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The Métis Right to Health

Under the *Constitution of Canada* and Under Selected International Human Rights Obligations

By

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[*] According to Tom McCallum, this word is Cree for someone who "deals in medicines." Tom McCallum and Lois Edge.(2006). *Métis Identity: Sharing Traditional Knowledge and Healing Practices at Métis Elders* Gatherings *Pimatisiwin Journal,* 4(2), pp.98.

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> *"But in the end, in my opinion it is the development of law to deal with claims of 'peoples' that lies the best hope of achieving justice and harmony." (Justice O'Sullivan, 1988)*[1]

I. Introduction

This report examines the case for asserting a right to health for the Métis peoples in Canada. There is disparity in health status between Canadians generally and the Métis communities that exist within Canada. Statistics regarding health status demonstrate that Métis peoples are worse off than Canadians. Moreover, Métis communities, despite possessing comparable poor health conditions to those of First Nations' populations, do not receive the same level of services or health benefits as do First Nations. From a policy perspective, this discrepancy is difficult to explain since both Métis and First Nations have experienced comparable racism, negative assimilation policies and degrading colonization. It is even more difficult to understand this inequitable treatment when one notes that the Métis are one of the Aboriginal Peoples included in the *Constitution* as possessing Aboriginal and Treaty rights and rely equally, as do First Nations and Inuit, on the promises that were made in the name of the *Constitution*

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[1]. *Dumont v. Canada (Attorney General)* [1988] 3 C.N.L.R. 39 (Man. C.A.) at p. 52.

of Canada for addressing the colonial injustices of the past experienced by Métis, Inuit and First Nations alike.[2]

The Métis population in Canada is unique in terms of health status and services. The communities face disproportionately poorer health status than Canadians generally. Moreover, Métis are uniquely under-serviced as an Aboriginal community with regards to receiving health services and benefits. Given the discrepancies in health quality of the Métis, one would expect government programs and services to target this population in an effort to bring their quality of health in line with the Canadian average, at a minimum. Yet, with the exception of the Northwest Territories there are no Métis-specific health programs in Canada.[3]

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[2] . These promises were manifest during the 1980s constitutional repatriation process. The entrenchment of s.35 in the ***Constitution*** in 1982 was seen as a new beginning in relations between Indigenous Peoples and Euro-Canadians. For a useful history of this process see Menno Boldt and J. Anthony Long, ***The Quest for Justice: Aboriginal Peoples and Aboriginal rights*** (Toronto: University of Toronto Press, 1985)

[3] . The Northwest Territories is the only jurisdiction in Canada that provides a supplementary health benefits program specifically for Métis residents. The Métis Health Benefits (MHB) Program provides additional health benefits similar to Non-Insured Health Benefits, but at a coverage level of 100 per cent. For more information see the Northwest Territories Government website at http://www.hlthss.gov.nt.ca/english/services/health_care_plan/metis_benefits/default.htm.

There are s. 15 ***Charter*** issues raised by these discrepancies between Métis communities in the North (as a comparator group) and Métis communities in the south. One rather obvious question is whether the simple division between northern Métis communities and southern Métis communities is a sufficiently relevant factor to treat Métis communities in the South differently than those in the North as regards health care? At first glance, there seems no logical basis for the discrepancy and the Government would have a difficult time justifying the differential treatment under s. 15 of the ***Charter*** on the relevance of the territorial boundary alone. However, the author argues that the strategy of a ***Charter*** claim is undesirable because it is inconsistent with Métis recognition as a People equal to other Canadians. Interestingly, if Aboriginal Peoples were to give up their status as Indigenous "Peoples," with their own collective citizen rights as against the state, and argue instead from the position of individual Canadian citizens, albeit from an ethnic group that has been unfairly treated by their exclusion to services due to state inaction, their chances of acquiring health services to address the unfairness and inequality might succeed (***Eldridge v. British Columbia***, [1997] 3 S.C.R. 624). Although Métis people may obtain the same result under the ***Charter*** as they might under a human-rights incorporated s.35 right, at what cost is such a victory achieved? When Métis people have to give up their identity as citizens of an Aboriginal nation in exchange for Canadian citizenship with an ethnic disadvantage, are they giving up too much of their indigenous political and legal citizenship? If Métis people want to make a claim for health services that address the injustice of the past and the current health imbalance of Métis people as a consequence of a colonial past, why must indigenous

South of the Northwest Territories, more often than not, Métis Peoples fall between the cracks of governmental responsibility, due to jurisdictional wrangling by the provinces and the Federal Government. Métis have often been denied access to health programming because the Federal Government disclaims any responsibility for the Métis as an Aboriginal People, and because provinces simultaneously disclaim responsibility for the Métis, arguing that such access to health services is a federal responsibility. Thus, Métis often fall in the middle of a jurisdictional vacuum.

There is no recognition by the federal or provincial governments of any serious obligation to address the health shortcomings experienced by Métis communities in Canada. Thus, it is a primary objective of this report to identify the legal arguments that support a Métis right to health under s. 35 of the ***Constitution***. If a Métis right to health is acknowledged as an Aboriginal right in the ***Constitution***, this would place Métis Peoples in a strategic position towards the acquisition of a Métis-specific health plan funded by governments to ensure compliance with that right.

It is unfortunate that the Métis community in Canada must identify legal rights as being in opposition to Canadian governments in order to achieve what is universally acknowledged as a basic human right. One would expect that governments charged with the responsibility to provide basic health care would be outraged that a portion of the Canadian population, and one that is socially, culturally and economically oppressed and vulnerable, is being virtually ignored.

Accordingly, this report first briefly highlights the state of Métis health in Canada to the extent possible, given the abysmal lack of Métis-specific health research and data. The lack of Métis-specific health research is well documented in the literature. For example, Joseé Lavoie et. al. made the following observations:

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national citizenship become subservient to Canadian citizenship? It is the author's opinion that the cost of such subservience is too high a price to pay. Consequently, the author does not address a right to health as a ***Charter*** right in this report. This is not to say, however, that the principle of equality is irrelevant to the analysis of a s.35 right as defined in this report. Equality of health services is an integral part of a human rights analysis incorporated in s.35 of the ***Constitution***.

> Important variations exist between Aboriginal groups, and from community to community. Despite the recent flurry of activities in creating national health indicators that also capture progress in Aboriginal health, data on the Metis … remains sketchy or nonexistent.[4]

It is not surprising that the Métis Centre of the National Aboriginal Health Organization identified in a recent publication the need for Métis-specific data, research and programming as a priority for both the organization and for Métis communities.[5]

After providing a brief overview of the status of Métis health in Canada, the author will review the understandings of Métis health concepts, customs and traditions. These understandings provide a cultural context to Métis health, and offer guidance in terms of how to implement improved health services that are consistent with, and support, a Métis right to health. Any legal right that supports the implementation of a Métis health plan must be culturally grounded.

Following an overview of Métis health status and Métis cultural perspectives on health, this report will then examine the legal case for asserting a Métis right to health as an Aboriginal right under s. 35 of the ***Constitution***. The author concludes that the current approach of the courts to interpreting s.35 is limited and inconsistent with the principles of human rights. The author is of the opinion that the current understanding of s.35 by the courts is fundamentally flawed as it fails to incorporate a human rights dimension in the definition of Aboriginal rights. To make the case, the author relies heavily on international human rights instruments, particularly those that relate to the human rights of Indigenous Peoples to health. A strong case can be made that the lack of a human rights dimension in the s.35 framework of analysis is contrary to Canada's human rights commitments and the true nature of Aboriginal-Canadian relations. Indeed, the author shows that the courts have failed to realize that s.35 already incorporates human rights (such as a right to health) of

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[4] . Joseé Lavoie, John O'Neil, Jeff Reading and Yvon Allard, "Community Healing and Aboriginal Self-Government" in Yale D. Belanger, ed., ***Aboriginal Self-Government in Canada*** (Saskatoon: Purich Publishers, 2008) at 174. Statistics Canada, in an analytical paper on the status of Métis health in Canada, also noted that "very little research has been done on the health and well-being of the Métis population". See Teresa Janz, Jocyce Seto and Annie Turner, ***Aboriginal Peoples Survey, 2006: An Overview of the Health of the Metis Population*** (Statistics Canada, 2009) at 7.

[5] . Dyck, M. (2009). ***Social Determinants of Métis Health.*** Ottawa: National Aboriginal Health Organization. 12.

Indigenous Peoples based on international customary law through the principle of adoption.

A synthesis of international indigenous human rights principles relating to health, with the existing legal framework and principles for interpreting Aboriginal rights in s.35 of the ***Constitution,*** is necessary to ensure that s.35 lives up to the promises originally proclaimed in 1982, and to ensure that Canada lives up to the minimum human rights standards that apply to Indigenous Peoples as reflected in various human rights instruments, including the Declaration of Indigenous Peoples Rights recently adopted by the United Nations General Assembly. When an indigenous human rights approach is incorporated into a s. 35 constitutional analysis, a strong case for recognition of a Métis right to a comprehensive and corrective health plan can be made. This approach also facilitates the further argument of recognizing that this right imposes a positive legal obligation on the Government to adequately fulfill (and fund) such a right.

II. The Métis Health Deficit

In the same way that the jurisdictional issue has resulted in a general under-servicing of Métis health services, so too has the jurisdictional issue resulted in a lack of specific health data on the Métis community. Although the health data deficit is slowly being addressed, there is still a huge gap in health knowledge and research on the Métis as compared to First Nations.[6] However, what data does exist provides compelling evidence of a serious health deficit in the Métis community.

