CANADA ELECTION 2015

opting for sexual health and rights

BACKGROUND INFORMATION AND RECOMMENDATIONS FOR CANADA ON KEY ISSUES RELATED TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AT HOME AND ABROAD

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In October 2015, Canada is holding a federal election. Elections represent key moments when individuals and groups have the opportunity to have their decision-makers, and the parties they represent, make commitments. Issues related to sexual and reproductive rights affect all people; yet, are often get left out of debates and discussions in the lead up to elections. This series of briefs outlines suggested priorities for the Government of Canada in terms of sexual and reproductive rights, both in Canada and globally.

Canada: Key issues addressed

Access to abortion services, **conscientious objection**, **comprehensive sexuality education**, **respect for diverse gender identities and expressions**, **sex workers' rights**, and **issues that intersect with sexual and reproductive rights**.

International: Key issues addressed

We're looking for the Government of Canada to **re-establish itself as a global leader** on gender equality, sexual and reproductive rights and human rights more broadly**.** In order to do so, we have mapped out what a Government of Canada **global policy on sexual and reproductive rights** would look like. It includes a plan to put an end to the current refusal to **fund abortion services abroad** and steps to **re-engage with multilateral organizations and in intergovernmental spaces**, like the United Nations.

The briefs are intended for many different stakeholders and audiences. They are for those who: Are interested in sexual and reproductive rights; are interested in key issues in the lead up to the federal election; are responsible for developing programmes and policies related to sexual and reproductive rights in Canada and through Canada's development assistance and foreign policy; are parliamentarians and working with parliamentarians; are activists who want to hold their decision-makers accountable, raise awareness and share information about sexual and reproductive rights; and anyone else who wants our federal Government to take positive action on sexual and reproductive rights!

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. Founded in 2014, three of Canada's leading sexual and reproductive health and rights organizations saw an opportunity for a strengthened voice in international and national policy, education and access as well as a way to engage others across Canada and around the world in the sexual and reproductive health and rights movement.

BACKGROUND INFORMATION AND RECOMMENDATIONS FOR CANADA ON KEY ISSUES RELATED TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: DOMESTIC POLICY

In anticipation of the 2015 federal election, Action Canada for Sexual Health and Rights has produced a series of thematic briefs outlining what actions we think the Government of Canada should take on a range of sexual and reproductive rights-related issues in the coming years. This section focuses on issues that we see as priorities in Canada.

Access to abortion services
Comprehensive sexuality education
Conscientious objection
Respect for diverse gender identities and expressions
Sex workers' rights
Issues that intersect with sexual and reproductive rights

These briefs are intended for a range of stakeholders, including individuals, organizations, collectives, political parties and government officials, among others, in thinking ahead toward the actions we want the federal government to take in guaranteeing sexual and reproductive rights in Canada.

Action Canada would like to thank Fédération du Québec pour le planning des naissances (FQPN) for their support in developing these materials.

Access to abortion services

Background information

In accordance with the 1988 Supreme Court of Canada decision Canada 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 constitutional 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. 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 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.

Still, the lack of access to safe abortion services is an ongoing obstacle and barrier for those who choose to terminate their pregnancies, particularly for individuals living in rural or remote areas. A 2006 study found that only 1 in 6 hospitals provide abortion services in Canada, the majority of which, like free standing sexual health clinics, are disproportionately dispersed across Canada, with most located in urban areas.[1] The overall limited availability of abortion services through clinics and hospitals is compounded by other barriers related to wait times, age, financial resources and geographic location, migration status,[2] and physicians refusing to provide the services on moral and religious grounds,[3] among others.

Unexpected travel time is a significant factor for individuals having to travel out of town or province, especially for later term abortions, delaying access to abortion services. Unforeseen monetary expenses such as travel, accommodation, lost wages, childcare, eldercare and possible procedural costs (in cases where no reciprocal billing agreement within the provincial or territorial health systems exists) disproportionately impact low-income individuals. Young people may also face disproportionate barriers in accessing abortion services due to limited access to resources and ability to travel independently, among other factors. They may also choose to delay or choose not to seek abortion services due to social stigma or concerns over violations of privacy or confidentiality by health professionals or their staff. In some provinces, adolescents are not able to obtain an abortion without parental consent, adding yet another requirement that restricts their autonomy in accessing services they might need.

The low number of abortion providers in Canada contributes to the poor availability of services adding to barriers related to geographic location. According to Medical Students for Choice, 40% of schools surveyed *did not teach any aspect of abortion in preclinical years*; abortion and counselling on pregnancy options is not included as a standard component of preclinical education.[4] Adding to this, there are many doctors who refuse to provide the service on moral or religious grounds or who cannot add abortion services to their practice for other reasons including workload and quotas. Another challenge is the reality that the vast majority of current abortion providers across Canada are over 50 years of age; many of whom will retire in the coming years. Recognizing these challenges, the Government is required to take active steps in working with the provinces and territories to ensure access to this essential medical procedure.

Reciprocal billing agreements require that individuals who are outside their province or territory of residence (either travelling, studying or changing their residence) and who need a specific medically necessary service or procedure are to be either covered or reimbursed in full for the monetary costs by their provincial or territorial health system. In the case that an individual decides to change their provincial or territorial residence, reciprocal billing will cover their costs for up to three months before bureaucratic changes have

been completed and the new provincial or territorial healthcare plan comes into function. Abortion is included on the List of Excluded Services under the Reciprocal Billing Agreement.[5] While some provinces have developed bilateral agreements allowing abortion services to be covered under reciprocal billing, five provinces and one territory continue to exclude abortion from their list of services to be covered under reciprocal billing.[6] Individuals coming from such provinces or territories who are in need of an abortion have to incur the expense of paying up front for the procedure, without an opportunity for reimbursement. This disproportionately impacts low-income individuals.

Discrepancies across provinces

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

In PEI, there are no abortion providers.[7] This is the only province in Canada that is still refusing to offer abortion services, in turn violating its obligations set by the Act. The only provinces to which they can travel, funded by their provincial government, are Nova Scotia and New Brunswick. In order to access a funded abortion in Nova Scotia,[8] individuals must be referred by both a PEI physician and the Department of Health and Social Services, and the abortion procedure must be done in a hospital (clinic abortion services are not eligible for funding in PEI). This process must also be completed within 16 gestational weeks. Due to stigma related to abortion, there is a lack of physicians in PEI who are willing to make the referrals and requests for funding.[9] In addition, healthcare providers are often unwilling to provide accurate information to individuals 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.[10]

As of January 2015, New Brunswick has reversed a regulation requiring individuals to obtain the authorization of two physicians in order for the procedure to be fully funded. Still, only three out of 23 hospitals in New Brunswick provide abortion services (two of which are in Moncton) and clinic abortions are not funded by the government. In some cases, individuals are required to make multiple visits before the procedure, which can result in delays, stigma and ultimately, barriers in access to abortion services. In contravention of the Act, New Brunswick is the only province that refuses to pay for, or reimburse individuals for, abortion services performed outside of hospitals. The province also refuses to provide reciprocal billing for individuals that require abortion services outside of the province. This policy can be especially difficult for individuals in small towns and for individuals who do not have a family physician. If an individual is unable to travel to one of the two hospitals, or fears stigma and discrimination in accessing services in such environments, they may either be forced to travel out-of-province in order to obtain abortion care, pay between $700.00 to $850.00 to have the abortion in province[11] or continue with the pregnancy and birth against their will. With such limited access, it has been reported that individuals are increasingly seeking abortion services out of country, and in some cases, engaging in unsafe practices to terminate unwanted pregnancies.[12]

Increasing access

One strategy to overcome challenges in access to abortion services is through increased access to medication abortions. It is widely accepted that medication abortion is more easily administered by family physicians, midwives and nurse practitioners,[13] which would greatly increase the availability of the services in rural and remote areas, as well as provinces and territories with few surgical abortion providers. The drug *Mifepristone* (RU-486) is the form of medication abortion recommended by the World Health Organization (WHO), used in combination with misoprostol.

