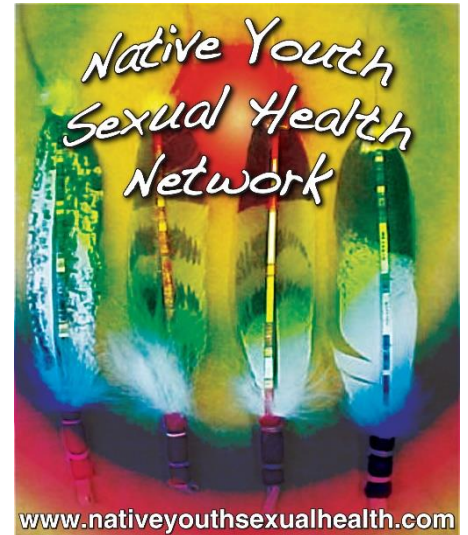




Action Canada
for Sexual Health & Rights



**JOINT SUBMISSION TO THE EXPERT MECHANISM ON THE RIGHTS OF
INDIGENOUS PEOPLES IN RESPONSE FOR STUDY ON THE RIGHT TO
HEALTH AND INDIGENOUS PEOPLES, WITH A FOCUS ON CHILDREN AND
YOUTH**

Date: March 4, 2016

Submitted by: Action Canada for Sexual Health and Rights & the Native Youth Sexual Health Network

Action Canada for Sexual Health & Rights is a progressive, pro-choice charitable organization committed to advancing and upholding sexual and reproductive health and rights in Canada and globally.

The **Native Youth Sexual Health Network (NYSHN)** is an organization by and for Indigenous youth that works across issues of sexual and reproductive health, rights and justice throughout the United States and Canada.

Introduction

1. Native Youth Sexual Health Network and Action Canada for Sexual Health and Rights make this submission in response to the resolution of the United Nations (UN) Human Rights Council A/HRC/RES/30/40 on Human Rights and Indigenous Peoples which calls for submissions on the right to health and Indigenous Peoples, with a focus on children and youth. This submission highlights some key considerations for policy making and programme development as it relates to the realization of Indigenous Peoples' right to health, with a particular focus on children and youth.
2. This report discusses the international human rights framework as it relates to Indigenous Peoples' right to health with a focus on the full spectrum of sexual and reproductive health, rights and justice issues related to children and youth. Specific issues raised for discussion include: linkages between environmental violence and sexual and reproductive health, incidences of forced sterilization and coercive contraceptive practices, sexual and reproductive health of people who are incarcerated, Indigenous midwifery and access to harm reduction programmes.

International human rights context

2. Indigenous peoples and organizations globally have advocated for the full application and implementation of the practice of free, prior and informed consent (FPIC) in line with Article 23 of the UN Declaration on the Rights of Indigenous Peoples and international human rights law. FPIC empowers Indigenous peoples and communities to meaningfully engage in decision-making that affects them, which includes decision-making around health laws, policies and programmes in the realm of sexual and reproductive rights.
3. The Committee on Economic, Social and Cultural Rights (CESCR) has recognized FPIC in relation to the realization of economic, social and cultural rights by calling on states to "take the legislative and administrative measures needed to ensure that free, prior and informed consent is obtained from Indigenous peoples in relation to decisions that may directly affect the exercise" of such rights.¹
4. Article 24 of the UN Declaration on the Rights of Indigenous Peoples states that "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," the right to access "without any discrimination, to all social and health services," and the right to enjoy "the highest attainable standard of physical and mental health."² States are obligated to take steps to ensure the progressive realization of this right.
5. According to the CESCR, the right to health involves "not merely the absence of disease or infirmity but a state of complete physical, mental and social well-being that embraces a wide range of socio-economic factors promoting conditions in which people can lead a healthy life and that extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."³ The CESCR has said that "the health of the individual is often linked to the health of the society as a whole and has a collective dimension and that development-related activities that lead to the displacement of indigenous peoples against their

¹ Committee on Economic, Social and Cultural Rights. Concluding Observations to Paraguay. E/C.12/PRY/CO/4. 2015.

² UN Declaration on the Rights of Indigenous Peoples. 2007.

