Action Canada
for Sexual Health & Rights

Submission to the UN Committee on Economic, Social and Cultural Rights' 57th session for Canada's review

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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.

Key words: maximum available resources, right to health, access to abortion information and services, access to sexual and reproductive health services and information, sexual and reproductive health of Indigenous peoples, conscientious objection, comprehensive sexuality education.

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Introduction

1. This report is submitted by Action Canada for Sexual Health and Rights for Canada's review during the 57th Session of the UN Committee on Economic, Social and Cultural (herein referred to as the 'Committee'), taking place from February 22nd to March 4th 2016. The report examines violations of articles 2, 12 and 13 of the International Covenant on Economic, Social and Cultural Rights with respect to ensuring the allocation of maximum available resources through international assistance for the realization of economic, social and cultural rights, access to safe abortion services without discrimination, providing young people with access to accurate, evidence-based sexuality education, and the denial of sexual and reproductive health care on moral or religious grounds.

2. The List of Issues[1] prepared by the Committee in March 2015 requests that Canada provide information on a number of issues outlined in this report. Specifically, the Committee requests that Canada provide information on: the legal framework regulating abortion in Canada, the availability and accessibility of sexual and reproductive health information and services, and the availability and accessibility of age-appropriate sexual education in schools.

Article 2 – Realization of economic, social and cultural rights

Background: progressive realization of economic, social and cultural rights through international development cooperation policy

3. Article 2.1 of the Covenant on Economic, Social and Cultural Rights obliges state parties to undertake steps, including legislative measures, to allocate the maximum available resources for the realization of economic, social and cultural rights through international assistance and co-operation.[2] In General Comments No. 2 and No. 3, prepared by the Committee, the Committee reiterates the obligation of states in a position to assist others in need.[3] The Committee has further recommended that efforts should be made to ensure that economic, social and cultural rights, which include sexual and reproductive rights, are taken into consideration at all phases of development initiatives.[4] In concluding observations to states, the Committee expressed concern regarding failure to meet the global 0.7% Gross National Income (GNI) target for international assistance, and called on states to step up efforts to meet the target.[5] The Committee has further recommended the adoption of a human rights-based approach to development cooperation, with a specific focus on economic, social and cultural rights.[6]

4. Article 2.2 of the Covenant further obliges state parties to guarantee economic, social and cultural rights without discrimination. Analysis of this provision by the Committee affirms that a lack of available resources cannot justify failure to eliminate discrimination.[7] In the context of international assistance, General Comment No. 20

[1] Committee on Economic, Social and Cultural Rights. List of issues in relation to the sixth periodic report of Canada. E/C.12/CAN/Q/6. 31 March 2015.
[2] International Covenant on Economic, Social and Cultural Rights. 1976.
[3] Committee on Economic, Social and Cultural Rights. General Comment 3: he Nature of States Parties' Obligations. Paragraph14. 14 December 1990, and Committee on Economic, Social and Cultural Rights. General Comment 2: International Technical Assistance Measures. 1990.
[4] Committee on Economic, Social and Cultural Rights. General Comment 2: International Technical Assistance Measures. Paragraph 8. 1990.
[5] Committee on Economic, Social and Cultural Rights. Concluding Observations to Finland. E/C.12/FIN/CO/6, Concluding Observations to Portugal. E/C.12/PRT/CO/4, among others.
[6] Committee on Economic, Social and Cultural Rights. Concluding Observations to Portugal. E/C.12/PRT/CO/4.
[7] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.

dissuades states from promoting or upholding discriminatory practices, and obliges states to "take steps to ensure that all actors under their jurisdiction do likewise."[8]

Situation in Canada: support for the realization of economic, social and cultural rights through international development cooperation policy

5. In the past, Canada has had a strong reputation of being a leader on these issues. But in recent years, this reputation has been diminished. Government of Canada spending on aid has plateaued at 0.24% Gross National Income (despite commitment to a minimum target of 0.7%), funding for women's rights organizations and *gender specific* projects has decreased significantly, and many partners and countries have criticized Canada for adopting ideological stances on development issues, specifically around sexual and reproductive rights.

6. Investing in sexual and reproductive health and rights yields significant returns on investment. Meeting the unmet need for modern contraception and achieving universal access to sexual and reproductive health services by 2030, for example, is estimated to yield US$120 for every dollar spent, and over US$400 billion in annual benefits.[9] Despite this, Canadian aid, specifically in the realm of sexual and reproductive rights, continues to fall short. Compared to its G7 counterparts, Canadian official development assistance (ODA), and specifically funding for sexual and reproductive rights, is among the lowest - behind the UK, Germany, Japan, the Netherlands, France, and others.[10] Despite being a vocal champion for maternal, newborn and child health, UK government spending on family planning in one year alone was more than double the total that Canada spent on family planning in the last four years of the Muskoka Initiative,[11] with a mere 1.2% of funding going to family planning.[12] Canada's overall support for sexual and reproductive health and rights is far below the 10% of ODA repeatedly agreed upon during International Parliamentarian Conferences on the Implementation of the International Conference on Population and Development (ICPD, IPCI/ICPD).[13] Figures from 2013-2014 demonstrate Canada is less than half way towards achieving this target, spending only 4.97% ODA (of an already small ODA budget) on reproductive health care and family planning.[14]

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[8] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[9] ICPD Task Force. 2015. http://icpdtaskforce.org/wp-content/uploads/2015/01/FinancingBriefSmartInvestments2015.pdf
[10] EuroMapping 2013. http://www.dsw.org/uploads/tx_aedswpublication/Euromapping_2013.pdf
[11] The Muskoka Initiative on Maternal, Newborn and Child Health (MNCH) was announced by Prime Minister Stephen Harper during the G8 summit in June 2010. It committed governments to collectively spend $5 billion between 2010 and 2015 to accelerate progress towards the achievement of MDGs 4 and 5, specifically the reduction of maternal, infant and child mortality in developing countries. Total Government of Canada contribution for the initiative is $2.85 billion with $1.1 billion in new money and $1.75 billion to renew existing funding over 5 years. In 2014, then Prime Minister Harper announced an extension of the Muskoka Initiative until 2020, committing $3.5 billion to be disbursed in the 2015-2020 period, under 3 strategic pillars: strengthening health systems, reducing disease burden and improving nutrition. The Initiative has been criticized for failing to meaningfully address maternal health by failing to ensure women have access to a comprehensive package of sexual and reproductive health services, which includes abortion services. Related to this, concern has been raised regarding contradictions regarding patterns of underfunding of reproductive health care and family planning by the Government of Canada, despite its public support for addressing maternal health. In response to concern raised by Canadian parliamentary committees regarding Canada's refusal to fund abortion services as part of its development assistance, the World Health Organization produced a technical opinion in which it concludes that ready access to contraception and safe abortion significantly reduces high rates of maternal mortality and morbidity, indicating that these interventions are essential components of any response to improve maternal health.
[12] Euromapping 2013. http://www.dsw.org/uploads/tx_aedswpublication/Euromapping_2013.pdf and McLeod Group. Aid Flows. http://www.mcleodgroup.ca/topics-3/development-assistance/aid-flows/.
[13] See outcome document from 2014 IPCI/ICPD http://www.unfpa.org/events/2014-stockholm-conference and 2012 IPCI/ICPD http://www.unfpa.org/events/2012-istanbul-conference.
[14] Global Affairs Canada. Statistical Report on International Assistance 2013-2014. http://international.gc.ca/development-developpement/dev-results-resultats/reports-rapports/sria-rsai-2013-14.aspx?lang=eng.