The discrepancy in health status is most evident in the degree to which Métis people suffer from chronic illnesses. Based on the 2006 Aboriginal Peoples Survey, Statistics Canada reports that:

> A significantly higher proportion of Métis than the general population reported they had been diagnosed with a chronic condition. In many cases the proportion of Métis with a chronic

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[6]. The author is personally aware of the lack of Métis-specific health research given his participation as a member of Health Canada's Research Ethics Board. His responsibilities included reviewing health research proposals submitted under the jurisdiction of Health Canada for compliance with ethical guidelines. He reviewed well over 100 files during his tenure. Many proposals addressed Inuit and First Nations health research. Not one research proposal concerned Métis health issues.

condition was ***double*** that reported by the total population in Canada[7] [emphasis added].

From the little Métis-specific health data that do exist, one can conclude that the health status of the Métis population is disproportionately poorer compared to Canadians as a whole. Moreover, older reports indicate that the health status has not improved much over the years. As reported by the National Aboriginal Health Organization (NAHO) in 2002, not much improvement in the health status of Métis has occurred since 1991. The report references the 1991 Aboriginal Peoples Survey on health status, noting that:

> Of those who responded to the questions pertaining to health in the survey, almost 43 per cent reported at least one health problem. This was the highest rate of the three groups in the APS. The most common problem reported was arthritis (40 per cent) followed by high blood pressure (27 per cent) and bronchitis (25 per cent)…
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> One of the most striking health statistics revealed in the APS was that of the incidence of disabilities in Aboriginal populations. For Métis, the incidence of disability reported was 32 per cent and was roughly equivalent to that of the First Nation and Inuit populations. This was almost twice the incidence reported by the Canadian population as a whole, which was 18 percent.[8]

The health status of Métis has been poor in the past and does not appear to be improving in any significant way.

Statistics Canada also reports that the Métis population's perception of their health status relative to Canadians generally decreases as the population ages, starting at the 35-44 year age category. These findings, as well as others documented by Statistics Canada, demonstrate that there is a serious Métis community health deficit in Canada.[9]

The Métis health deficit may be explained in part by examining some of the recognized social determinants of health status such as education attainment and employment income. Métis have lower rates of high school and university achievement. Métis also

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7 . Statistics Canada, ***supra*** note 4 at 13.
8 . Lamouche, J. (2002) ***Environmental Scan of Métis Health Information, Initiatives and programs.*** Ottawa: National Aboriginal Health Organization. 6-7.
9 . ***Ibid***, at 9.

disproportionately fall within the impoverished classes in Canada as measured by the Low Income (before tax) Cut-off (LICO) rates; "in 2006, 21 per cent of all Métis across the 10 provinces were living below the LICO, compared with 15 per cent **of the total population.**"[10]

The combined negative impact of low socio-economic status and lack of access to non-insured health benefits, such as funding for medical prescriptions, contributes to a systemic health deficit. For example, the combined lack of non-insured health benefits and poverty lead to a high incidence of inability to purchase necessary medicine. A report prepared by the Women of the Métis Nation found that:

> Economics also hinders the ability of many Métis women to access health services such as prescriptions. When asked whether they needed a prescription filled in the last 12 months the majority of Métis women (78 per cent) said they needed a prescriptions filled, but close to 14 per cent had foregone filling a prescription at least once due to a lack of money.[11]

The social/economic health determinants, although useful, only tell part of the story. There are health determinants specific to Aboriginal communities that are also significant factors contributing directly or indirectly to poor health status. Colonization (and the discrimination and oppression that accompanies it) is a major health determinant of Aboriginal communities. The Métis Centre of NAHO has begun discussing and identifying Métis-specific health determinants. Not surprisingly, the historical impact of colonization is a predominant one.[12]

1. Métis Health Determinants

Considerable literature exists that demonstrates the impact of colonization on other related health determinants of Aboriginal communities. The World Health Organization (WHO) has identified the impact of colonization as a significant health determinant which relates to increased states of poverty and social problems. The WHO identified the relationship between colonization and indigenous health in these terms:

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[10]. Statistics Canada, supra, note 4 at 9.
[11]. Women of the Métis Nation. (2007) ***Health Policy Paper.*** Ottawa: National Aboriginal Health Organization. 6.
[12]. Supra, note 5.

> The health of Indigenous Peoples is overwhelmingly affected by determinants outside the realm of the health sector, namely social, economic, environmental and cultural determinants. These are the consequences of colonization.[13]

Indeed, many international initiatives and agencies have identified the link between colonial oppression and the negative health conditions of indigenous communities. Consequently, many international agencies have identified the health needs of Indigenous Peoples as a priority in addressing the human rights of Indigenous Peoples. A number of these health concerns and initiatives are addressed in various international human rights instruments and translate directly into state obligations to address the health status of Indigenous Peoples.[14]

The link between Métis health, like other Aboriginal Peoples, and the impact of colonization is well understood and documented in health research and epidemiological studies.[15] The impact of colonization on health in all of its manifestations (physical, mental, social and emotional) has been nothing short of devastating. The Royal Commission on Aboriginal Peoples (RCAP) examined the health status of Aboriginal Peoples in 1996. The Commission made the link between **the "lasting effects of oppression and systemic racism experienced over the generations" with the current disproportionate status of ill**

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[13] . World Health Organization, Committee on Indigenous Health, ***Geneva Declaration on Health and Survival of Indigenous Peoples,*** WHO/HSD/00.1 (1999) Part IV [Geneva Declaration]

[14] . For an excellent overview of several of these international initiatives and obligations see Yvonne Boyer, ***Discussion Paper Series in Aboriginal Health: Legal Issues No. 3: The International Right to Health for Indigenous Peoples in Canada*** (NAHO and Native Law Centre, 2004)

[15] . For example see, James Frideres and Rene Gadacz, ***Aboriginal Peoples in Canada: Contemporary Conflicts, 6th ed.,*** (Toronto: Pearson Education Canada, 2001). The authors at page 71 make the following important observation:

> The effectiveness of the Native health care system is related as much to the environmental conditions in which Aboriginal Canadians live as it is to the treatment and facilities provided. Health care provided is sometimes countered by social and economic problems such as overcrowding, poor nutrition, chronic unemployment, and community and family violence. Thus, an Aboriginal person, after receiving effective medical treatment, finds him or herself returning to the social conditions that created the problem in the first place. In short, the causes of poor mental and physical health are not dealt with in Canada.

health experienced by the Métis and other Aboriginal Peoples in Canada.[16]

The Royal Commission placed the current health and healing concerns in the context of history and culture, a context, which in turn, demonstrates in unequivocal terms the imperatives of change in the **"way Aboriginal health is understood and promoted** and, by extension, **to transform the system of medical and social delivery."**[17] These imperatives of change include, for example, the need to increase funding for Métis Peoples to access health services above the level of services accorded the general population, and to provide health services which include, but are by no means limited to, the services provided Status Indians under the uninsured health benefits plan.

It is not surprising that the research and studies that lead the Royal Commission to this conclusion parallels the scope of a Métis right to health as defined in Part IV of this report. Although this report is a legal analysis of a Métis right to government funded health services and products, it is interesting and coincidental that the legal conclusions reached in this report parallel the conclusions the Royal Commission reached in 1996 as a matter of policy reform.

Recent efforts by researchers and health scientists have focused on the kinds of responses that would be necessary to correct the health imbalances caused by colonization. Strategies such as those promoted by the Royal Commission, the Aboriginal Healing Foundation, the Canadian Institutes of Health Research and the National Aboriginal Health Organization have addressed the issue of the health deficit by identifying health and healing programs and services within a broader strategy of decolonization. A small and select sampling of the many strategies include, for example:

1.The development of integrated and holistic health services or **"lodges" designed to address the health deficit and unique health** burden experienced by Aboriginal peoples by providing, in one space, the totality of health services in a culturally sensitive environment (RCAP, 1996, vol. 3, p. 234). See in particular RCAP recommendations 3.31 to 3.3.12.

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[16] . Royal Commission on Aboriginal Peoples (1996) ***Gathering Strength Volume 3.*** Canada: Royal Commission on Aboriginal Peoples. 111.
[17] . Ibid, at p. 110.

2.Address the negative health impacts of collective social trauma caused by generations of colonial and discriminatory social policy by adapting trauma-healing modalities in a culturally sensitive and community-based process (Aboriginal Healing Foundation. ***Historic Trauma and Aboriginal Healing,*** 2004, p.77).

3.All health research must be done in a way that respects and meaningfully includes Aboriginal communities and that will have a direct positive impact on their communities (Canadian Institute of Health Research. ***CIHR Guidelines for Health Research Involving Aboriginal People,*** 200 8, Article 2, p.18-20).

4.The Métis health knowledge base must be improved and Métis health issues must be promoted at national and provincial levels. There must be improved capacity building in Métis communities and the facilitation of community–based health research (NAHO, 2009, http://www.naho.ca/metiscentre/english/).

There are many agencies and organizations concerned with Aboriginal Peoples' health and, invariably, they all recommend increased governance autonomy over health care by their communities, and culturally sensitive and relevant health care delivery (which includes understanding the impact of colonization and the necessary health responses to offset the health deficit experienced by Aboriginal Peoples as a result).