RU-486 has been pending approval by Health Canada since 2012, despite its being widely accepted as the most effective non-surgical option for abortion, listed as an essential drug by the WHO and currently administered in 57 countries.[14] In January 2015, Health Canada requested additional information from the drug producers and is expected to release its decision by September 2015.[15]

International law guarantees all people the right to life and the right to the highest attainable standard of physical and mental health, which includes sexual and reproductive health.[16] International law also guarantees all people the right to liberty and security of person. Control over one's own body, including the decision whether to terminate a pregnancy or carry it to term, is an essential element of liberty. A person cannot enjoy personal security when such decisions are imposed onto their body or when they lack the means to carry out their reproductive decisions. Embedded in the right to liberty and to security, therefore, is the right to bodily autonomy: the ability to make sexual and reproductive decisions free of coercion and violence.[17] Undue restrictions on abortion detract from an individual's autonomy to determine her life's course, and thus to enjoy equal citizenship stature.[18]

The right to health obliges governments to ensure the availability, accessibility, acceptability and quality of comprehensive and integrated sexual and reproductive health information and services, including abortion, and to remove any barriers that impede access to such services. To be available, services must be provided in functioning and adequately-supplied facilities that are sufficient in number and appropriately distributed within a geographic territory so as to mitigate barriers related to physical location. To be accessible, barriers to accessing services must be removed, including financial costs and other barriers related to stigma and discrimination based on age, gender, economic status, ability, religion and marital status, among others. To be acceptable to the populations for whom they are intended, services and information must be gender-sensitive and youth-friendly. To be of the highest quality, they must be in line with quality of care standards.[19]

Action Canada for Sexual Health and Rights runs a Canada-wide toll-free 24-hour access line that provides information on reproductive and sexual health and referrals on pregnancy options. The line, often operated by volunteers, receives over 1,900 calls per year from individuals seeking support around accessing abortion services, who have questions about the procedure itself and who are seeking options counselling. Calls come from across the country, including both rural and urban centres. There is a clear need to ensure such information is available to all individuals across the country. While there are a number of civil society organizations and volunteer organizations that provide such services, Governments are responsible for ensuring all individuals have the information and resources available to access a range of sexual and reproductive health services and information. This includes prevention, counselling, treatment, care and referral.

The United Nations is in the process of crafting a universal framework for development for 2015-2030. A set of Sustainable Development Goals has been proposed as a way forward. The proposed goals are universal in nature and will apply to all countries, regardless of economic, social or political realities. The Government of Canada will need to take active steps to ensure access to abortion services, in order to achieve the following targets to which it has committed:

> **3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies**

and programmes

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

5.1 End all forms of discrimination against all individuals and girls everywhere

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

We call on the Government to:

Pending the Health Canada approval of Mifepristone, coordinate a range of stakeholders, including the CMA and relevant professional, training, certification and accreditation bodies to develop an effective implementation strategy, which includes clinical guidelines, with a particular focus on ensuring access to medication abortion in rural and remote areas that would include, at a minimum, training for new and existing family physicians. Such a strategy would include efforts to maintain and improve access to a comprehensive and integrated package of sexual and reproductive health services, including both surgical and medication abortion. Such a strategy would also look at ways to ensure appropriate task-shifting in the provision of medication abortion allowing and training other health professionals, such as nurse practitioners and midwives, to provide these services.

Request that Health Canada encourage the Interprovincial Health Insurance Agreements Coordinating Committee to remove abortion services from the list of Excluded Services under the Reciprocal Billing Agreement

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.

Withhold Cash Contributions to the provinces and territories when governments fail 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.

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.

Mandate the Standing Committee on Health to undertake a study on Health Canada's procedures for the drug review and approval process with a focus on sexual and reproductive health-related drugs.

Mandate the Standing Committee on Health to undertaken a study identifying the concrete strategies for the Government to meet its human rights obligations to ensure that abortion services are available, accessible, acceptable and of quality, including strategies to ensure that the practice of conscientious objection by health profes-

sionals does not pose a barrier to abortion services. 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.

Ensure all individuals have access to abortion services, regardless of immigration status. This include removing waiting periods for temporary and permanent residents to access health care, and the provision of health care to undocumented people.

This brief was developed in consultation with
Patricia LaRue, Executive Director of Clinique des Femmes de l'Outaouais.

Endnotes

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[3] For more information about conscientious objection, or the refusal of health professionals to perform particular services on the grounds of moral or religious beliefs, see the section on Conscientious Objection of this series, Canada Election 2015: A vote for sexual health and rights.
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[16] 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.
[17] Shalev, Carmel. 1998. Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination Against Individuals, p. 6.
[18] Gonzales v. Carhart. 2007. US Supreme Court. (Ginsburg, J., dissenting) p. 4 and Sexual Rights Initiative. 2013. The Decriminalization of Abortion: a human rights imperative.
[19] Hague Civil Society Call to Action on Human Rights and ICPD Beyond 2014, from the ICPD Beyond 2014 International Conference on Human Rights, held in July 2013, in The Netherlands.

Comprehensive sexuality education

Background information

Sex education that provides students with the skills to navigate their way in this diverse, digital world has to go beyond biology. It needs to be "understood as age-appropriate education about human rights, human sexuality, gender equality, relationships, and sexual and reproductive health through the provision of scientifically-accurate, nonjudgmental information and the development of decision-making, critical thinking, communication and negotiation skills." Comprehensive sexuality education aims to eliminate gender norms and stereotypes, discrimination and stigma while embracing diversity and respect for the evolving capacities of children and youth.

This requires a concerted shift away from speaking about issues of sex, sexuality, gender and health in a negative way and towards an approach that empowers young people to experience their sexuality in positive ways. In doing so, young people are provided the tools for healthy and positive sexual lives. Effectively implemented comprehensive sexuality education curriculums recognize the economic, social and political contexts in which sexuality and gender are constructed and how stigma and discrimination exists within them. It recognizes diverse experiences of sexuality and gender, based on disability, sexual orientation, gender identity and expression, class, race, religion, ethnicity, and along other lines, by taking these experiences into account across the curriculum.

Comprehensive sexuality education is recognized as a basic human right of all children and youth in the annual report of the UN Special Rapporteur on the right to education to the UN General Assembly in 2010, General Comment No. 4 of the UN Committee on the Rights of the Child, and General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights. Both Committees recognize that young people's and adolescents' right to access education and information is essential for their health, including sexual and reproductive health.

In Canada, education is a provincial issue and provinces and territories are responsible for the development and implementation of curricula. Regardless, the Government of Canada, as a party to numerous international human rights treaties, is obligated to ensure that all individuals are guaranteed their right to comprehensive sexuality education. The federal government must hold the provinces accountable to ensuring that there are no denials of this human right, including through the refusal to provide or weak implementation of comprehensive sexuality education curricula.

The implementation of sexuality education in Canada has not been consistent, effective or implemented in a manner that recognizes young people's rights. This can reinforce the stigma associated with their sexual activity, can lead to discrimination and can have negative health outcomes. In Canada, there is evidence that demonstrates an overall lack of knowledge on sexual and reproductive health among youth populations. In 2011, over one quarter of positive HIV tests 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.[1]

High rates of violence against young women and girls further demonstrates a lack of awareness regarding gender norms and stereotypes and respectful behaviour and relationships. Young women are eight times more likely than boys to be

victims of a sexual offence;[2] nearly half (46%) of high school girls in Ontario are victims of sexual harassment.[3] Indigenous girls face more frequent incidents of violence than non-Indigenous girls, with 17% of missing and murdered Indigenous women being under the age of 18.[4]

When effectively implemented, comprehensive sexuality education recognizes young people's realities and the need to provide information on preventing the transmission of STIs and unwanted pregnancies as well as having healthy sexual and non-sexual relationships. In the Netherlands, where sexuality education is mandatory beginning from primary school, research has shown that the majority of first sexual experiences has been positive, 9 out 10 adolescents used contraceptive during their first sexual experience and the adolescent pregnancy rate is among the lowest in the world (at 6 births for every 1,000 women between the ages of 15-19) (compared to 14/1,000 in Canada). In contexts like the Netherlands, the implementation of comprehensive sexuality education programs is coupled with access to youth-friendly sexual and reproductive health information and services – which includes a range of contraceptives.[5]

National leadership

The Federal government has 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. This allows governments to modify existing programs and policies and create new ones aimed at improving health outcomes and reducing stigma and discrimination. In this regard, in 2008, the Public Health Agency of Canada (PHAC) revised its Guidelines for sexual health education, which were developed to provide a framework for the development and evaluation of comprehensive evidence-based sexual health education. Unfortunately, these guidelines have not been consistently implemented across the country nor are there standards through which sexual health education curriculums can be monitored and evaluated.