7. Not only has the Government of Canada underfunded central components of a comprehensive package of sexual and reproductive health services and information, it has also refused to fund safe abortion services as part of its international assistance. Canada's refusal to fund abortion services was not a written policy and therefore not subjected to parliamentary scrutiny. Grounded in ideology rather than human rights, evidence and best practice, the government's approach to development has discriminated against women. It is also feared that the refusal to fund abortion services has had a 'chill effect' on the provision of other related services and information.[15]

8. The new government elected in October 2015 has committed to ensuring Canada's focus on maternal, newborn and child health is "driven by evidence and outcomes, not ideology, including by closing existing gaps in reproductive rights and health care for women."[16] Despite the clarity brought by the mandate letter to the new Minister of International Development, the government has yet to indicate what steps it will take to support sexual and reproductive health in the future. According to the Official Development Assistance (ODA) Accountability Act, the Government must align development assistance with international human rights right standards which hold the Government and implementing partners accountable to promoting international human rights standards.[17]

Background: non-discrimination in economic, social and cultural rights of persons with diverse sexual orientations, gender identities and expressions

9. Referring to article 2.2 of the Covenant, General Comment No. 20, produced by the Committee in 2009, requires states to "guarantee non-discrimination in the exercise of each of the economic, social and cultural rights enshrined in the Covenant" – and that discrimination "constitutes any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights."[18] In the same General Comment, the Committee makes specific reference to gender identity as a prohibited grounds for discrimination, recognizing that "persons who are transgender, transsexual or intersex often face serious human rights violations, such as harassment in schools or in the workplace."[19] [20] To address such forms of discrimination, the Committee calls upon states to adopt legislation that prohibits discrimination on the field of economic, social and cultural rights, ensure that strategies, policies and plans are implemented to address formal and substantive discrimination, and conduct human rights education

[15] Similar to Ministerial statements which denied funding of safe abortion services abroad, the Helms Amendment in the United States (banning the provision of abortion services as a form of family planning in all US-funded development initiatives) unintentionally led to shortages in resources "and…an incomplete and inconsistent approach to addressing unsafe abortion injuries."(http://www.guttmacher.org/pubs/gpr/16/3/gpr160309.html). The overly broad application of the Amendment has resulted in denials of lawful care related to abortion. This includes the denial of lawful safe abortions, post-abortion care, and referrals, counselling and information with regard to abortion services.

[16] Minister of International Development. Mandate Letter. November 2015. http://pm.gc.ca/eng/minister-international-development-and-la-francophonie-mandate-letter#sthash.zcc0x3VT.dpuf

[17] http://www.international.gc.ca/development-developpement/partners-partenaires/bt-oa/odaaa-lrmado.aspx?lang=eng

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

[19] For definitions, see the Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity.

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

and training programmes for public officials. All efforts in this regard should include effective remedies and mechanisms for accountability.[21]

10. The Committee, in its concluding observations to states, has often expressed concern regarding ongoing forms of discrimination against persons with diverse gender identities and expressions, and has called for awareness raising and the enactment of specific legislation prohibiting discrimination against persons on grounds covered under the principles on gender equality. [22]

11. The Human Rights Council (herein referred to as the 'Council') has addressed the issue of sexual orientation and gender identity through the passing of specific resolutions as well as a report which studies discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity.[23] The report calls on states to:

- "enact comprehensive anti-discrimination legislation that includes discrimination on grounds of sexual orientation and gender identity among prohibited grounds and recognizes intersecting forms of discrimination;"
- "implement appropriate sensitization and training programmes for police, prison officers, border guards, immigration officers and other law enforcement personnel, and support public information campaigns to counter homophobia and transphobia among the general public and targeted anti-homophobia campaigns in school;" and
- "facilitate legal recognition of the preferred gender of transgender persons and establish arrangements to permit relevant identity documents to be reissued reflecting preferred gender and name, without infringements of other human rights."[24]

Situation in Canada: discrimination on the grounds of sexual orientation, gender identity and expression

12. In a 2011 nationwide survey, over three-quarters of transgender youth reported experiencing verbal harassment in school and 1 in 3 reported experiencing physical violence.[25] People of diverse and non-conforming sexual orientations, gender identities and expressions, who challenge socially accepted norms and behaviours, are most at risk of experiencing heightened levels of stigma, discrimination and violence, often by teachers, medical professionals, police and others in positions of authority. Such experiences are often exacerbated by multiple and intersecting forms of discrimination, including those related to income, immigration status, age, level of education, housing situation and employment, among many other factors.

13. Fearing stigma or discrimination, or lacking access to comprehensive rights-based and integrated health services, individuals are often left with no option but to choose to avoid seeking health services, particularly sexual and reproductive health services. Such situations result in poor health outcomes, which can lead to socio-economic

[21] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[22] Committee on Economic, Social and Cultural Rights. Concluding Observations to Slovenia (E/C.12/SNV/CO/2), Gambia (E/C.12/GMB/CO/1), and Peru (E/C/12/PER/CO/2-4), as examples.
[23] A/HRC/RES/17/19 and A/HRC/19/41.
[24] A/HRC/19/41, paragraph 84 (e), (g) and (h).
[25] Egale: Canada Human Rights Trust. 2011. "Every Class in Every School." http://egale.ca/every-class/.

challenges, including reduced income, reduced mobility, inability to stay in school or access decent employment, among other related impacts. For example, trans persons experience heightened rates of HIV: "in Ontario, self-reported HIV prevalence among trans persons was ten times the overall provincial prevalence estimate."[26] A 2011 study found that 27.7% of trans women in Canada were living with HIV, representing a significantly higher HIV prevalence rate than the general population.[27] According to researchers, HIV vulnerability of trans persons, and trans women of colour in particular, "may include multiple forms of stigma and discrimination resulting in poverty and the need to engage in survival sex work, lower rates of HIV testing, less education about sexually transmitted diseases, inequitable power in relationships, a longing for affirmation, and decreased desire for self-care, among other factors."[28] According to the United Nations Special Rapporteur on the right to the highest attainable standard of physical and mental health, "stigmatization prevents legislative and policymaking institutions from adequately addressing health-related matters in communities that are especially vulnerable to the infringement of the enjoyment of the right to health."[29]

14. Trans persons also face barriers in accessing the services and information required to proceed with the medical treatment they might need as part of their transition. Barriers include cost of the procedures, limited access to trained professionals, risk of experiencing stigma or discrimination at the hands of health professionals, travel-related costs and age restrictions, among others. As a result, many trans persons may not proceed with the treatment. Recognizing such barriers, all provinces except New Brunswick and PEI fund a range of sex reassignment surgeries through provincial insurance plans.[30]

15. In Canada, a number of provinces and territories have added both gender identity and gender expression to the list of protected grounds from discrimination including: Ontario, Nova Scotia, Newfoundland and Labrador and Prince Edward Island. Manitoba and Northwest Territories have listed gender identity. While such efforts at provincial and territorial levels are critical, they nonetheless create discrepancies between levels of government, which can result in further discrimination depending on the legal context. Federal leadership on this issue is therefore required to ensure that all trans persons across the country have the same human rights protections.

Recommendations to the Government of Canada relating to Article 2 of the Covenant:

16. **Increase foreign aid to meet the international commitment of 0.7% GNI to ODA, and exceed the commitment of 10% of OA for sexual and reproductive health information and services.**[31]

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[26] R. Longman Marcellin G. R. Bauer A. I. Scheim. 2013. "Intersecting impacts of transphobia and racism on HIV risk among trans persons of colour in Ontario, Canada", Ethnicity and Inequalities in Health and Social Care, Vol. 6 Iss 4.

[27] Interagency Coalition on AIDS and Development & Beausoleil K, and Halverson J, Public Health Agency of Canada. 2011. Presentation at Towards the Development of a Coordinated National Research Agenda for Women, Transwomen, Girls and HIV/AIDS in Canada: A Multi-stakeholder Dialogue.

[28] Operario and Nemoto, 2010; Nemoto et al., 2004 & R. Longman Marcellin G. R. Bauer A. I. Scheim , (2013).

[29] UN Human Rights Council. 2010. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf.