³ Committee on Economic, Social and Cultural Rights. General Comment No. 14. "The right to the highest attainable standard of health." 2000.

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.”⁴

2. CESCR General Comment No. 14, explicitly defined the right to health to include “the right to control one’s health and body, including sexual and reproductive freedoms.”⁵ It calls on state parties to implement “measures to improve...maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information,”⁶ and that the “realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.”⁷
3. Indigenous communities often experience inequalities in the social determinants of health, specifically as they relate to access to adequate housing, safe drinking water, nutritious food, among others. Many such inequalities persist due to systemic forms of discrimination. CESCR General Comment No. 20 on non-discrimination defines systemic discrimination as “legal rules, policies, practices or predominant cultural attitudes in either the public or private sector which create relative disadvantages for some groups, and privileges for other groups.”⁸ According to the Special Rapporteur on the Right to Health, “discrimination and stigma continue to pose a serious threat to sexual and reproductive health for many groups, including women, sexual minorities, refugees, people with disabilities, rural communities, Indigenous persons, people living with HIV/AIDS, sex workers, and people held in detention. Some individuals suffer discrimination on several grounds, e.g. gender, race, poverty and health status.”⁹
4. States are obliged to adopt measures to address multiple and intersecting forms of discrimination experienced by Indigenous peoples. CESCR General Comment No. 20 outlines such measures, which include reviewing laws, policies and programmes, teaching the principle of equality and non-discrimination in formal and non-formal education, creating temporary special measures, incentives to encourage public actors to change their attitudes and behaviours in relation to groups facing systemic discrimination, awareness raising, devoting resources to traditionally neglected groups and ensuring the implementation of laws and policies that in practice disproportionately affect specific groups.¹⁰
5. In the area of health of Indigenous peoples, states must initiate effective and practical steps to ensure the protection of Indigenous peoples against discrimination with regard to health.¹¹ This includes increasing health-related budgets and taking “necessary measures to consolidate a national health system accessible to all without discrimination of any kind, in accordance with article 12 of the covenant and taking into consideration general comment no. 14 (2000) on the right to the highest attainable standard of health (article 12 of the covenant).”¹² Further, the Committee calls upon states to “strengthen measures to ensure the coverage and accessibility of the health-care services provided by the state”¹³ in rural areas and those inhabited by Indigenous peoples.

⁴ UN Committee on Economic, Social and Cultural Rights. 2000. “General Comment no. 14.”

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11.

⁵ CESCR. 2000. General Comment No. 14. “The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights),” para 8.

⁶ CESCR. 2000. General Comment No. 14. “The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights),” para 14.

⁷ CESCR. 2000. General Comment No. 14. “The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights),” para 21.

⁸ Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.

⁹ UN Special Rapporteur on the right to the highest attainable standard of health, 2004. Annual report. E/CN.4/2004/49.

¹⁰ Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.

¹¹ Committee on Economic, Social and Cultural Rights. Concluding Observations to Ecuador. E/C.12/1/ADD/100. 2004.

¹² Committee on Economic, Social and Cultural Rights. Concluding Observations to Guatemala. E/C.12/GTM/CO/3. 2014.

¹³ Committee on Economic, Social and Cultural Rights. Concluding Observations to Guatemala. E/C.12/GTM/CO/3. 2014.

