SUBMISSION OF MASKWACIS CREE TO THE EXPERT MECHANSIM ON THE RIGHTS OF INDIGENOUS PEOPLES STUDY ON THE RIGHT TO HEALTH AND INDIGENOUS PEOPLES WITH A FOCUS ON CHILDREN AND YOUTH

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Introduction and Summary

The subject of this submission is broadly our Treaty Right to Health, which our ancestors negotiated as a pillar of Treaty.

Indigenous Peoples entered into historic Treaty No.6, and adhesions, in the province of Alberta (and Saskatchewan, which is not the subject of this submission) with the British Crown; Canada (and by extension the provinces and territories) is a 'successor state' to that Treaty and as such is a Treaty Partner. We entered into treaty with the spirit and intent of ensuring the sharing of lands and resources and the continued provision of specific treaty obligations on the part of the British Crown. Those obligations are now to be upheld by Canada and the province of Alberta, by virtue of Indigenous laws, British law, international law, Canadian Constitutional law, jurisprudence of the Supreme Court of Canada and the common law system.

The Maskwacis Cree comprise four Indigenous Nations – Ermineskin Cree Nation, Montana First Nation, Louis Bull Tribe and Samson Cree Nation - within the Treaty No. 6 territory (Alberta). This submission was compiled and contributed to by Maskwacis Health Foundation. The following organization supports and endorses the content of this submission: Confederacy of Treaty 6 First Nations (Alberta).

Treaty does not contain all of our rights and obligations – prior to Treaty, Indigenous Peoples existed and continue to exist within a framework of natural laws, custom laws, Indigenous knowledge systems and with our own languages. We continue to speak, practice and implement these within the context of the modern world. Our laws operate in equal weight with Treaty, Canadian and International laws and standards. The principles we utilize in our approach to Health are as follows:

> ***Kisêwâtisowin*** *– 'absolute compassion'*
> ***Kitimâkêyimsowin*** *– 'the kind of compassion that you would have for an infant child – applied to yourself'*
> ***Kitimâkêyhtowin*** *– 'the kind of compassion that you would have for an infant child and having the ability to apply to everyone else'*
> ***Sakaskêyhtowin*** *– 'a bonding compassion'*
> ***Sâkihtowin*** *– 'Love one another'*
> ***Sitoskohtatowin*** *– 'supporting each other'*
> ***Manâcihtowin*** *– 'having respect for each other'*
> ***Miyo Wîcêhtowin*** *– 'getting along with each other'*
> ***Wîcihtowin*** *– 'helping one another'*
> ***Ohtatapêk'sinowin*** *– 'Our Sacred Clan System of Kinship'* [1]

Entering into Treaty with the Crown did not destroy those principles, natural laws or knowledge systems. In fact, these understandings formed the basis for our negotiation of Treaty and the subsequent interpretation of the true spirit and intent of Treaty – as long as the grass grows, the sun shines and the water flows.

From the perspective of the Cree and many other Indigenous peoples, Indigenous Nations and the Crown affirmed each other's sovereignty in the treaty process. The treaty parties entered into treaty making because of inherent powers as sovereign nations. As a matter of historical record, this is confirmed by Treaty Commissioners who negotiated on behalf of the Crown, and chose to abide by international law at the time - which required treaty or conquest for the settlement of lands and territories. There was also trust expressed from Indigenous Peoples in the official translators at the Treaty negotiation, that provisions and desired outcomes for future generations would be captured in writing by the Treaty Commissioner as the representative of the Crown.

The parties to the Agreement entered into negotiations with their respective traditions and legal orders. For Indigenous Peoples, oral traditions and legal orders constituted the foundation for entering into Treaty and continue to this day. For the Crown representatives, written and codified legal traditions and legal orders were their foundation for entering into Treaty. Today, the Supreme Court of Canada has

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[1] List of Principles derived from the Confederacy of Treaty Six First Nations draft Health Law, 2014

recognized that oral traditions are essential to interpretation and implementation of the sacred and Constitutionally protected Treaty relationship.

This is also evident from the ceremonial / spiritual context of Treaty negotiations on the Indigenous side and on the side of the Crown. Ceremony and prayer formed an integral part of the negotiation process. The parties to the Treaty chose to include wording that referenced "God" as an element of the text of the agreement. These approaches, leading up to treaty signing and the terms that were used in the treaty negotiations were also used in concluding the treaty.

In the book *Treaty Elders of Saskatchewan*, it is described in the following way:

> *The treaties, through the spiritual ceremonies conducted during the negotiations, expanded the First Nations sovereign circle, bringing in and embracing the British Crown within their sovereign circle. The treaties, in this view, were arrangements between nations intended to recognize, respect, and acknowledge in perpetuity the sovereign character of each of the Treaty parties, within the context of rights conferred by the Creator to the Indian nations.*[2]

As such, the Creator constituted a witness to Indigenous Nations and non-Indigenous settlers entering into Treaty. Due to the sacredness of ceremony and prayer, the trust of Indigenous Peoples in the strength and abiding nature of the Treaty built the foundation for the Treaty relationship.

Like any law, the Treaty must be understood as a whole, taking into account the written text and the "spirit and intent" of the Treaty as well, being the understanding of the Indigenous Peoples. This spirit and intent is as valid as the written text and will last "as long as the sun shines, the rivers flow and the grass grows." The world *Witaskiwin* was used in the negotiations when describing the accord relating to lands. *Witaskiwin* means sharing or living together on the land.

We take the "spirit and intent" of treaty analysis with regard to the written text of the treaty as well. When our ancestors secured the clauses respecting provision of health care (delivery and services) – the medicine chest & famine and pestilence clauses - they did so in the understanding that our health and wellness was also tied to the implementation of the rest of the Treaty, respecting lands, territories, waters, resources and continuing our life ways.

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[2] Cardinal, Harold and Walter Hildebrandt *Treaty Elders of Saskatchewan: Our Dream is that Our Peoples will One Day be Clearly Recognized as Nations* (2000) Canada Council for the Arts, Ottawa at 41

The Treaty Commissioner for Treaty No. 6, Alexander Morris, stated it as follows:

> *What I trust and hope we will do is not for today or tomorrow only; what I promise and what I believe and hope you will take, is to last as long as that sun shines and yonder river flows*.[3]

Treaty was necessary in order to establish our relationship for living together in these lands and territories. Treaty is a part of the Canadian Constitution because the Canadian Crown is a successor to the British Crown, and the land could only have been settled with Treaty in place.

The medicine chest clause, as well as the pestilence and famine clauses of Treaty No.6 reads as follows:

> *That a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent…. That in the event hereafter of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents, will grant ... assistance of such character or to such extent as the Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians of the calumet that shall have befallen them*.

The interpretation of these clauses is quite definite in the context of Canadian law.

The medicine chest clause is understood as providing a guarantee of all health care services, delivery, medicines, and supplies as may be required by Indigenous Peoples. The famine and pestilence clause is understood as providing a guarantee of appropriate and expedient support for Indigenous Peoples in the face of any famine or pestilence, which in modern terms speaks to food security and food sovereignty, as well as pestilences such as chronic diseases, outbreaks, epidemics and other similar health matters.

There are specific obligations flowing from the Crown under the Treaty, which can be interpreted as either the federal government in right of the Crown, or the provincial government in right of the Crown. These entitlements are not only respecting access, delivery, quality and efficacy of health programs and services. These entitlements extend to require that all members of the Treaty be treated equitably under the law and both within and outside of the traditional territories of Treaty 6. This means that members, no matter where they reside, are entitled to equal health benefits under the Treaty to the highest attainable standard of health.

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[3] Morris, Alexander *The Treaties of Canada with the Indians of Manitoba and the North-West Territories, Including the Negotiations on Which They were Based, and other Information Relating Thereto*, (Saskatoon: Fifth House Publishers, Saskatoon, 1991) at 202

These entitlements extend as well to prevention, treatment and control of disease; access to essential medicines; maternal, child and reproductive health; the provision of health related education and information; and the Free, Prior and Informed Consent (meaning active participation) of the members of Treaty 6 in decisions impacting their Treaty Right to Health.