[30] DailyXtra. 2014. "Sex reassignment surgeries funded in all but two provinces." http://www.dailyxtra.com/canada/news-and-ideas/news/sex-reassignment-surgeries-funded-in-two-provinces-89914.

[31] As agreed to during past International Parliamentarians Conferences on the Implementation of the International Conference on Population and Development (ICPD).

17. **Increase funding for multilateral and civil society organizations working on the rights contained in this Covenant,** including those related to gender equality, sexual and reproductive health and rights. Such organizations include: the United Nations Population Fund (UNFPA), UN Women, and the Office of the High Commissioner for Human Rights (OHCHR).

18. **Ensure alignment with international human rights instruments, including this Covenant, by establishing a Canadian global policy on sexual and reproductive rights** that would bring a human rights-based approach to Canadian foreign policy and development assistance in the realms of gender equality, sexuality and reproduction.

19. **Introduce legislation to add real or perceived gender identity and gender expression to the list of prohibited grounds for discrimination** in the Canadian Human Rights Act and make it illegal to willfully or publically incite hatred based on these grounds in the Criminal Code, ensuring the meaningful participation of persons with diverse sexual orientations, gender identities and expressions in all relevant legislative reforms.

20. **Create a third gender marker** on all government forms, census and other means of data collection.

21. **Initiate dialogue with provinces and territories to ensure laws and policies related to trans persons are aligned and consistent across jurisdictions,** including human rights protections and the ability to access medical treatment free of charge, and identification that matches the gender and name of their choosing, regardless of immigration status or age.

Article 12 – Right to health

Background: availability & accessibility of sexual & reproductive health services, including safe abortion services

22. In General Comment No. 14, the Committee explicitly defined the right to health to include "the right to control one's health and body, including sexual and reproductive freedoms."[32] 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,"[33] 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."[34] The Committee's General Comment No. 16, in reference to article 12 of the Covenant, requires that state parties, "at a minimum […] [remove] legal and other obstacles that prevent men and women from accessing and benefiting from health care on a basis of equality. This includes, inter alia […] the removal of legal restrictions on reproductive health provisions."[35]

[32] 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.
[33] 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.
[34] 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.
[35] CESCR. 2005. General Comment No. 16. "The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3 of the International Covenant on Economic, Social and Cultural Rights), para 29.

23. The removal of "other obstacles" also requires states to guarantee the realization of the right to health, which includes the right to access safe abortion services, without discrimination.[36] According to General Comment No. 20, states must not treat individuals belonging to certain economic or social groups arbitrarily.[37] States must adopt special measures to address the "discrimination, stigmatization and negative stereotyping which can lead to the refusal of, or unequal access to, the same quality of […] health care as others."[38] The Committee has also expressed concern regarding disparities across regions within a country with regard to access to and quality of health care services. This includes the concentration of health care providers in urban centres. In such cases, the Committee has expressed concern regarding insufficient spending on health budgets to provide adequate coverage for the entire population.[39]

24. The Committee has, on numerous occasions, outlined governments' obligation to ensure access to safe abortion services, as part of the right to health. In its concluding observations to state parties, the Committee has called for "affordable access for everyone, including adolescents, to […] safe abortion services, especially in rural and deprived urban areas, by eliminating formal and informal user fees for public and private family planning services, adequately funding the free distribution of contraceptives, raising public awareness and strengthening school education on sexual and reproductive health[…],"[40] "tak[ing] all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection."[41]

Situation in Canada: availability and accessibility of sexual and reproductive health services

Accessibility of safe abortion services in Canada

25. The barriers that exist to safe abortion services in Canada represent violations of article 12 as interpreted within this cited work of the Committee. The Government of Canada, despite having the responsibility and authority to address these barriers, has failed to take action to address discriminatory policies and the barriers that are created as a result.

26. In accordance with the 1988 Supreme Court of Canada decision *R. v. Morgentaler*, there are no criminal laws restricting access to abortion in Canada. In Canada, the provincial governments are responsible for the administration, organization and delivery of health care. The federal government has constitutionally granted "spending power," which enables it to fund the health systems under provincial jurisdiction, subject to provincial compliance with certain requirements set out in the 1984 *Canada Health Act* (herein the Act). It regulates the conditions to which provincial and territorial health insurance programs must adhere in order to receive the full amount of the Canada Health Transfer (herein the CHT) cash contribution. If any of the provinces or territories fail to meet any one of the criteria set out in section 13 of the Act, or if the province allows extra billing by medical

[36] Committee on Economic, Social and Cultural Rights. Article. 2.2 1966.
[37] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[38] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[39] Committee on Economic, Social and Cultural Rights. Concluding Observations to Guatemala. E/C.12/GTM/CO/3. 2014.
[40] Committee on Economic, Social and Cultural Rights (CESCR). 2008. E/C.12/KEN/CO/1.
[41] CESCR. 2009. E/C.12/POL/CO/5.

practitioners or permits user charges for insured health services, the province will face as the penalty a reduction or withholding of the cash contribution. The Act states that provinces and territories must provide universal coverage for all insured persons for all medically necessary hospital and physician services, which abortion is considered to be.

27. Lack of access to safe abortion services continues to be an obstacle and a barrier for women who choose to terminate their pregnancies, particularly for women living in rural or remote regions.[42] A 2006 study found that only 1/6th of hospitals provide abortion services[43], the majority of which, both hospitals and free standing sexual health clinics, are disproportionately dispersed across Canada, with most located in urban areas. For example, the majority of sexual health centres are located within 150km of the US border, and in major urban centres. Twenty percent of people in Canada live in rural areas where they must travel sometimes thousands of kilometres to access abortion services, which in particular often require timely care, placing a further impediment to access for this twenty percent. Adding to this, there are few points of services that offer services beyond 16 weeks gestation.[44] This makes it particularly difficult for individuals living in areas with only one service provider (where the provider may only offer services until 10 or 12 weeks gestation, for example) or those living thousands of kilometers away from major urban centers where there are multiple service access points.

28. The overall limited availability to abortion services through clinics and hospitals is compounded by other barriers including significant wait times, age, financial burdens and geographic location. Unexpected travel time is a factor since some of the abortion providers put a gestational limit to the termination of the pregnancy, delaying a woman's right to abortion. In addition, these women face unforeseen monetary expenses incurred for things such as travel, accommodation, lost wages, childcare, eldercare, and possibly procedural costs (in the case where there is a lack of reciprocal billing within their provincial or territorial health systems), these factors disproportionately impacting low-income women. While there are no laws requiring parental consent or laws imposing restrictions to abortion access based on age, young people seeking abortion services have reported experiencing stigma and discrimination from health care providers.[45]

29. Reciprocal billing states that individuals who are not present (either travelling or changing their residence) within their province or territory of residence at the time of needing a specific medically necessary service or procedure are to be either covered or reimbursed in full of the monetary costs by their provincial or territorial health system. Up until June 2015, abortion was on the List of Excluded Services under the Reciprocal Billing Agreement. While some provinces had developed bilateral agreements allowing abortion services to be covered under reciprocal billing in certain points of service, five provinces and one territory continued to exclude abortion from their list of services to be covered under reciprocal billing. Individuals coming from such provinces or territories who were in

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[42] Norman WV, Soon JA, Maughn N, Dressler J (2013). *Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS).* PLoS ONE 8(6).
[43] Shaw, Jessica (2006). *Reality Check: A Close Look At Accessing Hospital Abortion Services In Canada.* Ottawa: Canadians for Choice. [This qualitative study has not been updated, thus this data has not been validated since 2006 – but to our knowledge a number of hospitals have ceased offering abortion services since that time, and as a result we would expect the current picture to reflect an even more significant disparity.]
[44] There are approximately 20 points of service for those beyond 16 weeks gestation. The majority are located in Québec and Ontario. There are no providers offering services beyond 16 weeks in Manitoba, New Brunswick, Newfoundland, Nova Scotia, Nunavut, and Yukon.
[45] The Guardian. "Women turning to desperate measures due to lack of abortion services." November 2011. http://www.theguardian.pe.ca/News/Local/2011-11-10/article-2802198/Women-turning-to-desperate-measures-due-to-lack-of-abortion-services/1 and http://projects.upei.ca/cmacquarrie/files/2014/01/trials_and_trails_final.pdf.

need of an abortion had to incur the expense of paying up front for the procedure, without an opportunity for reimbursement. This disproportionately impacted low-income individuals. No other medically necessary service faced these administrative restrictions. Despite the impact of such restrictions and having the necessary power, responsibility and authority to ensure that abortion services were provided without financial or other barriers, the Government of Canada had not taken any action to address the discriminatory abortion policies of provinces that contravene the Act until very recently.[46] In June 2015, the Interprovincial Health Insurance Agreements Coordinating Committee, chaired by the federal Department of Health, removed abortion services from the list of excluded services.

