESEARCH RECOMMENDATION #6

To get a clearer picture of how these Health Canada regulations and the Codex Alimentarius will affect the collection of natural medicines and how it will affect people who practice traditional medicine, these issues must be explored and more research conducted with legal analysis. This is a pressing issue.

Chapter 6.4.3 reviewed the *Criminal Code of Canada* provisions. Under subsection 91(27) of the *Constitution Act, 1867*, the federal government has jurisdiction over "[t]he Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters."¹⁷ It may seem odd to rely on the criminal law power to support public health, but where public health regulations are concerned, the criminal law power can be useful. The public needs protection against wrongdoings such as tainted food, advertising tobacco to minors, and false therapeutic claims for medicines.¹⁸

However, Aboriginal healers can face serious problems in this area. Anyone who provides medical services to individuals in Canada may be exposed to some level of criminal liability for their actions. The legislation does not exempt Aboriginal traditional healers. In fact, because of

¹⁶See, Health Canada, "Overview of the Natural Health Products Regulations Guidance Document," online: http://www.hc-sc.gc.ca/dhp-mps/prodnatur/legislation/docs/regula-regle_over-apercu-eng.php#1 (accessed October 15, 2010).

¹⁷ *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c.3 s.s. 91(27), reprinted in R.S.C. 1985, App. II, No. 5.

¹⁸ See, *RJR-MacDonald v. Canada (A.G.)*, [1995] 3 S.C.R. 199, 127 D.L.R. (4th) 1; *R. v. Wetmore*, [1983] 2 S.C.R. 284, 2 D.L.R. (4th) 577 [cited to S.C.R.].

the nature of Aboriginal traditional medicine—its unwritten traditions and the lack of visible internal or external regulation—traditional healers may find themselves vulnerable to criminal prosecution.

In addition to the liability outlined in existing legislation, such as the *Food and Drugs Act* and the Natural Health Products Regulations,¹⁹ the Crown may use the several sections of the *Criminal Code* to prosecute traditional healers. Generally, prosecution occurs when a patient suffers injury during the course of treatment. Additionally, the *Controlled Drugs and Substances Act*²⁰ regulates a number of substances that may include those used by traditional healers. The legislation makes it illegal for anyone other than provincially licensed medical practitioners to dispense controlled substances. Provincial governments do not have constitutional jurisdiction to directly regulate Aboriginal traditional healers (and arguably, may be seen to breach s. 35 rights if they do and rights are infringed). Traditional healers may get caught in the provincial regulatory scheme. Unless they also qualify as some other type of medical practitioner licensed provincially, traditional healers are not subject to or nor should they be required to comply with this statute.

Aboriginal healers may find themselves in conflict with various provisions of the *Controlled Drugs and Substances Act*, such as trafficking in substance (s. 5) and importing and exporting (s. 6). The basis for this conflict is that the medicine(s) used in traditional and ceremonial practices may fall within a list(s) of controlled drugs or substances. Traditional healers have reason to be concerned. Among reported cases, Aboriginal people have, in fact, been charged under the *Criminal Code* for a variety of offences that arose in connection with their healing work.

A conflict also arises between the evidentiary laws and the Aboriginal laws and practices that govern “traditional medicine peoples” and healers. For example, in some cases where a healer

¹⁹ Canada Gazette. (2003a). *Food and Drugs Act. Natural Health Products Regulations*. (Part II, 137(13). June 18). See also, Canada, Health Canada, Natural Health Products Directorate, 2010, online: <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/nhpd-dpsn/index-eng.php> accessed September 10, 2010).

²⁰ *Controlled Drugs and Substances Act*, S.C. 1996, c-19.

is working within a sweat lodge, the confidentiality of what was spoken in the sweat lodge remains within that ceremony. The moral, ethical and spiritual aspect compels them not to share the sacred. This remains the case even if a judge, doctor, psychologist or anyone else is interested in what was said in the ceremony.

RESEARCH RECOMMENDATION #11

The issue of “Privilege” and compelling of a healer to testify in court is a topic that requires additional review. **Therefore:** Research and legal analysis is required to provide guidance to the courts and to Aboriginal Peoples on this topic.

Generally, Aboriginal healing practices and traditional medicines are not recognized through legislation. The use of the Canadian legal system as a means of regulation of traditional healing is generally considered unsatisfactory. Healers, educators and communities have resisted the regulation of traditional practices. This resistance is expected to continue, particularly given that the Canadian legal system has clashed with the systems and beliefs of Aboriginal peoples.

Chapter 7 examined Aboriginal and treaty rights in relation to its confirmation in Canadian law through s. 35 of the *Constitution Act, 1982*: “existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.”²¹ These ‘existing’ rights are affirmed at face value without definition or providing a reference to the sources of the rights.

Aboriginal rights are inherent to Aboriginal people in Canada and are derived from Aboriginal knowledge, heritage and law.²² These rights have been practiced since time immemorial and are evident in the practices of Aboriginal people and Aboriginal society. A large body of historical evidence confirms that the explorers, missionaries, and traders witnessed healing practices by the people they encountered. Aboriginal healing practices cannot be dismissed as merely incidental to Aboriginal society in the pre-contact period. The documented operations of these pre-contact and pre-control practices affirm an Aboriginal right to health and an Aboriginal right to achieve and maintain health by traditional Aboriginal means. Europeans did not teach Aboriginal people how to heal or practice healing methods; these methods of healing

²¹ *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

²²M. Battiste & J.Y. Henderson, *Protecting Indigenous Knowledge and Heritage: A Global Challenge* (Saskatoon: Purich Publishing, 2000) at 212.

and health-preserving ways were already in existence when the Europeans arrived in North America. The fact that these methods were in existence before contact (or Crown assertions of sovereignty) proves they are an integral element of Aboriginal society and has met any common law tests the Supreme Court of Canada has directed that determines an Aboriginal right

In addition to Aboriginal rights, some First Nations also possess treaty rights. A treaty is an agreement and an exchange of promises between the Crown and the Indian Nations who signed the treaties. Treaties must be considered within the context of the historical ceremonies and the assurances of friendship and brotherhood and of the Queen's concern for her Indian subjects which were such a prominent feature of the historical treaty negotiations. The treaties must be interpreted not only in cultural and historical terms, but within the context of a modern and ever changing Canada.