The Guidelines can provide context for effective and inclusive sexual health education programs and policies in Canada. In revising them, the guidelines must recognize the need for sexuality education to: begin at primary school; integrate participatory methodologies and the use of information and communications technologies; be implemented in and out of schools (with supportive policy and legal frameworks in place); integrate an effective health referral mechanism; respect privacy and confidentiality; include training for teachers; and meaningfully engage young people in the design, implementation, monitoring and evaluation of sexuality education programs.[6]

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. 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 STIs within an abstinence-based approach. Such an approach has the potential to increase the prevalence of STIs, unwanted pregnancies and negative health outcomes, as it limits young people's access to comprehensive, evidence-based and scientific information related to sexual and reproductive health.

In Quebec, there is no standalone sexuality education curriculum, rather a range of issues (including gender identity, STIs, etc.) are integrated into core courses. This approach results in school boards, individual schools and teachers having complete discretion when it comes to how and when these topics are covered. Unsurprisingly, with little guidance on how to teach sexual education, Quebec has seen rising rates of STIs, intimate partner violence and sexual violence in the last ten years.[7]

Challenges also exist between school boards within provinces. Following the introduction

of a new sexuality education curriculum in Ontario, Catholic school board trustees have attempted to persuade their boards to not implement the new curriculum.[8]

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 others.

Though limited, there are a few remedies that exist for individuals in Canada to hold their leaders accountable to ensuring that young people have access to comprehensive sexuality education. One such mechanism is the Optional Protocol (OP) on a communications procedure to the Convention on the Rights of the Child (CRC). It allows individuals to initiate complaints against States who fail to meet their human rights obligations found in the Convention, once domestic remedies have been exhausted. UN Committees that oversee international human rights treaties associated complaints mechanisms support States in meeting their human rights obligations by providing them with concrete measures to address violations and denials of rights. OPs also support States in maintaining transparent and democratic decision-making at all levels of government. Forty-six States have ratified the OP to the CRC. The Government of Canada has yet to do so.

The United Nations is in the process of crafting a universal framework for development for 2015-2030. A set of Sustainable Development Goals have been proposed as a way forward. The proposed goals are universal in nature and will apply to all countries, regardless of economic, social or political realities. In the context of respecting, protecting and fulfilling individuals' right to comprehensive sexuality education, the following targets will therefore apply in Canada:

> **3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes**
>
> **3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all**
>
> **4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and nonviolence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development**
>
> **5.6 Ensure universal access to sexual and reproductive health and reproductive rights agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences**

We call on the Government to:

Request that the Minister of Health task PHAC with engaging in a multi-stakeholder revision of Guidelines for sexual health education, with full and meaningful participation of a diverse representation of stakeholders,

including: young people, service providers, public health professionals, academics and relevant civil society working to advance comprehensive sexuality education in Canada, among other experts, ensuring that the revised Guidelines include effective monitoring mechanisms.

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.

Meaningfully engage young people and adolescents in the design, development, implementation and evaluation of policies and programs that affect their lives. This should also include seeking the views of adolescents and young people of different genders, locations, ethnicities, sexual orientations and other relevant characteristics, as to how they feel the sexuality education they received prepared them for their early sexual lives, including sexual debut, and integrating this subjective data into curriculum alterations and redesign.

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.

Ratify the Optional Protocol to the Convention on the Rights of the Child on a communications procedure

Task the Standing Committee on Health to undertake a study to explore the current state of sexuality education in Canada and produce recommendations aimed at strengthening the development and implementation of sexuality education across the country.

Endnotes

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Conscientious objection

Background information

In the context of health, conscientious objection is the refusal by a health professional to perform particular services on the grounds of moral or religious beliefs. The specific sexual and reproductive health services that are most often refused on the basis of conscientious objection are abortion, contraception and assisted reproduction.

In Canada, over the past year, the issue of conscientious objection has emerged quite visibly with physicians not only refusing to provide reproductive health services to patients in need but also refusing to refer patients to alternative providers. In one such case, a physician in Prince-Edward-Island refused to provide emergency care or referral to a woman experiencing post-abortion complications.[1]

The College of Physicians and Surgeons of Ontario (CPSO) adopted a groundbreaking new policy[2] that very clearly defines the responsibilities of physicians who refuse to provide services. The robust nature of the duties placed on objecting physicians within the new policy ensures that a patient's right to access health services and to be treated with dignity are central.

International Guidance

It should be noted, however, that, while the Ontario policy represents an important, progressive step forward, it is the standard for the regulation of conscientious objection set by international professional, technical and accountability bodies.[3] The guidance provided by these international bodies clearly lays out the ethical obligations of physicians and other health professionals that must be set by governments and professional regulatory bodies in order to ensure the protection of the human rights of individuals seeking health care. The duties that these guidelines impose on physicians and other health professionals are as follows:

> **the primary duty of a health professional 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.[4]
>
> While, in non-emergencies, health professionals are permitted to refuse to provide specific health services on the basis of conscience, **a health professional has an obligation to provide patients with an effective referral**[5] to another practitioner who is willing and trained to provide the service and who is working within the same health facility or another easily accessible health facility. This duty remains the same regardless of whether the refusal is a moral or religious objection or an assertion that they do not possess the necessary clinical skills to perform the procedure.[6]
>
> **Where a timely referral is not possible and a delay would jeopardize a patient's health or well-being, or in emergency situations, practitioners have an obligation to provide the medically-indicated care of the patient's choice** regardless of the practitioner's personal beliefs.[7]
>
> **In all cases, practitioners have duties to: provide information on all medically-indicated options** of procedures for a patient's care, including relating to procedures that they object to on grounds of conscience; **not**

misrepresent or mischaracterize services to which they object on the basis of personal beliefs, through inter alia adhering to scientifically and professionally-determined definitions of such services; and **respect patients' choices of medically-indicated care** options, even when a patient chooses the option to undergo a procedure to which the practitioner objects on the basis of personal beliefs.[8]

Governments have an obligation to ensure that conscientious objection is regulated in a manner that clearly enshrines the above-listed duties of health professionals and holds them effectively accountable to honouring these duties. In this way, governments can also enact their related obligation to ensure that the conscientious objection of health professionals does not form a barrier to accessing sexual and reproductive health services.[9]

Despite legal obligations, the model adopted in the new CPSO policy remains more of an exception than the rule in Canada, with most jurisdictions adopting an outdated approach set out by the Canadian Medical Association (CMA), which falls far short of the above-detailed minimum standards set by international agencies and bodies. The Code of Ethics of the CMA requires physicians to Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants,[10] but does not require physicians to provide timely referrals. In addition, the Code is at best unclear as to whether physicians are required, as part of their ethical obligations, to provide unbiased information and urgent or emergency care to which they personally object.[11]

Conscientious objection and sexual and reproductive rights

By failing to address and mitigate a barrier to accessing necessary and often life-saving health services, the lack of regulation on conscientious objection and the requirement to provide accurate and unbiased information about medical options, effective referrals and urgent or emergency care, constitutes a violation of international human rights law.[12] The barrier created by unregulated or improperly-regulated conscientious objection also compounds or exacerbates other barriers to accessing sexual and reproductive health services.