30. While the removal of abortion services from the list of excluded services is an important step forward, certain restrictive conditions for reciprocal billing persist. Specifically, the change only applies to abortion services provided in hospital settings.[47] This will continue to present barriers in access for people in Canada as abortion services provided in clinics represent a significant number of the points of service across the country. In some areas, clinics are the only point of service in a city or large area (for example in Edmonton, Alberta or in Fredericton, New Brunswick), meaning that people who need to access abortion services in a hospital are still asked to travel significant distances as well as cover travel and accommodation expenses. At a very basic level, it also reduces choices and options in terms of treatments available if the hospital only offers to perform abortions under general anesthetic or if someone would prefer to access services in a less institutional setting.

31. In the province of Prince Edward Island there are no abortion providers. This is the only province in Canada that is still refusing to offer abortion services in-province, thereby violating the obligations set by the Act. Individuals seeking abortion services funded by the government must travel to either Nova Scotia or New Brunswick where they can obtain the services in hospital. Abortion services provided in clinics are not eligible for funding by Prince Edward Island (or New Brunswick). Costs associated with travel and accommodation are to be paid out-of-pocket.[48] Those seeking the service must do so before 16 gestational weeks. Due to stigma related to abortion, those seeking referrals to travel to Nova Scotia or New Brunswick for abortion services are deterred from seeking them.[49] There are also doctors on the Island who refuse to provide referrals or request funding for those who must travel to obtain the service.[50] In addition, healthcare providers are unwilling to provide accurate information to women who are seeking information on the procedure itself, where to obtain referrals for an abortion, as well as where they can obtain this medical service. In January 2015, the Women's Legal Education and Action Fund, together with Abortion Access NOW PEI initiated a legal challenge against the province on the grounds that the

[46] In 2001, the Federal Health Minister warned four provinces, Quebec, Manitoba, New Brunswick and Prince Edward Island, that their failure to cover fees charged at private abortion clinics constituted violation of the Act. In August 2006, the Superior Court of Quebec ordered Quebec to refund fees paid by women for abortions in private clinics between 1999 and 2006. Deductions have been made from cash contributions to Newfoundland and Labrador in 1998 and to Nova Scotia in 2003 based on charges made to patients for facility fees at private abortion clinics.
[47] Government of Ontario. Health Services Branch. Bulletin to hospitals. September 8, 2015. "Reciprocal Billing of Abortion Services." http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/na_65/na_65.pdf.
[48] The provincial department of health does specify that some individuals may be eligible for support for costs associated with travel and accommodation. http://www.healthpei.ca/abortionservices.
[49] Research suggests that physicians on Prince Edward Island create and maintain stigma surrounding access to abortion on the Island. For example, many believe that the procedure is illegal which deters them from requesting a referral (MacQuarrie, C., MacDonald, J., Chambers, C. January 2014. "Trials and Trails of Accessing Abortion on PEI: reporting on the impact of PEI's abortion policies on women." http://projects.upei.ca/cmacquarrie/files/2014/01/trials_and_trails_final.pdf).
[50] GUTS: Canadian Feminist Magazine. April 30, 2015. "Abortion Access on PEI." http://gutsmagazine.ca/blog/abortion-access-on-pei.

province is violating women's rights by denying them equal access to health care services under section 15 of the Canadian Charter of Human Rights.[51]

32. In 2014, New Brunswick reversed a regulation[52] requiring women to obtain the authorization of two doctors, and consent of the gynaecologist performing the procedure, in order for the procedure to be fully funded. Despite this, New Brunswick only has an 8% access rate, with only two hospitals in the entire province providing abortion services.[53] In contravention to the Act, New Brunswick is the only province that refuses to pay for, or reimburse women for, abortion services performed outside of hospitals; hence, this province refuses to fund clinic abortions. This policy can be especially difficult for women in small towns and for women who do not have a family doctor. If a woman in unable to travel to one of the two hospitals, or fears stigma and discrimination in accessing services in such environments, she may either be forced to travel out-of-province in order to obtain abortion care, pay over $700 to have the abortion at the one clinic in the province, or continue with the pregnancy and birth against her will. With such limited access, it has been reported that women are increasingly seeking abortion services out of country and, in some cases, engaging in unsafe practices to terminate unwanted pregnancies.[54]

33. An additional barrier relates to the ability to access a range of abortion services across the country. In July 2015, the federal department of health approved the use of the medical abortion drug RU-486, known by the World Health Organization as the 'gold standard' in medical abortion. Currently, only British Colombia and Ontario have billing codes for medical abortion. It is expected that the cost of the drug will be approximately $270.00 per package. In some instances, there may be a slight markup depending on the provider. This will present a significant barrier for individuals with limited access to services. Furthermore, only physicians will be permitted to prescribe mifepristone in Canada. This will limit the availability of the services as there are many areas throughout Canada where there is a shortage of physicians coupled with the reality that many physicians refuse to provide certain sexual and reproductive health services on moral or religious grounds.

34. Despite having the necessary power and authority to ensure that abortion services are provided without financial or other barriers, the Government of Canada has not taken any actions to address the discriminatory abortion policies of provinces that contravene the Act.[55] No other medically necessary service faces these administrative restrictions.

Affordability of sexual and reproductive health services

35. Canada is the only country with publicly funded universal health care and no national drug plan. While most health services are covered through provincial health insurance plans, prescribed medications are not covered through provincial public insurance plans. According to a survey by Statistics Canada, 24% of the Canadian population report that they have no drug coverage and so are forced to pay out of pocket for pharmaceutical

[51] Women's Legal Education and Action Fund. Reproductive Justice. Accessed Jan. 8 2016. http://www.leaf.ca/legal/reproductive-justice/.
[52] 84-20 of the Medical Services Payment Act.
[53] Action Canada for Sexual Health and Rights. Mapping Abortion Access in Canada. 2015. http://www.sexualhealthandrights.ca/wp-content/uploads/2015/10/Map-Access-CHC-and-AC.pdf.
[54] Allen, Tess. October 20 2014. 'Lacking access to abortion access, New Brunswick women head to Main abortion clinics.' http://rabble.ca/news/2014/10/lacking-abortion-access-new-brunswick-women-head-maine-abortion-clinics and http://rabble.ca/columnists/2014/05/new-brunswick-invites-return-unsafe-abortions.
[55] See footnote 46.

products, including contraceptive drugs and devices.[56] Those most likely to fall through the gaps are people who are working but who have low earnings, as they may not be eligible for public benefits and are less likely to have employer-provided benefits. This results in differential access to essential health commodities across provinces and territories, and in barriers and inequalities in accessing them within each province and territory – particularly so for those with more limited financial resources. Sexual and reproductive health-related drugs are required by many to live healthy, productive lives, yet many people in Canada lack affordable access to them.

36. For instance: access to HIV affordable medication in Canada is a challenge. Every province has a different system for covering HIV drug costs, meaning the out-of-pocket costs for obtaining drugs depends on many factors.[57] Discrepancies between provinces, as well as who gets covered in each province, mean that the quality of care received and the access to medication and devices vary greatly. This leads some people in Canada to relocate to another province in order to receive the care they need, sometimes severing important support networks. The current patchwork of coverage puts many people's heath at risk.