An equitable response will require services above and beyond those provided the general population if the human rights of Aboriginal Peoples with regards to health are to truly be respected by Canada. In this way, the imbalance between the Métis and Canadians in terms of health status can be effectively adressed, countering the historical trauma, so that Métis can live healthy lives without the added burden of suffering that is the colonial legacy in this country.

The kind of response that will fulfill the spirit and intent of the recommendations listed above is not only essential for addressing the inequality in Métis health status caused by the impact of colonization, but it is necessary in order to protect the global population for it is in the poorer communities of the world that lies the greatest threat to global health. This next section briefly highlights that this issue is not just a "Canadian" issue, but a global one.

2. The Deficit and the Impact of Globalization

Communities that experience high-risk health determinants such as poverty, and under-development such as inadequate housing, are potential sources of public health concerns in that such communities are increasingly a threat in the spread of infectious disease. This threat is due to the increased "vulnerability to the prevailing and re-emerging threats of disease."[18] A scholar on global health recently commented on this phenomenon:

> One consequence of globalization is the mutual vulnerability of populations within the "global village" to the transnational spread of deadly infectious diseases and other non-communicable threats. Microbes carry no national passports, neither do they recognize geo-political boundaries or state sovereignty. Propelled by travel, trade, tourism, the phenomena of globalization, and a host of other factors, public health threats occasioned by an outbreak of disease in one remote part of the world can easily transcend national boundaries and threaten populations in distant places.[19]

Because poverty and under-development breed disease, it is not alarmist to propose that the conditions of some Aboriginal communities in Canada could become the next source of a global health crisis. The recent H1N1 virus outbreak and the reported disproportionate effect of its prevalence in Aboriginal communities, particularly those in northern Manitoba, indicate that this concern is real.[20] Such circumstances, if unchecked, put the rest of the population at increased risk because of Canada's failure to implement the health care standards necessary to fulfill their human rights obligations to Aboriginal Peoples.

Thus Canada has a global obligation to provide sufficient health services to balance the health deficit in Aboriginal communities in order to protect the rest of the world from the threat of transnational disease. It would be particularly ironic and embarrassing for Canada if

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[18] . Aginam, O. (2005) *Global Health Governance: International Law and Public Health in a Divide World.* Toronto: University of Toronto press. 6.
[19] . Ibid. at 6.
[20] . Puxley, C. (2009) Swine Flue on Remote Manitoba Reserve a "Wake up call": Chief. *Canadian Press*. Online: http://www.google.com/hostednews/canadianpress/article/ALeqM5jAKmtz5NFiXtUdTunEdiiyi--dXA

the next global disease crisis emerged from within its borders because of **Canada'**s failure to adequately address the health deficit in Aboriginal communities. This failure would also be contrary to **Canada's international obligations under the** ***Alma – Ata Declaration on Primary Health Care***[21] by not ensuring effective health services within Aboriginal communities.

Addressing the health deficit that Métis communities face would not only result in Canada upholding its honor to Aboriginal Peoples as a goal of our ***Constitution***, but would also be undertaking significant steps towards implementing **Canada'**s international obligations to address health disparities. In so doing, it would also mean taking steps **in protecting all populations from Canada's own failure to control** circumstances that give rise to increased risk of disease.

III. Métis Health Concepts, Customs and Traditions

Métis Peoples generally possess a broad holistic sense of health. At the individual level, health is understood to involve several dimensions which are inter-related, including the spiritual, mental, emotional and physical. But health is also understood to be directly related to the health of the family and the community, both socially and ecologically. Health is promoted when the individual, family and community have strong foundations in Métis culture, values, language and spirituality.[22]

Being a mixed-race people, Métis are generally open to both western and indigenous forms of health care. Historically, if someone was ill, and a western-trained doctor was available, the doctor may be called upon if the family could afford it. However, Métis would also rely heavily on their maternal indigenous heritage which includes the traditional teachings of medicines based on indigenous knowledge.

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[21] . International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978. Relevant to this discussion is the recognition in Article II of the Declaration of the need to address health inequalities. It states:

> II. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

[22] . For an excellent summary of how Métis culture, values, language and spirituality, as discussed by Métis Elders, relate to Métis health and well-being, see ***In the Words of Our Ancestors: Métis Health and Healing*** (National Aboriginal Health Organization, 2008).

Many Métis Elders possess knowledge on the medicinal properties of local plants and herbs. Subject to proper cultural protocols, this knowledge will be passed on to those who wish to learn. There is concern that this knowledge will disappear unless youth are engaged more with Métis Elders, language and culture; "there is a critical need to share and develop traditional cultural and health information resources."[23]

A Métis health tradition or custom would, therefore, include the collecting of plants, berries, and herbs on the land, and making a spiritual offering for their healing gifts. This custom would also include a process for recognizing the knowledge and skills of those that could heal or assist others.[24] This custom of healing might include other dimensions, such as spiritual cleansing ceremonies as required. Where western medicine was available, this custom might include calling upon a western-trained healer in addition to traditional practice, or as an alternative.[25]

A Métis concept of health, however, was not limited to a specific formula of illness and identifying the appropriate plant and/or spiritual ceremonies, but was broadly conceived, and could not be divorced from considerations of culture, language, identity, lifestyle, family, land, water or the Creator. Métis Elders have always understood that there are many "determinants" of health and so there are a corresponding variety of inter-dependent approaches to address health issues.[26]

Thus, it may be appropriate to conclude that a Métis health custom or tradition must be defined broadly to be more than the right to collect herbs. It must be a full and broadly conceived right to health. This definition would implicitly recognize that the process is holistic and inter-dependent of a number of activities and processes.

This report will now examine whether the law as it is currently understood is prepared to recognize a Métis Aboriginal right to health or whether the courts interpret "Aboriginal right" in s.35 of the *Constitution* to narrowly, preventing any recognition of a broadly defined Métis concept of health.

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[23] . Ibid at page 71.
[24] . Ibid at page 21.
[25] . Shore, F. & Barkwell, L. (1997) ***Past Reflects the Present: The Métis Elders Conference.*** Winnipeg: Manitoba Metis Federation.
[26] . Ibid at page 55-56.

IV. The Legal Dimensions of the Métis Right to Health

The doctrine of Aboriginal rights is defined in reference to s.35 of the ***Constitution***, 1982. The Supreme Court of Canada has refined a number of legal tests for proving the existence of an Aboriginal right protected under s.35. This provision states that "Aboriginal and Treaty rights are hereby recognized and affirmed." The first opportunity for the Supreme Court of Canada to interpret the provision came in 1990. The Supreme Court of Canada commented on the significance of the promises made to Aboriginal Peoples in s.35 of the ***Constitution*** as signaling an era of positive change. The Supreme Court, in the leading decision of ***R. v. Sparrow,*** quoted a passage written by Professor Noel Lyons:

> The context of 1982 is surely enough to tell us that this is not just a codification of the case law on Aboriginal rights that had accumulated by 1982. Section 35 calls for a just settlement for Aboriginal Peoples. It renounces the old rules of the game under which the Crown established courts of law and denied those courts the authority to question sovereign claims made by the Crown.[27]

Moreover, the Supreme Court of Canada expressly affirmed that this new era of change applied equally to the Métis communities in Canada by their inclusion in s.35 as one of the Aboriginal Peoples to which the protections and promises of s.35 apply. The Court stated that "the inclusion of the Métis in s. 35 is based on a commitment to recognizing the Métis and ***enhancing their survival*** as distinctive communities" [emphasis added].[28]

If enhancing the survival of the Métis is an explicit objective of s.35, what does that mean in terms of Métis health? Does this mean that the Government has a positive obligation under the ***Constitution*** to address the health imbalance experienced by Métis communities? Standing alone, this phrase arguably supports a broadly framed right to health.

Unfortunately, Aboriginal rights doctrine, as it is reflected in the leading cases on proving an Aboriginal right under s.35, is not likely to recognize a Métis right to health broadly framed. Under existing

[27] . Noel Lyon, "An Essay on Constitutional Interpretation" (1988), 26 Osgoode Hall L.J. 95 at 100 in ***R. v. Sparrow***, [1990] 3 C.N.L.R. 160.
[28] . ***R. v. Powley*** [2003] 4 C.N.L.R. 321 at 328.

Aboriginal rights doctrine, the courts would likely limit the inquiry to whether the Métis possess an Aboriginal right to the ***means*** or ***practices*** of ensuring healthy lifestyles. The courts would not likely recognize a broadly framed right to health ***per se*** or even health services. Presently, the courts, in interpreting Aboriginal rights in s. 35, would likely delimit and restrict its scope to certain traditional activities like harvesting plants and herbs culturally characteristic of the Aboriginal Peoples concerned. This judicial approach is explained more fully in the next section.

This limited judicial approach is problematic. At this point in the legal history of Aboriginal-Canadian relations, one must seriously question whether the analysis should stop there (i.e. limited to traditional cultural practices distinctive to the Aboriginal community), as if international human rights developments regarding Indigenous Peoples' rights did not exist. It is arguable that developments at the international level have progressed to the point that Canada and Canadian courts can no longer ignore them in the interpretation of s.35 of the ***Constitution***.[29] Based on the preponderance of judicial and academic thought, the time has now arrived for international law, as it pertains to the rights of Indigenous Peoples, to be taken into account in defining the scope and content of s.35 rights.