Treaties are legal instruments of Canadian law, international law and the law of the Indian signatories.²³ The purpose of the treaties was to ensure peaceful relations, military alliances, and trade as well as for the British sovereign and Canadian governments to provide protection and services for Aboriginal people.²⁴ Some treaties supplement the Aboriginal right to health care such as the medicine chest clause and the pestilence and famine clause of Treaty 6. Other treaties contain references to medicine, health care and protection (written and verbal texts of Treaties 6, 7, 8, 10 and 11). These protections continue to exist today in modern forms and have evolved and manifested themselves into the modern provision of health care.

The *Report of the Royal Commission on Aboriginal People* stated that it is “indisputable, however, those existing treaties have been honoured by governments more in the breach than in the observance.”²⁵ The Report concluded that the treaty relationship between the Treaty Nations and Canadian government are “mired in ignorance, mistrust and prejudice. Indeed, this

²³ James Sákéj Youngblood Henderson, “Treaty Rights in the Constitution of Canada” (Carswell: 2007).

²⁴ J.Y. Henderson, “Treaty Rights to Health” (2002) [unpublished, Native Law Centre, University of Saskatchewan] at 15 [Treaty Rights to Health]. See also H. Cardinal & W. Hildebrandt, *Treaty Elders of Saskatchewan* (Calgary: University of Calgary Press, 2001) at 31–38.

²⁵ Canada, *Report of the Royal Commission on Aboriginal Peoples* (Ottawa: Communication Group, 1996) at vol. 2(1) at 3 [RCAP].

has been the case for generations.”²⁶ The dishonoured treaties are part of the negative “ghosts” of Canadian history.²⁷ Although small steps have occurred, treaty obligations and rights of Aboriginal people remain unfulfilled while Aboriginal health continues to suffer.

ACTION RECOMMENDATION #11

In spite of possessing the identical rights to health care that all Canadians possess by virtue of being Canadians Aboriginal people possess in addition Aboriginal and treaty rights to health that are protected by the *Constitution Act, 1982* and yet Aboriginal health is in crisis. The government has not fulfilled its obligations in relation to Aboriginal rights to health or treaty promises relating to health. In light of disparities in outcomes in standards of health, it is clear that past and present government legislation, policies, actions and inaction have adversely impacted upon Aboriginal people with devastating results. It is untenable to think that Aboriginal people have either agreed to accept this, or that the Canadian government is removed from its constitutional obligations with respect to Aboriginal and treaty rights. **Therefore** in light of the constitutional obligations and judicial interpretations surrounding Aboriginal and treaty rights, lawmakers and policy-makers should be compelled to accept the existence and implementation of Aboriginal and treaty rights to health in Canada and implement them in laws, policies and procedures that will have a positive effect on the outcome of Aboriginal health in Canada.

Further, the connection between medical care and treaties creates a fiduciary duty to provide this care,²⁸ as well as a reasonable and legitimate expectation to receive supplemental medicines and health care in its modern form.

Chapter 8 reviewed fiduciary law and discovered that in addition to the positive duty to act as a fiduciary there logically may be obligations that would result from inaction as well. So there is not only a duty that flows but a fiduciary duty may be found in the situations of inaction or omissions to act. Ignoring the fiduciary duty may give rise to a breach in law as well. In other areas of law omissions are recognized breaches, for instance a criminal offence may consist of a failing to act when there is a duty; or the tort law of negligence recognizes that the failure to act may be seen as a breach of this lawful duty. The concept of fiduciary duty and the duty to consult and accommodate should also be extended to omissions and applied in the case of the government not providing adequate health care and services to Aboriginal people in Canada.

²⁶ *Ibid* at vol. 2(1) at 38.

²⁷ *Ibid*, See, *People to People, Nation to Nation, Highlights from the report of the Royal Commission on Aboriginal Peoples* (Ottawa: Minister of Supply and Services Canada 1996) at 5.

²⁸ Treaty Rights to Health, *supra* note 24.

RESEARCH RECOMMENDATION #7

Using the Criminal Code of Canada sections as a template that detail crimes of omission, such as the mischief section 430 (5.1) which states: “Every one who wilfully does an act or wilfully omits to do an act that it is his duty to do...” as well as the case of criminal negligence in section 219(1) “Every one is criminally negligent who (a) in doing anything, or(b) in omitting to do anything that it is his duty to do...”

Therefore: the concept of fiduciary duty and the duty to consult and accommodate should be extended to omissions. This must be researched, studied and analysed and extended to the provision of health care for Aboriginal people.

Chapter 9 reviewed Aboriginal health policies that continue to reflect the political trust theory long rejected by the courts, i.e., that Aboriginal Peoples are incapable of making decisions on their own behalf. Such policies were developed pre-*Guerin* but continue today despite constitutional legal Aboriginal rights entrenchment and reform. The age-old approaches still relied upon in developing new policies have not helped in equalizing Aboriginal health in Canada; in fact, they have been the overarching source of Aboriginal health problems. There is however a precedent example provided through the First Nations and Inuit Health Branch’s *Aboriginal Child’s Rights Special Needs Focus*. It ensures that the constitutional obligations of the federal government are listed and implemented in relation to children’s rights. It is a starting point for the correct development of policies relating to Aboriginal health. It is an Aboriginal health rights based approach.

ACTION RECOMMENDATION #12

Using the federal government document “*Aboriginal Child’s Rights Special Needs Focus*” expand and develop this policy for future implementation in all Health Canada’s policies that affect Aboriginal Peoples in Canada.

Chapter 9 also reviewed the Health Impact Assessment process that uses a wide model of health factors and works across sectors to provide a systematic approach for assessing how a health proposal affects a population, with particular emphasis on the distribution of effects

between different subgroups within the population. Recommendations can specifically target the improvement of health for vulnerable groups.