37. Similarly, people in Canada have a narrower range of birth-control options than people in other developed countries. In most Canadian jurisdictions, once someone gets a prescription from a physician for birth control, they have to pay[58] for it out of pocket unless their private drug plan, if they have one, happens to cover that particular contraceptive option. People rely on the method they can afford but cheaper methods such as external condoms have higher failure rates. Considering that statistics show that nearly half of all pregnancies are unintended, it is possible to say that our current lack of coverage restricts people's ability to make meaningful choices about contraception and about their bodies. Emergency contraceptive methods[59] play an important role in reducing the risk of unplanned pregnancies. Access to forms of emergency contraception is uneven, and the costs are not covered under provincial health insurance – meaning their cost falls upon the individuals requiring use of them, thus restricting access for many people.

38. When choosing to end a pregnancies, it is important individuals have options to safely carry out the decision. Such options are finally expanding in Canada, yet cost-related barriers will still prevent many individuals from choosing certain options – namely, medical abortion. After an almost three-year long review, the gold-standard of medical abortion[60] was finally approved. Already available in 60 countries worldwide,[61] Mifepristone will be available in Canada this spring. Packaged under the name Mifegymiso, it is expected to cost a $270.00 per package which is significantly more expensive than the previous regimen.

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[56] Canadian Centre for Policy Alternatives. 2010. "A public drug insurance plan would save Canada billions." http://pharmacarenow.ca/wp-content/uploads/2009/11/Monitor-Pharmacare.pdf.

[57] Among them: where you live, who is eligible for coverage, whether you have a low income, if you have developed resistance to certain types of medications, are newly diagnosed, what caps are imposed on prescriptions payouts in your benefit package, whether you have third-party insurance, and many other factors.

[58] The monthly price of pills is in the range of $15 to $30 a month, depending on the brand. The Mirena IUD costs at least $350 up front. A non-hormonal Intrauterine Device (IUD) can cost between 50$ and 200$, and Depo-Provera, an injection effective for three months, costs about $45.

[59] There are two methods of emergency contraception in Canada: emergency contraceptive pills (ECP) or the insertion of a copper IUD. The cost of either of these methods is significant and prohibitive to many: as a copper IUD can cost up to $200, and the average cost of ECP is $35-$50.

[60] World Health Organization. 2015. List of Essential Medicines (19th, list, April 2015). http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_AUG2015.pdf?ua=1.

[61] Gynuity.org. List of Mifepristone Approvals. http://gynuity.org/resources/read/llist-of-mifepristone-approval-en/.

39. Regarding medication for treatment of sexually transmitted infections (STIs), the Human Papilloma Virus (HPV) is said to be one of the most common STIs in Canada. In the case where people are infected with less benign strains, which can lead to genital or anal warts and cervical or anal cancers, preventative measures like vaccination and regular pap tests can mean early diagnoses and effective treatment. The vaccine costs about $400-$500 in Canada. While there are existing programs to provide it to cisgender[62] females of school age, the vaccines are not covered for cisgender males or for females who fall outside of the programme's parameters, or the age range covered by each province.

40. Finally, medically assisted reproduction is legal in Canada, yet many people in Canada experience significant barriers in access – particularly due to its cost.[63] People in Québec and Ontario are able to seek reimbursement for certain costs associated with assisted reproduction. Such programmes were instituted to equalize access to treatment for people facing infertility as well as to reduce complication rates associated with more cost effective but higher risk practices.[64] In the absence of adequate public funding for assisted reproduction, people in Canada with greater financial resources are better able to overcome infertility than those with lesser means, in opposition to the principle of universality that is the foundation of our health-care system and of the recognized human right to health.

Background: sexual and reproductive health of Indigenous peoples

41. Indigenous rights groups globally, and in Canada, have advocated for the application of the principle of free, prior and informed consent (FPIC) in line with 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. The Committee 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.[65] The Government of Canada has repeatedly denied the validity of FPIC in international fora[66], stating that the concept could be applied as a 'veto' by Indigenous groups.

42. According to the Committee, 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

[62] Cisgender female refers to someone who was female at birth and identifies as a woman. *Cis* is borrowed from chemistry, meaning *same*.
[63] Average cost of fertility medication in Canada is $75-$1,000, sperm preparation costs $500, a standard in-vitro fertilization (IVF) is $7,000, IVF medication costs between $2,000 and $5,000 and embryo freezing costs $750.
[64] Such as inserting multiple embryos at once during IVF cycles.
[65] Committee on Economic, Social and Cultural Rights. Concluding Observations to Paraguay. E/C.12/PRY/CO/4. 2015.
[66] Government of Canada. Permanent Mission of Canada to the UN. "Canada's Statement on the World Conference on Indigenous Peoples Outcome Document." September 2014. http://www.canadainternational.gc.ca/prmny-mponu/canada_un-canada_onu/statements-declarations/other-autres/2014-09-22_wcipd-padd.aspx?lang=eng and Amnesty International Canada. "Free, Prior and Informed Consent." 2013. http://www.amnesty.ca/sites/amnesty/files/fpic_factsheet_nov_2013.pdf

healthy working conditions, and a healthy environment."67 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. 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."[68]

43. States are obliged to adopt measures to address multiple and intersecting forms of discrimination experienced by Indigenous peoples. 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.[69]

44. 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.[70] 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)."[71] Further, the Committee calls upon states to "strengthen measures to ensure the coverage and accessibility of the health-care services provided by the state" [72] in rural areas and those inhabited by Indigenous peoples.

Forced sterilization and coercive contraceptive practices

45. 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."[73]

46. 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,

[67] Committee on Economic, Social and Cultural Rights. General Comment No. 14. "The right to the highest attainable standard of health. 2000.
[68] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[69] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[70] Committee on Economic, Social and Cultural Rights. Concluding Observations to Ecuador. E/C.12/1/ADD/100. 2004.
[71] Committee on Economic, Social and Cultural Rights. Concluding Observations to Guatemala. E/C.12/GTM/CO/3. 2014.
[72] Committee on Economic, Social and Cultural Rights. Concluding Observations to Guatemala. E/C.12/GTM/CO/3. 2014.
[73] Committee on the Elimination of Discrimination Against Women. General Recommendations 19, 1992, and 24, 1999.

guaranteeing adequate resourcing for investigations, and to financially compensate victims of coercive or non-consensual sterilizations.[74]

Right to health of incarcerated people

47. The Committee has recognized the rights of those in prison, calling upon states to give special attention to those who face traditional difficulties exercising their rights.[75] In its Concluding Observations, the Committee has expressed concern regarding challenges in access to health care for those in prison.[76] 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,"[77] and to "take measures to ensure that effective treatment of drug dependence is made accessible to all, including to those in detention."[78]

Situation in Canada: sexual and reproductive health of Indigenous Peoples

Forced sterilization and coercive contraceptive practices among Indigenous peoples in Canada

48. In November 2015, media outlets released reports of women in the province of Saskatchewan having undergone forced sterilization in the last five years.[79] 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 health care system.[80] This is despite the elimination of policies which permitted and promoted forced sterilization in the 1970s.[81]

49. According to the Native Youth Sexual Health Network (NYSHN), forms of sterilization persist in the treatment of Indigenous Communities.[82] 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."[83] NYSHN has also reported incidences of forced sterilization in Canadian prisons.[84] 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

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[74] 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).
[75] Committee on Economic, Social and Cultural Rights. General Comment 19: the right to social security. 2008.
[76] Committee on Economic, Social and Cultural Rights. Concluding Observations to Madagascar. E/C.12/MDG/CO/2. 2009.
[77] Committee on Economic, Social and Cultural Rights. Concluding Observations to Ukraine. E/C.12/UKR/CO/5. 2008.
[78] Committee on Economic, Social and Cultural Rights. Concluding Observations to Poland. E/C.12/POL/CO/5. 2009.
[79] 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.
[80] 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.
[81] 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.
[82] Radical Criminoogy. "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.
[83] Radical Criminoogy. "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.
[84] 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.