As a country, we can no longer continue to put our heads in the sand and ignore global developments towards addressing the wrongs of the colonial past. Some countries offer guidance that Canadian governments could benefit from as to how to incorporate international human rights standards of Indigenous Peoples into domestic law. The Philippines has already responded to the need to comply with Indigenous Peoples' human rights by enacting national legislation that adopts, and even enhances, the United Nations Declaration of Indigenous Peoples Rights into their own domestic legal order.[30]

In this section, I will first examine how a court would approach recognizing a Métis right to healing by reference to the existing legal tests for asserting an Aboriginal right under s.35, currently understood as devoid of a human rights dimension. I will then re-examine the issue from a legal interpretation perspective of s.35, which is inclusive of a human rights dimension reflected in international law.

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[29] . Yvonne Boyer, Supra, note 14 at 26.
[30] . ***Indigenous Peoples Rights Act***, (1997), Republic Act 8371, Republic of the Philippines. Online at: http://www.grain.org/brl/?docid=801&lawid=1508

1. A Métis Aboriginal Right to Healing Activities

In 2009, it is possible to assess whether the promises of s.35 made in 1982 have come to bear fruit. Unfortunately, over the last 27 years, little good fruit has emerged. The provision has been interpreted narrowly, incorporating onerous rules for proof of claims largely within a Eurocentric (English common law and French civil law) legal tradition and worldview to the exclusion of indigenous legal traditions and worldviews.

In 2003, the Supreme Court of Canada in the ***Powley***[31] case adopted the legal principles for proving an Aboriginal right from leading cases such as ***Sparrow***, ***Van der Peet*** and ***Gladstone,***[32] and adopted them to the context of Métis claims to Aboriginal rights, with one notable exception. The Court modified the time frame for claims by the Métis. Instead of requiring that a Métis claimant group establish that a practice, custom or tradition existed ***prior to European contact,*** which was the principle established in ***Van der Peet***, the court modified the test for the Métis to the requirement of establishing a practice, custom or tradition ***prior to the European assertion of effective governmental control*** in the area. Other than this particular modification, the legal principles for applying s.35 to the Métis remain the same as for any other Aboriginal group.

Although the ***Powley*** case specifically examined whether the Métis community of Sault St. Marie could hunt moose without a license contrary to provincial law, the case set out and clarified a general legal test for establishing a Métis right under s.35 of the ***Constitution*** for all Métis rights claims, regardless of their nature. In other words, the legal principles applied by the Court are not restricted to moose hunting claims, or even resource use claims, but are to be applied broadly to all Métis claim contexts and would likely include more uncommon claims such as a right to health.

In order for a claim to be successful, ***Powley*** held that a contemporary Métis community, which has continuity with a historic Métis community, must show that the practice, custom or tradition being claimed as an Aboriginal right is integral to the Métis community's distinctive culture

[31]. ***Powley***, supra, note 28.
[32]. ***R. v. Sparrow***, [1990] 3 C.N.L.R. 160, ***R. v. Van der Peet***, [1996] 4 C.N.L.R. 177, ***R. v. Gladstone***, [1996] 4 C.N.L.R. 65.

prior to effective European political and legal control in the particular area.[33]

The first step that a court is asked to consider in assessing the existence of an Aboriginal right is to identify the precise nature of the **appellant's claim.**[34] A Métis right to health may potentially be asserted at varying levels of specificity. A Métis right may potentially be framed as follows:

1. A Métis right to health (an unrestricted right to all health services and products to achieve a healthy life).
2. A Métis right to healing (Metis cultural processes or actions taken to achieve a state of healthy existence).
3. A Métis right to the protection, use and application of traditional medicines.
4. A Métis right to health governance, which could potentially apply to the management of all three characteristics of a Métis right to health listed above.

It is unlikely that a court would recognize a broadly framed Métis right to health services because it may be considered so broad **as to "cast** the c**ourt's inquiry at a level of excessive generality**."[35] If a claim was made by a Métis community that it possessed a Métis right to health (all means to achieve a state of being healthy), the court would likely characterize the claim as excessively general. For example, in the ***Pamajewon*** case, the Aboriginal claimants argued that they possessed **an Aboriginal right to "manage the use of their reserves" (a self**-government type claim). The reason for the claim was so the community could continue to run a gambling enterprise on the reserve. The court re-characterized the claim more narrowly as an Aboriginal right to conduct high-stakes gambling and its regulation. The claimants failed to provide evidence of high-stakes gambling or its regulation prior to European contact, and thus failed to prove the existence of such a right.

In addition, an unrestricted right to health services would not fit the legal test as currently understood by the courts because of the courts requirement that the right be based in a particular traditional ***activity,*** rather than a state of being or broad access to health resources. Courts have consistently defined the test for proving an Aboriginal

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33 . ***Powley***, Supra, note 28 at ¶ 38.
34 . ***R. v. Van der Peet***, supra, note 32 at ¶ 53.
35 . ***R. v. Pamajewon***, [1996] 4 C.N.L.R. 164.

right as limited to either a practice, custom or tradition. In other words, Aboriginal rights must be ***activities*** that were practiced prior to contact, in the case of non-Métis claims, and prior to European governmental control in the case of Métis claims. This emphasis on activities was recently reaffirmed by the Supreme Court of Canada in ***R. v. Sappier and Gray***.[36] This case involved the right to log or use wood from Crown lands. The Court held that:

> The difficulty in the present cases is that the practice relied upon to found the claims as characterized by the respondents was the object of very little evidence at trial. Instead, the respondents led most of their evidence about the importance of wood in Maliseet and Mi'kmaq cultures and the many uses to which it was put. This is unusual because the jurisprudence of this Court establishes the central importance of the actual practice in founding a claim for an Aboriginal right. Aboriginal rights are founded upon practices, customs, or traditions which were integral to the distinctive pre-contact culture of an Aboriginal People. They are not generally founded upon the importance of a particular resource. In fact, an Aboriginal right cannot be characterized as a right to a particular resource because to do so would be to treat it as akin to a common law property right. In characterizing Aboriginal rights as sui generis, this Court has rejected the application of traditional common law property concepts to such rights …
>
> First, in order to grasp the importance of a resource to a particular Aboriginal People, the Court seeks to understand how that resource was harvested, extracted and utilized. These practices are the necessary "Aboriginal" component in Aboriginal rights.[37]

It would be difficult to argue that a state of health or a right to health services, broadly framed, could be characterized as a "practice, custom or tradition" as those terms have been defined by the courts at the present time. However, the Métis practices of obtaining medicines off the land described by Métis Elders in the report by NAHO referred to in Part III of this report (above) would most certainly fit within the definition of a practice, custom or tradition as defined by the courts.

[36] . ***R. v. Sappier; R. v. Gray,*** [2007] 1 C.N.L.R. 359.
[37] . Ibid, at ¶ 21 and 22.

A more interesting question would be whether the Métis practice of consulting a western-trained medical doctor would be considered a practice, custom or tradition distinctive to the Métis culture. There is some evidence that Métis families consulted European-trained medical doctors when they were available for health needs.[38] Is this practice sufficient to constitute a Métis Aboriginal right to such health services? As framed, this right, even if accepted, would not likely amount to much. Everyone has a right to consult a western-trained doctor. However, if framed slightly more broadly as a right to western medical services when available, then there is potential for recognition of a benefit that is more than the status quo if we define the right to include free medical services. However, this would require some detailed historical analysis of the prevalence of western medicine and its reliance by the Métis prior to European control in a given area. It would also require an examination of how the services were provided and the costs involved. It is beyond the scope of this report to examine this issue in detail, but it is an issue that may warrant further research.[39]

Describing a Métis right as a practice to obtain plants and herbs, and administer such as medicines, would likely fit the definition of an Aboriginal right required by the courts. It is less certain if the more broadly framed characterization of the right (second way) as a Métis Aboriginal right to healing processes or lifestyle would meet the test.

Such a characterization (second way) would be far more useful and more consistent with the Métis concept of health as an holistic and inter-dependent phenomenon. This broader conceptualization of the right would theoretically include more than the practice of collecting herbs for medicinal purposes. It would potentially include other lifestyle choices that Métis view as relevant to health, such as spiritual ceremonies and living a more traditional life connected to the land, and the health benefits associated with such a lifestyle.[40]

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[38] . Shore and Barkwell, supra, note 25.

[39] . There is some evidence from Métis Elders on this issue. For example, in one report, Métis Elders said that some communities had "Indian medicine persons," nuns would be called upon, or a doctor would be used if there was enough money. Ibid.

[40] . For example, it has been noted that a traditional diet of wild game and food gathering is healthier than more modern "processed" foods. See *The Métis Cookbook and Guide to Health Living* (National Aboriginal Health Organization, 2006) and the studies cited therein.

Given the choice between the second and third characterizations described above of a Métis right to health, the narrower third approach to defining the scope of the right has been subject to significant criticism by dissenting judgments in the leading authorities of ***Van der Peet*** and ***Gladstone*** and by the academic community concerned with the study of culture. This gives support for arguing that the broader characterization is more true to the nature of societies and their cultures.