The British House of Lords held that treaty could not be altered through Canadian policy without the consent of us as Treaty Peoples, since consent also forms a major pillar of Treaty. The Canadian courts have, over the course of our shared history, held over and over that the Treaties are to be interpreted and implemented broadly, taking into account our Indigenous understanding of the content of the Treaties, and not to be "frozen rights" or described in a minimal way referencing only standards of health of 1876. The Canadian Constitution provides particular protection to treaty rights (section 35(1)) – and the Treaty right to Health has been recognized as an existing right by the Canadian Courts. There are also a long line of Canadian cases, Canadian policies and legislation requiring consultation prior to taking any actions that impact our Treaty rights.

It is clear that both our laws (as Indigenous Peoples), and Canada's laws (as a successor state to the British Crown) have demonstrated consistent and ongoing recognition of the Treaty as a nation-to-nation agreement, fully legally binding and continuing to develop in terms of implementation, taking into account contemporary challenges and issues.

We wish to work with our Treaty partners in strengthening that Treaty relationship based on good faith, partnership and mutual respect.

Of note is Canada's Statement of Support on the *United Nations Declaration on the Rights of Indigenous Peoples* (November 12, 2010) containing references to health:

> *The Government's vision is a future in which Aboriginal families and communities are* ***healthy, safe, self-sufficient and prosperous*** *within a Canada where people make their own decisions, manage their own affairs and make strong contributions to the country as a whole…. This government has also taken concrete and viable actions in important areas such as education, skills development, economic development, employment, health care, housing and access to safe drinking water. These are part of a continuing agenda focused on real results with willing and able partners*.

We have been encouraged by the promise of the recently elected Governments of Canada and Alberta, who have both undertaken to adopt and implement the United Nations *Declaration on the Rights of Indigenous Peoples* as well as the Truth and Reconciliation Commission's Calls to Action. If accomplished and implemented, there will be significant ripple effects into the delivery of health care and services for First Nations in the territory of Treaty No. 6 (Alberta).

Our laws and knowledge must be understood in an equitable manner along with Treaty No. 6, Canadian laws and International law. The lives of and health of our peoples must be valued equitably in the province of Alberta and the state of Canada, with basic international standards of health being met.

This is how we have chosen to frame this submission – that, when read together, these different legal systems and standards provide **completely** for all aspects of the health of Indigenous Peoples, including men, women, children, youth, elders, the disabled, and all those who often fall through the cracks of health care service and delivery.

Background

The health of Indigenous peoples of Canada is recognized as being the worst in the country. High infant mortality rates; low life expectancy; poor or limited access to drinking water; lack of adequate housing; toxic contamination of lands, waters and resources; high suicide rates and significant challenges related to mental health and wellness; and prevalence of chronic diseases are but a few examples of areas where Indigenous peoples lag far behind other Canadians.

In Maskwacis, we have faced significant challenges around mental health, addictions and suicide. The Maskwacis Cree are a population of over 15,000 of which the majority are youth.

Youth have been plagued by drugs, alcohol, domestic violence, loss of identity, child welfare cases, sexual assaults and gang activity. These afflictions are compounded in some cases which ultimately results in suicidal tendencies by those who are affected with an unfortunate end result of suicide. The Maskwacis Cree communities are in crisis. Over the last two years, this has been evident by the sheer numbers of those who have chosen to end their young lives as a result of the effects of hopelessness and trauma. Even more troubling, is that we are seeing more and more suicides of individuals who are adults or in advanced age.

Existing human resources, in particular counselors, is inadequate in terms of numbers. The counselors who are currently working are in desperate need of assistance from community members who are willing to help - but are in need of training and guidance. One only needs to review the high number of emergency calls of the Royal Canadian Mounted Police (RCMP), Ambulance, Victims Services, Child Welfare and hospital emergency cases in and around Maskwacis. The Emergency Medical Services (EMS) also needs support in addressing the compounded issues and with the help of those who are willing to come together to assist with the development of a strategy and capacity to do so.

It has been so pronounced for us that we attended at the UN Permanent Forum on Indigenous Issues in 2015 to insist upon international attention regarding our high suicide rates and impacts on children and families in particular.

International Chief Wilton Littlechild made the following verbal submission to the UN Permanent Forum on Indigenous Issues in 2015:

> *You see, Madame Chairperson and Members of the Permanent Forum, our cultural teachings inform us that life is the greatest gift of our Creator, that there are consequences when someone terminates it before his or her time. Indeed, for some faith groups, burial was not allowed within their graveyard. ….You will hear about a myriad of root causes of Indigenous youth suicide and self-harm. Recently, in desperation our leaders asked, "What more can we or could we have done? What are some losses that contribute to this situation? The loss of identity and/or a sense of belonging, losses resulting from intergenerational or historical trauma and dispossession? Is it mental health issues contributing, at times compounded by poverty, addictions? Is it the stress, doubt and deep desperation of a loss of hope? Is it new phenomena like cyber-bullying?*
>
> *The social circumstances that differ between Indigenous and non-Indigenous youth in relation to poverty, domestic violence, addictions and the known rates of disparity in overall socio-economic conditions.*
>
> *Notwithstanding the dire situations that exist there have been advancements made in the areas of preventing youth suicide and self-harm. There is evidence available that cultural, spiritual and linguistic revitalization, that the provision of healthy, positive lifestyle choices be it arts, sports, recreation and leisure activities, all contribute to prevention.*[4] *They provide youth an opportunity to choose life.*
>
> *Unfortunately, the persistent and ongoing obstacles are the lack of political will to dedicate, adequate ongoing financial and human resources to prevention. Even where there is political will the level of resources must be substantially increased.*
>
> *While there is some available data regarding youth self-harm and suicide,*[5] *further disaggregated data is needed. In our community's recent epidemic there is no clear, reliable data to provide the exact situation on any given time frame from all sources.*
>
> *As already mentioned…, "culture as treatment" is a good practice. Teaching relevant cultural practices and associated spiritual teachings*[6] *in schools (Kindergarten to Grade 12) and in homes is critical. The provision of*

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[4] Hallett et al, "Aboriginal language knowledge and youth suicide," Cognitive Development 22 (2007) 392-399.

[5] National Centre for Suicide Prevention, National Statistics.

[6] For example, the Seven Sacred Teachings.

mandatory cultural education in all school curricula is required. Asking for help must be viewed as a sign of strength, not weakness.

What does not work is shaming and blaming. Neither does making young people feel they have no value as human beings. Exposure to culture at a surface level is not sufficient – this happens to some of our children in care who are brought to a cultural ceremony once a year without a real opportunity to access their cultural practices on a meaningful level.[7]

Regarding mental health, we struggle with negative stigma of mental illness within the communities of Maskwacis Cree, in addition to facing significant mental health challenges without appropriate capacity or assistance to address mental health issues.

In terms of addictions, we have identified an urgent need to establish detox centres or facilities that are conducive to First Nations specific needs, including culture as treatment. Currently, in Alberta, Indigenous Peoples are reliant on the provincial system of limited detox facilities which are backlogged and providing services to high risk individuals in a clinical setting (without culture or language of Indigenous Peoples). Such existing limited facilities are located off-reserve and do not provide adequate opportunities for First Nations to utilize such facilities. **Maskwacis Cree recommends that the Expert Mechanism emphasize the importance of facilities addressing mental health and addictions to be designed and operated in an accessible and equitable fashion, with Indigenous Peoples-specific needs, for example with culture as treatment.**

Importantly, our connection with our lands, waters and territories is fundamental to good mental health and wellness. In fact, this is expressed by many elders as wholistic wellness, inclusive of not only our internal individual wellness but how that is shaped and supported by others, our environment and Mother Earth.

In addition, Indigenous Peoples in Canada are facing serious challenges and impacts of climate change and environmental contamination, in particular with regard to our health and wellness. Our unique exposures and sensitivities to climate change is a function of our relationships with and dependence on lands, waters, natural resources for livelihood, culture and habitation. Climate change and environmental contamination poses a significant risk which is completely different from those faced by mainstream populations. We experience these risks through our traditional foods, which are increasingly too contaminated for consumption or else impossible to access due to industrial development, destructive agriculture, toxic contamination or environmental degradation as a result of climate change.