It is possible to apply these same principles to programs, policies, laws, legislations and projects that affect Aboriginal health. At the very least, there is great value to be gained through its application within the most dire health circumstances. For example, a screening could occur with a checklist to monitor how far ranging the impacts are, when Aboriginal and treaty rights are affected and what the long term impacts could be. This could include the Haudenosaunee principles of “the effect of their decision on peace; the effect on the natural world; and the effect on seven generations in the future.”²⁹

ACTION RECOMMENDATION #13

The Health Impact Assessment can prove a useful holistic tool for assessing how certain programs and policies are affecting Aboriginal health. **Therefore:** it would be a useful exercise to review the health impact assessment system for consideration to application to Aboriginal health in general.

Chapter 9 also reviewed the health delivery systems for Indigenous populations in the United States, Australia and New Zealand. While the similarities between all four Indigenous populations are clear but direct comparisons are impossible. More in-depth research is essential. It is evident that there are enough commonalities to justify the extrapolation of best practices and lessons learned from each case which may be adapted to improve conditions elsewhere. It is the similarities in the *gaps* that should be studied to compare against each other and how one country has alleviated some of the health problems.

An interesting example gleaned from the Maori includes the Maori core values. Although the Maori health strategy does not call for a separate role/responsibility for Maori people or communities in the delivery of health services, it instead demands that the three principles of the Treaty of Waitangi are to be recognized in health through, “working together with iwi, hapu, whanau and Maori communities to develop strategies for Maori health gain and appropriate health and disability service” (Partnership); “involving Maori at all levels of the

²⁹ Six Nations, *The Oldest Living Democracy in the World*, online: http://www.ratical.org/many_worlds/6Nations/ (accessed October 15, 2010).

sector, in decision-making, planning, development and delivery of health and disability services”(Participation); and “working to ensure Maori have at least the same level of health as non-Maori, and safeguarding Maori cultural concepts, values and practices” (Protection).³⁰

ACTION RECOMMENDATION #14

In order to have meaningful policies and ones that reflect the Indigenous society that they are targeted for it is important that they are comprised of societal values. **Therefore:** The reflection of core values of the Aboriginal people must underlie all policies that affect them and be developed and created by the people who will be using them.

International links are important. The Indigenous peoples in Canada, United States, New Zealand and Australia all have similar colonial histories and also experience a high rate of chronic, communicable disease and social ills. These similarities and contrasts and trends are critical to the exchange of information and to developing research through international links.

RESEARCH RECOMMENDATION #8

In order to improve health through comparisons, a comparative study between the Indigenous populations of United States, Australia, New Zealand and Canada is desirable. **Therefore:** More in-depth research is required to draw comparables between each country focussing on the gaps

Another phenomenon unearthed by the comparisons found in Chapter 9 is the vastly different dialogues surrounding the provision of health care for Indigenous populations in each of the four countries. For example, in New Zealand, the dialogue is mostly one of equal services, while in the other three countries it is one of special services. Most important, however, is the existence of a rights dialogue concerning the provision of health care. In Australia, the debate on health care is not integrally linked with that of Aboriginal rights, whereas in New Zealand, Canada and the United States the two debates are intimately linked. It is possible that the dialogue in which the demand for health care takes place may have an influence on the provision of that care, although the relationship is not a direct one.

³⁰ He Korowai Oranga, Maori Health Strategy, online: [http://www.moh.govt.nz/moh.nsf/0/8221e7d1c52c9d2ccc256a37007467df/\\$FILE/mhs-english.pdf](http://www.moh.govt.nz/moh.nsf/0/8221e7d1c52c9d2ccc256a37007467df/$FILE/mhs-english.pdf) at 2 (accessed July 22, 2010).

RESEARCH RECOMMENDATION #9

There are several important ways in which the rights dialogue has infiltrated the debate on health care, and discussing its impact could lead to important lessons for Canada. **Therefore:** Further research is warranted.

Additionally, in Chapter 9 it is noted that one of the most interesting disparities is that between Australia and the other countries discussed. In Australia, despite innovative approaches like the elected Aboriginal and Torres Strait Islander Commission and the development of community-based comprehensive care, the fact that the health status of ATSI remains the lowest of all the countries elicits serious questions and warrants serious responses. Although there are different explanations, the one that is most often cited is that of rights recognition. The information presented in Chapter 9 is insufficient to establish such a causal relationship, but the possibility presents an important direction for future research.

RESEARCH RECOMMENDATION #10

In order to advance Aboriginal health through treaty relations and to determine if the absence or presence of a treaty is a significant factor affecting Aboriginal health: the causal relationships should be examined between treaty and non-treaty Indigenous nations.

Chapter 9 also called for a strategic vision for mobilizing recommendations into action through a distinction based approach that should be implemented to address the specific needs of First Nations, Métis and Inuit respectively. Sensibly, the 2005 *Blueprint for Aboriginal Health* called for a 10 year transformative plan and called for the recognition of the constitutionally protected rights of Aboriginal Peoples in Canada. The *Blueprint* did not confine itself to health necessities but looked at policy developments from a collaborative, holistic perspective – confirming that there are no “quick fixes”.

To implement strategic Aboriginal health changes, a new Blueprint must be created.³¹

³¹ The Department of National Defence has developed an interesting a model where DND is restructuring on how it does business based upon polls from members and management on how to run the military more effectively. They call the process a “Transformation”. Major John A. MacCaull, Masters of Defence Thesis, Canadian Forces College *Canadian Air Force Transformation Demands Cultural Change*, 29 April 2004, online: <http://www.cfc.forces.gc.ca/papers/csc/csc30/mds/maccaull.doc> (accessed July 23, 2010).

**THE VISION MUST BE
ABORIGINAL HEALTH
STATUS AS A**

**HEALTHY - VIBRANT –
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Aboriginal health certainly needs a restructuring and a Blueprint could be created through several methods, including revisiting the 2005 Blueprint, confidential polling of National Health organizations, regional and community based organizations, tribal councils and communities. Even non-Aboriginal health organizations may have input on how to change the current framework and plan for the future in 1 year, 5 years, and 10 and 20 years. A general vision may be created that is common to all parties and ideas may add to the knowledge base we currently have. Previous history confirms that strategic thinking requires courage and perseverance. It requires courage because courage demands taking a risk and departing from mainstream thinking. It requires perseverance because it takes time for the large institutional machinery to move and join the "discovered" innovative courses of thought brought on through efforts such as the Aboriginal Renaissance.