Abortion services are among the sexual and reproductive health services that physicians are most frequently unwilling to provide. This reality impacts other barriers to abortion services, including the limited availability of such services across the country. Only 1 in 6 hospitals in Canada offers abortion services.[13] In communities where there is generally limited access to health care providers, patients seeking to terminate a pregnancy may not have access to a health service provider willing to provide an abortion and therefore have to travel outside the community, which is particularly difficult for adolescents and young people or those with limited access to resources. In the case of time-sensitive abortion services, the requirement that referrals be made in a timely manner to the nearest available service provider is particularly crucial, as is the requirement that such a referral be made as a matter of ethical duty by any primary health care professional seeing a patient wishing to access abortion services.

The low number of hospitals in Canada that provide abortion services also raises the critical issue of how institutional decisions are made. Legally, institutions cannot refuse to provide specific services on the basis of conscience or belief.[14] Increasing the availability of abortion services in Canada will require close investigation of the reasons why hospitals do not offer abortion services in their facilities and may also require reviews of relevant laws and regulations to ensure that moral and religious influences are not behind a hospital's failure to provide abortion services. In addition to investing more resources in the training of abortion providers.[15]

The right to the highest attainable standard of health is the fundamental right of every individual, and includes access

to timely, acceptable and affordable health care of appropriate quality. Sexual and reproductive health is recognized by international human rights bodies as integral to the right to health.[16] Canada has a legal obligation to respect, protect and fulfill the right to health across the country. While health is in large part a provincial responsibility, there are many steps that the federal government needs to take with respect to the practice of conscientious objection to ensure it meets its obligations under international human rights law.

The United Nations is in the process of crafting a universal framework for development for 2015-2030. A set of Sustainable Development Goals have been proposed as a way forward. The proposed goals are universal in nature and will apply to all countries, regardless of economic, social or political realities. Recognizing that sexual and reproductive health services are most often refused on the basis of conscientious objection, the Government of Canada needs to ensure that conscientious objection is regulated in a manner that places on objecting health professionals the duties described above in order to achieve the following targets:

> **3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes**
>
> **5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences**

We call on the Government to:

Mandate the Standing Committee on Health to undertake a study on the prevalence and implications of the exercise of conscientious objection to 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 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.

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 the 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.

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 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 (as detailed above) and by ensuring that they are effectively held accountable for violations of these ethical duties.

Endnotes

[1] CBC. May 22 2015. "P.E.I. woman who used abortion drug unhappy with ER care." http://www.cbc.ca/news/canada/prince-edward-island/p-e-i-woman-who-used-abortion-drug-unhappy-with-er-care-1.3084304
[2] The College of Physicians and Surgeons of Ontario. 2015. "Policy Statement #2-15: Professional Obligations and Human Rights." http://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/Human-Rights.pdf?ext=.pdf
[3] International Federation of Gynecology and Obstetrics. 2005. Ethical Guidelines on Conscientious Objection.
[4] International Federation of Gynecology and Obstetrics. 2005. Ethical Guidelines on Conscientious Objection, p. 25-27.
[5] An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency.
[6] International Federation of Gynecology and Obstetrics. 2005. Ethical Guidelines on Conscientious Objection, pp. 25-27; World Health Organization. 2012. Safe abortion: technical and policy guidance for health systems, 2nd ed., pp. 69 and 96.
[7] International Federation of Gynecology and Obstetrics. 2005. Ethical Guidelines on Conscientious Objection, pp. 25-27; World Health Organization. 2012. Safe abortion: technical and policy guidance for health systems, 2nd ed., pp. 69 and 96; Special Rapporteur on the Right to Health, Mission to Poland (2010), 54, para. 50.
[8] International Federation of Gynecology and Obstetrics. 2005. Ethical Guidelines on Conscientious Objection, pp. 25-27; World Health Organization. 2012. Safe abortion: technical and policy guidance for health systems, 2nd ed., pp. 69 and 97.
[9] CEDAW Committee Concluding Observations: Croatia, para. 117, UN Doc. A/53/38/Rev.1 (1998); Italy, para. 360, UN Doc. A/52/38/Rev.1 (1997); United Nations. 2011; World Health Organization. 2012. Safe abortion: technical and policy guidance for health systems, 2nd ed., p. 89; 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).
[10] Canadian Medical Association. 2004. CMA Code of Ethics. http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf
[11] Canadian Medical Association. 2004. CMA Code of Ethics. http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf
[12] CEDAW Committee, Concluding Observations: Croatia, para. 117, UN Doc. A/53/38/Rev.1 (1998); Italy, para. 360, UN Doc. A/52/38/Rev.1 (1997); Poland, para. 25, UN Doc. CEDAW/C/POL/CO/6 (2007).
[13] Shaw, J. 2006. Reality Check: a close look at accessing abortion services in Canadian Hospitals. Ottawa: Canadians for Choice, p.15.
[14] Only individuals (and not institutions) can be said to have a conscience within the meaning of the right to freedom of thought, conscience and religion.
[15] An important problem is a lack of training in medical schools on the provision of abortion. A 2005 study conducted by Medical Students for Choice found that "nearly 40% of the more than 50 schools surveyed do not teach any aspect of abortion in the preclinical years." This leads to few doctors having the medical competency to perform abortion services, adding to other barriers preventing access to timely and efficient care.
[16] As recognized by the United Nations Human Rights Council and the Committee on Economic, Social and Cultural Rights.

Diverse gender identities and expressions

Background information

Gender identity is an internal sense or an internal awareness. For most people, it can be described as a kind of manness or woman-ness but gender is not limited to two and is not binary. An individual's gender identity may or may not correspond to their assigned sex at birth. Transgender (or trans) is a term used to describe people whose gender identity differs from their assigned sex, while cisgender is used to describe those whose gender corresponds to their assigned sex. Trans is an identity that a person chooses for themselves and is not imposed on or determined by others. Some trans people choose and/or have the resources to change their bodies through hormones or surgical operations, others do not.[1] While gender identity is internal, gender expression is how a person publicly presents their gender. This can include behaviour and outward appearance such as how someone dresses, wears their hair, if they use make-up, their body language and their voice. Disclosure of trans identity and/or having a non-conforming gender expression can bring many different social consequences in schools and health centres, among other spaces.

All people, regardless of their sexual orientation, gender identity or expression are entitled to human rights protections. They have the right to live free from discrimination, to equality, to life and to personal security, to be free from torture or degrading treatment, to expression, to privacy and to the highest attainable standard of health, among other human rights. These rights are recognized in international human rights documents ratified by the Government of Canada; yet, violations of these rights are ongoing. 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.[2] 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.

The needs of persons with non-conforming sexual orientations, gender identities and expressions are often marginalized or omitted from the planning of laws, policies and programs. This can impact the ability to access services without fear of stigma or discrimination or to seek legal recourse for violations of their rights. Service providers lacking appropriate training, for example by refusing to treat trans persons or failing to provide them with information that meets their needs and is respectful of their human rights can create barriers in access to services and information. Similarly, without access to identity documents that match the gender of their choosing, individuals may face barriers in accessing health, educational, legal and migration services, or, for fear of stigma or discrimination, may choose to delay or not access services. The majority of trans persons in Canada are required to demonstrate proof of sex reassignment surgery or other medical treatment in order to change the name and sex in official documentation. However, some provinces are making progress. In Quebec, for example, expected modifications to existing law will no longer require individuals seeking to change their gender marker to have undergone medical treatment or surgery.[3]

Other countries have also made significant progress in this area. Argentina and Colombia have recently passed legislation allowing individuals who wish to change the gender marker on official identification to simply sign a declaration – with no proof of surgery or other medical treatment required. The law in Argentina further requires public and private doctors to provide free sex reassignment surgery, including for individuals under the age of 18.[4]

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 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."[5] 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.[6] 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."[7] 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."[8]

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.[9]

It is therefore critical that specific initiatives be undertaken in order to safeguard and promote the human rights of trans persons, including the right to live free from all forms of stigma and discrimination and the right to the highest attainable standard of health. Initiatives include adding gender identity and gender expression to the list of prohibited grounds for discrimination. 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. Addressing such situations requires governments at all levels to engage in meaningful dialogue with trans persons and their allies so as to ensure their experiences and realities are considered.