[7] Statement by International Chief Wilton Littlechild, Samson Cree Nation
Fourteenth Session of the UN Permanent Forum on Indigenous Issues
(20 April to 1 May 2015) Agenda Item 3(c): Youth, Self-Harm and Suicide, 21 April 2015

In a wealthy country such as Canada such gross inequality and neglect is shameful and abhorrent. It is also preventable. The necessary first step in resolving the present crisis in Canada is to recognize that it is not inevitable.

Canada must recognize that the crisis began with colonization and dispossession and became endemic when social and economic disadvantage became entrenched. The crisis will not end until these conditions are changed.

If the health of Indigenous peoples in Canada is to be improved, all levels of Canadian government must resolve to provide health care, goods and services, through true collaboration and partnerships with Indigenous peoples in the design and operation of appropriate mechanisms and structures. These mechanisms and structures must be identified, articulated and constructed *with* Indigenous peoples of Canada - this means taking into account and recognizing Treaty members, First Nations, Tribes other Indigenous peoples as speaking for themselves, in their own varied individual and collective voices.

The purpose of this submission is to provide the platform for understanding vis-à-vis the laws and policy-related matters that have developed which have a significant bearing on our future Treaty relationship and the achievement of the highest attainable standard of health for Indigenous Peoples, and Indigenous children and youth in particular.

Health refers not only to the physical well being of a person, but also to the social, emotional, spiritual and cultural well-being of the communities within which they live. There are linkages between poor health and social disadvantage; to stress, social exclusion, unemployment, racism and discrimination. Drug use, alcohol dependence and domestic violence are familiar and inevitable parts of the same cycle.

Thus, measures to improve the health of Indigenous peoples must include the application of principles of self-determination and models of health care based in the culture and knowledge of the Indigenous Peoples of Treaty No. 6. The Tipi Model has already been put forward as the administrative model for the further development of health care in and for the Confederacy of Treaty 6 members (Alberta). This model, and the self-determination attendant to it, form part of the basis for sustainable, durable and resourceful communities.

The Tipi Model Approach

The tipi represents a part of our identity and is understood by our people as an element that has been ours for thousands of years.

The teaching was given to the five Health Technicians of: Maskwacis, Paul First Nation, Saddle Lake First Nation, Tribal Chiefs and Yellowhead Tribal Council by the

Elders of Treaty No. 6 (Alberta) that the tipi encompasses a tribe as a whole. As directed by the Confederacy of Treaty Six leadership, the technicians, with the advice of Elders, recommended to the Confederacy of Treaty Six Chiefs provide a pragmatic response to concurrent federal health policies as the administrative process of health service delivery to the Treaty No. 6 (Alberta) peoples. This model was presented and passed by resolution unanimously at a duly convened meeting of the Confederacy of Treaty Six held in Edmonton June 29, 2005.

While the Tipi Model is not "owned" by Maskwacis Cree, as it was adopted by the Confederacy of Treaty Six Chiefs in 2005 it may be referred to by all members of the Confederacy of Treaty Six.

Summary of the Tipi Model

The Elders voices were clear; "We are not aboriginal, nor are we pan aboriginal". That is the western world terminology. We must return to our tribes, as Cree, Saulteaux, Nakota Sioux, and Dene Nation. We must begin and encourage our brothers and sisters to begin reclaiming their identity.

The tipi is unique to our tribes; just as in the past and still exists. We could identify the camps by the style of the tipi.

The tipi is our identity. The message and teachings of the Elders was: "As women of the tribes we must stand up to protect our tipi". A return to our tipi is our return to our identity. Teachings will preserve our language and traditions; it will provide our tribes with responsibility for our survival. Each teaching of the tipi provides leadership and responsibility. Each of the health technicians play a significant accountability in maintaining the tipi in our communities. This model can and will provide a return to our survival (health and social) and remove dependency.

Since time immemorial, the Treaty No.6 peoples have relied on the land for life sustaining elements. This includes the medicines to combat diseases throughout the life cycle of the Treaty No. 6 peoples. The way of life centered on maintaining and preserving an optimal healthy life and the provisions of what is required to maintain good health is seen as a gift from the Creator. The Peoples of these traditional territories, prior to contact, flourished because of the elements that were gifted by the Creator for survival; and at that time, the elements were in a pure and balanced state.

Health is all encompassing, intertwined within every aspect of life which includes the elements of Natural Law. Mother Earth, also known as the Environment, is the source of ongoing sustenance required for survival for all peoples and is a key element for maintaining good health.

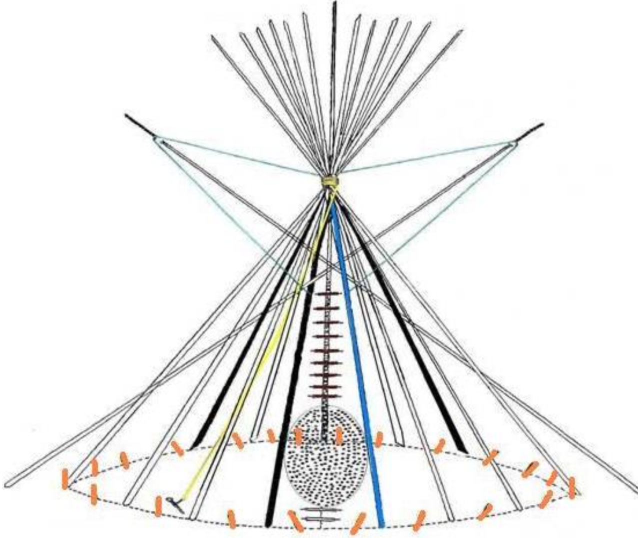
The Tipi and all of its elements required for set up retain many significant features that are applied to health in the worldview of the Treaty No. 6 Peoples. Within this all encompassing life cycle is the Tipi which is significant in many different ways for our peoples within its design, and is dependent on what geographic area and what tribe of peoples live within them. When the Treaty No.6 Peoples still resided in these camps one could tell which tribe the camp belonged to by the resurrection and design of the tipi. Literature often views the tipi as just a shelter to protect from the climate but in fact, the tipi is very significant in terms of principles and values of First Nations who reside and utilize them.

As told by a Cree Elder, the poles signify the community support and are viewed as the *rib cage of our mother*. The crown/nest that ties the poles together at the top signifies the *youth*. The cord that binds the poles together signifies *strength*. The cover of the tipi signifies not only shelter but warmth and protection and is viewed as the *womb*. The flaps of the tipi signify spirituality and are viewed as an *old man praying* for the youth above him (crown/nest). The pins that hold the tipi together over the entry signifies the *birth cycle that consists of nine pins representing the nine months of the birth cycle.* The *Fire* in the center signifies the life force of the Treaty Six peoples.

> *The entry is kept by an old man to the left and an old woman to the right. The old man represents nurturing and is the provider of provisions such as firewood and food. Working with the old man are the fire keeper/ cultural keeper. The old woman is the keeper of the medicine bag and the doorkeeper of the tipi as well as the keeper of the children. All of the elements of the Tipi capture the life cycle of the Treaty Six peoples and is an all encompassing model that includes the whole community. The pegs that hold the whole structure together represents the Elders who transmit knowledge through language, culture and traditions and are the most important aspect of holding the Tipi Model together.*

The Treaty Right to Health as substantiated by Treaty No.6 Medicine Chest & Famine and Pestilence clauses continues to be breached by the inadequate provisions of Health Services to the Peoples of Treaty No. 6 traditional territories (Alberta).

The Treaty Right to Health cannot be compromised in order to accommodate the Federal Government's initiatives with respect to "*Aboriginals*". It is with this strong belief that the Treaty No. 6 Peoples forward this model that is unique to the Indigenous Peoples and is a model that reaffirms the purpose of the "*Treaty No. 6 Medicine Chest/Famine & Pestilence Clauses*". In terms of utilizing the Tipi model one could capture the delivery of health services from the worldview of our ancestors and our Peoples today in a contemporary manner. Further, one could also visualize the resurrecting of not only one tipi but in essence a whole camp that addresses the immediate health needs of our Peoples.