In order to transform Aboriginal health in Canada the culture that created it must change and transform the organizational culture into an innovative course of thought. This is critical to the transformation process. A vision is only an academic exercise if people don't buy in. A vision alone is not enough to change organizational structure but it is important when a vision is established (of healthy Aboriginal people), that the cultural assumption (that Aboriginal people are biologically inferior and predetermined to vanish) is destroyed– to do this is not quick or easily accomplished. Leaders must articulate what is currently believed about Aboriginal health and espouse what basic assumptions should be in the future and the people must believe will work.

The vision must be achieved through tangible experience, education and hands on corrections of basic incorrect assumptions. Only then can the basic assumptions change to reflect the new

vision. A vision is important; however, it must be validated prior to becoming part of a healthy Aboriginal health culture. Leadership and political will is the basic starting point and it must funnel down through the provinces to the communities whilst the communities and the provinces are funneling up. Failure of communities to validate and reinforce the vision with the establishment of a new basic assumption will allow old basic assumptions and thinking to remain unchanged. As past transformations have illustrated (eg: *Blueprint on Aboriginal Health*), changing the deep-rooted basic assumption of Canada about Aboriginal health will be difficult without the political will to do so. In summary:

Every Aboriginal person born in Canada has a powerful set of constitutionally protected rights through Section 35 of the *Constitution Act, 1982*.

These constitutional rights include (among others) the inherent right to self determination, self government, to control one's own living circumstances and quality of life.

Root causes of ill health (colonization, historical policies, legislative policies, guardian and ward theories and so on) must be addressed and rejected and replaced with policies that reflect the fiduciary relationship between the government and Aboriginal people.

10. Conclusion

Disparities typically arise from social, political, cultural, and economic determinants, which lie largely outside of the health realm. Certain disparities inevitably have an impact on individuals, their communities, and their nations. These determinants also have an impact across generations. Determinants impact the health of both the individual and the communities in which they live. Many underlying health determinants for Aboriginal people include poverty, homelessness, inadequate or substandard housing, unemployment, violence, lack of access to health services, lack of cultural awareness within the existing health system, lack of education, and high rates of unemployment indicating that “social inequality, whether measured at the population or individual level, is the single leading condition for poor health.”³² Social and economic disadvantages increase the risk to the health and well-being of Aboriginal people. The negative impact of these socioeconomic factors extends further. They damage the

³² Geyorfi-Dyke, E. (2008). Poverty and Chronic Disease: Recommendations for Action. In Chronic Disease Prevention Alliance of Canada (Ed.): CDPAC in Chronic *infra* note 37 at 10.

biological development of Aboriginal children and youth, reducing their immunity to disease. The consequences of weakened health accumulate across individual life spans as well as through succeeding generations.

Although, the poor health of Aboriginal people is directly linked to “the corrosive effects of poverty and economic marginalization,”³³ the determinants of health are themselves both direct and indirect consequences of historic policies of colonization.³⁴ It follows, then, that the damages caused by colonization are directly related to the risks to health caused by colonial socio-economic disadvantage.

The social conditions of many Aboriginal communities show the results of colonization in the form of addictive behaviors and violence. Alcohol and drug abuse are the most prevalent types of addictive behaviours in Aboriginal communities, and they are associated with a range of serious physical and mental health problems. Aboriginal women face additional problems unique to their gender and place in Canadian society.

As noted throughout this dissertation, Indigenous populations have a lower life expectancy than non-Indigenous populations, higher incidence of most diseases (diabetes, cardiovascular diseases, cancers etc.) and commonly experience high rates of communicable third world type diseases such as tuberculosis. It is difficult to make completely accurate comparisons when variable methods of enumeration and statistics for Aboriginal populations are used. It is however, clear that inequalities in health status are an important measure of the quality of the health system.

Noted New Zealand Professor Mason Durie notes that explanations for the current poor Indigenous health status can be categorized into four main sections: genetic vulnerability, socioeconomic disadvantage, resource alienation, and political oppression.³⁵ All of these

³³Kirmayer, L., Brass, G., & Tait, C. (2000), The mental health of Aboriginal peoples: Transformations of identity and community. *Canadian Journal of Psychiatry*, 45, 607-615 in J. Reading, *The Crisis of Chronic Disease among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy* (University of Victoria Centre for Aboriginal Health Research: 2009), online: <http://www.cahr.uvic.ca/docs/ChronicDisease%20Final.pdf>, at 10, [Chronic], (accessed November 4, 2009).

³⁴ First Nations Centre (2005). First Nations Regional Longitudinal Health Survey (RHS) 2002/2003: Results for Adults, Youth and Children Living in First Nations Communities. Ottawa: First Nations Centre at the National Aboriginal Health Organization [FNCO], King, D. (2006). A Brief Report of The Federal Government of Canada's Residential School System for Inuit. Ottawa: Aboriginal Healing Foundation in Chronic *ibid* at 10 (accessed November 4, 2009).

³⁵ As Professor Durie noted:

categories make sense in a fundamental and interdependent way and have been discussed in this thesis. For instance examining the impacts of genetic mutations and abnormal cell growth (from nutritional deficiencies) and, at the other end of the spectrum examining how government policies, laws and legislation have impacted on Aboriginal health. In between these two lay standards of living (that is health determinants), self determination for standards of living, lifestyles and cultures – and these factors alone play a huge role in affecting the fundamentals of Aboriginal health.

The human cellular processes and the in between spectrums of the determinants of health are where health care workers are the most familiar and have the most impact, but to be truly effective a very broad approach must be taken that involves a wide range of interventions, studies, actions and developments by a wide range of disciplines. This is the approach that Professor Sákéj Henderson champions as the “Aboriginal Renaissance model.”

Similar to this model, the *New Zealand Declaration of Health and Survival* also advocates for a whole and inclusive approach that “capacity building, research, cultural education for health professionals, increased funding and resources for Indigenous health, a reduction in the inequities accompanying globalization, and constitutional and legislative changes by states.”³⁶ This seems like a long list to fill but if we look at solutions one at a time, the task is not so daunting.