6. The CESCR has recognized the rights of those who are incarcerated, calling upon states to give special attention to those who face traditional difficulties exercising their rights.¹⁴ In its Concluding Observations, the CESCR has expressed concern regarding challenges in access to health care for those in prison.¹⁵ It has further called upon states to take measures to improve access to HIV prevention “and the treatment, care and support of persons living with HIV/AIDS, including in prisons and detention centres,”¹⁶ and to “take measures to ensure that effective treatment of drug dependence is made accessible to all, including to those in detention.”¹⁷
7. General Comment No. 19 of the Committee on the elimination of discrimination against women states that “compulsory sterilization or abortion adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children.” General Comment no. 24 by the same Committee on women and health calls upon states to “ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures [...] because of lack of appropriate services in regard to fertility control.”¹⁸
8. The Committee has, on numerous occasions, expressed concern regarding incidences of forced sterilization, particularly among marginalized communities. In its Concluding Observations to states, the Committee has called for the elimination of forced sterilization, raising awareness among health professionals of their prejudices towards marginalized women, providing social and health services support to vulnerable women, developing a clear definition of free, prior and informed consent in cases of sterilization, investigating cases of forced sterilization, guaranteeing adequate resourcing for investigations, and to financially compensate victims of coercive or non-consensual sterilizations.¹⁹
9. The 13th session of the Permanent Forum on Indigenous Issues (2014) affirmed the report and recommendations emerging from the International Expert Group Meeting on the theme “Sexual and Reproductive Rights: article 21, 22 (1), 23 and 24 of the UN Declaration on the Rights of Indigenous Peoples” (2014). The report from the meeting highlights the lack of available data and the failure of some states to legally recognize the identity and status of Indigenous peoples. Together, this results in the invisibilization or sub-summation of Indigenous peoples under generic categorizations such as 'ethnic minorities' or 'impoverished and marginalized communities' which makes it difficult to design policies and programmes and creates significant barriers in ensuring access to basic social services and the ability to claim rights.²⁰ In line with the UN Declaration on the Rights of Indigenous Peoples, the report acknowledges the “right to self-determination, the right to maintain and develop their own systems or institutions, the right to traditional medicines and health practices and the principle of free, prior and informed consent are cornerstones for the achievement of sexual and reproductive health and rights for Indigenous peoples.”²¹ The report also recognizes that “intercultural sexual and reproductive health promotes physical, emotional, spiritual, individual and community well-being in all aspects of human sexuality and reproduction in ways consistent with the human dignity and rights of both men and women.”²²

Sexual and reproductive health of Indigenous Peoples

Linkages between environmental violence and sexual and reproductive health and rights

¹⁴ Committee on Economic, Social and Cultural Rights. General Comment 19: the right to social security. 2008.

¹⁵ Committee on Economic, Social and Cultural Rights. Concluding Observations to Madagascar. E/C.12/MDG/CO/2. 2009.

¹⁶ Committee on Economic, Social and Cultural Rights. Concluding Observations to Ukraine. E/C.12/UKR/CO/5. 2008.

¹⁷ Committee on Economic, Social and Cultural Rights. Concluding Observations to Poland. E/C.12/POL/CO/5. 2009.

¹⁸ Committee on the Elimination of Discrimination Against Women. General Recommendations 19, 1992, and 24, 1999.

¹⁹ Committee on the Elimination of Discrimination Against Women. CEDAW/C/CZE/CO/5 (2010), CEDAW/C/JOR/CO/5 (2012), CEDAW E/C.12/PER/CO/2-4. 2012, and CEDAW/C/HUN/CO/7-8 (2013).

²⁰ International Expert Group Meeting on the theme “Sexual and Reproductive Rights: article 21, 22 (1), 23 and 24 of the UN Declaration on the Rights of Indigenous Peoples. January 2014. <http://esango.un.org/irene/desa.html?page=viewContent&nr=23125&type=8>

²¹ International Expert Group Meeting on the theme “Sexual and Reproductive Rights: article 21, 22 (1), 23 and 24 of the UN Declaration on the Rights of Indigenous Peoples. January 2014. <http://esango.un.org/irene/desa.html?page=viewContent&nr=23125&type=8>

²² International Expert Group Meeting on the theme “Sexual and Reproductive Rights: article 21, 22 (1), 23 and 24 of the UN Declaration on the Rights of Indigenous Peoples. January 2014. <http://esango.un.org/irene/desa.html?page=viewContent&nr=23125&type=8>