To limit the analysis of Aboriginal rights to an artificial categorization of cultural attributes (i.e. practices, traditions and customs) separate from any political/legal authority is consistent with the views of "difference theorists" and therefore attractive to liberal-minded political thinkers.[41] Such theorists focus on the need to accord certain disadvantaged groups in society with special political and legal rights in order for them to maintain their cultural differences against the weight of mainstream society's pressure to assimilate. Attention is spent on identifying those cultural differences that need protection. Such an approach is inherently an exercise of cultural comparison relative to the dominant society. Only those activities that are culturally distinct from mainstream activities need protection. This perspective arguably influenced Chief Justice Lamer's definition of what qualifies as an Aboriginal right. In ***Van der Peet***, he stated:

> It is only by focusing on the aspects of the Aboriginal society that make that society distinctive that the definition of Aboriginal rights will accomplish the purpose underlying s.35(1).[42]

According to Lamer C.J., it is to the pre-contact period that the courts must look to identify Aboriginal rights. Thus, if an activity arose because of the influence of European culture, the activity can no longer be regarded as distinctive to the Aboriginal society itself.[43] It is

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[41]. Schneiderman, D. (1996) Theorists of difference and the interpretation of Aboriginal and Treaty Rights. 14 ***International Journal of Canadian Studies, 35 at 36***.
[42]. ***Van der Peet, supra*** note 32 at 204.
[43]. ***Ibid*** at 209. It is important to note that Lamer argues that his concept of "distinctive" does not involve a comparison between Aboriginal and non-Aboriginal society. He explains that the distinctive requirement of the test only requires the Aboriginal group to show that the activity "makes the culture *what it is,"* not that the activity is different from the activities of another culture. However, if the court truly wanted to avoid a cultural comparison exercise, it would not have grounded its considerations to an analysis going back in time to pre-contact existence. Consequently, his reassurance that his test is not one that involves a cultural

no longer 'different' and therefore no longer in need of special protection.

To date, the courts have tended to define Aboriginal Peoples by reference to their cultural distinctiveness; by focusing on the term "Aboriginal" instead of "Peoples."[44] According to the legal discourse of cultural differences, Aboriginal Peoples are Aboriginal Peoples because they are racially and culturally different from European Peoples, not because they are Peoples in their own right.

The difficulty of using culture as a basis for explaining the nature and content of Aboriginal rights is further reinforced by the opinions of leading anthropologists. Schulte-Tenckhoff and Michael Asch have both renounced the use of cultural distinctiveness, as characterized by the courts in ***Van der Peet*** and ***Delgamuukw,*** as contrary to accepted anthropological evidence and scholarship. According to Asch, reliance on the notion of cultural distinctiveness will lead to arbitrary decisions. This is attributed to the "naïve and outmoded conceptualization of the nature of culture" as applied by the Supreme Court.[45] Schulte-Tenckhoff elaborates:

> By and large, the anthropological culture concept is basically an holistic one as prefigured by Tylor's classic definition:
>
> > Culture or civilization, taken in its wide ethnographic sense, is that complex whole which includes knowledge, belief, art,

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comparison is unconvincing. Justice L'Heureux-Dube, writing in dissent in *Van der Peet*, captured this logical inconsistency of the Chief Justice's reasoning in this way:

> An approach based on a dichotomy between Aboriginal and non-Aboriginal practices, traditions and customs literally amounts to defining Aboriginal culture and Aboriginal rights as that which is left over after features of non-Aboriginal cultures have been taken away…. The criterion of "distinctive Aboriginal culture" should not be limited to those activities that only Aboriginal people have undertaken or that non-Aboriginal people have not. Rather, all practices, traditions and customs which are connected enough to self-identity and self-preservation of organized Aboriginal societies should be viewed as deserving of protection. (at. 232, 234)

[44] . Bell, C. (1997) ***Métis Constitutional Rights in Section 35(1)*** Alberta Law Review, 180 at 186. Professor Bell explains that it is "peoplehood, not lineage, that is the source of rights to self-government and cultural institutions essential to the self-identity and preservation of distinct Aboriginal societies.

[45]. Asch, M. (1999) ***The Judicial Conceptualization of Culture After Delgamuukw.*** (Speaking Notes for A Post-Delgamuukw Universe Conference) Montreal: McGill University, at 1.

morals, law, custom and any other capabilities and habits, acquired by man as a member of society.

> It is important to note, however, that the holistic perspective commanding it … hardly allows one to decide with any precision 'what makes a society what it is'. It cannot credit any notion of a central culture trait removed from the realm of history as evidence admissible in court.
>
> From an anthropological viewpoint, the *Van der Peet* test therefore seems arbitrary and fails to account for two central features of the culture concept in its contemporary and critical meaning, namely, its systemic character and its historicity.[46]

According to Asch, the emphasis on "distinctive" is likely an attempt by the court to discover a method by which to differentiate between what is central and what is peripheral to a culture.

> Yet, we know that culture is a system and a process rather than items and arrangements. It is simply inappropriate to approach a study by attempting to ferret out whether a practice, custom or tradition is 'distinctive.'[47]

Moreover, the comparative aspect implicit in a test that focuses on cultural distinctiveness tends to focus attention on the concept of "Aboriginal" as meaning a certain socio-economic lifestyle.

> Indigenous peoples are said to be those whose modes of life differ fundamentally from modern industrial society with its sophisticated technology and consumption patterns, being based on hunting and gathering, trapping, swiden agriculture, or transhumance.[48]

Thus, from a social science perspective, it is illogical to examine the rights of a people in isolation from their existence as an autonomous organic political entity. Culture is a dynamic process.[49] It is not a product that can be captured and then displayed in the frozen-food department of your local grocery store.

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[46]. Schulte-Tenckhoff, I. (1998) ***Reassessing the Paradigm of Domestication: The Problematic of Indigenous Treaties*** 2 Review of Constitutional Studies, 239 at 273.
[47]. Asch, M. ***supra*** note 45 at 12.
[48]. Schulte-Tenckhoff, I. ***supra*** note 46 at 275.
[49]. See, generally, Michael Asch, ***supra*** note 45 and Isabelle Schulte-Tenckhoff, ***supra*** note 46.

Leading Aboriginal law scholars agree with the social-scientist critic of the court's approach:

> Locating the 'centrality,' 'integrality', or 'purity' of the Lamer Court test is philosophically impossible. It cannot be objectified by reviewing courts, as the test is inescapably subjective and not static; the test wrongly presumes that fragmented, rather than holistic, Aboriginal cultures exist.[50]

Put another way, the authors note that the court's search for difference

> continues to value the 'pure' over the composite, mixed , or mosaic. Such distinctions have historically not only created the racial masks, identities, and politics of Indians, Métis and Inuit, but have also attempted to perpetuate the idea of the 'pure' or integral Aboriginal law and rights before European colonization. The result is to reject the Aboriginal compromises with the colonizers and their resulting inter- and intra-culturality, cross-culturality, or syncretic visions as ineligible for constitutional protection.[51]

Professor Rotman has described this limited judicial approach to defining Aboriginal rights as a tendency to compartmentalize them into such narrow and discrete categories as to make them virtually meaningless to the Aboriginal society that is to benefit from them. He explains:

> The courts seem intent on separating those claims from the circumstances that initially gave rise to them. By isolating these claims from their historical, cultural, social, political and legal contexts, the court's examinations invariably take place in a jurisdictional vacuum.... By reducing broad Aboriginal and treaty rights like self-government or fishing to specific practices in such cases as *Pamajewon* and *Van der Peet*, the judiciary divorces those rights from the larger context within which they both originated and continue to exist.[52]

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[50]. Youngblood Hendersn, James, Benson, M.L., & and Findlay, I.M. (2000) *Aboriginal Tenure in the Constitution of Canada* Toronto: Carswell, at 326.
[51]. Ibid*.* at 323.
[52]. Rotman, L. (1997) ***Creating A Still-Life Out of Dynamic Objects: Rights Reductionism at The Supreme Court of Canada.*** 36 Alberta Law Review, 1 at 2, 3.

The combined effect of this legal history on the interpretation of s. 35 is profound. There is a marked hesitancy by the court to go beyond Aboriginal rights as simple manifestations of cultural activities to an appreciation of Aboriginal rights as belonging to distinct political groups of Indigenous Peoples. However, if Aboriginal rights are to have any relevance to Aboriginal communities, they must be protected in such a way that acknowledges the fact that the group benefiting from the protection is a social and political group existing in the here and now. Although often teetering on the edge, the courts have consistently failed to go that extra step of incorporating the additional analysis of according the necessary political room for management by the Aboriginal collective of the right. The exercise of a right is meaningless to a group if it cannot be interpreted in a manner that is **consistent with the group's collective understanding of its history,** language, and relationship to its land and environment, as expressed through subsequent generations from the past to the present.

This critique is relevant to both the right to collect traditional medicines and the broader right to healing processes. Both require a cultural comparative analysis for recognition as an Aboriginal right, and therefore are limited to a right to perform certain healing activities (even if broadly interpreted to include spiritual and cultural pursuits that support a healthy lifestyle) without state interference due to protection under s. 35 of the ***Constitution***.

Such a limited definition of a Métis right to health as including only the means and practices of securing traditional medicines (and perhaps western medicine where available) does not address the underlying causes of poor health. As Frideres and Gadacz observe, once the illness is addressed (whether by traditional or western means) the person is often returned to the same social environment which contributed to an increased risk of illness in the first place.[53]

An Aboriginal right that fails to address the health status of a Métis community in any meaningful positive way over the long term is not much of a benefit to the community. Recognition of an Aboriginal right, generally, to all necessary health services and products would **arguably be more beneficial than being allowed to perform "cu**lturally **distinctive" healing processes and practices without** state interference.