The United Nations is in the process of crafting a universal framework for development for 2015-2030. A set of Sustainable Development Goals have been proposed as a way forward. The proposed goals are universal in nature and will apply to all countries, regardless of economic, social or political realities. In the context of respecting, protecting and fulfilling the rights of individuals with diverse gender identities and expressions, the following targets will therefore apply in Canada:

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

5.6 Ensure universal access to sexual and reproductive health and reproductive rights agreed in accor-

dance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

10.2 By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status

10.3 Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard

We call on the Government to:

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 publicly incite hatred based on these grounds in the Criminal Code.

Ensure all departments of the federal government who are responsible for official identification, or require proof of official documentation, including: Passport Canada, Aboriginal Affairs and Northern Development Canada, Canadian Airport Security Authority and Canada Border Services Agenda, among others, allow individuals to use their name and gender of choosing and request that whenever they do not correspond with the self-perceived gender identity or expression, the recorded sex be amended along with the changes in first name and image without requiring proof of surgical procedure for total or partial genital reassignment, hormonal therapies or any other psychological or medical treatment.

Ensure the Governor in Council and the Chief Statistician create a third gender marker on all government forms, census and other means of data collection.

Allocate funds to PHAC and other relevant departments, for awareness raising campaigns aimed at addressing stigma and discrimination experienced by persons with diverse sexual orientations, gender identities and expressions.

Establish a human rights training program for all employees of the federal government who engage with the public. The training would include specific focus on the treatment of persons with diverse sexual orientations, gender identities and expressions, ensuring that they are treated with respect, in accordance with their human rights.

Revise PHAC Sexual Health Guidelines to integrate recognition of diverse sexual orientations, gender identities and expressions, and strategies that address discrimination against trans persons recognizing that trans persons are at heightened risk of experiencing bullying and violence.

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.

Meaningfully engage persons of diverse gender identities and expressions, and allied organizations, in the design, development and implementation of laws, policies and programs that affect their lives.

Endnotes

[1] For more information see http://www.ohrc.on.ca/en/gender-identity-and-gender-expression-brochure

[2] Egale: Canada Human Rights Trust. 2011. "Every Class in Every School." http://egale.ca/every-class

[3] Government of Quebec. Ministry of work, employment, and social security. 2015. "Change of name." http://www.etatcivil.gouv.qc.ca/en/change-name.html#sexe

[4] New York Times. 2012. "Transgender advocates hail new law erasing rules in Argentina." http://www.nytimes.com/2012/05/25/world/americas/transgender-advocates-hail-argentina-law.html?_r=1

[5] R. Longman Marcellin, G. R. Bauer and 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.

[6] 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.

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

[8] 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

[9] 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 Note: While some procedures related to *sex reassignment* are covered by most provinces, the extent to which individuals can access comprehensive care varies province to province. For example, some provinces require trans people to travel out of province to access certain procedures. Other provinces have significant wait times to be seen by relevant health professionals or impose limitations on the number of procedures that can be done annually. These situations create barriers in access to timely, effective and comprehensive care, particularly for young people and those with limited access to resources.

Sex workers' rights

Background information

On DECEMBER 20th 2013, the Supreme Court of Canada (SCC) handed a unanimous ruling in Canada v Bedford, which struck down elements of the Criminal Code that were determined to violate the rights of sex workers by undermining their health and safety. The Supreme Court decided that its ruling would take effect in one year's time, at which point those unconstitutional parts of the law would no longer be in force.

In response, the federal government tabled a new piece of legislation (Bill C-36) in early June of 2014. The Protection of Communities and Exploited Persons Act (PCEPA) received royal assent on December 6th 2014, effectively criminalizing the purchase of sexual services; communicating for the purpose of purchasing and selling sexual services; receiving a material benefit from the crimes of purchasing sexual services or communicating to obtain them; procuring a person to offer or provide sexual services for consideration; and prohibiting advertising of sexual services.

With PCEPA, the federal government reinstated provisions very similar to those already found by the SCC to be harmful to sex workers' lives, health and safety, simply by rewording some of them and re-labelling provisions with new and broader objectives. This indicates that the new prostitution laws, like the old ones, are likely in violation of sex workers' Charter rights. The government's response also creates new issues of constitutional validity with the prohibition on advertising and the blanket ban on the purchase of sexual services. This approach continues to impose danger, increased criminalization, little control over working conditions and fewer safe options for sex workers. It runs contrary to the requirement of the SCC to address these dangerous and ineffective laws and does not appear to conform to the December 2013 ruling in Canada v Bedford.

The social science evidence from Canada and throughout the world clearly indicates that this type of legislation forces sex workers into unsafe and unprotected areas restricting access to important safety strategies that can have significant and profound negative consequences on sex workers' health, security, safety, equality and human rights.

This is especially alarming for people in precarious immigration situations. Canada's new sex work-related laws do not explicitly address migrant sex workers but their stated objective is to "ensure consistency between prostitution offences and the existing human trafficking offences." This means that human trafficking frameworks are being used to understand prostitution. Because migrant sex workers are often identified as "trafficked victims" and because their work is often referred to as "sexual exploitation," laws and policies criminalizing both sex work and migration lead to both racialized and sex workers of colour being specifically targeted. This puts already vulnerable populations at higher risk of criminalization and violence.[1]

The UN Special Rapporteur on the right to health has condemned the criminalization, full or asymmetrical, of sex work as violating sex workers' right to health by creating barriers to their access to health services, which can lead to poor health outcomes. Governments have an obligation to show due diligence in the protection of sex workers' human rights, including their right to health and to freedom from violence. Laws and policies must be evidence-based and address the intersecting and layered systems of oppression impacting sex workers' experiences.

Facing the facts

Right to Health the criminalization of both the selling and the purchase of sexual services:

Creates fear among sex workers that they may face legal consequences or harassment if they carry condoms and lubricant, which can be used as evidence of prostitution.[3]

Reduces sex workers' ability to negotiate safer sex with clients, on the street as well as online, or on the phone.[4]

Affects the relationship between sex workers and any service providers (such as those providing condoms and harm reduction supplies) as sex workers may fear being reported to the police, which can lead to police entrapment.[5]

Heightens risks of HIV and other sexually transmitted infections as sex workers face substantial barriers in accessing prevention, treatment, and care services, largely because of stigma, discrimination and criminalization. Decriminalization of sex work was determined to be the single most efficient structural intervention to reduce HIV infections among sex workers through reducing the risk of violence.[6]

Freedom from Violence the criminalization of both the selling and purchase of sexual services:

Invites police harassment as well as makes sex workers more vulnerable to violence as it pushes sex work underground where it is harder to negotiate safer working conditions and consistent condom use.

Increases sex workers' isolation and marginalization while it concurrently limits access to police protection and support services, as well as decreases their ability to report violence to police.

Results in sex workers having to take risks with new, less familiar or less desirable clients as they have less time to screen them and are being displaced to isolated areas as the client's fear of arrest may also have a dispersal effect.

Prevents sex workers from implementing simple safety enhancing measures such as working in pairs, working in familiar areas or having the time to consult bad date lists, which provides critical information for people to protect themselves.

Intensifies the social stigma of selling sex.

Bodily Autonomy and Women's Agency the criminalization of both the selling and purchase of sexual services:

Is a violation of the right to bodily autonomy and to have control over and decide freely upon all matters relating to one's sexuality; the new law's assumption about sex workers as women strongly links this approach with the desire to control women's sexuality.

Hinders sex workers' ability to communicate with their clients about what services they consent to provide and which ones they do not.

Rests on the incorrect conflation of consensual sex work with coercion or trafficking, which prohibits the

former. There are laws that directly target exploitation, violence and non-consensual sexual activities, including those that prohibit physical assault, sexual assault, threatening, harassment, murder, extortion, human trafficking and child exploitation.