7. The ways in which we live in and engage with our physical environment have a direct impact on our well-being and health, including our sexual and reproductive health. Research has shown correlations between living in proximity to extractive resource sites and contaminated breast milk, increases in the number of miscarriages, reproductive health cancers, sterility, and birth defects, among others.²³ According to NYSHN, “Indigenous women and children often bear the brunt of negative consequences of resource extraction and therefore suffer the health-related consequences. The International Indian Treaty Council has termed this particular impact of environmental racism on Indigenous women and children as ‘environmental violence.’²⁴
8. Indigenous communities in Canada, and globally, are at greater risk of experiencing these health outcomes, which represent violations of the right to health, as Indigenous people are more likely to live in proximity to extractive sites. Similarly, according to NYSHN, Indigenous people are disproportionately impacted by the “manufacture and export of harmful products to other, primarily developing countries, which is not only unethical and unjust, but also violates the rights to health and life of all peoples, particularly women and children.”²⁵ Many areas affected by extractive industries have also seen an increased prevalence of sexual violence, HIV and other sexually transmitted infections, among other negative impacts.²⁶

Forced sterilization and coercive contraceptive practices

9. In November 2015, media outlets released reports of women in the province of Saskatchewan having undergone forced sterilization in the last five years.²⁷ The women reported being pressured by health professionals and social workers to undergo tubal ligation surgeries. In response, the regional health authority committed to launching an independent investigation to examine the issue. Many advocates believe there are other women in Canada, particularly Indigenous women, who have had similar experiences within the healthcare system.²⁸ This is despite the elimination of policies which permitted and promoted forced sterilization in the 1970s.²⁹
10. According to NYSHN, forms of sterilization persist in the treatment of Indigenous communities.³⁰ NYSHN writes that ‘modern forms of forced sterilization’ occur through the “over-prescription of Depo-Provera to Indigenous youth, which has been proven to cause signs of infertility when over-used.”³¹ This misuse and over-prescription of Depo-Provera occurs despite calls for accessible and community-based contraceptive education, a centrally important component in ensuring Indigenous peoples and youth can exercise self-determination when it comes to their reproductive futures and address sexual violence as it occurs. To resist the over-prescription of Depo-Provera to Indigenous youth, health providers must create the

²³ Hoover et al. 2012. “Indigenous Peoples of North America: Environmental Exposures and Reproductive Justice.” *Environmental Health Perspectives*. Vol 120. No 12. <http://ehp.niehs.nih.gov/wp-content/uploads/120/12/ehp.1205422.pdf> and Statement developed by the Sexual Rights Initiative and the Native Youth Sexual Health Network for the 25th session of the UN Human Rights Council. Also see: 2nd Declaration for health, life and defense of our lands, rights and future generations. April 29th 2012. Chickaloon Native Village, Alaska. <http://www.nativeyouthsexualhealth.com/apr292012.pdf>.

²⁴ 2nd Declaration for health, life and defense of our lands, rights and future generations. April 29th 2012. Chickaloon Native Village, Alaska. <http://www.nativeyouthsexualhealth.com/apr292012.pdf>

²⁵ Hoover et al. 2012. “Indigenous Peoples of North America: Environmental Exposures and Reproductive Justice.” *Environmental Health Perspectives*. Vol 120. No 12. <http://ehp.niehs.nih.gov/wp-content/uploads/120/12/ehp.1205422.pdf> and Statement developed by the Sexual Rights Initiative and the Native Youth Sexual Health Network for the 25th session of the UN Human Rights Council. Also see 2nd Declaration for health, life and defense of our lands, rights and future generations. April 29th 2012. Chickaloon Native Village, Alaska. <http://www.nativeyouthsexualhealth.com/apr292012.pdf>.

²⁶ Pauktuutit Inuit Women of Canada. “Impacts of Resource Extraction on Inuit Women.” http://pauktuutit.ca/wp-content/blogs.dir/1/assets/08-Mining-Fact-Sheet_EN.pdf.

²⁷ National Post. “Saskatoon Health Region apologizes after aboriginal women felt pressured by staff to have tubes tied.” November 2015.

<http://news.nationalpost.com/news/canada/saskatoon-health-region-apologizes-after-aboriginal-women-felt-pressured-by-staff-to-have-tubes-tied>.

²⁸ Radical Criminology. “Art through a birch bark health: an illustrated interview with Erin Marie Konsmo.”

<http://journal.radicalcriminology.org/index.php/rc/article/view/29/html>, 2013, and Vice News. “This Woman Says a Hospital in Canada Pushed Her to Undergo Sterilization.” November 2015. <https://news.vice.com/article/this-woman-says-a-hospital-in-canada-pushed-her-to-undergo-sterilization>.