[53]. Frideres and Gadacz, supra, note 15.

An unrestricted Métis right to health services would be a more beneficial characterization of the right. In such a case, the state would have a positive obligation under s. 35 (informed by the human rights principles of international law as they relate to the right of Indigenous Peoples to health) to provide the necessary culturally relevant health services to ensure the Métis community is able to enjoy a healthy state of being.

Thus, this next part examines the argument of interpreting s.35 from a human rights perspective rather than the restricted cultural comparison approach that courts presently apply.

2. A Métis Aboriginal Right to Health

A Métis right to health can be said to fall within the meaning of an "Aboriginal right" in s.35 if one incorporates international human rights principles regarding both health as a human right, generally, and Indigenous Peoples' right to health specifically. It is argued that s. 35 is not simply limited to rights which are recognized as Aboriginal rights under the standard legal doctrine as it has come to be applied by Canadian courts, but the provision is broad enough to also include international human rights standards as they apply specifically to the right to health of Aboriginal Peoples. As explained below, this approach to s.35 is more consistent with the goals of s.35 as a means to reconcile Crown sovereignty with the interests of Aboriginal Peoples, and is more consistent with the recognition of Aboriginal Peoples as ***peoples*** in a relationship with the Canadian state.

The phrase "Aboriginal and Treaty rights are hereby recognized and affirmed" is silent as to the legal sources that give rise to these rights. Courts have held that the phrase does not create rights. The courts have said that Aboriginal common law rights have become incorporated into s.35 and thus now have constitutional protection from state interference. No court, however, has said that it is only Anglo-Canadian born common law rights that are protected by s.35. It is open to argue that s.35 means more. It is open to argument that the term "Aboriginal rights" not only includes common law rights based on domestic Anglo-Canadian law, but includes Aboriginal rights based on internationally recognized human rights law.

Is it sufficient for the courts to continue to simply apply domestic Aboriginal rights analysis based on the limited doctrine of the common law, as currently applied, to determine the content and scope of s.35?

Or has the recent developments regarding the adoption of the United Nations Declaration of Indigenous Peoples Rights constitute "Aboriginal Rights" for the purpose of s.35? The history of Indigenous Peoples' oppression world wide, the intent of the Declaration to address this historical oppression, and the social and economic disparities that colonization and racism towards Indigenous Peoples has caused, creates state obligations ***vis a vis*** their Indigenous Peoples. The converse is then logically true. Where a state obligation exists to Indigenous peoples, so must a right ***vis a vis*** the state exist.

A. The Human Right to Health Under International Law

There are a number of international treaties and declarations that identify the right to health as a basic human right. Appendix 1 of this report contains a select number of extracts from various international human rights instruments that guarantee the right to health. Prominent among these international statements is the International Covenant on Economic, Social and Cultural Rights (ICESCR).

Article 12 states that:

> The states party to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The Article also provides a number of specific steps that states must undertake towards the realization of this right. In interpreting the right to health provisions of the ICESCR, the United Nations Commission on Human Rights made a number of observations about a state's obligations:

Importantly, the Commission noted that the concept of health is broader than the mere absence of illness, but extends to factors that promote conditions for living a healthy life. In this sense, the Commission's understanding of health is more in line with a Métis cultural understanding of health as a holistic concept. In addition, the Commission emphasized that the right to health is based on principles of equity and non-discrimination. Everyone has the right to access health services and products without discrimination:

> Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the

population, in law and in fact, without discrimination on any of the prohibited grounds.

This right to equality is substantive in nature and not one of mere formality. The Commission emphasized that there are heightened obligations on the s**tate to ensure that "poorer households should not** be disproportionately burdened with health expenses as compared to **richer households."**[54]

Thus, arguably, Canada would have a positive obligation to ensure that health care which is not covered by a general health care plan be **subsidized for those who can't afford it. This is especially** the case, as the Commission points out, for Indigenous Peoples:

> 27. In the light of emerging international law and practice and the recent measures taken by states in relation to Indigenous Peoples, (19) the Committee deems it useful to identify elements that would help to define Indigenous Peoples' right to health in order better to enable states with Indigenous Peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that Indigenous Peoples have the right to ***specific*** measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for Indigenous Peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of Indigenous Peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of Indigenous Peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health [emphasis added].[55]

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[54] . Committee on Economic, Social and Cultural Rights. (2000). ***The Right to the highest attainable standard of health, 22nd Session, General Comment 14*** , United Nations Document. E/C. 12/2000/4 at para. 12.

[55] . Ibid at para. 27

Canada is a signatory to this treaty and is bound by it, including the importance of the right to health for Indigenous Peoples. In addition, it is increasingly recognized that the right to health reflected in the various international treaties, declarations and conventions is now a part of customary international law.[56] Customary norms and treaty norms can co-**exist "even where the two categories of law have an** identical content."[57] The existence of the right to health in international treaty instruments, that Canada is legally obliged to implement, and the existence of a customary international norm of a right to health is directly relevant to how s.35 of the ***Constitution*** is to be interpreted. This is discussed in the next section.

B. The Human Right to Health of Indigenous Peoples

Recently the United Nations, in an overwhelming endorsement, adopted a Declaration of Indigenous Peoples' Rights.[58] The Declaration contains provisions directly relevant to the right to health. Articles 23 and 24 state:

> ***Article 23*** Indigenous Peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous Peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.
>
> ***Article 24 (1)*** Indigenous Peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
>
> ***Article 24 (2)*** Indigenous individuals have an equal right to the

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[56] . Kinney, E. (2001) ***The International Human Right to Health: What does this mean for our nation and world***. 34 Indiana Law Review, 1457. See also, Chirwa, D.M. (2003) ***The Right to Health in International Law***. 19 SAJHR, 541.
[57] . Kindred, H., Saunders, P., et. al. (2006) ***International law: chiefly as interpreted and applied in Canada, 7th Ed.*** Toronto: Emond Montgomery Publications Ltd.,, 110.
[58] . See Appendix 1.

enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

The importance of singling out Indigenous Peoples as possessing a right to health cannot be underestimated. The provision reflects the reality that Indigenous Peoples' health status is poorer than the general population as a whole in member states. It reflects a common intention that because of this disparity in health status, the issue of health is a priority for Indigenous Peoples, and is a therefore recognized as a unique human right for Indigenous Peoples.

The national application of international law in Canada is dependent on the source of the international obligation. Whether and how international law is adopted into Canadian law is dependent on whether the obligation is sourced in a treaty, such as the ISESCR, or is sourced in customary law. With regards to a treaty, the Canadian position is that terms must be "transformed" into Canadian law by statutory enactment. In the case of customary law, such laws are automatically adopted into Canadian law and do not need the authority of Parliament or the legislature to recognize their validity. In terms of the ICESCR Covenant on the right to health, Canada would need to specifically authorize the treaty provisions through statutory recognition. This is complicated in a federal state such as Canada.

It is not necessary, however, to examine in detail the issue of whether and to what extent Canada has transformed the health provisions of the ISESCR into Canadian law because the human right to health as stated above is also an internationally recognized customary law norm As such, it is directly adopted into the common law of Canada. Nevertheless, it is noteworthy to consider the Supreme Court of Canada's position on the significance of international treaty norms and their relevance to the interpretation of domestic statutory law. Specifically, Chief Justice McLachlin stated in a 2004 decision that "[s]tatutes should be construed to comply with Canada's international obligations."[59] Arguably, the term "Aboriginal rights" in s. 35 of the Constitution should, according to Chief Justice McLachlin, be interpreted to comply with Canada's international obligation to provide for the right of Aboriginal Peoples to health services and programs aimed to ameliorate the health deficit of such vulnerable populations. Although this principle of international and domestic law compatibility

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[59] . *Canadian Foundation for Children, Youth and the Law v. A.G. Can*. [2004] 1 S.C.R. 76 at 100.

is important in its own right, it also reinforces the conclusion discussed below that the customary international right to health of Aboriginal Peoples is an Aboriginal right in s.35. This is because s.35 is a statutory recognition of the common law right to health of Aboriginal Peoples as a result of the principle of adoption of customary law rights into the domestic law of Canada.

The principle of adoption of customary law norms was recently affirmed in the Supreme Court of Canada's decision in *R. v. Hape*:

> According to the doctrine of adoption, the courts may adopt rules of customary international law as common law rules in order to base their decisions upon them, provided there is not valid legislation that clearly conflicts with the customary rule.[60]

The combined impact of the customary law of right to health and the provisions of the United Nations Declaration of Indigenous Peoples Rights, which target the right to health as essential to the rights of Indigenous Peoples, is strong support for the recognition of a corresponding international right to health targeted specifically to Indigenous Peoples. It is therefore logical that the right to health of Indigenous Peoples becomes adopted into s.35 because it is based on an Aboriginal-specific right in the common law of Canada adopted from international customary law. It is thus now protected and incorporated into the ***Constitution***.

The argument is simple. International law now recognizes a customary international law of right to health for Indigenous Peoples. Under Canadian law, international customary law is adopted into Canada and becomes a part of the common law as a result. Thus, there exists an Aboriginal common law right to health. Section 35 of the ***Constitution*** protects Aboriginal common law rights and incorporates them into the ***Constitution***. Thus, the Aboriginal right to health is now one of the "existing Aboriginal rights." Unless the right has been extinguished, the right continues to exist.