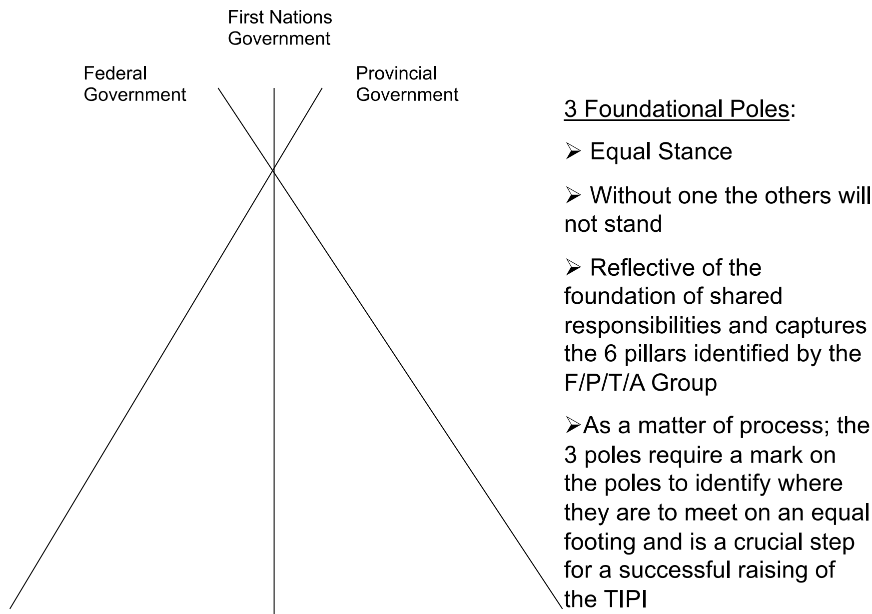


The Tipi Model is flexible enough to fit community's needs & priorities of First Nations and this model is specific to Treaty No. 6 Peoples (Alberta). The tipi is portable as are our Treaty rights; therefore, access should not be determined by Provincial/ Territorial boundaries nor jurisdiction within Canada.

Elements of the Tipi Model

Note: The significance of the elements are dependent on the needs of the communities. The following is an example of an outline of what the elements will signify in a contemporary manner

- 12 Poles – reflective of the months/moons in one year and is a continuous cycle of addressing health needs for the Treaty Six peoples (Alberta).
- Crown/Nest – To enhance and develop programs for the youth with their assistance so they may take ownership and control over what they need at their community level.
- Cover – Inter-departmental representatives working at the community level in addressing community issues by utilizing health information mechanisms both traditional and contemporary knowledge
- Flaps – the two flaps control the mechanism of funding with the use of flexibility and accountability measures. The two poles that support the flaps signify the balance between the political and administrative



The Tipi Model was endorsed by the Chiefs in assembly at a Confederacy of Treaty 6 First Nations meeting. The Tipi Model, developed by First Nations under the guidance of Elders, is in the implementation phase which requires investment by governments in Canada. **We call on the Expert Mechanism to recognize Indigenous wholistic approaches to health care service and delivery and urge states to support, endorse and invest in such Indigenous models that have been derived through the advice of Indigenous Elders and Leaders.**

Canadian Law, Policy and Standards

Since "health" was not a matter of specific constitutional assignment under the Canadian Constitution Act, 1867, the current Canadian health care system has developed over the years as an inter-related mix of Treaty law, federal and provincial laws, regulations and programs. Later in this document you will find a discussion of the role of Alberta as a province. However, the purpose of this section is to address specifically the roles and responsibilities of the federal government and the Treaty Right to Health.

Under section 91(24) of the Constitution Act, 1867, Parliament has constitutional authority over "Indians, and Lands reserved for the Indians". The Indian Act and the Indian Health Regulations deal directly with the delivery of health services to status Indians living on reserves.

The provision of health services by the federal government is a Treaty Right. A direct reference to the obligations of the federal Crown in this regard is found in Treaty 6, signed in 1876 between the federal government and the Cree of Central Alberta and Saskatchewan. Specific Treaty obligations related to health care include

protections and non-interference, medicine and medical care, and protections related to pestilence and famine.

In 1876 during the negotiations for Treaty 6, the Treaty Commissioner fully explained to the Cree and other Peoples that they would "not interfere with their present mode of living" and that what was being offered "does not take away your living, your will have it then as you have it now, and what I offer you is put on top of it." Additionally, the Treaty Commissioner said, "We have not come here to take away anything that belongs to you."

Dr. A.G. Jackes, Secretary to the Treaty Commission, provided insight into the provision of medical services when he recorded the Indians' request that medicine be provided free of charge, and as such Treaty 6 provides, in relevant part:

> *That a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent*.

There is ample evidence that sickness and disease brought to Turtle Island from Europe played an important part of decision making to enter into Treaty and this was also recognized in the text of the Treaty, in the famine and pestilence clause:

> *That in the event hereafter of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by her Indian Agent or Agents, will grant to the Indians assistance of such character and to such extent as her Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians from the calamity that shall have befallen them...*

We understand pestilence as not only encompassing such illnesses as smallpox or TB, which were the prevalent illnesses at the time of Treaty, but also modern day incarnations of illnesses imported to our lands and territories such as diabetes, SARS, epidemics, pandemics and other outbreaks of disease.

The Treaty Right to Health must be understood in as broad a manner as possible. The Treaty Right to Health goes far beyond a simple medical kit, access to health care and the building of hospitals. It is also about what can help us lead a healthy life.

The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights, calls these the "underlying determinants of health". They include:

- Safe drinking water and adequate sanitation;
- Safe food;
- Adequate nutrition and housing;

- Healthy working and environmental conditions;
- Health-related education and information;
- Gender equality

The United Nations *Declaration on the Rights of Indigenous Peoples*, which sets the minimum standard for our rights, has a number of articles related to health.

Article 21 requires that Indigenous Peoples have the right, without discrimination, to the improvement of their social and economic conditions including health. This relates well to the requirement under the Canadian Charter of Rights and Freedoms section 15 that requires non-discrimination with regard to rights. In implementing this right, the UN Declaration requires that Canada pay particular attention to the rights and special needs of Indigenous elders, women, youth, children and persons with disabilities.

The UN Declaration also requires that we have the right to our traditional medicines and to maintain our health practices. Most importantly, Article 24 says: “Indigenous individuals also have the right to access, without discrimination, to all social and health services.” The article goes on to say, “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 to achieving progressively the full realization of this right.”

Article 29 of the UN Declaration says that “states shall also take effective measure to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of Indigenous Peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.” This article ties in with another article in the UN Declaration requiring Indigenous participation in decision-making (Article 18), as well as the requirement to achieve the “free, prior and informed consent” when there is a legislative, administrative or development that impacts upon our rights (Articles 19 and 32).

We know that Canada and the province of Alberta have a legal obligation to consult with us about decisions made that might impact our Treaty rights, this obligation being found in Supreme Court of Canada decisions about consultation and accommodation, as well as in the Treaty itself which contains the principle of consent. The Crown, as represented by Canada and the province, cannot take any action that abrogates or derogates from those Treaty rights.

The Canadian courts have attempted, over the years, to touch upon the Treaty right to Health. In 1935 the Dreaver case appearing to set an important precedent, went to Federal Court whereat the Court ruled that the medicine chest clause meant that all medicines, drugs, medical supplies and health care service delivery etc. were to be provided free of charge to Treaty Indians.

Other cases followed, some taking a reductionist approach to the interpretation of the medicine chest clause of Treaty 6. Most of these cases were decided prior to 1982, when the Canadian *Constitution Act* entrenched Treaty rights, and must also be understood in the line of cases setting out the tests for establishing a Treaty Right, as well as interpreting such rights. The more recent case of Wuskwi Sipihk Cree Nation v. Canada (1999) was heard in the Federal Court on the interpretation of the medicine chest clause in Treaty 6, finding that the 1935 Dreaver decision to interpret the medicine chest clause in a contemporary and inclusive manner was correct.

There are specific obligations flowing from the Crown under the Treaty, which can be interpreted as either the federal government in right of the Crown, or the provincial government in right of the Crown. These entitlements are not only respecting access, delivery, quality and efficacy of health programs and services.