²⁹ sVice News. “This Woman Says a Hospital in Canada Pushed Her to Undergo Sterilization.” November 2015. <https://news.vice.com/article/this-woman-says-a-hospital-in-canada-pushed-her-to-undergo-sterilization>.

³⁰ Radical Criminology. “Art through a birch bark health: an illustrated interview with Erin Marie Konsmo.”

<http://journal.radicalcriminology.org/index.php/rc/article/view/29/html>, 2013, and Vice News. “This Woman Says a Hospital in Canada Pushed Her to Undergo Sterilization.” November 2015. <https://news.vice.com/article/this-woman-says-a-hospital-in-canada-pushed-her-to-undergo-sterilization>.

³¹ Radical Criminology. “Art through a birch bark health: an illustrated interview with Erin Marie Konsmo.”

<http://journal.radicalcriminology.org/index.php/rc/article/view/29/html>, 2013.

conditions for clients and patients to fully exercise free, prior and informed consent related to contraceptive options, including the provision of more permanent health care options in remote communities.³²

11. NYSHN has also reported incidences of forced sterilization in Canadian prisons.³³ At an institutional level, “the ideology that justified historical coerced sterilization continues to shape state and medical interventions in the reproductive lives of women, (especially) marginalized, racialized and Indigenous women, pressuring them to get sterilized for their own good, to save them and society from having to care for additional children.”³⁴ This speaks to the longstanding forms of systemic racism, and other types of discrimination, that have contributed to the marginalization of Indigenous people in Canada. Such forms of marginalization and discrimination can lead to barriers in access to health care and negative health outcomes.

Sexual and reproductive health of Indigenous people who are incarcerated or in detention (including but not limited to prisons, jails, juvenile detention centres, mental health facilities and group homes or foster care where high security measures are used)

12. Longstanding forms of systemic racism, and other types of discrimination, have resulted in the targeted profiling, policing and increased criminalization of marginalized populations in Canada. Indigenous communities in Canada have experienced the detrimental impacts of systemic racism and discrimination resulting in increased policing simultaneously experiencing increased rates of violence and little to no protection of rights. While Indigenous youth in Canada account for “6% of the general youth population, they account for 26% of youth admitted to correctional services”³⁵. Furthermore, Indigenous young women comprise 36% of all young women incarcerated. American Indian and Alaska Native youth are arrested at a rate of 3 times the national average, and 79% of youth in the Federal Bureau of Prison’s custody are American Indian and Alaska Native.³⁶ Overall, Indigenous peoples now account for 21.5 per cent of prison population in Canada despite being only 4% of the general population.”³⁷
13. Within Canada the United States, the focus on increased mandatory minimum sentencing has not been met with an increase in community-based restorative justice practices. Rather, the Supreme Court ruling “Gladue” that mandated the responsibility of judges to take into account the history of colonization when sentencing Indigenous people has not been invoked as much as it could as evidenced by the significant number of Indigenous people who account for those who are incarcerated in federal prisons.^{38 39}
14. Reports indicate human rights violations of Indigenous women who are incarcerated, including through the “shackling of pregnant women also while in labor, coerced sterilization and sexual violence from prison staff and guards”⁴⁰ and the absence of effective facilities for mothers who are incarcerated.⁴¹ Given the fact that Indigenous people account for disproportionately high rates of people who are incarcerated, they are more likely to be given the mandatory minimum sentences, which judges are now required to impose on a range of offences despite other precedent laws that should allow for judges to take into consideration systemic

³² Morgan, L., & Wabie, J. L. (2012). “Aboriginal Women’s access and acceptance of reproductive health care.” *Pimatisiwin*, 10(3), 313.

<http://www.pimatisiwin.com/online/wp-content/uploads/2013/02/05MorganWabie.pdf>.

³³ Native Youth Sexual Health Network. 2013. Presentation during 6th session of the Expert Mechanism on the Rights of Indigenous Peoples July 8-12, 2013;

<http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf>.