In spite of the disproportional health and societal status, Aboriginal people hold special constitutionally entrenched rights. Aboriginal and treaty rights are recognized and affirmed in the *Constitution Act, 1982*. These rights are in addition to the rights that all Canadians are

Genetic causes [and genetic mutations] have been investigated in diabetes, alcohol related disorders, and some cancers, although they are generally regarded as less significant than socioeconomic disadvantage, which is often central to contemporary indigenous experience. Poor housing, low educational achievement, unemployment, inadequate incomes, are known to correlate with a range of lifestyles that predispose to disease and injury. Alienation from natural resources along with environmental degradation has also been identified as a cause of poor health while cultural alienation has been recognised as an important consideration for [effective] *sic* health care.(Durie M. *Whaiora Maori Health Development*. 2nd ed. Auckland: Oxford University Press, 1998:26-27).

³⁶Committee on Indigenous Health. The Geneva Declaration on the Health and Survival of Indigenous Peoples 1999. WHO, Geneva. (WHO/HSD/00.1.).

entitled to through the *Canada Health Act*.³⁷ While the *Canada Health Act* is geared to distributing health care to all Canadians equally, Aboriginal Peoples argue that their constitutional difference is relevant to the just distribution of health rights and entitlements. Treatment of Aboriginal Peoples as merely “other peoples” ignores their constitutional rights and creates inequality of services for Aboriginal Peoples. The Supreme Court recognizes the constitutional supremacy of these rights and has provided guiding principles for the legislature, governments and lower courts. Aboriginal and treaty rights are remarkable sets of rights that recognize Aboriginal people as distinct rights bearing holders of unique customs, practices and traditions. Moreover, these rights are constitutionally entrenched in the Supreme law of Canada. However, twenty five years have elapsed since the Constitution of Canada was amended. In light of these incredible rights, Aboriginal people still suffer disproportionately.

This thesis has identified a broad spectrum of sources that has led to the poor health of Aboriginal people today – it has also identified a broad spectrum of interventions to improve the health of Aboriginal people in Canada. Within that spectrum, politicians, legislative drafters, policy makers, academics, Aboriginal communities, (locally, regionally and nationally), lawyers, health professionals and scientists can have a major role in contributing to equalizing Aboriginal health in Canada. Together these groups can produce dramatic reductions in mortality and morbidity through: a) high quality primary healthcare services for proactive detection, prevention and early treatment, b) changes to the legislative schemes that affect Aboriginal and treaty rights to health, c) implementation of health policies that reflect a holistic approach, and d) implementation of Health Impact Assessments before Aboriginal and treaty rights to health are affected.

In terms of health institutions, capacity building, research, cultural education for health professionals, funding and resources for Aboriginal health are critical to improve health. It is also important to cultivate an Aboriginal workforce with Aboriginal health and cultural perspectives. The knowledge must be utilized that is already available to effectively diagnose and treat the conditions that cause illness and death. The critical health service issue is one of adequate primary healthcare services for prevention and for early diagnosis and treatment of

³⁷ *Canada Health Act*, R.S.C. 1985, c.C-6.

the high levels of illness and illness precursors that are already present in much of the Aboriginal population. This could be achieved through nation-wide initiatives to further develop Aboriginal community controlled primary healthcare services at an adequate needs based funding level.

Change in the culture of Aboriginal health care itself is critical. Tertiary institutions, universities and colleges must acknowledge their inherent responsibilities to recruit and retain culturally relevant and competent, responsive clinicians. All governments, Aboriginal and non-Aboriginal agencies and funding bodies must support the access and delivery of appropriate services.

The acceptance of continuing disparities in health for Aboriginal people is not appropriate when the root causes of those disparities and the solutions/remedies are well understood. Politicians, legislators and policy makers must be educated on the process that not only created the poor health status but that will improve health outcomes. The process must include the recognition and implementation of Aboriginal and treaty rights to health and the implementation of constitutional health care for all Aboriginal people in Canada. If all governments are to truly contribute to positive change, they must commit to transcending political agendas and election cycles and recognize and halt the colonization that was implemented with the early health policies and legislation and that remains a barrier to progress in the health of Aboriginal people today.

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P.J.K., K.K.R., D.Y.K., M.A.R., C.S.J., S.C., R.V.F., P.M.H., J.M.W.S., L.C.M., R.J., F.A.B., M.K.C., G.E.F.M., R.C., M.A.S., I.C., JOHN DOE 1-100, JANE DOE 1-100, plaintiffs).

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APPENDIX “A”