Upholds misconceptions about sex work and sex workers: that all sex workers are women or that they are inherently victims. It posits that sex workers, and by extension women, are in essence vulnerable or in need of state protection. This approach denies sex workers, and women more generally, their agency as rational decision-makers who each navigate more or less constrained choices, as it is laden with the misbelief that no one would choose this profession.

The United Nations is in the process of crafting a universal framework for development for 2015-2030. A set of Sustainable Development Goals has been proposed as a way forward. The proposed goals are universal in nature and will apply to all countries, regardless of economic, social or political realities. In the context of respecting, protecting and fulfilling sex workers' rights, the following targets will therefore apply in Canada:

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

5.6 Ensure universal access to sexual and reproductive health and reproductive rights agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

10.2 By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status

10.3 Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard

We call on the Government to:

Protect sex workers' rights under the Canadian Charter of Rights and Freedoms and international human rights law by:

Repealing the Criminal Code sections that individually and as a whole threaten sex workers' health and safety, including the offences of purchasing sexual services; communicating for the purpose of purchasing and selling sexual services; receiving a material benefit from the crimes of purchasing sexual services or communicating to obtain them; procuring a person to offer or provide sexual services for consideration; and prohibiting advertising of sexual services.

Including sex workers in policy and law reform process as the human rights principles of participation, transparency and accountability require that sex workers must have a say in modernizing the laws and policies that affect them.

Studying the documented impacts of the Prostitution Reform Act passed in 2003 in New Zealand.

Supporting concrete measures to improve the safety of individuals selling sexual services and to assist those who wish to transition out of the sex industry, which include increasing transfer payments to the provinces and territories to enable them to ensure a social safety net by providing significant resources for income support, housing, education and training, poverty alleviation, and treatment and support for addictions.

Endnotes

[1] Canadian Alliance of Sex Work Law Reform. www.sexworklawreform.com and Supporting Women's Alternatives Network (SWAN Vancouver). 2015. "Chinese Sex Workers in Toronto and Vancouver." http://swanvancouver.ca/wp-content/uploads/2015/05/Chinese-sex-workers-in-Toronto-amp-Vancouver-Ziteng-SWAN-amp-ACSA.pdf

[2] 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

[3] Canadian Alliance for Sex Work Law Reform: factsheet "Why Decriminalization is Consistent with Public Health Goals" https://drive.google.com/folderview?id=0B-3mqMOhRg5FeLWpPd21VYTlidTA&usp=sharing&tid=0B3mqMOhRg5FeNlY4ZkxFb2pLaWM

[4] Blankenship and Koester, supra note 5, p.550;Eriksson, supra note 25, para. 5; Stridbeck, supra note 11, p.12 citing Socialstyrelsen, Kännedom om Prostitution 2003 (Socialstyrelsen, 2004); Östergren, supra note 11; Campbell and Storr, supra note 14; Pro Sentret, supra note 2, p.57

[5] Helsedirektoratet, supra note 7, p.95 to 102.

[6] The Lancet. HIV and sex workers. 2014. http://www.thelancet.com/series/HIV-and-sex-workers

Intersecting issues

Background information

This brief examines areas for potential intervention in terms of addressing issues related to sexual and reproductive health and rights. Due to their nature, the following related rights-based issues can greatly impact how individuals can exercise and claim their sexual and reproductive rights as well as access to quality sexual and reproductive health services and information, that are available to anyone regardless of race, age, religion, migration status, class, geographic location, gender, sexual orientation, and gender identity or expression, among other factors.

Recognizing the ways in which these factors intersect with sexual and reproductive health and rights, this brief reviews how, among many things, laws and policies related to family life and child care intersect with gender, race and class; how racialized individuals are more vulnerable to experiencing violence and oppression; how current immigration policies affect migrants' access to health services; how the targeted profiling and policing of racialized communities can lead to poor health outcomes and rights violations; and what physical and non-physical impacts environmental degradation has on health and well-being, and who is put most at risk. Throughout this brief, attention is drawn to the importance of establishing laws, policies and programmes that contribute to the full realization of sexual and reproductive rights for all.

Progressive policies for families

Poverty is one of the best predictors of poor health.[1] Low levels of socio-economic development facilitate the spread of sexually transmitted and blood-borne infections (STBBIs), including HIV; create challenges in access to prevention, treatment and support; and coincide with an increasing rate of unintended pregnancies.[2] When governments invest in job creation, health services and social assistance, and legislate increases in the minimum wage, children and families see improved outcomes in both the short and long term.[3] Measures that can reduce poverty rates in the community lead to better health outcomes, including sexual and reproductive health outcomes, and help limit the growing costs of treating poor health.[4]

The 1994 Programme of Action of the International Conference on Population and Development (ICPD) and the 1995 Beijing Declaration and Platform for Action make clear the linkages between human rights, bodily autonomy, poverty, dignity, sustainable development, discrimination, well-being, and sexual and reproductive health. The 1979 UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) also includes among its goals: to encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities.[5]

Building on existing international human rights law and development frameworks, reproductive justice makes central the critical intersections between racial, economic, cultural and other power structures that enable and constrain the ability of individuals, particularly women of colour, to make personal decisions about their lives, such as whether to have children, and, when parenting children, to have the ability to do so in healthy environments.[6]

Examining laws, policies and programs related to child care, pay equity, paid parental leave, and child and family tax policies, among others, therefore facilitates a more holistic approach to sexual and reproductive health and rights; these structural factors relating to social and economic rights have an impact on the ability of individuals to carry out decisions to have children without falling into poverty or to effectively parent and provide for their children. Without access to affordable child care, parents may face constraints when returning to the workforce, which contributes to reduced earnings and creates male-dominated workforces that can perpetuate gender stereotypes and violence.[7] This often has gender, class and race implications as women are more often those who exit the workforce to care for children. Racialized women who may experience multiple and intersecting forms of discrimination (along gender, age, economic, educational, and migration status lines, among others) are, among other things, further hindered in their ability to exert control over their reproductive choices and provide for their families.[8] Such situations can lead to barriers in access to support services and health care more broadly, including sexual and reproductive health care.

We call on the Government to:

Create support for families to allow them to raise their children with dignity by creating a national child care strategy that is universal, comprehensive and of high-quality.[9]

Legislate an Act to reinstate minimum national standards for provincial income assistance to ensure that welfare is accessible and adequate.[10]

Re-establish a federal minimum wage covering all workers under federal jurisdiction at CAD 15.00 per hour, indexing to inflation.[11]

Violence and oppression

Gender-based and sexual violence is rooted in gender inequality, unequal power relations, gender norms and stereotypes, and often aim to control women's choices, sexualities and bodies. Violence occurs across religions, ages, genders, socioeconomic status, among other communities and lived experiences and has profound effects on physical, sexual, reproductive, and mental health, and on levels of morbidity and mortality. These effects include, among others, HIV infection, sexually transmitted infections, alcohol abuse, depression and suicide, injuries, death from homicide, adolescent pregnancy, unintended pregnancy, nutritional deficiency, neurological disorders, disability, hypertension, anxiety and post-traumatic stress disorder.

Marginalized individuals have a greater likelihood of being subjected to violence, including those living in poverty, women and girls, people with disabilities, sex workers, racial, ethnic, religious and linguistic minorities, and lesbians and transgender women, among others. In Ontario, nearly half (46%) of high school girls in Ontario experience sexual harassment.[12] Indigenous girls face more frequent incidents of violence than non-Indigenous girls, with 17% of missing and murdered Indigenous women being under the age of 18.[13]

Regardless of the relationship or situation, violence is likely to be underreported; facing the legal or health system can be oppressive or hostile toward marginalized people, thereby making it more difficult to seek help and receive appropriate support.[14] Sexual assault rates have stagnated in the last five years, with less than 10% of sexual assaults being reported to police.[15] Those who do seek support may not be able to access the services they need due to geographic location, socio-economic status, age, and migration status, among other factors, or for fear of stigma and discrimination by service providers. These factors can often also result in delays accessing emergency contraception, counselling and other essential services.