³⁴ Saskatoon Star Phoenix. “Saskatchewan women pressured to have tubal ligations.” November 17, 2015. <http://thestarphoenix.com/news/national/women-pressured-to-have-tubal-ligations>.

³⁵ Canadian Centre for Justice Statistics. (2012). Youth correctional statistics in Canada, 2011/2012.

³⁶ American Indians and Crime: A BJS Statistical Profile, 2004 <http://www.bjs.gov/content/pub/pdf/aic02.pdf>.

³⁷ <http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf>.

³⁸ Martel, J., Brassard, R., & Jaccoud, M. (2011). “When Two Worlds Collide Aboriginal Risk Management in Canadian Corrections.” *British Journal of Criminology*, 51(2), 235-255.

³⁹ <http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf>.

⁴⁰ Native Youth Sexual Health Network. 2013. Presentation during 6th session of the Expert Mechanism on the Rights of Indigenous Peoples July 8-12, 2013;

<http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf>.

⁴¹ Brennan, S. 2014. “Canada’s Mother-Child Program: Examining its emergence, usage and current state.” *Canadian Graduate Journal of Sociology and Criminology*. file:///C:/Users/Sarah/Downloads/84-444-1-PB.pdf.

colonial implications of incarceration and to consider diversion or alternative sentencing.⁴² Longer sentences increase the likelihood of poor health outcomes of those who are incarcerated, especially related to sexual and reproductive health.⁴³

Access to comprehensive sexual and reproductive health care, including harm reduction programmes

15. HIV and hepatitis C rates are on the rise among those who are incarcerated. This increase can be attributed to the lack of culturally safe and effective harm reduction policies⁴⁴ and limited access to comprehensive sexual and reproductive health services and information in and out of prisons. In Canada, the Correctional Investigator has reported delays in inmates' access to health services, cuts to essential health-related programs, unsupported harm reduction strategies, and the exacerbation of inmates' existing health conditions.⁴⁵ According to the Public Health Agency of Canada, between 1998 and 2012, of the reported HIV cases among Indigenous people (n=3,121), 47.3% were females, ranging from a low of 40.2% in 2002 to a high of 54.9% in 2007. By contrast, among people of other ethnicities (n=10,299), females account for 20.1% of cases. During that surveillance period, injection drug use accounted for 63.6% of new infections among Indigenous women versus 24.4% for women of other ethnicities.⁴⁶ Indigenous women account for a higher percentage of new HIV infections in their communities and are testing positive at relatively younger ages. Indigenous people account for more 'health disparities' than non-Indigenous people in all categories and still, Indigenous health concerns are relegated to a few specialized agencies and services instead of being put at the center of health initiatives across the board.

16. Indigenous peoples have experience reducing harm in many ways, especially the violence of colonialism. Mainstream harm reduction models and practices, while certainly a step in the right direction, do not always fit the contexts of northern, rural, or remote communities. Indigenous peoples have many Nation-specific understandings, traditions and needs that mainstream services often ignore or interrupt. NYSHN advocates for a shift away from such mainstream models towards an approach that recognizes the relationship between colonialism, power, health and oppression. This model centers on community wellbeing and the restoration of different Indigenous knowledge systems, life ways, ceremonies, culture and governance structures. It does so by focusing on cultural safety, sovereignty, self-determination and reclamation.⁴⁷

Indigenous midwifery

17. Indigenous midwifery and the ability for Indigenous peoples to birth within their communities is at the heart of realizing the full right to health. Yet many Indigenous families are not able to access midwifery care in their communities. Perinatal and infant mortality rates are nearly twice those of the general population.⁴⁸

18. Not only do traditional Indigenous practice of midwifery address health disparities within pre- and post-natal care, reducing negative birth outcomes and maternal mortality, they also play a role in supporting the cultural empowerment of Indigenous women, children and youth through providing education and often spiritual guidance throughout the life cycle.⁴⁹

⁴² BC Civil Liberties Association. "More than we can afford: the cost of minimum sentencing." <https://bccla.org/wp-content/uploads/2014/09/Mandatory-Minimum-Sentencing.pdf>.

⁴³ Public Health Agency of Canada. 2013. "The Chief Public Health Officer's Report on the State of Public Health in Canada, 2013. Infectious Diseases – The never ending threat." <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2013/sti-its-eng.php>.