them to get sterilized for their own good, to save them and society from having to care for additional children."[85] 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 incarcerated Indigenous people

50. Longstanding forms of systemic racism, and other types of discrimination, have resulted in the targeted profiling, policing and criminalization of marginalized populations in Canada. Indigenous communities in Canada have experienced the detrimental impacts of systemic racism and discrimination. There is an over-representation of Indigenous peoples in federal prisons: "[While] Aboriginal people in Canada comprise just four per cent of the population, in federal prisons nearly one in four is Métis, Inuit, or First Nations."[86] Indigenous women make up 36% of all young women incarcerated.[87] Reports indicate human rights violations of incarcerated Indigenous women, including through the "shackling of pregnant women also while in labor, coerced sterilization and sexual violence from prison staff and guards"[88] and the absence of effective facilities for incarcerated mothers.[89] Given the disproportionately high rates of incarceration among Indigenous populations, they are more likely to be given the mandatory minimum sentences, which judges are now required to impose on a range of offences.[90] Longer sentences increase the likelihood of poor health outcomes of those who are incarcerated, especially related to sexual and reproductive health. [91]

51. HIV and Hepatitis C rates are on the rise among incarcerated populations. The rise in STI rates can be attributed to the lack of effective harm reduction policies and limited access to comprehensive sexual and reproductive health services and information in and out of prisons. The Correctional Investigator of Canada 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.[92] This is despite the fact that incarcerated people have a right to health, as recognized in sections 85-86 of the *Corrections and Conditional Release Act*, which requires Corrections Services Canada to provide essential health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.[93]

Background: conscientious objection

[85] Saskatoon Star Phoenix. "Saskatchewan women pressured to have tubal ligations." November 17, 2015. http://thestarphoenix.com/news/national/women-pressured-to-have-tubal-ligations.
[86] Native Youth Sexual Health Network, http://www.nativeyouthsexualhealth.com/january15172014.pdf.
[87] Native Youth Sexual Health Network, http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf.
[88] 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.
[89] 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.
[90] 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.
[91] 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.
[92] 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.
[93] Corrections and Conditional Release Act (S.C. 1992, c. 20). http://laws-lois.justice.gc.ca/eng/acts/C-44.6/page-24.html#docCont.

52. In 2009, in its concluding observations to Poland, the Committee recommended that the government "take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by […] implementing a mechanism of timely and systematic referral in the event of conscientious objection."[94] Similarly, the Committee on the Elimination of Discrimination Against Women, in its Concluding Observations to Hungary raised concern regarding health professionals increasingly resorting to conscientious objection without an adequate regulatory framework. In response, the Committee on the Elimination of Discrimination Against Women urged Hungary to "establish an adequate regulatory framework and a mechanism for monitoring of the practice of conscientious objection by health professionals and ensure that conscientious objection is accompanied by information to women about existing alternatives and that it remains a personal decision rather than an institutionalized practice."[95] Explored within the context of women's access to abortion services, the 2011 Report of the UN Special Rapporteur on the Right to Health recognizes conscientious objection as a legal restriction which creates a barrier to access to sexual and reproductive health services and information.[96]

53. Restricting individuals' right to access sexual and reproductive health information and services, including through conscientious objection without timely referral, represents violations of article 12 as interpreted within this cited work of the Committee and that of the Committee on the Elimination of Discrimination Against Women, as well as the work of the Special Rapporteur on the Right to Health.

Situation in Canada: conscientious objection

54. The Code of Ethics of the Canadian Medial Association (CMA) requires physicians to "[i]nform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants," but does not require physicians to provide timely referrals. While the Code does include an anti-discrimination clause, including on the grounds of sex, arguing violations on such grounds have not been successful. Following the news that Ottawa-based doctors were refusing to provide sexual and reproductive health services and information on moral and religious grounds, the Ontario College of Physicians and Surgeons is reviewing its policy on the issue.

55. Communities of global medical experts have also established policies and guidelines on this topic. The 2012 World Health Organization Safe Abortion Guidelines seeks to ensure that conscientious objection does not prevent individuals from accessing services to which they are legally entitled. In 2005, the International Federation of Gynecologists and Obstetricians (FIGO) developed its Ethical Guidelines on Conscientious Objection, which states that practitioners have a "duty to abide by scientifically and professionally determined definitions of reproductive health services and to exercise care and integrity not to misrepresent or mischaracterise them on the basis of personal beliefs." The Guidelines state that "the primary conscientious duty of [practitioners] is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty." Practitioners must also "provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardise patients'

[94] CESCR. 2009. E/C.12/POL/CO/5.
[95] Committee on the Elimination of Discrimination Against Women. 2013. CEDAW/C/HUN/CO/7-8.
[96] United Nations. 2011. Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. A/66/254. New York, UN General Assembly; para 24 and para 65 (m).

health and well-being, such as by patients experiencing unwanted pregnancy." Moreover, "[i]n emergency situations, to preserve life or physical or mental health, practitioners must provide the medically indicated care of their patients' choice regardless of the practitioners' personal objections."[97] The CMA Code of Ethics is in contravention with not only the FIGO guidelines, but also Committee jurisprudence on the issue in that it does not require practitioners to provide timely referrals and therefore does not appropriately safeguard the right to health in the face of purported conscientious objection.

56. In recent years, there have been several reported incidents in which women have been refused sexual and reproductive health information and services as a result of doctors' conscientious objection on moral or religious grounds. In January 2014, when attempting to access contraceptive services, an Ottawa resident received a letter explaining the doctor's decision to refuse to provide "vasectomies, abortions, the morning after pill and any artificial contraception," on the grounds of "medical judgement as well as professional ethical concerns and religious values."[98] This incident resulted in the emergence of evidence of other doctors in the province refusing to provide women with conceptive services.[99]

Recommendations to the Government of Canada relating to Article 12 of the Covenant:

Access to safe abortion services

57. **Engage provincial and territorial governments in discussions towards ensuring that access to abortion services in all jurisdictions complies with the requirements of international human rights law.** Such discussions, which could also form part of a renewed federal-provincial-territorial health accord, would need to contain: mechanisms to ensure the accessibility, availability, acceptability and quality of abortion services across the country; guidelines for the implementation of appropriate monitoring and accountability mechanisms with respect to the accessibility of abortion services, in line with Canada's obligations under the right to health; and offer remedy and redress for violations of the right to health.

58. **Withhold Cash Contributions to provinces and territories failing to ensure the availability and accessibility of abortion services** and initiate dispute resolution procedures under sections 14-17 of the Canada Health Act as violations of the Accessibility or Universality program criteria established in sections 7, 10 and 12 of the Act.

59. **Establish a national protocol for individuals seeking abortion services post-24 weeks outside of Canada,** including funding to cover travel and accommodation costs prior to leaving the country.

60. **Explore ways to ensure appropriate task-shifting in the provision of medical abortion, and allowing the training of other health professionals, such as nurse practitioners and midwives, to provide these services; and coordinate with provinces to include mifepristone on their provincial drug formularies.**

[97] International Federation of Gynecology and Obstetricts. 2005. Ethical Guidelines on Conscientious Objection, p. 25-27.
[98] "It Happened To Me: I Asked For Birth Control And Got A Form Letter Saying 'No.'" *XO Jane*, February 4, 2014. http://www.xojane.com/it-happened-to-me/it-happened-to-me-my-doctor-refused-to-refill-my-birth-control.
[99] Grant, Kelly. "Policy allowing doctors to deny treatment on moral or religious grounds under review." *The Globe and Mail*, July 02, 2014.