Article	Conventions on the Rights of a Child	Canada's Current/Past Initiatives via "A Canada Fit for Children"			Treaty Rights	Constitutional rights
1	Unless otherwise stated, a child is under 18.					"aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada Section 35(2)
2	State Parties need to respect the rights of a child without discrimination of any kind including disability and birth.	• "The federal government has a primary although not an exclusive responsibility for the health of First Nations children on reserves and Inuit children" (#44).	• See conventions #23.1, #23.2, and #30			In S35(4), treaty rights are assured to both sexes. Aboriginal and Treaty rights of the aboriginal peoples of Canada are recognized as constitutional rights under section 35 (1) 1982
3.1	In all actions concerning children, the best interest of the child should be taken into consideration first.	• "The 2004 Budget announced a further investment in ELCC for F.N. children living on reserves, in addition to the increased investment announced in the 2003 Budget" (#44)				The purpose of treaties was to secure a positive future for their children and future generations. At the time of the treaty, all understood an enriched livelihood as a sufficient, sustainable, supplemental livelihood (Boyer 2003)
5	"States Parties shall respect the rights, duties and responsibilities of parents or the members of the extended family or community"	• See conventions #9.2, #14.2, #18.1, #26.2, and #27.3				
6.2	"States Parties shall ensure to the maximum extent possible the survival and development of the child"	• "The F/P/T Ministers of Health agreed to work together on an Integrated Pan-Canadian Healthy Living Strategy...aimed at reducing non-communicable diseases by addressing their contributing health indicators" (#37).	• The RCMP National Aboriginal Policing Services Branch has developed an Aboriginal youth suicide prevention program" (page 46)	• The National Homelessness Initiative helps the homeless population (#41). The CMHC's Shelter Enhancement Program restores or acquires shelters for victims of family violence (#47).	• See Conventions #18.2, #19.1, #23.2, #23.3, #24.1, #24.2b-c, #26.1, #27.3, and #33.	Treaty Commissioner for Treaty 7 said that the purpose of the Treaty was so that the Great Mother 'would hold them in the palm of her hand, protect them, and look after them just like a child...[The Queen] will take the best care of you. Whatever you ask for will be given to you' (Boyer 2003)
9.2	States Parties shall ensure that a child shall not be separated from his or her parents against their will, except if such separation is necessary for the best interests of the child.	• The National Crime Prevention Strategy and the Family Violence initiative concentrate on violence prevention. The f/p/t governments and partners work against parental abductions & have children returned via Canada's Our Missing Children program and the National Missing Children's Service (#42).	• The FNICC Initiative and the CPNP First Nations and Inuit Component enable the promotion of health and social development for children and families living in conditions of risk (#32/82).	The CAPC funds coalitions that establish programs and deliver services to meet the developmental needs of children 0-6 (#32,82). AHS has culturally appropriate early intervention programs for children between 0-6 years old and their families, and is part of the ECD Initiative (#32,46,82).	• See article 27.3, see Treaty 6 as per article 2, see Treaty 4 as per article 6.2, see Treaty 7	as per article 23.2, see Children's Aid Society in the Treaty section • "Provincial child adoption law applies to Aboriginal people on & off-reserve. Adoptions under Aboriginal customary law is recognized by Canadian courts. Courts will decide what is in the best interests of the child [...] In some provinces, the law requires that priority be given to placing an Aboriginal child in an Aboriginal home, and/or placement must consider the importance of Aboriginal culture, traditions and heritage" (Imai :1999, pp227)
14.2	States Parties shall respect the rights and duties of the parents/legal guardians	• See Conventions #5, #9.2, #18.1, #26.2, and #27.3				
18.1	"States Parties shall use their best efforts to ensure recognition that both parents have common responsibilities for the upbringing and development of the child."	• The Child-Centred Family Justice Strategy (2002) helps parents focus on the needs of their children following separation, and assists in reaching parenting arrangements (#31).	• See Conventions #5, #9.2, #14.2, #26.2, and #27.3			
18.2	States Parties shall appropriately assist parents and legal guardians in the performance of their child-rearing responsibilities, and ensure the development of institutions, facilities and services for the care of children.	• Canada's recent record on economic growth and job creation, the Canada Child Tax Benefit, etc., has reduced poverty and ensured that more families have the resources to care for their children (#28).	• "Under the First Nations National Child Benefit Reinvestment initiative, F.N. are reinvesting social assistance savings in programs & services for low income families in areas of ECD, etc." (#45).	• The Aboriginal Head Start on Reserve provides an early intervention program for First Nations children (0-6 years) and their families living on reserves. The AHS Urban and Northern Communities (AHSUNC) provides the program for FN/I and Métis children and their parents.	• See Conventions #6.2, #19.1, #23.2, #23.3, #24.1, and #27.3.	as per article 2, see Treaty 4
19.1	"States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms violence, abuse, neglect, or maltreatment."	• The Family Violence Initiative and National Clearinghouse on Family Violence focuses on reducing occurrence of violence and provides prevention and intervention approaches (#32).	• The National Crime Prevention Strategy and The RCMP National Youth Strategy promotes crime prevention and victimization (#46)	• The Canadian Criminal Code protects children from abuse & exploitation. A National Strategy was launched against internet sexual exploitation of children (#43). "Canada signed the Framework Convention on Tobacco Control"	• The National Homelessness Initiative helps the homeless population (#41). The CMHC's Shelter Enhancement Program restores or acquires shelters for victims of family violence (#47).	as per article 2, see Treaty 4 Treaty 11: the intent of treaty 11 was to alleviate their suffering as per article 23.2, see Children's Aid Society in the Treaty section
23.1	States Parties recognize that a disabled child should enjoy a full and decent life.	• Several tax measures & programs have been enhanced to address this concern (#28)	• See conventions #2, #23.2, and #30			as per article 2, see Treaty 4
23.2	States Parties recognize the right of the disabled child to special care and will extend appropriate assistance for which application is made.	• The AHS provides culturally appropriate ELCC and special needs care to Aboriginal children. • The FNICC Initiative supports culturally appropriate and affordable Aboriginal child care services & is part of the ECD initiative (#32/82); See #24.2e regarding UEY. • The CAPC funds community coalitions that meet the developmental needs of children in conditions of risk (#32/82)	• The Child-Centered Family Justice Strategy helps parents focus on needs of their children after separation (#31) • The CPNP FN/I Component develops or enhances community-based initiatives helping vulnerable pregnant women. It offers food & vitamins, counseling, etc.	• The Residential Rehabilitation Assistance Program offers financial assistance for accessibility of low income dwellings for persons with disability. The government provides other forms of financial assistance through tax measures • See #24.2d regarding the NIHB Program • The First Nations Home and Community Care Program provides personal care/home health aid workers.	• See #23.3 regarding the FASD program • The Social Development Partnerships Program promotes the generation, dissemination and application of knowledge, innovative solutions and best practices via investments of early childhood learning and care.	as per article 6.2b, see Treaty 7; as per article 24.1b, see Treaty 8 as per article 24.2b, see Treaty 6 "F.N. children in need of protection are cared for by Children's Aid Societies, an independent organization. The Children's Aid Society receives money from the provincial government and is governed by provincial laws" (Imai: 1999, pp 185). "Some treaties in force in the prairie provinces provide for a "medicine chest", education..." (Imai: 1999, pp 36-37).
23.3	Assistance for special needs of a disabled child shall be provided free of charge, whenever possible.	• The Aboriginal Head Start (AHS) program, the Education Reform Initiative, and the Special Education Program are a few of a number of programs and initiatives aimed to increase accessibility to education.	• The Canadian Healthy Living Strategy, the Canada Sport Policy, and Canada's Guide to Healthy Eating and Physical Activity aim for recreation opportunities.	• The Community Program Directorate & the NIHB program gives services & transportation for health & rehabilitative services. Nationally, initiatives, programs & benefits ensure accessibility to health. Federal there are programs and initiatives ensuring assistance is provided free of charge.	• The FASD Program has training activities such as workshops, information, sessions & the development of practical tools, etc.	as per article 6.2, see Treaty 7; as per article 24.1b, see Treaty 8 as per article 24.2b and 27.3, see Treaty 6; as per article 2, see Treaty 4 as per article 23.2, see Children's Aid Society in the Treaty section as per article 23.2, see Treaties in force in prairie provinces
24.1	"States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health"	• See Conventions #6.2, #18.2, #19.1, #23.2, #23.3, #24.2b-c, #26.1 #27.3, and #33.	• See Convention #24.2b notes			Treat 8: Indians were "assured that the government would always be ready to avail itself of any opportunity of affording medical service." (Boyer: 2003)
"States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:						