⁴⁴ <http://www.aidslaw.ca/site/on-point-recommendations-for-prison-based-needle-and-syringe-programs-in-canada/>.

⁴⁵ Correctional Investigator of Canada. 2014. "Annual Report 2013-2014 of the Office of the Correctional Investigator." <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.

⁴⁶ Public Health Agency of Canada. <http://www.phac-aspc.gc.ca/aids-sida/publication/epi/2010/8-eng.php#a10>.

⁴⁷ <http://www.nativeyouthsexualhealth.com/harmreductionmodel.pdf>.

⁴⁸ Verstrateen, B., Mijovic-Kondejewski, J., Takeda, J., Tanaka, S., and Oldson, D. "Canada's pregnancy-related mortality rates: doing well but room for improvement." *Clin Invest Med. Voc.* 38, No.1. February 2015.

⁴⁹ <http://www.nativesexualhealth.com/january15172014.pdf>.

19. In Canada, the National Aboriginal Council of Midwives has produced a toolkit⁵⁰ for Indigenous Communities to bring birth closer to home utilizing the expertise and knowledge of Indigenous Communities. The toolkit recognizes that access to culturally safe midwifery care for Indigenous women and families is very limited across Canada.

Recommendations

In drafting the report on the right to health of Indigenous people we urge the Expert Mechanism on the rights of Indigenous Peoples to consider the following recommendations:

General recommendations

- 20. Examine and take steps to implement the recommendations from the international Expert Group Meeting on the theme “Sexual and Reproductive Rights: article 21, 22 (1), 23 and 24 of the UN Declaration on the Rights of Indigenous Peoples,”⁵¹ and the 13th session of the Permanent Forum on Indigenous Issues.⁵²**
- 21. Examine the intersections between criminalization of Indigenous peoples and impacts on sexual and reproductive health,** in part by addressing the systemic forms of racism, and other forms of discrimination, that result in the targeted profiling, policing and criminalization of marginalized populations.
- 22. Identify and document the disproportionate impacts of environmental toxins on Indigenous women and children as "environmental violence" for which States and corporations can be held accountable.**
- 23. Research and understand the impacts of current state funding models (eg. public health) that limit Indigenous peoples’ and communities’ abilities and right to self-determine health priorities and address their own needs.** The availability of culturally safe and accessible resources and spaces is imperative for Indigenous people residing in both rural and urban settings to realize their right to health. Further understand how implementing by and for Indigenous models globally (such as the First Nations Health Authority in BC, the National Aboriginal Health Organization and the model of Aboriginal Community-Controlled Health Organizations) realizes rights to health and ways to implement similar models globally.

This study must recognize the state obligations to realize the right to health of Indigenous peoples, that include:

- 24. Applying the principle of free, prior and informed consent to affected Indigenous peoples and communities** as a means of respecting, protecting and fulfilling the sexual and reproductive rights of Indigenous persons, beginning with the empowerment of Indigenous and other women and youth to participate in decision-making related to laws and policies that affect them.⁵³
- 25. Strengthening collection of data on Indigenous children and youth, including epidemiological data with a focus on Indigenous ethnicity,** so as to strengthen evidence demonstrating that HIV and AIDS disproportionately affect Indigenous peoples not simply because of cultural identity or individual behavior but because of structural barriers including racism, stigma, and discrimination.
- 26. Ensuring all individuals who have been criminalized, or been in conflict with the law, have access to comprehensive and culturally safe sexual and reproductive health services and information.** This must include strategies to address increasing STI transmission rates, establishing evidence-based prevention,

⁵⁰ <http://www.aboriginalmidwives.ca/toolkit/using-the-toolkit>.

⁵¹ http://www.un.org/esa/socdev/unpfii/documents/EGM_14_SHRR_paper_danforth.pdf.

⁵² <https://www.un.org/development/desa/indigenouspeoples/unpfii-sessions-2/thirteenth-session-of-the-unpfii.html>.