These entitlements extend to require that all members of the Treaty be treated equitably under the law and both within and outside of the traditional territories of Treaty 6. This means that members, no matter where they reside, are entitled to equal health benefits under the Treaty to the highest attainable standard of health. These entitlements extend as well to prevention, treatment and control of disease; access to essential medicines; maternal, child and reproductive health; the provision of health related education and information; and the Free, Prior and Informed Consent (meaning active participation) of the members of Treaty 6 in decisions impacting their Treaty Right to Health.

The provincial health systems are planned and reformed independently from the federal-First Nation systems. This creates opportunities for cost shifting between both governments or for gaps in service to emerge, leaving First Nations in a substandard or no care situation. By virtue of being a federal jurisdiction, First Nations have only a marginal role in provincial health care reforms.

The Indian Act

The *Indian Act*[8] of Canada (originally enacted in the late 1800s with various amendments over the years) has in its substance, function and implementation, violated constitutional protections of Treaty rights including the right to health.

One example is the issue of birth registrations and access to health care services and delivery, which we must describe through a short history of "status" and recognition of Indigenous identity in Canada.

In the decades following Treaty No. 6 (1876), the concept of Indigenous Peoples (known as "Indians" under Canadian law) being members of the historic nation-to-

[8] Canada, *Indian Act* R.S.C. 1985 c. I-5

nation Treaties was confirmed over and over as the basis for the legal relationship between Indigenous and non-Indigenous peoples.

For example, Indigenous Peoples in Canada did not have the right to vote until 1960. Prior to that date, they became enfranchised if they voluntarily gave up their status as Treaty Indians, or (if a woman) married a non-Indian (which was not "voluntary" rather women were stripped of their status without their consent). Certain western Indian people gave up their Indian status to take scrip as Métis in the period from 1885 to 1910. These were not enfranchised; instead, they were "discharged from treaty" under special provisions in the Indian Act of the time.[9]

Prior to 1951, all members of Treaty No. 6 had been issued "Treaty Cards" as proof of identity for the purposes of implementation of the *Indian Act*. With the 1951 amendments to the Indian Act, the federal government chose to create a new definition of "Indian" rescinding the previously issued Treaty Cards as forms of identification and implementing a new definition of "Indian Status." This new definition, containing various categories of what constituted "status" under the Indian Act, has been proven to be discriminatory and in function, to gradually reduce the population numbers of federally recognized "Indians" for the purposes of obtaining health care services and delivery. [10]

The Indian Act of 1951 said that an Aboriginal woman who married a non-Aboriginal man lost her Indian status. However, an Aboriginal man who married a non-Aboriginal woman got to keep his status, and his non-Aboriginal wife even obtained Indian status.

As a result of this sexist law, any Aboriginal woman who married a non-Aboriginal man not only lost her status, but her children were also not eligible to obtain status. As a result, many Aboriginal women lost their Indian Status and their children never obtained Indian status.

In 1985 the Indian Act was changed with the passage of Bill C-31. These changes meant that some women who lost their status before 1985 were able to regain their status under a new section of the Indian Act called section 6(1)(c).

In spite of the changes made by Bill C-31, the Indian Act continued to be sexist because they still preferred descendants who traced their ancestry through the male line. Since Bill C-31 numerous amendments have been made to the Indian Act to address issues of gender discrimination under the Act. However, none of the those amendments have definitively eliminated gender discrimination, and under current rules such as the "double mother" clause, birth registrations of Indigenous Peoples continue to be fraught with discrimination and registration denials.

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[9] Citation John

[10] Ibid.

Due to the complexity of the status categories that have developed over the years under unilateral amendments to the Indian Act, many Indigenous Peoples have been prevented from being beneficiaries of the Treaty Right to Health. This is mainly a result of non-registeration under the Indian Act.

Jordan's Principle

The Indian Act also provides for the application of provincial laws and decision making authority vis-a-vis section 88. As such, this has created significant jurisdictional issues that have only been somewhat addressed through the adoption of Jordan's Principle, which requires health care services and delivery regardless of any conflict between the federal and provincial jurisdictions on the matter.

Jordan's Principle is named in honour of Jordan River Anderson, a boy from Norway House Cree First Nation in Manitoba. Jordan was born with a rare medical condition that required him to be hospitalized for the first years of his life. He remained in hospital long after his medical team had recommended discharge because neither the federal nor provincial government would take responsibility for funding his out of home care. Due to the fact of government disputes over funding of services ordinarily available to non-Indigenous children in Canada, Jordan was deprived of the opportunity to experience life outside a hospital setting and he passed away in hospital at the age of five. The refusal of both the federal and provincial governments to fund Jordan's out-of-hospital services is an example of a "jurisdictional dispute" where the structure of public service funding and provision leaves Indigenous children more vulnerable to such disputes than non-indigenous children. While funding and delivery of public services to most children in Canada falls under provincial – territorial jurisdiction, responsibility for services to Indigenous children is often shared by federal, provincial- territorial and Indigenous governments. This leads to major challenges to Indigenous children in accessing health services.

The Crown still has a fiduciary obligation to deliver health care and services (including medicines etc.) regardless of where First Nations are located, due to the medicine chest and pestilence clauses. However, now the Crown is understood as including both the federal and provincial crown.

For example, the enforcement of health laws or the development of strategies regarding health care service and delivery that may not comply or may infringe upon the medicine chest clause or the famine and pestilence clause. In those instances, provincial governments would need to meet the requirements for justifying the infringement of the treaty right. See Article 19 of the UN Declaration:

> States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

The basic requirements for justifying the infringement of Aboriginal title and for justifying the infringement of a treaty right are the same. First, the Crown must establish a compelling and substantial objective consistent with the Crown's fiduciary obligations to Indigenous peoples. For a government objective to be compelling and substantial, it must be considered from both the public and the Aboriginal perspective. It must also further the goal of reconciliation of Indigenous peoples' rights and interests with the Crown's assertion of sovereignty over Indigenous lands. Our Treaty Right to Health must necessarily cover our children and families, wherever they may find themselves throughout the country.

Jordan's Principle was unanimously endorsed by the House of Commons in 2007 and is formally supported by thousands of stakeholders and observers. It states that in cases involving jurisdictional disputes the government or government department first approached should pay for services that would ordinarily be available to other children in Canada – the dispute over payment for services can be settled afterwards. A 2013 Federal Court ruling held that Jordan's Principle should be implemented in a way that ensures First Nations children receive services in accordance with normative provincial/territorial practices that are in compliance with legislated standards. In a landmark ruling released in January 2016, the Canadian Human Rights Tribunal found that the Canadian government was racially discriminating against 163,000 First Nations children living on reserve. Among the remedies is the full implementation of Jordan's Principle.[11]

International Standards Relevant to the Treaty Right to Health

Maskwacis Cree have had a consistent presence in the international arena for over 30 years due to the fact that domestic avenues have not provided effective remedies for breaches of Treaty Right to Health and health determinants.

The right to health as guaranteed by the International Covenant on Economic, Social and Cultural Rights Article 12(1) provides a 'guarantee' not for the absence of disease – but rather to ensure certain preconditions for health and normal function (not to health care)

When read together, the ICESCR, the UN Declaration on the Rights of Indigenous Peoples and Treaty No. 6 provide a strong and irrevocable protection for Indigenous peoples of Treaty No. 6 territories from ALL attacks to their health, not

[11] See generally the work of Cindy Blackstock, the First Nations Child and Family Caring Society of Canada (www.fncaringsociety.com) and Assembly of First Nations, "Without denial, delay or disruption: Ensuring First Nations children's access to equitable services through Jordan's Principle" online at: http://www.afn.ca/uploads/files/jordans_principle-report.pdf

only the traditional infectious diseases and other health problems arising from poverty and unsanitary conditions.

In particular children have had specific attention to their needs through the Convention on the Rights of the Child, Article 24 which reiterates "the right of the child to enjoyment of the highest attainable standard of health" and in particular Article 30 which states that a child of indigenous origin has the right to "enjoy his or her own culture." The Committee on the Rights of the Child General Comment on Indigenous Children's Rights includes a provision that states that "health services should to the extent possible be community based and planned and administered in cooperation with the peoples concerned."[12]

This is supported by the preamble of the UN Declaration on the Rights of Indigenous Peoples: "*Recognizing in particular* the right of indigenous families and communities to retain shared responsibility for the upbringing, training, education and well-being of their children, consistent with the rights of the child," as well as Article 22 which states that "1. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with dis- abilities in the implementation of this Declaration. And 2. States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination."