The right to live free from violence is enshrined in international human rights law. Article 3 of the Universal Declaration of Human Rights states that everyone has the right to life, liberty and security of person. Other related rights include the right to bodily autonomy and the right to health, among others.

The UN Human Rights Council (HRC) and its special procedures have examined the issue of violence as it relates to sexual and reproductive rights. The 2009 UN HRC resolution on Violence against Women[16] specifically addressed issues related to sexuality and sexual rights including the elimination of policies and practices that violate the human rights of individuals to have control over and make decisions related to their sexuality. The UN Special Rapporteur on Violence against Women has similarly said that in recognizing women's sexual and reproductive autonomy, rather than protecting women's sexual purity, one can tackle the roots of gender-based violence.[17] Addressing the root causes of gender-based violence requires the adoption of a holistic approach to discrimination and violence. In meeting their human rights obligations, efforts initiated by States must extend beyond immediate health outcomes to include strategies across sectors, involving legal, economic, social and political considerations.

We call on the Government to:

Develop a national strategy to address violence against women that is holistic, gives full effect to the sexual rights of women and girls, and includes concrete measures to address the issue of missing and murdered Indigenous women.[18]

Immigration

Recent cuts to health care for refugees and changes in immigration law disproportionately affect refugee women.[19] The removal of coverage for sexual and reproductive health, including labour and delivery, put refugee women at particular risk as it bars some claimants from getting pre/post-natal and delivery care, as well as limiting access to contraception, cancer screenings, abortion services, and supports in cases of intimate partner violence.[20] Supporting equitable access to health care for migrants and specifically migrant women is therefore paramount, regardless of refugee, immigration or marital status, in addition to developing policies and programs that are grounded in human rights and uphold the principle of universality in the *Canada Health Act*.

The recently passed "so called" *Zero Tolerance for Barbaric Cultural Practices Act*[21] similarly poses substantial risk of creating significant barriers for non-citizens, or those in precarious immigration situations, to access health and other support services, including the sexual and reproductive health services they need. It does so by identifying forced marriages as a separate criminal offence in Canada, which, according to research, creates barriers in access to and deters survivors of forced marriage from seeking support services,[22] including sexual and reproductive health services. The criminalization of forced marriage creates barriers in access to health services out of fear that the health professional will report the individual, which could result in a loss of immigration status, stigma and discrimination associated with reporting forms of domestic violence, and fear that health professionals lack the training to provide appropriate support services.[23] Experts also argue that criminalization could become a tool for police to further profile and harass racialized communities,[24] coupled with the reality that there is no evidence to support that the criminalization of forced marriage would in fact serve to prevent it.[25]

International human rights law requires States to respect, protect and fulfil human rights, without distinction of any kind, including on the basis of migration status. These rights include the right to health, including sexual and reproductive health. UN human rights bodies have outlined that States are obligated to provide access to health care services for all, including migrants regardless of legal status and documentation.[26] States are similarly required to *respect the right of non-citizens to health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services.*[27]

We call on the Government to:

Restore Interim Federal Health coverage for refugees and refugee claimants as it existed before the 2012 changes so as to ensure all individuals in Canada have access to health care, especially sexual and reproductive health services, regardless of immigration status. This includes the removal of waiting periods for temporary and permanent residents to access health care and the provision of health care coverage to undocumented people.

Repeal the Act to amend the Immigration and Refugee Protection Act, the Civil Marriage Act and the Criminal Code and make consequential amendments to other acts, ensuring that women's anti-violence experts, survivors of violence, and service providers, among other experts, are consulted in developing relevant proposed changes to the immigration and criminal justice systems.[28]

Increase funding to Citizenship and Immigration Canada to improve the quality of and access to settlement services, including sexual and reproductive health services, to meet the needs of all migrants, regardless of status.

Criminalization and the justice system

Longstanding forms of systemic racism, and other types of discrimination, have resulted in the targeted profiling, policing and criminalization of marginalized populations in Canada. Racialized and 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.*[29] Indigenous women make up 36% of all young women incarcerated.[30] In 2011, the Correctional Investigator of Canada reported an 80% increase in Black prisoners in federal jails over the last decade, making Black people the fastest growing prison population in Canada – despite Canada's Black population representing just 2.5% of the total population.[31] Given the disproportionately high rates of incarceration among racialized and 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.[32] Longer sentences increase the likelihood of poor health outcomes of those who are incarcerated, especially related to sexual and reproductive health. High rates of incarceration also deeply impact communities as a whole; research shows that the impact of incarceration extends beyond those individuals who are themselves incarcerated.[33] In particular, incarcerating mothers is commonly associated with negative implications for her family and especially her children,[34] including depression, anger, poor school performance, and environmental disruptions.[35]

There are significant issues concerning sexual and reproductive health and rights in prisons. HIV and Hepatitis C rates are on the rise and the sexual and reproductive rights of incarcerated Indigenous persons, in particular, are often violated, including through the *shackling of pregnant women also while in labor, coerced sterilization and sexual violence from prison staff and guards*[36] and the absence of effective facilities for incarcerated mothers.[37]

Current patterns of incarceration put those who are more likely to become incarcerated, specifically Indigenous persons and racialized communities, more susceptible to contracting STIs and HIV.[38] The rise in STI rates can be attributed to the lack of effective harm reduction policies, 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.[39] 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.[40]

Realizing incarcerated individuals' right to health requires not only addressing their immediate needs, through for example, information required to prevent the transmission and treat STIs, including HIV, but also strategies to address the underlying determinants of health – which include systemic stigma and discrimination that lead to disproportionately high rates of STIs among racialized communities in Canada. According to the UN Committee on Economic, Social and Cultural Rights (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.*[41] Meeting the sexual and reproductive health needs of incarcerated individuals – and particularly racialized individuals in Canada who are disproportionately criminalized and incarcerated – therefore requires addressing immediate health needs as well as underlying root causes of discrimination and other social determinants of health.

We call on the Government to:

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, free of charge. This must include strategies to address increasing STI transmission rates by repealing the law established through the enactment of Bill C-2 An Act to amend the controlled drugs and substances act and by establishing evidence-based prevention, harm reduction and treatment services,[42] including needle exchange programmes, to be implemented in all federal prisons and urban centres.

Address systemic forms of racism, and other forms of discrimination, that result in the targeted profiling, policing and criminalization of marginalized populations, and the poor sexual and reproductive health outcomes that result, by:

- **Addressing the overrepresentation of Indigenous and other racialized groups in custody over the next decade**, and issue detailed annual reports that monitor and evaluate progress in doing so.[43]

- **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.[44]

- **Amending the Criminal Code to allow trial judges, upon giving reasons, to depart from mandatory minimum sentences** and restrictions on the use of conditional sentences.[45]

Environment

Realizing the right to health includes *a wide range of socio economic factors that promote conditions in which people can lead a healthy life, and 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.*[46] The UN Committee on Economic, Social and Cultural Rights (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 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.*[47]

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.[48] Indigenous communities in Canada, and globally, are at great risk of experiencing these health outcomes, which represent violations of the right to health. According to the Native Youth Sexual Health Network, *the manufacture and export of harmful products to other, primarily developing, countries is unethical and unjust, and violates the rights to health and life of all peoples in developing countries, with greater impact on Indigenous Peoples, particularly women and children.*[49] 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.[50]

Indigenous rights groups 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.