61. **Eliminate financial barriers to accessing a comprehensive package of sexual and reproductive health services by establishing a national drug plan.**

62. **Conduct regular national monitoring, through *inter alia* broad-based surveys, of a robust set of sexual health indicators disaggregated by relevant factors including gender, age, location, ethnicity and others.** One approach to doing this could involve requiring PHAC to regularly implement the Canadian Sexual Health Indicators Survey, for which a pilot test and validation phase was undertaken in 2012. Another approach to doing this could involve substantially expanding the Sexual Behaviours Module of the Canadian Community Health Survey, by adding further questions including in relation to contraception and pregnancy intention.

<u>Sexual and reproductive health of Indigenous Peoples</u>

63. **Develop strategies to address the underlying determinants of health** – including systemic stigma and discrimination – that lead to disproportionately high rates of STIs among Indigenous communities in Canada.

64. **Ensure all individuals who have been criminalized, or been in conflict with the law, have access to a comprehensive and integrated package of sexual and reproductive health services and information.** This includes repealing Bill C-2 (*An Act to amend the controlled drugs and substances act*), and establishing evidence-based prevention, harm reduction and treatment services,[100] including needle exchange programmes, to be implemented in all federal prisons and urban centres.

65. **Implement the *Guidelines for the Implementation of Mother-Child Units in Canadian Correctional Facilities* in all federal prisons.**

66. **Apply 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.

67. **Take steps to ensure the non-repetition of non-consensual sterilization and contraceptive practices,** especially within Indigenous communities.

<u>Conscientious objection</u>

68. **Engage provincial and territorial governments in discussions toward ensuring that the regulation of conscientious objection in all jurisdictions complies with international human rights law requirements and the guidance of international technical and professional bodies.** Such an agreement, which could also form part of a renewed federal-provincial-territorial health accord, would need to ensure appropriate regulation of individual conscientious objection that would apply to physicians as well as other health professionals lawfully allowed at present or in the future to provide sexual and reproductive health services. Such an agreement would also need to contain measures to effectively prohibit any attempted institutional objection to the provision of sexual and reproductive health services, and national guidelines for the implementation of appropriate monitoring and accountability mechanisms with respect to conscientious objection in line with Canada's obligations under the right to health – and offer remedy and redress for violations of the right to health.

[100] "Statement to Canadian Parliamentarians Opposing Bill C-2, An Act to Amend the Controlled Drugs and Substances Act." March 2015. http://www.aidslaw.ca/site/wp-content/uploads/2015/03/March23Stmt-BillC2-ENG.pdf.

69. **Study the prevalence of the exercise of conscientious objection and its implications for the provision of health services.** Such a study should look at concrete strategies for the government in meeting its human rights obligations, to ensure that the practice of conscientious objection by health professionals does not pose a barrier to the availability and accessibility of health services, including those regarding sexual and reproductive health. The study must also examine the non-provision of abortion services within hospitals, with a view to developing strategies to ensure that moral and religious considerations are not a part of a hospital's failure to provide abortion services.

70. **Withhold Cash Contributions to Provinces and Territories and initiate dispute resolution procedures under sections 14-17 of the Canada Health Act as violations of the Accessibility or Universality program criteria established in sections 7, 10 and 12 of the Canada Health Act when provincial and territorial governments fail to prohibit institutional objection or to regulate individual conscientious objection** by requiring health professionals to provide accurate and unbiased information about medical options, effective referrals and urgent or emergency care; and by ensuring that they are effectively held accountable for violations of these ethical duties.

71. **Ratify the Option Protocol to the Covenant on Economic, Social and Cultural Rights.**

Article 13 – Right to education

Background: comprehensive sexuality education

72. The Committee has, on numerous occasions, recognized governments' obligation to provide sexuality education. The Committee's General Comment No. 14 stated that the right to health includes "access to health-related education and information, including on sexual and reproductive health."[101] In its concluding observations to governments, it called on governments to:
    a. implement "adequate programmes in sexual and reproductive education in national school curricula,"[102]
    b. include "sexual and reproductive health education programmes in schools,"[103]
    c. establish "comprehensive educational programmes on sexual and reproductive health, including public awareness-raising campaigns about safe contraceptive methods and inclusion of appropriate information on sexual and reproductive health in the curricula,"[104] and
    d. provide "comprehensive age-appropriate sexual and reproductive health education."[105]

73. Sexuality education is recognized as a basic human right of all children and youth in both the Annual Report of the Special Rapporteur on the right to education to the UN General Assembly in 2010[106] and in General Comment No. 4 of the Committee on the Rights of the Child.[107] Effective sexuality education must go beyond

[101] CESCR. 2000. General Comment No. 14, supra note 2, para. 11.
[102] CESCR, Concluding Observations: Poland, para. 31, U.N. Doc. E/C.12/POL/CO/5 (2009). See also, e.g., CESCR, Concluding Observations: Bolivia, para. 43, U.N. Doc. E/C.12/1/Add.60 (2001); China, para. 100, U.N. Doc. E/C.12/1/Add.107 (2005); Poland, paras. 28, 50, U.N. Doc. E/C.12/1/Add.82 (2002); Senegal, para. 47, U.N. Doc. E/C.12/1/Add.62 (2001); Ukraine, para. 31, U.N. Doc. E/C.12/1/Add.65 (2001). http://reproductiverights.org/sites/crr.civicactions.net/files/documents/CESCR_shadowletter_Russia_FINAL_web%20version.pdf
[103] CESCR. 2010. Concluding observations, Kazakhstan. E/C.12/KAZ/CO/1.
[104] CESCR. 2010. Concluding observations, Sri Lanka. E/C.12/LKA/CO/2-4.
[105] CESCR. 2014. Concluding observations, Armenia. E/C.12/ARM/CO/2-3
[106] United Nations Special Rapporteur on the right to education. Annual report to the General Assembly on the human right to comprehensive sexual education. 2010.
[107] Committee on the rights of the child. General Comment 4 on adolescent health and development in the context of the Convention on the rights of the child. 2003.

biology. It must educate children and youth about gender equality, sexual and reproductive health, relationships, gender-based and sexual violence, sexual and gender diversity, healthy emotive processes, informed consent and human rights, and should promote empowerment and autonomy. Such education must be free of and aim to eliminate stereotypes, discrimination, and stigma; respect the evolving capacities of children and youth; and be tailored to meet the specific needs of particular groups, e.g. young people with disabilities and those living on the streets. When effectively implemented, comprehensive sexuality education contributes to reducing the transmission of sexually transmitted infections, gender-based violence, stigma and discrimination, unwanted pregnancies, and to developing healthy sexual and non-sexual relationships, among other outcomes.[108]

74. According to General Comment No. 20 on non-discrimination, age is a prohibited grounds for discrimination.[109] Therefore states are obligated to respect young people's right to access sexual and reproductive health information and services without discrimination.[110] Further to this, states must adopt measures to realize the right to participate in decision-making processes for individuals who may be "distinguished by one or more of the prohibited grounds."[111] Young people must therefore be meaningfully engaged in the planning, development, implementation and evaluation of comprehensive sexuality education curricula.

75. Canada played an instrumental role establishing the position of UN Special Rapporteur on violence against women, and in leading the annual resolution on the same topic at the UN Human Rights Council. In 2015, Canada played a leadership role along member states adopting a strong resolution on violence against women, which includes for the first time at the Council reference to 'comprehensive sexuality education,'[112] recognizing its linkages with efforts to prevent violence against women.

Situation in Canada: comprehensive sexuality education

76. Documented discrepancies in the quality and delivery of comprehensive sexuality education curriculums in Canada represent violations of article 13 as interpreted within this cited work of the Committee. Specifically, the Government of Canada has failed to implement a comprehensive set of national guidelines for sexual health education resulting in severe discrepancies between provinces in related curriculum.