All of the above must be understood concurrently with UN Declaration Article 37 on Treaties, Agreements and other constructive arrangements providing for the recognition, observance, enforcement, honour and respect of Treaties.

Of course we know that all the articles must be read together.

Article 26 of the UN Declaration says we have a "right to land" but does not specify whether that "right" to specific territories is only quantitative or whether the question of the quality of the lands has been considered. The problem is that even establishing rights to an area or region is insufficient unless that area or region is protected from pollutants of various kinds and is actually available for traditional pursuits. The land is needed to exercise our rights to hunt, fish, and gather wild foods and traditional medicines; but if the contamination or appropriation of land have made it unsafe for animals, plants and medicines, then our Right to Health cannot be exercised.

This is truly about the functionality of our Treaty Right to Health, within the context of International law. Within our Treaty territories, the Right to Health is a pillar right, a right on which other rights are based – but it is also a specific right.

[12] Committee on the Rights of the Child 2009 at para 51

It must be protected by the international law enforcing the pre-conditions to health that Canada is legally bound to abide by under the ICESCR.

Unfortunately, there are no existing legal standards specific to Indigenous Health beyond the PAHO Resolutions referenced elsewhere in this submission.

The World Health Organization could utilize its role to engage in the creation of such a standard.

The promotion of the right to health is explicitly present in the preamble of the WHO constitution, and also WHO has the "legal capacity to initiate discussion among member nations and to serve as a platform for international law making efforts in relation to the right to health." The WHO can also develop regulations under its constitution (Article 21) and under Article 19 it can work on conventions; under Article 23 it can make recommendations to states on any matter on which it is competent to speak. WHO should be taking a leadership role on Indigenous health. Not just to develop an office for a "focal point" for Indigenous Peoples, but also to lead the development of an international legally binding standard on Indigenous Health.

United Nations Seminars on Treaties, Agreements and Other Constructive Arrangements (2003-2012)

The First Seminar took place in 2003, and found as follows:

> *ii.The experts note that historic treaties, agreements and other constructive arrangements between States and indigenous peoples should be understood and implemented in accordance with the spirit in which they were agreed upon. The experts also note that treaties, agreements and other constructive arrangements between States and indigenous peoples have not been respected, leading to loss of lands, resources and rights, and that non-implementation threatens indigenous peoples' survival as distinct peoples*.

The 2003 Report also recommended that the OHCHR make available technical cooperation to assist Indigenous Peoples with their negotiations in relation to treaties, agreements and other constructive arrangements. This might be extended to be inclusive of the Treaty Right to Health.

The Enoch River Cree Declaration of the International Indigenous Nations Treaty Summit presented at the Second UN Expert Seminar on Treaties, Agreements and Constructive Arrangements (2006) stated as follows:

> *Affirming that the fundamental sacredness of our Indigenous understanding of our treaties and the relationships they represent is based on our traditions, histories, our ceremonial ways, our relationships with our lands that are reflected in our creation stories, blood and sacrifices of our ancestors; and*

Affirming also that Treaties and Agreements between states and Indigenous Nations are to be regarded from our respective spiritual understandings; and

Understanding that the inherent rights, responsibilities and relationships encompassed in treaties impact every aspect of our lives, including our health, cultural practices, means of subsistence and food sovereignty, access to and protection of our sacred sites and our rights to our lands, territories and natural resources, to self determination and free, prior and informed consent; and

Considering that the legally-binding Nation to Nation Treaties which were freely, entered into by Indigenous Peoples with non-indigenous governments constitute an important body of international law ….

Calling attention to the reality that Canada and other states continue to undermine our Treaties and related Treaty Rights, specifically by:

ii.Developing policies and laws designed to extinguish states' legal recognition and responsibility under Treaties and Agreements made with Indigenous Peoples.

iv.Denying, undermining, and diminishing rights recognized and upheld in Treaties to social services, child and family wellness, traditional subsistence, health care, education, culture, spiritual practices and language among others.

This speaks to the tendency of the Federal and provincial governments in the Treaty No. 6 (Alberta) territory to attempt to undermine or change the Treaty Right to Health through simple policy initiatives. This cannot continue.

The Final Report of the 3rd United Nations Seminar on Treaties, Agreements and other Constructive Arrangements made the following recommendation to the UN system and human rights bodies and mechanisms:

*That United Nations agencies contribute to strengthening and integrating the rights affirmed in treaties, agreements and other constructive arrangements, including Indigenous Peoples' treaty rights to food, education, **health**, culture, lands and resources, in their programmes and standard setting activities;* (emphasis added)

The Report of the 3rd UN Seminar on Treaties also noted that the treaty rights to food, water, health and also land, culture and education constitute essential aspects of self-determination and that efforts should be pursued to bring those issues to the international arena, including through the findings and recommendations of special procedures mandate holders on the rights to food and health.

United Nations Permanent Forum on Indigenous Issues

The UN Permanent Forum on Indigenous Issues has long considered the theme of health throughout the work conducted since it was created.

In 2002, the UNPFII noted "the significance of incorporating indigenous understanding of the human body, the causes of health and illness and existing practices of treatment of women and men, respectively, for the development of policies and guidelines on health care."[13] In the same year, the UNPFII called for a study on access to health care which included how health services that are sensitive to traditional health-care practices may be provided to indigenous peoples.[14]

The following year, the UNPFII called on UN Agencies including the World Health Organization to incorporate indigenous healers and cultural perspectives on health and illness into their policies, guidelines and programmes, and to undertake regional consultations with Indigenous Peoples on these issues, in order to mainstream Indigenous health issues into the UN system.[15]

In 2004, the UNPFII provided substantive recommendations on health **including the treaty right to health**. The UNPFII in particular recommended to the UN System and member states:

> *Fully incorporate the principle that health is a fundamental human right in all health policies and programmes, and foster rights-based approaches to health,* ***including treaty rights*** *[and the] right to culturally acceptable and appropriate services….encourage states to include and accredit traditional, indigenous health practitioners (physicians), including traditional birth attendants (midwives), and to integrate them into state health-care systems, and give full recognition to the medicinal knowledge and medicines of these indigenous practitioners.*[16] (emphasis added)

In the following year, 2005, the UNPFII invited the World Health Organization together with UNDP and the World Intellectual Property Organization amongst others to organize, host and report on "methods, processes and best practices of integrating indigenous traditional knowledge, medicine, health, and other health practices in mainstream health-care systems and sensitizing health personnel concerning the protection of indigenous knowledge systems."[17]

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[13] E/CN.19/2002/3/Rev.1 at para 9.
[14] Ibid at para 12.
[15] E/C.19/2003/22 at para 63 (a).
[16] E/C.19/2004/23 at para 89 (a) & (e)
[17] E/C.19/2005/9 at para 141.

The result of this recommendation was the Report of the International Technical Workshop on Indigenous Traditional Knowledge[18] which was presented the following year at the UNPFII and did indeed attempt to address these issues. In that Report, the Pan American Health Organization provided information on the challenge of developing and implementing intercultural primary health care programmes for indigenous communities in the Americas.