24.2b	"To ensure the provision of necessary medical assistance and health care to all children."	<ul style="list-style-type: none"> Canada provides a publicly financed health care system (#36). 	<ul style="list-style-type: none"> The NIHB Program provides medically necessary goods and services to the FN/I population (#36) 	<ul style="list-style-type: none"> The f/p/t governments is committed to accelerate primary health care reform (#36). 	<ul style="list-style-type: none"> See Conventions #6.2, #18.2, #19.1, #23.2, #23.3, #24.1, #24.2c, #26.1 #27.3, and #33. 	The 2 clauses on pestilence & a medicine chest in Treaty 6 has been interpreted as federal relief when overtaken by calamity (Boyer 2003).	
24.2c	To combat disease & malnutrition via the application of technology and provision of adequate nutritious foods & clean drinking water;	<ul style="list-style-type: none"> Canada's public health efforts address concerns on diseases, injuries, nutrition, and threats to health (#35). 	<ul style="list-style-type: none"> Health Canada established the Office of the Children's Environmental Health to better protect children from environmental threats (# 48). 	<ul style="list-style-type: none"> Water is the federal government's and FN communities' responsibility. The federal government committed to: invest \$1.3 billion, the F.N. Water Management Strategy, the Drinking Water Safety Program, & developing community based education and awareness programs. 		<ul style="list-style-type: none"> as per article 2, see Treaty 4; as per article 6.2b, see Treaty 7 as per article 24.1b, see Treaty 8, as per article 24.2b & 27.3, see Treaty 6 as per article 19.1, see Treat 11 as per article 23.2, see Children's Aid Society in the Treaty section as per article 23.2, see Treaties in force in prairie provinces 	
	"To ensure appropriate pre-natal and post-natal health care for mothers,"	<ul style="list-style-type: none"> Maternity & parental benefits was extended to 1 year, & Canada committed to improve access to p/t regulated early learning & child care programs (#29). 	<ul style="list-style-type: none"> The NIHB Program provides medically necessary goods and services to the FN/I Inuit population (#36). 	<ul style="list-style-type: none"> See #23.3 on the FASD Program The Tobacco Control Strategy gives tools and training for tobacco control, with focus on pregnant women The CPNP, a community-based initiative, helps vulnerable pregnant women (# 44) 	<ul style="list-style-type: none"> The Canadian Perinatal Surveillance System is an initiative to provide a response related to perinatal health. 	<ul style="list-style-type: none"> as per article 2, see Treaty 4 as per article 6.2b, see Treaty 7 as per article 24.1, see understandings of Treaty 8 as per article 24.2b, see Treaty 6 as per article 23.2, see Treaties in force in prairie provinces 	
24.2e	To insure all segments of society are informed, have access to education, and support;	<ul style="list-style-type: none"> Understanding the Early Years (UEY) "provides information to make informed decisions on policies programs" (p.46). 	<ul style="list-style-type: none"> See #18.2 notes. See conventions #24.2d & f, and 27.1 	<ul style="list-style-type: none"> The CPNP aims to reduce the incidence of unhealthy birth weights, improve the health and encourage breastfeeding.1 	<ul style="list-style-type: none"> The CAPC, the CPNP and AHS promote child health and social development (#32). 	<ul style="list-style-type: none"> as per article 3.1, see the purpose of Treaties 	
24.2f	"To develop preventive health care, guidance for parents & family planning education & services."	<ul style="list-style-type: none"> See conventions #24.2d-e, and # 27.1 					
24.3	States Parties shall abolish traditional practices prejudicial to the health of children.						
25	A child placed by authorities has the right to a periodic review of the treatment.						
26.1	Every child has the right to benefit from social security	<ul style="list-style-type: none"> See Convention #6.2 and 26.2 notes See Conventions #6.2, #18.2, #19.1, #23.2, #23.3, #24.1, #24.2b-c, #27.3, and #33.; See convention # 27.1 				<ul style="list-style-type: none"> as per article 6.2b, see Treaty 7 	
26.2	Benefits should be granted w.r.t. resources & circumstances of the child/parent/guardian.	<ul style="list-style-type: none"> The government provides various forms of financial assistance through tax benefits, credits, and deductions which have a child and disability focus. 	<ul style="list-style-type: none"> The (EI) Program provides temporary income relief for Canadians who are sick, pregnant, or caring for a newborn child. 	<ul style="list-style-type: none"> See #23.3 regarding NIHB and CHP 		<ul style="list-style-type: none"> as per article 2, see Treaty 4 as per article 6.2, see Treaty 7 as per article 24.1b, see Treaty 8 as per article 24.2b, see Treaty 6 as per article 19.1, see Treat 11 as per article 23.2, see Treaties in force in prairie provinces as per article 3.1, see the purpose of Treaties 	
27.1	Every child has the right to a standard of living adequate for his/her 5 developmental spheres.	<ul style="list-style-type: none"> See conventions #24.2d-f See convention # 26.1 				<ul style="list-style-type: none"> as per article 3.1, see the purpose of Treaties 	
27.2	Parents have the primary role to secure living conditions needed for the child's development.					<ul style="list-style-type: none"> as per article 2, see Treaty 4 	
27.3	States Parties shall assist parents to implement this right.	<ul style="list-style-type: none"> See Conventions #5, #9.2, #14.2, #18.1, and #26.2 See Conventions #6.2, #18.2, #19.1, #23.2, #23.3, #24.1, #24.2b-c, #26.1, and #33. See Convention #24.2e notes 	<ul style="list-style-type: none"> Canada, in partnership with P/T's, launched the Affordable Housing Initiative to improve the affordability & supply of rental housing (#41) 			<ul style="list-style-type: none"> as per article 2, see Treaty 4; as per article 6.2b, see Treaty 7 as per article 24.1b, see Treaty 8; as per article 24.2b, see Treaty 6 "sections on reserves...required for public works or buildings may be appropriated[...],due compensation being made for the value of any improvements thereon. (treaty 6) 	
"States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:							
28.1a	"Make primary education compulsory and available free to all;"	<ul style="list-style-type: none"> Canada has a universally accessible system of primary and secondary education (#31). 	<ul style="list-style-type: none"> See #28.1 b & d-e, #26.2, and #29.1 b-e 				
28.1b	Encourage the development and accessibility of different forms of secondary education	<ul style="list-style-type: none"> See #28.1a notes See #28.1d-e, #26.2, and #29.1 b-e 					
28.1c	"Make higher education accessible to all on the basis of capacity by every appropriate means;"						
28.1d	"Make educational and vocational information available and accessible to all children;"	<ul style="list-style-type: none"> See #28.1a-b & e, #26.2, and #29.1 b-e 					
28.1e	"Take measures to encourage regular attendance at schools and the reduction of drop-out rates."					<ul style="list-style-type: none"> as per article 24.2b and 27.3, see Treaty 6 as per article 3.1, see purpose of the Treaties 	
"States Parties agree that the education of the child shall be directed to:							
29.1a	"The development of the child's personality, talents and mental and physical abilities to their fullest potential;"	<ul style="list-style-type: none"> The Canadian Sport Policy enables Canadians to experience & enjoy involvement in sport to the extent of their abilities & interests (#37). 					
29.1b	"The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations"	<ul style="list-style-type: none"> See #26.2, 28.1a-b & d-e, and #29.1 c-e 				<ul style="list-style-type: none"> as per article 29.1c, see the intent of Treaty 8 	