77. In 2008, the Public Health Agency of Canada revised its guidelines for sexual health education, developed to provide a "framework that outlines principles for the development and evaluation of comprehensive evidence-based sexual health education. Guideline statements support each principle and provide the context for effective and inclusive sexual health education programs and policies in Canada."[113] Due to the division of power between federal and provincial jurisdictions, the guidelines have not been consistently implemented across Canada in a manner that recognizes young people's rights. This can reinforce the stigma associated with their sexual activity, can lead to discrimination and have negative health outcomes. In Canada, there is evidence demonstrating an

[108] Upworthy. "Oh kindergarten. Finger painting, ABCs, and sexuality education." June/July 2015. http://www.upworthy.com/kids-dont-usually-learn-about-the-birds-and-bees-in-kindergarten-unless-of-course-theyre-dutch
[109] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[110] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[111] Committee on Economic, Social and Cultural Rights. General Comment 20: non-discrimination. 2009.
[112] UN Human Rights Council. Resolution: Accelerating efforts to eliminate all forms of violence against women: eliminating domestic violence. June 2015. A/HRC/RES/29/14.
[113] *Canadian Guidelines for Sexual Health Education.* Ottawa: Public Health Agency of Canada, 2003.

overall lack of knowledge on sexual and reproductive health among youth populations. In 2011, over one quarter of positive HIV diagnoses were attributed to young people between the ages of 15 and 29. Women are overrepresented in the younger age group (15-19), accounting for 56.5% of the total positive HIV tests reported. Other sub-groups may also be more vulnerable to HIV infection, particularly Indigenous youth. Moreover, young Canadians have the highest reported rates of STIs, and reported rates of chlamydia, gonorrhea and syphilis have been steadily rising since the late 1990s. According to 2010 national STI surveillance data, 81% of new cases of chlamydia, 67% of new cases of gonorrhea and 27% of new cases of infectious syphilis were among youth.[114]

78. Despite the federal government having a role to play both in fulfilling young people's sexual and reproductive rights (in part through the implementation of comprehensive sexuality education) and in gathering and analyzing data on trends in relation to the sexual and reproductive health of all people in Canada, there are no standards through which sexual health education curricula can be monitored and evaluated. Regular national studies are required in order to determine the effectiveness of sexuality education and ultimately to determine if curriculums are contributing to positive health outcomes and reductions in stigma and discrimination, among other outcomes. Such studies must look beyond objective information related to STI and HIV transmission rates and unwanted pregnancies. They must integrate subjective measures including young people's satisfaction with the curriculum, their ability to access youth-friendly services and information, violence-related outcomes and shifts in public perceptions, among other factors.

79. In 2010, the Public Health Agency of Canada carried out a pilot survey to assess the sexual health of young people across Canada, in terms of their access to both sexual and reproductive health services and sexual health education. The pilot was initiated in response to a lack of routinely gathered, comprehensive data on sexual health, which is recognized as a need for the development of effective policies and programmes (including the comprehensive sexuality education programmes). At the time, it was also recognized that Canada "lags behind several other countries in its ability to collect national comprehensive data on this important aspect of the health of youth."[115] The survey measured positive and negative aspects of sexual health, including sexual satisfaction, access to sexual health services, access to sexual health education, experiences of sexual violence, use of contraception, types of sexual behaviours engaged in and the contexts of such behaviours, collecting both qualitative and quantitative information. It also allowed for the collection of important disaggregated data, including age, gender (including transgender individuals), sexual orientation, language, level of education, race, ethnicity, among other factors. Results from the pilot confirmed the validity and reliability of the indicators, concluding that it would be feasible for the study to be replicated at the national level, and that in doing so it would provide Canada the opportunity to "meet this challenge posed by other countries that currently collect national data on sexual health."[116]

[114] Public Health Agency of Canada. 2010. Population Specific Status Report: HIV/AIDS and other sexually transmitted and blood born infections among youth in Canada. http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/youth-jeunes/chapter-chapitre-3-eng.php#footnotei.
[115] Public Health Agency of Canada. 2012. Canadian Sexual Health Indicators Survey – Pilot Test and Validation Phase: a report on results from the pilot-testing and validation of the Canadian Sexual Health Indicators Survey. http://publications.gc.ca/collections/collection_2012/aspc-phac/HP40-67-2012-eng.pdf.
[116] Public Health Agency of Canada. 2012. Canadian Sexual Health Indicators Survey – Pilot Test and Validation Phase: a report on results from the pilot-testing and validation of the Canadian Sexual Health Indicators Survey. http://publications.gc.ca/collections/collection_2012/aspc-phac/HP40-67-2012-eng.pdf.

80. In Ontario, the curriculum was only recently updated to reflect sexual orientation and gender identity, among other issues, following criticism that it was the most outdated curriculum in the country.[117] In response, in 2010, the Ontario Ministry of Education released a revised Health and Physical Education curriculum covering a range of issues related to health, physical activity and sexual health based on the gathering of evidence and best practices, and in consultation with relevant stakeholders. While this represents a positive step forward, there remains significant work to be done in terms of implementation. Since the integration of the new sexuality education curriculum into the broader provincial curriculum, some vocal opponents have removed their children from school and publically protested the new curriculum.[118]

81. In Alberta, some school boards allow religious groups to deliver sexuality education, which can contain inaccurate and misleading information regarding sexual and reproductive health, diverse family formations and scientific evidence.[119] In 2014, an Edmonton student launched a human rights complaint with the Alberta Human Rights Commission providing evidence that religious groups were delivering misleading information to students on issues related to contraception and sexually transmitted infections, within an *abstinence*-only-based framework. Research shows the correlation between the implementation of *abstinence-based* approaches and rises in sexually transmitted infections, unwanted pregnancies and other negative health outcomes,[120] as it limits young people's access to comprehensive, evidence-based and scientific information related to sexual and reproductive health.

Recommendations to the Government of Canada relating to Article 13 of the Covenant:

82. **Task the Public Health Agency of Canada (PHAC) with engaging in a multi-stakeholder revision of the Guidelines for sexual health education,** with full and meaningful participation of a diverse representation of stakeholders, and ensuring that the revised Guidelines include effective monitoring mechanisms.

83. **Conduct regular national monitoring, through inter alia broad-based surveys, of a robust set of sexual health indicators** disaggregated by relevant factors including gender, age, location, ethnicity and others. One approach to doing this could involve requiring PHAC to regularly implement the Canadian Sexual Health Indicators Survey. Another approach to doing this could involve substantially expanding the Sexual Behaviours Module of the Canadian Community Health Survey by adding further questions including in relation to contraception and pregnancy intention.

84. **Meaningfully engage diverse young people and adolescents in the design, development, implementation and evaluation of policies and programs that affect their lives.** This should also include: 1) seeking the views of adolescents and young people as to how they feel the sexuality education they received prepared them for their early sexual lives, and 2) integrating this subjective data into curriculum alterations and redesign.

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[117] Rushowy, Kristin. "Sex education in Ontario schools outdated, teachers say." *The Toronto Star*, October 10, 2013.
[118] Canadian Broadcasting Corporation. "Ontario parents opposed to sex ed changes threaten to pull kids from school." May 2015. http://www.cbc.ca/news/canada/toronto/ontario-parents-opposed-to-sex-ed-changes-threaten-to-pull-kids-from-school-1.3059455.
[119] "Teen, mother launch complaint against abstinence-based sex ed." CBC News, July 10, 2014.
[120] Guttmacher Institute "Consequences of Sex Education on Teen and Young Adult Sexual Behaviors and Outcomes." (2012). https://www.guttmacher.org/pubs/journals/j.jadohealth.2011.12.028.pdf and Advocates for Youth. "Abstinence-Only-Until-Marriage Programs: Ineffective, Unethical, and Poor Public Health." (2007) http://www.advocatesforyouth.org/publications/publications-a-z/597-abstinence-only-until-marriage-programs-ineffective-unethical-and-poor-public-health.

85. Allocate sufficient funds to PHAC for public awareness raising campaigns, on positive sexuality and consent, sexual and reproductive health information, and stigma and discrimination, among other issues.