⁵³ Recommendation jointly developed by the Sexual Rights Initiative and the Native Youth Sexual Health Network in advance of the 25th session of the UN Human Rights Council. Full report can be found here: <http://www.nativeyouthsexualhealth.com/march112014.pdf>.

harm reduction and treatment services, including syringe exchange and needle distribution programmes, both in the community as well as in prisons and in detention centers.

27. **Provide sufficient and stable funding for prison health and harm reduction programmes, as part of a holistic approach to culturally safe services and supports that range from treatment to prevention, in the community, in prisons and detention centres.** This includes confidential and easy access to sterile injection supplies, and accessible information, education and support from trained personnel regarding safer drug injection.⁵⁴
28. **Providing sufficient and stable funding to implement and evaluate community-based strategies that provide realistic alternatives to imprisonment for Indigenous and racialized offenders,** and respond to underlying causes of offending. Stable funding models honour the right to Indigenous self-determination through encouraging the creation of community-based health strategies in line with priorities set by Indigenous peoples.
29. **Taking measures to restore the sexual and reproductive health of individuals and communities affected by environmental violence and remedy harms done,** in part by halting the production, use and export of products that are harmful to sexual and reproductive health and the environment and by applying the precautionary principle in relation to extractive industries and the use of pesticides.
30. **Immediately undertaking restoration and clean up-programmes where Indigenous communities are already impacted by environmental contaminants, and hold corporations which contributed to the contamination accountable.**
31. **Taking measures to protect and promote the sexual and reproductive health rights of mothers in prison, in part by implementing the Guidelines for the Implementation of Mother-Child Units in Canadian Correctional Facilities.**⁵⁵ Women who are expected to give birth while in prison, or who are the primary caregivers of dependent children, should remain in their communities wherever possible. The criminal justice system should prioritize community alternatives to custody for these women, particularly given the history of colonization that has resulted in the forcible removal of Indigenous children from families and communities.⁵⁶
32. **Recognizing the knowledge and practices of Indigenous women's health, birthing, traditional midwifery, and the use of Indigenous medicinal knowledge on equal footing with other health systems and methods, and the right of Indigenous healers to protect and use this knowledge as they so choose.**

Recommendations to UN actors:

33. **UNFPA, UNAIDS, UNICEF and other relevant UN bodies and mechanisms collaborate with Indigenous organizations in all regions to develop comprehensive guidelines for culturally safe sex education best practices by and for Indigenous peoples.**
34. **UNAIDS, UNFPA, UNICEF, WHO, OHCHR, UN Human Rights Council, UN functional commissions, and others, to strengthen existing (and develop new) approaches to examining the sexual and reproductive health needs and realities of Indigenous peoples.**

⁵⁴ <http://www.aidslaw.ca/site/on-point-recommendations-for-prison-based-needle-and-syringe-programs-in-canada/>.

⁵⁵ Guidelines for the Implementation of Mother-Child Units in Canadian Correctional Facilities. November 2015. University of British Columbia and the Collaborating Centre for Prison Health and Education.

⁵⁶ <http://ccphe.ubc.ca/bonding-through-bars-new-guidelines-for-mother-child-prison-units-put-interests-of-child-first-2/>.

- 35. Implement models of peer leadership that address the full and effective leadership of Indigenous youth.**

- 36. Relevant UN agencies, including the UN Permanent Forum on Indigenous Issues, the UN Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous Peoples are urgently requested to focus attention and collect information from Indigenous Peoples on the links between environmental contamination and reproductive health and justice, for the purpose of recommending effective solutions and remedies at the international level.**

- 37. Ensure that the Expert Mechanism on Rights of Indigenous Peoples' study on the right to health examine the criminalization of HIV with a focus on Indigenous women and youth, as well as legal standards and prosecutorial guidelines that are culturally safe for Indigenous peoples.**

- 38. UN agencies and Member States must continue to seriously consider Indigenous methods of accountability and justice, including restorative justice models that include the full, effective and meaningful participation and leadership of Indigenous youth.**

Appendix: Recommendations for Prison-Based Needle and Syringe Programs in Canada

Full report can be accessed here:

<http://www.ryerson.ca/content/dam/criminology/tank/faculty/PNSP%20Report%20Jan%202016.pdf>