Unlike many of the rights recognized in s.35, the right to health is a positive right and thus imposes obligations on the government to actively implement it to make it meaningful. The government must take action. It is not a question of ensuring government non-interference in the exercise of a right. The positive right characterization may challenge the courts' understanding of what s.35

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[60] . ***R. v. Hape*** [2007] 2 S.C.R. 292 at para. 36.

can accomplish. As explained below, a proper understanding of s.35 in the context of Aboriginal-Canadian relations supports the viability and capacity of s.35 to protect positive-framed Aboriginal rights of this nature.

3. The Capacity of S. 35 to Embrace a Human Rights Dimension

The issue addressed in this section is whether s.35 can embrace a human right to health along with the positive duty of government to affect the implementation that such a right requires.

The issue of Aboriginal–Canadian relations cannot be examined from a liberal democratic perspective, as is generally presumed. This is something that the courts and policy makers have a very difficult time understanding. Liberal legal theory cannot be presumed to be the basis of a common understanding between Indigenous nations and the Canadian State. Yet, this perspective infiltrates the legal analysis that the courts apply in interpreting Aboriginal and Treaty rights.

It is argued here that the adoption of international human rights of Indigenous Peoples, as an integral part of the content and analysis of s.35, is better understood and addressed if we challenge the presumption of liberal legal thought that has tended to inappropriately govern its interpretation thus far. When we challenge the presumption of liberal legal theory and conclude that its application is inappropriate to s. 35 of the ***Constitution***, it opens up the possibilities of s.35 to then be an effective means of protecting the collective and individual human rights of Indigenous Peoples based on legal principles more akin to those normally associated with peaceful relations; as between distinct autonomous political societies (peoples).

In other words, s. 35 is not about how the Aboriginal rights of individuals (or even collectivities that are legally treated like individuals from a liberalism perspective) can be balanced against the interests of the Government or society as a whole. Unfortunately, this perspective is prevalent in almost every step in an Aboriginal rights analysis. For example, this is evident even in how a court characterizes the nature of the right claimed. The questions that a court asks in assessing the nature of a claim starts from a liberal perspective of government and presumes interference with a right (read freedom). There are three factors (although not exhaustive) the

court considers in determining the appropriate character and scope of the Aboriginal right. They are:

- The nature of the action which the applicant is claiming was done pursuant to an Aboriginal right.
- The nature of the government regulation, statute or action impugned.
- The tradition, custom or practice being relied upon to establish the right.[61]

Note how the second question presumes a situation where specific government action is allegedly infringing upon a freedom (right) to engage in an activity.

Moreover, the addition of a step for justification, which allows the Government to justify an infringement of a constitutionally protected Aboriginal right, is further evidence of a domestic liberal legal theory unduly influencing the legal relations of independent political societies that have unique and differing epistemologies, worldviews, and legal understandings of rights and obligations. The imposition of a "justification" analysis, akin to a s.1 *Charter* analysis, is explained from a liberal legal theory perspective as an exercise of balancing the rights of individuals against the interests of the state. This theory is fine as a basis for understanding rights and obligations within a state, between state interests and citizen interests. It is not appropriate for understanding rights and obligations between peoples.

The courts must appreciate that Aboriginal rights under s.35 are not typical or similar to the kind of legal rights that citizens possess "within" a state like Canada. In a liberal democracy, the relationship between the state and its citizens is based on the fundamental principle of non-interference. Within this legal philosophical environment, the state is not normally considered as having a "positive" obligation to legislate or pro-actively develop programs to ensure effective access to a right. Rights in a liberal democracy are usually seen as freedoms from state interference.

However, the relationship between Canada and Aboriginal Peoples is not analogous to that of a state and its citizens. Rather, it is more analogous to international relations such as those between governments, peoples, and nations. As such, there is no presumed common or fundamental political premise as to how rights and

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[61] . ***Van der Peet***, supra note 32.

obligations are to be addressed. If there is any fundamental common basis from which to approach the relationship between Canada and Aboriginal Peoples, it is more appropriate that it be grounded in the principles of peaceful relations between nations, namely the right to self-determination of peoples and the right to be free from undue foreign influence.[62]

The relationships between Canada and the various independent Aboriginal Peoples are between political collectivities (each representing a community) with a legal relationship that is not based on any common legal theory, but on historically determined and locally developed obligations (often reciprocal in nature) based on agreements between political representatives from each community over time.

Aboriginal Peoples as collectivities are not part of the contract between the state and its citizens. Aboriginal collectivities, ***as collectivities***, do not have a political vote or legally recognized institutional role in law making in Canada. Thus, the argument that Aboriginal political units are part of Canada and can lobby or participate in the democratic process to institute change is not possible. It is unfair to hold Aboriginal Peoples to a political and legal theory of liberalism in the interpretation of their rights because they are powerless to affect any democratic change if liberalism proves to be unresponsive to their political aspirations. Certainly, individual Métis citizens can vote as Canadian citizens because of the second citizenship bestowed upon them, but this is an individual choice and does not necessarily involve consideration of the interests of the Aboriginal collective.

Thus, any obligations that Canada has towards Aboriginal Peoples ***as peoples*** must be negotiated politically through agreements, treaties, or through accepted principles of Aboriginal rights grounded in customary principles of peaceful relations between peoples.

Active positive duties of a state to other states or peoples are commonly found in international law, either in the form of treaties or as customary law obligations. Positive obligations can and do readily exist in the context of international relations. A presumption of rights being grounded in liberal theory, and thus assumed to be only negative rights such as those against state interference, is not appropriate in this context.

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[62] . See generally Kindred and Saunders, supra note 57 at p. 13 – 43.

Section35 of the ***Constitution*** is a provision to establish good relations between Aboriginal Peoples and Canada. It is about reconciliation between political collectivities. Thus, the presumptions of customary principles of peaceful relations, as found in international law, are more appropriate for the interpretation of s. 35 rights than the current doctrine that mistakenly characterizes Aboriginal rights as akin to individual rights subject to the presumptions of liberalism.

Moreover, the purpose of s.35 is to protect. The creation of a constitutional provision to affirm Aboriginal rights was meant to protect Aboriginal Peoples from unilateral derogation by governments.[63] Prior to 1982, Aboriginal rights were merely common law rights and were therefore subject to the whim of Parliament or the legislatures. The protection of Aboriginal rights in the ***Constitution*** was seen as a victory for Indigenous Peoples in Canada, a means to achieve justice in the face of past violations of their rights and protect them from future violation. It is arguable that the objective of protection is just as valid an objective in the context of internationally recognized rights as it is for domestically recognized common law rights. Indeed, given the lack of enforcement machinery at the international level, the protection of such rights is all the more compellable and would serve the purpose of s.35 more fully if Indigenous Peoples' human rights were also protected by the strong arm of the ***Constitution***. Moreover, such an understanding of the purpose of s.35 would advance the principle of equity from the point of view that internationally recognized rights should be treated no differently than domestically recognized rights.

Attempts by Aboriginal Peoples in Canada to have Aboriginal rights protected in the ***Constitution*** of 1982 were part of a larger global context or movement to redress past injustices inflicted on Indigenous Peoples by nations that exploited them and their lands in centuries past. In this sense, Aboriginal rights in s.35 are collective human rights designed to address and compensate for inhumane treatment and denial of fundamental human rights in the past – an imperative of justice that is not unique to Canada.

It is, therefore, wrong for the Newfoundland Court in ***Davis v. Canada*** **to hold that s.35 "imposes no positive obligation on government to** protect and preserve any A**boriginal right."**[64] On the contrary, a contextual approach based on assumptions of reconciliation in a post-

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[63] . ***Sparrow***, supra note 32.
[64] . ***Davis v. Canada*** [2007] 263 Nfld & P.E.I.R. 114 at para. 92

assimilation, post-colonial society, where the Crown is presumed to act honorably, will no doubt require positive obligations on the party that has perpetuated disrespectful relations in the past. The very agreement to incorporate Aboriginal rights into the *Constitution* affirms that commitment to right the wrongs of the past. Correcting the imbalance between Aboriginal Peoples and Canada necessarily requires positive action.

Where an Aboriginal right is affirmed in s.35 and involves affirmative and positive government action for its implementation, then the right carries with it the government obligation to fulfill it. This is the logical outcome of a relationship between peoples which is founded on mutual respect, and that takes into account the social/historical context which gave rise to the current imbalanced relationship. This logically requires correction that only government positive action can achieve, as fairness now demands that the party which caused the inequity in the first place be responsible for its rectification. These are principles that guide relations between nations and peoples as they further the cause of peaceful inter-relations. These are the principles that should inform the courts in defining s.35, not the liberalism assumptions that the Newfoundland Court based its decision upon.

Interestingly, the Supreme Court of Canada appears to be more receptive to the imposition of a positive duty in the recent line of "duty to consult" cases. For example, in the *Taku River* case, the Court explicitly made the connection between the Crown's obligation to "change government plans or policy to accommodate Aboriginal concerns," and the purpose of s. 35 as requiring a "just settlement of Aboriginal claims."[65]

The term "accommodate" is not usually thought of as passive in nature or embodying only the notion of non-interference. On the contrary, it connotes a pro-active response like a funding change in government programming or policy reform to implement the Crown's duty. A dictionary defines "accommodate" to include the meaning: "to provide suitably; supply (usually followed by with); to accommodate a friend with money."[66]

This understanding of s.35 recognizes that a positive obligation may indeed be a necessary remedy imposed on the Crown in order to

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65 . *Taku River Tlinget First Nation v. British Columbia* [2004] 3 S.C.R. 550, para. 24-25.