29.1c	"The respect for the child's parents, cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;"	• "The Government of Canada launched an Education Reform Initiative with F.N. stakeholders and communities, to strengthen management capacity, improve the quality of classroom instruction, increase parental and community involvement, and support school-to-work transitions" (#45).	• "The Aboriginal Language and Culture Centre helps preserve, revitalize and promote the languages and culture of Aboriginal peoples. It supports the Aboriginal Languages Initiative" (#48).	• See #26.2, 28.1a-b & d-e, and #29.1b & d-e		(Treaty 8) Elders stressed the importance of maintaining their way of life and livelihood during negotiations and the treaty commissioners made it clear that there wouldn't be any interference with their traditional way of life (Boyer 2003) see 29.1d as well	s.35(1) provides the framework through which the fact that aboriginals lived on the land in distinctive societies, with their own traditions and cultures, is acknowledged and reconciled with the sovereignty of the Crown. Boyer 2003) as per article 2, see section 35; see 29.1d also
29.1d	The preparation of the child for responsible life in a free society.	• Cadets Program and Junior Canadian Rangers Program teach valuable life and work skills (#48)		• See #26.2, 28.1a-b & d-e, and #29.1b-c & e.			
29.1e	"The development of respect for the natural environment."	• See #26.2, 28.1a-b & d-e, and #29.1b-d					
30	A child belonging to a minority group or who is indigenous shall not be denied the right to enjoy his/her own culture, to profess and practise his/her own religion, or to use his/her own language."	• Several programs and initiatives offered by the federal government provide culturally appropriate assistance such as the Canada Prenatal Nutrition Program (CPNP) First Nations and Inuit Component, and The First Nations and Inuit Child Care Initiative	• The Aboriginal Language and Culture Center aims to preserve, revitalize, and promote the languages and culture of aboriginal people and their children, and supports the extension of the Aboriginal Language Initiative.			as per article 29.1c, see Treaty 8; as per article 43.1, see interpretation • "General Murray's letter [states] "free exercise of their Religion, [and] their Customs"(as cited in Isaac, p. 130)." http://www.csse.ca/CJE/Articles/FullText/CJE26-2/CJE26-2-Carr.pdf "Courts knows the best interests in custody issues. There is priority in placing an Aboriginal child in an Aboriginal home, and/or to consider their culture & traditions" (Imai:1999, pp 227).	
33	States Parties shall take all appropriate measures to protect children from narcotic drugs and psychotropic substances.	• The Youth Justice Renewal Initiative addresses prevention, consequences for youth crimes, rehabilitation, and reintegration to help youths return to their communities.	• Canada signed the Framework Convention on Tobacco Control (#37).	• See Conventions #6.2, #18.2, #19.1, #23.2, #23.3, #24.1, #24.2b-c, #26.1, and #27.3.			
43.1	There shall be established a Committee on the Rights of the Child, which shall carry out the functions hereinafter provided.	• The Canadian Council of Provincial Child & Youth Advocates commit to further the voice, rights & dignity of children, and includes 5 provincially appointed Children's Advocates (#34)	• See #43.2 notes • See #43.3, and #43.4				In interpretations of treaties, the Supreme Court of Canada judges to choose the mutual intent of the shared interests of parties & recognize that Treaties are not frozen in time. (Boyer 2003)
43.2	The Committee shall consist of 10 experts, where members of the Committee shall be elected by States Parties.	• The Government of Canada is working together with Aboriginal communities, leaders & Elders, & p/t's to improve the health & wellbeing of Aboriginal families (#44)	• See #43.1, #43.3, and #43.4				
43.3	The members of the Committee shall be elected by secret ballot.	• See #43.1, #43.2, and #43.4					
43.4	The initial election to the Committee shall be held no later than 6 months after entry of the Convention and thereafter every second year.	• See #43.1, #43.2, and #43.3					