PAHO programmes were presented as incorporating indigenous perspectives, medicines and therapies into national health systems in a holistic way and at policy level, and they pointed to PAHO resolutions CD37.5 (1993) and CD40.R6 (1997) signed by the 34 PAHO member states (including Canada as of 1971). Those resolutions speak to the:

> *"establishment or strengthening of a **high level technical commission** or other mechanism of consensus, as appropriate, **with the participation of leaders and representatives of indigenous peoples**, for the formulation of policies and strategies and the development of activities in the areas of health and the environment for the benefit of specific indigenous populations;"[19] and further to "[p]romote the transformation of health systems and support the development of alternative models of care, **including traditional medicine** and research into quality and safety, for indigenous populations within the local health system strategy."*[20]

While this Technical Workshop Report had been presented to the UNPFII 2006 Session, the Members of the Permanent Forum still felt it was necessary to reiterate a nearly identical recommendation to those issued in previous Sessions:

> *48.The Permanent Forum, reaffirming the recommendations on health made at its first, second, and third sessions, further recommends that all relevant UN entities, especially WHO, the United Nations Childrens' Fund (UNICEF) and UNFPA, as well as regional health organizations and Governments, fully incorporate a cultural perspective into health policies, programmes and reproductive health services aimed at providing indigenous women with quality health care, including emergency obstetric care, voluntary family planning and skilled attendance at birth. In the latter context, the roles of traditional midwives should be re-evaluated and expanded so that they may assist indigenous women during their reproductive health processes and act as cultural brokers between health systems and the indigenous communities' values and world views.*[21]

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[18] E/C.19/2006/2
[19] CD37.5 at para 2.a
[20] Ibid at para 2.d
[21] E/C.19/2006/11

In 2007, the UNPFII recommended that regardless of the absence of birth registration for Indigenous children and adolescents, that the allocation of funds for their health benefits should not be affected.[22]

In 2008, the UNPFII noted for the first time the linkages between climate change and health. In the same year, the UNPFII noted the high rates of TB amongst Indigenous Peoples and supported the Assembly of First Nations in Canada to hold an expert group meeting on Tuberculosis, which was held in November of 2008 in Toronto, Canada. The Report was provided as a CRP to the 2009 Session of the UNPFII.

In 2010, the Permanent Forum recommended that "States include ethnic identification in vital statistics and health records, allocate more funding for intercultural services that ensure indigenous women's access to quality health care, including emergency obstetric care, voluntary family planning and skilled attendance at delivery, and that the role of traditional midwives be strengthened and extended.[23]

In 2012, the UNPFII urged "States to promote indigenous community-controlled models for the health, social, legal and other sectors of indigenous communities and service providers to follow in implementing the Declaration [on the Rights of Indigenous Peoples]. It recommends that WHO revisit the report of the WHO Commission on Social Determinants of Health to address the cultural determinants of health, such as land, language, ceremony and identity, which are essential to the health and well-being of indigenous peoples."[24]
In 2013, the UNPFII noted that "[g]ood practices are emerging that complement public health services with traditional health practices. These practices emphasize intercultural dialogue and discussion to ensure that health care is delivered in a culturally specific way, consistent with articles 23 and 24 of the United Nations Declaration on the Rights of Indigenous Peoples. These practices should be supported and promoted."[25] In addition, in this year the UNPFII also noted previous recommendations regarding youth suicides and encouraged "community organization for safe spaces and low threshold health services, respecting non-discrimination, in particular where discrimination based on ethnicity, gender and sexual orientation is concerned. The United Nations system, in particular the World Health Organization and UNICEF should emphasize the provision of mental health services, with particular efforts to address suicide amongst indigenous youth."[26]

In its 2014 Final Report[27], the UN Permanent Forum on Indigenous Issues made the following recommendations (paras 14, 15 & 41) relevant to health:

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[22] E/C.19/2007/12 at para 66.
[23] E/C.19/2010/15 at para 166.
[24] E/C.19/2012/13 at para 35.
[25] E/C.19/2013/25 at para 6.
[26] Ibid., at para 8.
[27] E/2014/43-E/C.19/2014/11

14.The Permanent Forum recommends that the World Health Organization, the United Nations Population Fund and other relevant entities coordinate in the formulation of key intercultural standards and indicators of quality of care to be considered in the definition of a future post-2015 goal on universal health coverage that includes the sexual and reproductive health of indigenous peoples.

15.The Permanent Forum recommends that United Nations agencies and actors coordinate in the development and implementation of an international research project on the sexual and reproductive health of indigenous peoples, ensuring an active partnership with indigenous peoples and organizations in all stages of the project.

41.The Permanent Forum acknowledges the efforts and initiatives of States and United Nations agencies to promote mother-tongue based multilingual education, develop health programmes and provide skills to indigenous children and youth. In this regard, the Forum encourages States and United Nations agencies to increase their efforts in a targeted and wide-scale manner to respond to the needs and priorities of indigenous children and youth, especially in the areas of education and health, in a manner that is culturally sensitive and ensures their overall well-being consistent with articles 11, 14, 41 and 42 of the United Nations Declaration on the Rights of Indigenous Peoples.

46.The Permanent Forum also urges States to fund and deliver training in suicide prevention and mental health awareness to all teaching and non-teaching staff in all schools attended by indigenous children. The development of localized training programmes adapted to each culture consistent with articles 11, 14, 15 and 31 should be encouraged.
47.The Permanent Forum further urges the General Assembly to proclaim an international year of the world's indigenous children and youth.

United Nations System Observations, Conclusions and Reviews of Canada

The Review of Canada under the International Convention on the Elimination of All Forms of Racial Discrimination took place in 2012, with significant observations and recommendations being made. The Committee on the Elimination of Racial Discrimination, the treaty monitoring body of the Convention, made the following observations and recommendations:

19. …the Committee remains concerned about the persistent levels of poverty among Aboriginal peoples, and the persistent marginalization and difficulties faced by them in respect of employment, housing, drinking water, health and education, as a result of structural discrimination whose consequences are still present (art. 5)

The Committee recommends that the State party, in consultation with Aboriginal peoples, implement and reinforce its existing programmes and policies to better realize the economic, social and cultural rights of Aboriginal peoples, in particular through:
(d) Facilitating their access to health services;

The Committee requests that the State party, in consultation with indigenous peoples, consider elaborating and adopting a national plan of action in order to implement the United Nations Declaration on the rights of indigenous peoples.

20.In light of its General Recommendation no. 23 (1997) on the rights of indigenous peoples, the Committee recommends that the State party, in consultation with Aboriginal peoples:

(a) Implement in good faith the right to consultation and to free, prior and informed consent of Aboriginal peoples whenever their rights may be affected by projects carried out on their lands, as set forth in international standards and the state party's legislation[28]

The Special Rapporteur on the Right to Food conducted a country visit to Canada in 2012. During that visit, the Special Rapporteur held a day long hearing at Alexis First Nation, where various representatives of Maskwacis Cree made interventions and provided submissions linking the right to food with our Treaty Rights to traditional lands, territories and resources and related Treaty rights to hunt, fish, and gather traditional foods and medicines. Maskwacis Cree representatives emphasized the linkages between traditional foods and the health of our people, demonstrating that our health has been compromised by the shift away from traditional foods towards highly processed food and "food-like substances." In the Report of the Special Rapporteur on his Mission to Canada[29], he made the following recommendations:

- *Formulate a comprehensive rights-based national food strategy clearly delineating the responsibilities of public officials at the federal, provincial/territorial, and municipal/local levels, identifying the measures to be adopted and the associated time frames, and ensuring that initiatives adopted at municipal and provincial levels, particularly for the rebuilding of local food systems, are adequately supported; as part of this strategy, create a nationally funded children and food strategy (including school-feeding food literacy and school garden programmes) to ensure that all children, at all times, have access to healthy and nutritious food; launch the process of adoption of a framework law on the right to food, for the regular updating of the Canadian food strategy;*

[28] CERD/C/CAN/CO/19-20 at para 19
[29] A/HRC/22/50/Add.1 Recommendations at pp 20-21.