66 . http://dictionary.reference.com

ensure that Aboriginal rights are fulfilled. Indeed, the Supreme Court of Canada expressly guarded against a narrow interpretation. It stated:

> In all dealings with Aboriginal Peoples, the Crown must act honourably, in accordance with its historical future relationship with the Aboriginal Peoples in question. The Crown's honour 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).[67]

Thus, given the recent articulation of the purpose behind s.35 and the duty to accommodate, reconciliation may require defining the obligations of the Crown with respect to Aboriginal rights (or claims). There is ample support for the view that, in the unique context of Aboriginal-Canadian legal relations, the remedy of positive duties, including the allocation of targeted funds to fulfill those obligations, is now supported by the highest Court of the country. The dicta in lower courts, such as in ***Davis,*** which precludes the existence of a positive right, cannot be regarded as authoritative on this issue.

It is useful to summarize the legal position in support of a Métis right to health at this point. Firstly, there is a compelling argument that a Métis right to health exists in common law through the adoption of international customary law of the right to human right to health, which is especially targeted to Indigenous Peoples. Secondly, s.35 of the ***Constitution*** is not foreclosed to the protection of common law rights based on the principle of adoption. Indeed, the rights of Indigenous Peoples recognized at the international level are based on principles that are arguably more consistent with the nature of the relationship between Aboriginal Peoples and Canada than they are with the domestic legal principles currently being applied by the courts, which have been highly criticized as culturally arbitrary, overly narrow and inappropriately grounded in Eurocentric political theories of liberalism. The purpose of s.35 is thus better served by principles relating to the fulfillment of peaceful and respectful relations between independent political actors – principles which do not preclude the recognition of positive obligations being imposed on one of the parties for the purposes of furthering peaceful and respectful relations.

The international community, and Canadian policy, regarding the rights of Indigenous Peoples has spoken loudly and clearly. The

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[67] . ***Taku River***, supra note 65 at para. 25.

injustices that have been inflicted on Indigenous Peoples need to be rectified. The status quo is not enough. Positive pro-active action on the part of states is recognized as essential to this goal. The provision of health services targeted to Indigenous Peoples to address the health deficit within their communities is part of a broader global and domestic objective.

4. Application of the Aboriginal Right to Health to the Circumstances of the Métis

This section will examine how the Aboriginal right to health, as defined in reference to the international human rights of Indigenous Peoples and protected in s.35 of the ***Constitution***, would apply to a Métis claim. One approach would be for the Métis to argue an Aboriginal right to health that would meaningfully address the current health imbalance between Métis and other Canadians. If a court was asked to consider such a claim, the court would need to examine the context of a right to health in international law, then determine what the expectations would be to implement a claim to health services and products in the context of Métis communities. Where there is a negative discrepancy between the current state of health services for the Métis community and the state of health that is required as a Métis Aboriginal right under s.35, the Crown would have a positive obligation to provide the means, and if necessary the funds, to bridge the imbalance in services and programming. The Crown would be obligated to fulfill the Aboriginal right of the Métis community to the highest attainable standard of health.

In making this assessment, the court would no doubt examine the exclusion of the Métis from the non-insured health benefits program. The Government would need to show that the Métis are not being discriminated against by their exclusion. Arguably, a court may find that the specific obligation of the state to address the health imbalance of Indigenous Peoples be done in a non-discriminatory way, and find that there is no logical basis for denying Métis the same services that are accorded Status Indians under federal health policy. Both Métis and Status Indian communities have experienced the negative impact of colonization and the consequential negative health effects of such experiences. Both communities are to be served by the protective and ameliorative purpose of s.35. Discrimination between the groups would, on this basis, seem particularly arbitrary and inconsistent with the goal of s.35 and international human rights law as it applies to

Indigenous Peoples. It is certainly inconsistent with the Government's obligation to "ensure their survival" as a people.

The author of this paper once attended a Manitoba Metis Federation meeting on self-government. There was a good showing of Métis members in the audience. The discussion at one point turned to the issue of health; the lack of health services and their affordability. A Métis Elder stood up and asked, "what good is a right to collect and use herbs when I need my teeth fixed? We may have bannock to eat at our meeting, but they [Status Indians] get their teeth fixed!" This Elder was obviously frustrated because he needed his teeth fixed, yet could not afford such treatment. He did not understand the unfairness and inequity between his circumstances as a Métis person and the circumstances of a Status Indian who could access dental services for free as a result of federal health policy.

This inequity between Indigenous Peoples is a clear violation of the principles of the right to health of Indigenous Peoples recognized in international law and adopted into the domestic constitutional law of s.35.

V. Conclusion

Defining Aboriginal rights in s.35 in reference only to cultural practices that have continuity with pre-contact European society reduces Aboriginal Peoples to museum-like caricatures with rights that are socially and economically marginal in contemporary society. It is dehumanizing and contrary to a global trend requiring states to acknowledge the rights of Indigenous Peoples as equal in status to all peoples of the world, whether they are located in existing states or not. Consistent with this approach to understanding Aboriginal Peoples' rights is the need to address the health deficits that exist in Aboriginal communities in "post-colonized" Canada. Compensation and reconciliation due to the past effects of dehumanizing policies by Canada on the health status of the Métis requires positive state action and plans that address the health imbalance in a culturally appropriate manner.

If s.35 of the Canadian *Constitution* were to include a human rights dimension by adopting principles of international customary and treaty rights, the Métis community could achieve the substantive equality of health services that their status as Indigenous peoples demand. Through required government action, this would correct the imbalance

Métis peoples currently experience as a result of past wrongs. Substantive justice would then truly be achieved. All Canadians could stand tall and proud of such a result.

Appendix 1

Universal Declaration of Human Rights, GA Res. 217 (III), UN GAOR 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71.

Article 25 (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Full text: http://www.un.org/Overview/rights.html

International Covenant on Economic, Social and Cultural Rights, 16 December 1966, 993 U.N.T.S. 3, Can. T.S. 1976 No. 46 (entered in to force 3 January 1976).

Article 12 (1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Full text: http://www.unhchr.ch/html/menu3/b/a_cescr.htm

Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, 1249 U.N.T.S. 13, Can. T.S. 1982 No. 31 (entered into force 3 September 1981).

Article 12 (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

(2) Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 12 (2) States Parties shall take all appropriate measures to eliminate

discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right: … (b) To have access to adequate health care facilities, including information, counselling and services in family planning ….

Full text: http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm

Convention on the Elimination of All Forms of Racial Discrimination, 21 December 1965, 660 U.N.T.S. 195, Can. T.S. 1970 No. 28 (entered into force 4 January 1969).

Article 5 In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: … (e) Economic, social and cultural rights, in particular: … (iv) The right to public health, medical care, social security and social services ….

Full text: http://www.unhchr.ch/html/menu3/b/d_icerd.htm

Convention on the Rights of the Child, 20 November 1989, 1577 U.N.T.S. 3, Can. T.S. 1992 No. 3 (entered into force 2 September 1990).

Article 24 (1) States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

(2) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; (f) To develop preventive health care, guidance for parents and family planning education and services.

(3) States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

(4) States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25 States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 33 States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Full text: http://www.unhchr.ch/html/menu3/b/k2crc.htm

American Declaration of the Rights and Duties of Man (adopted by the Ninth International Conference of American States, Bogota, Colombia, 1948, which also created the Organization of American States)

Article 11 Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.

NOTE: Canada ratified the Charter of the Organization of American States on 8 January 1990, Can. T.S. 1990 No. 23.

Full text: http://www1.umn.edu/humanrts/oasinstr/zoas2dec.htm

American Convention on Human Rights, 22 November 1969, U.N.T.S. 123, O.A.S.T.S. No. 36 (entered into force 18 July 1978).

Additional Protocol, *Article 10* (1) Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.

(2) In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right: (a) Primary health care, that is, essential health care made available to all individuals and families in the community; (b) Extension of the benefits of health services to all individuals subject to the State's jurisdiction; (c) Universal immunization

against the principal infectious diseases; (d) Prevention and treatment of endemic, occupational and other diseases; (e) Education of the population on the prevention and treatment of health problems, and (f) Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

NOTE: Canada is not signatory to this agreement.

Full text: (Additional Protocol) http://www.oas.org/juridico/English/treaties/a-53.html
(Convention) http://www.cidh.org/Basicos/English/Basic3.American%20Convention.htm

European Social Charter, 18 October 1961, 529 U.N.T.S., Eur. T.S. 35 (entered into force 26b February 1965).

Article 11 With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*: (1) to remove as far as possible the causes of ill-health; (2) to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; (3) to prevent as far as possible epidemic, endemic and other diseases.

Article 13 With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake: (1) to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition; (2) to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights; (3) to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want; (4) to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953.

Full text: http://conventions.coe.int/treaty/en/treaties/html/035.htm

United Nations Declaration on the Rights of Indigenous Peoples, GA Res.61/295, UN GAOR 61st Sess., UN Doc. 419 (2006).

Article 23 Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24 (1) Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

(2) Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

NOTE: Canada was one of four countries (along with Australia, New Zealand, and the United States) to vote against this UN resolution. There were 143 votes in favour and four abstentions.

Full text:
http://daccessdds.un.org/doc/UNDOC/GEN/N06/512/07/PDF/N0651207.pdf?OpenElement