- *Accord status to those Aboriginal peoples unrecognized as such under the Indian Act in order to enable all Aboriginal peoples to have access to land and water rights to which they are entitled; encourage the federal, provincial and territorial governments to meet, in good faith, with indigenous groups to discuss arrangements to ensure access to land, natural resources, Nutrition North Canada and the right to food, among others;*

In 2014, the Special Rapporteur on the Rights of Indigenous Peoples conducted a country visit to Canada. During that country visit, the Special Rapporteur conducted a one day long meeting at Maskwacis with the Maskwacis Cree and other First Nations participants. In his Report on the Situation of Indigenous Peoples in Canada,[30] he made the following observations specific to the health of Indigenous Peoples:

> *15. The most jarring manifestation of these human rights problems is the distressing socio-economic conditions of indigenous peoples in a highly developed country. Although in 2004 the previous Special Rapporteur recommended that Canada intensify its measures to close the human development indicator gaps between indigenous and non-indigenous Canadians in health care, housing, education, welfare, and social services, there has been no change in that gap in the intervening period in relation to registered Indians/First Nations, although socio-economic conditions for Métis and non-status Indians have improved, according to government data. The statistics are striking. Of the bottom 100 Canadian communities on the Community Wellbeing Index, 96 are First Nations, and only one First Nation community is in the top 100*.
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> *24. The housing situation in Inuit and First Nations communities has reached a crisis level, especially in the north, where remoteness and extreme weather exacerbate housing problems. Overcrowded housing is endemic. Homes are in need of major repairs, including plumbing and electrical work. These conditions add to the broader troubling water situation in First Nations reserves, in which more than half of the water systems pose a medium or high health risk to their users*
>
> *Health and well-being*
>
> *29. The health of First Nations, Inuit and Métis people in Canada is a matter of significant concern. Although overall the health situation of indigenous peoples in Canada has improved in recent years, significant gaps still remain in health outcomes of aboriginal as compared to non-aboriginal Canadians, including in terms of life expectancy, infant mortality, suicide, injuries, and communicable and chronic diseases such as diabetes. The health situation is exacerbated by overcrowded housing, high population growth rates, high poverty rates, and*

[30] A/HRC/27/52/Add.2

the geographic remoteness of many communities, especially Inuit communities in the north.

30. Healthcare for aboriginal people in Canada is delivered through a complex array of federal, provincial and aboriginal services, and concerns have been raised about the adequacy of coordination among these. A recent positive development in British Columbia, which could provide a model for other areas, is the 2013 implementation of a tripartite agreement to achieve a more responsive health cares system. The oversight and delivery of federally funded health services in British Columbia have been transferred to First Nations, while the three levels of government (First Nations, provincial and federal) work collaboratively to support integration and accountability.

69. One of the most dramatic contradictions indigenous peoples in Canada face is that so many live in abysmal conditions on traditional territories that are full of valuable and plentiful natural resources. These resources are in many cases targeted for extraction and development by non-indigenous interests. While indigenous peoples potentially have much to gain from resource development within their territories, they also face the highest risks to their health, economy, and cultural identity from any associated environmental degradation. Perhaps more importantly, indigenous nations' efforts to protect their long-term interests in lands and resources often fit uneasily into the efforts by private non-indigenous companies, with the backing of the federal and provincial governments, to move forward with natural resource projects.

The Special Rapporteur on the Rights of Indigenous Peoples made the following recommendation regarding the health of Indigenous Peoples in Canada:

84. The Government should ensure sufficient funding for services for indigenous peoples both on and off reserve, including in areas of education, health, and child welfare, in light of the rights and significant needs of indigenous peoples and the geographic remoteness of many indigenous communities; and insure that the quality of these services is at least equal to that provided other Canadians.

85. Federal, provincial and aboriginal governments should improve upon their coordination in the delivery of services. Continued efforts should be made to support indigenous-run and culturally appropriate social and judicial services, and to strengthen and expand programs that have already demonstrated successes.

86. Canada must take urgent action to address the housing crisis in indigenous communities both on and off reserve, especially communities in the north, and dedicate increased funding towards this end.

In 2015, the Committee on the Elimination of Discrimination Against Women (CEDAW) released its Report of the inquiry concerning Canada of the Committee of the Elimination of Discrimination Against Women under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women.[31] CEDAW noted that "[t]he impact of laws enacted during the colonial period has significantly reinforced gender-based discrimination and inequality, such as provisions in the Indian Act on eligibility to be registered as an Indian as well as on the transmission of Indian status. Notably, eligibility to certain rights and social benefits, such as housing on reserves, voting rights in relation to election of reserve band councils, the right to reside on reserve lands, harvesting rights, access to on reserve housing, support for education, social services, and health benefits are attached to such status**." This is very relevant to issues of birth registration and access to health care for Indigenous Peoples**. In fact, CEDAW also noted that "[t]he Indian Act discriminated against First Nations women for over a century, by depriving them of their Indian status upon marriage to a non-Indian1. Amendments brought respectively in 1985 and 2010 addressed some of the discriminatory aspects against descendants of First Nations women, but a number of issues were left unaddressed. Indeed, according to the 2010 amendments, those newly entitled to Indian status cannot transmit their status if they have a female rather than a male First Nations ancestor. In addition, pursuant to the 1985 amendments, children of mothers registered under section 6 (2) who have unstated fathers cannot be eligible for registration. Given the high rates of unstated and/or unrecognised paternity, Aboriginal women are more adversely affected by non-registration and non-membership than men and as a result cannot access the rights and benefits for their children conferred by registration and membership."[32]

Regarding the high number of Indigenous children and youth in state care or custody in Canada, CEDAW noted that "[t]he experts were also informed that women who were victims of violence often avoided seeking help from health or social service organizations for fear that their children would be apprehended by child welfare authorities. The experts were also informed by civil society organisations that there are more First Nations children in child welfare care today than at the height of residential schools, by a factor of three."[33]

The Recommendations of the CEDAW Inquiry included the following:

> B*. Improving socio-economic conditions of Aboriginal women*
> *iii. Develop national anti-poverty, food security, housing, education and employment strategies focusing on women in the Aboriginal community; take measures to increase access to health services, including mental health services and drug dependency treatment; ensure access to sanitation and safe drinking water; and develop adequate public transport in areas and along highways*

[31] CEDAW/C/OP.8/CAN/1
[32] Ibid, at para 24
[33] Ibid at para 113

where Aboriginal women are in danger when moving between communities and travelling to work or school;
iv. Address the issue of the disproportionately high number of Aboriginal children institutionalized by child welfare authorities which impacts on Aboriginal women's vulnerability to violence as they are reluctant to seek help from authorities for fear that their children be taken away.

Recommendations of Maskwacis Cree to the Expert Mechanism on the Rights of Indigenous Peoples

1. The Maskwacis Cree recommend that access to remedy regarding Treaty violations or breach of Treaty through policy changes is developed in full and equitable partnership with Indigenous Peoples, and through mechanisms that have Indigenous representatives and the capacity to address Treaty matters.
2. Maskwacis Cree recommends that the Expert Mechanism emphasize the importance of facilities addressing mental health and addictions to be designed and operated in an accessible and equitable fashion, with Indigenous Peoples-specific needs, for example with culture as treatment.
3. We call on the Expert Mechanism to recognize Indigenous wholistic approaches to health care service and delivery such as the Tipi Model, and urge states to support, endorse and invest in such Indigenous models that have been derived through the advice of Indigenous Elders and Leaders.
4. The Maskwacis Cree recommend that the World Health Organization develop a focal point on the health of Indigenous Peoples, and further that the World Health Organization fully utilize their standard setting processes to collaborate and engage in partnership with Indigenous Peoples towards data collection (including development of indicators and monitoring) and improved health outcomes for Indigenous Peoples in North America and other regions.
5. The Maskwacis Cree reiterate that the Treaty right to health is not a financial burden that is realized through policy decisions, but rather a legal obligation under Treaty, Canadian law and international law. As such, when benefits and health care service delivery are withheld, this constitutes a breach of legal obligations and must be acknowledged as such.
6. The Maskwacis Cree recommend that formal bilateral negotiations, processes or mechanisms regarding implementation of the Treaty Right to Health be established. As a follow up to the 2003 Recommendation of the UN Seminar on Treaties, Agreements and Other Constructive Arrangements, Maskwacis Cree recommend that the OHCHR make available technical cooperation to assist Indigenous Peoples with their negotiations in relation to the medicine chest and famine and pestilence clauses of Treaty No. 6.
7. Maskwacis Cree recommend that the Expert Mechanism call on the Food and Agriculture Organization (FAO) to work in partnership with the World Health Organization (WHO), further to their respective guidelines and

regulations,[34] promote healthy environments contributing to the health of Indigenous Peoples and their lands, waters and territories as a whole. This must in part be achieved through the appropriate information-sharing during unexpected or unusual public health events such as chronic wasting disease in animals which constitute the traditional food sources of such Indigenous Peoples.

[34] In particular Article 7 of WHO International Health Regulations (2005)