We call on the Government to:

Take measures to restore the sexual and reproductive health of individuals and communities affected by environmental degradation 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 extractives industries and the use of pesticides.[51]

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.[52]

The United Nations is in the process of crafting a universal framework for development for 2015-2030. A set of Sustainable Development Goals has been proposed as a way forward. The proposed goals are universal in nature and will apply to all countries, regardless of economic, social or political realities. In the context of the issues discussed above, the following targets will therefore apply in Canada:

1.3 Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable

1.5 By 2030, build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and nonviolence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including tra¬cking and sexual and other types of exploitation

5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

8.8 Protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment

10.2 By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status

10.3 Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard

10.4 Adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality

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[52] 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

BACKGROUND INFORMATION AND RECOMMENDATIONS FOR CANADA ON KEY ISSUES RELATED TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: FOREIGN POLICY

In anticipation of the 2015 federal election, Action Canada for Sexual Health and Rights has produced a series of thematic briefs outlining what actions we think the Government of Canada should take on a range of sexual and reproductive rights related issues in the coming years. This section focuses on how the Government of Canada can re-establish itself as a global leader on gender equality, sexual and reproductive health and rights and the advancement of human rights more broadly.

Canadian global policy on sexual and reproductive rights
Engagement in multilateral institutions and intergovernmental spaces
Supporting access to abortion services

These briefs are intended for a range of stakeholders including individuals, organizations, collectives, political parties and government officials, among others, in thinking ahead toward the actions we want the federal government to take in guaranteeing sexual and reproductive rights globally.

Canada was once a leader on gender equality and human rights, including sexual and reproductive rights. But in recent years, this reputation has diminished. Government of Canada spending on aid has plateaued at 0.24% Gross National Income, 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 related to sexual and reproductive rights.

The Government of Canada has also recently disengaged from global decision-making processes and decreased its support for multilateral institutions. On this issue, Action Canada has developed a brief that looks at how the Government can meaningfully re-engage with multilateral organizations and in intergovernmental spaces, like the United Nations, looking specifically at the advancement of sexual and reproductive rights, gender equality and human rights.

This re-engagement must be undertaken within the context of a broader strategy. As such, Action Canada is calling for the development of a Global policy on sexual and reproductive rights. This would be accompanied by strong accountability mechanisms, strategies to engage a diverse range of stakeholders in its development, monitoring and evaluation, as well as funding for its effective implementation. The policy would also put an end to the current refusal to fund abortion services abroad. For too long, the Government of Canada has adopted an ideological stance on this issue by ignoring women's human rights and international guidance.

Policy on sexual and reproductive rights

Background information

This brief examines how the Government of Canada can re-establish itself as a global leader on gender equality, sexual and reproductive rights and the advancement of human rights, more broadly.

In the past, Canada has had a strong reputation of being a leader on these issues. But in recent years, this reputation has 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. In addition, there has been a general disengagement from global decision-making processes and a decrease in Canada's support for multilateral institutions. Canada has the potential to re-establish itself as a leader on these issues, but strategic guidance, resources and political will are required. What is needed is a **Canadian Global Policy on sexual and reproductive rights** that would guide Canada's overseas development efforts both in terms of foreign policy and international development.

A tranformative vision

The Policy would build on existing successes and resources (as they relate to sexual and reproductive rights, gender equality and human rights in the Canadian overseas development context)[1] to incorporate a human rights-based approach into Canadian development policies and programs in accordance with the Official Development Assistance Accountability Act.

A human rights-based approach to sexual and reproductive health was promoted at both the 1994 International Conference on Population and Development (ICPD)[2] and the 1995 Fourth World Conference on Women in Beijing. The ICPD Programme of Action commits governments to ensuring the realization of reproductive rights for all, including women and adolescents, and to providing a comprehensive range of sexual and reproductive health information and services. The Beijing Platform for Action recognizes that women's human rights *include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.*[3] Beyond these development frameworks, the work of the UN Human Rights Council and its special procedures and resolutions have further articulated a human rights-based approach to sexual and reproductive health and how it can be applied to policy formulation, institutional strengthening and program design, implementation and evaluation. This includes the *UN Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality.*[4]

The Canadian Global Policy on sexual and reproductive rights would comprise an important part of the Government of Canada's foreign and development policies and would support government efforts in its diplomatic engagements and in its development programs and strategies. It would contain elements related to:

Providing a comprehensive and integrated package of sexual and reproductive health services and information, with a focus on the needs of adolescents and youth, and marginalization related to sexuality and reproduction

In meeting their human rights obligations, governments, with the support of donor actors, are required to provide individuals with a comprehensive package of sexual and reproductive health information and services.[5] In providing this package, under international human rights standards concerning the right to health, governments are obligated to ensure the availability, accessibility, acceptability and quality of health information and services and to remove any barriers to access.[6] The Policy must signal that the Government of Canada supports the assisting of governments and UN agencies or other multilateral actors to ensure universal access to a comprehensive and integrated package of sexual and reproductive health information and services, consistent with international human rights standards.

Sexual and reproductive health cannot be realized through the provision of services alone. The dominant assumptions underlying the structural determinants of sexual and reproductive health of different population groups must be identified and addressed. The Policy must therefore recognize changing systems of power and decision-making at all levels and in all spaces, including the household, community, workplace, State and non-State institutions at a local, national, sub-regional, regional and international level, and address root causes of various forms of gender and social inequalities. It must also consider the ways in which multiple and intersecting forms of discrimination and stigma create both barriers in access to essential health services and information that lead to poor health outcomes, and the perpetuation of harmful taboos and practices around sexuality and reproduction.[7] The Policy must reflect a commitment to work across sectors and include capacity building for those working outside of the health system.

There is significant evidence from the HIV/AIDS response that demonstrates the pitfalls associated with creating silos in HIV prevention, treatment and care. Services that are integrated across health issues and sectors, lead to greater success and contribute to positive outcomes beyond those anticipated.[8]

Support in this area should not replace the Governments' responsibility to improve health systems but rather aim to strengthen the capacity of national health systems in advancing sexual and reproductive rights.[9] The Government should therefore avoid the creation of parallel health systems by working in collaboration with existing infrastructure and government mechanisms.[10]

Prioritizing gender equality and women's empowerment, including support for women's rights organizations

Gender equality and women's empowerment is central to the realization of sexual and reproductive rights. Support for such rights enables women to make the best possible decisions regarding their lives and aspirations by empowering them with the ability to decide if, when and how to have children; if, when and whom to marry; and which sexual and reproductive health options are best for them, among a vast number of other choices.

Discriminatory laws and policies and harmful practices however continue to violate the sexual and reproductive rights of women and girls. They include laws that criminalize abortion, impose spousal consent requirements, failing to criminalize marital rape, female genital mutilation, early and forced marriage, and others. These violations are rooted in gender norms and stereotypes that seek to control women's bodies and sexualities. The Policy must therefore support multi-tiered approaches that involve addressing the underlying determinants and drivers of gender-based inequalities, gender norms and stereotypes, adolescent pregnancy, poverty, sexual violence, harmful cultural and religious traditions, and the legal, social and economic barriers that interfere with women's and girls' access to information and services, among others.

In conjunction with this, specific attention must be paid within the Policy to strengthening the capacities of women's rights organizations, and other organizations working to advance sexual and reproductive rights, who are actively engaging in policy dialogue geared at changing laws and policies that impede the realization of sexual and reproductive rights.[11] The Policy must recognize the need to support such organizations and advocates in ways they find supportive so that they can influence the design, implementation and evaluation of initiatives.

Supporting comprehensive sexuality education

Young people and adolescents often experience heightened levels of stigma and discrimination, which can lead to barriers in their access to sexual and reproductive health information and services. This is often grounded in the failure to recognize young people as sexual beings, while in reality, sexual health is a key component of overall health and well-being. Young people and adolescents are entitled to accurate, scientific, and human rights-based sexual and reproductive health information that is appropriate to their age and stage of development, providing them with the tools to make informed choices that are conducive to their sexual health.[12] Comprehensive sexuality education that provides young people with the skills to navigate their way in this diverse, digital world has to go beyond biology. As outlined by the High Level Task Force for the International Conference on Population and Development, it needs to be *understood as age-appropriate education about human rights, human sexuality, gender equality, relationships, and sexual and reproductive health through the provision of scientifically-accurate, nonjudgmental information and the development of decision-making, critical thinking, communication and negotiation skills.*[13]

Comprehensive sexuality education aims to eliminate gender norms and stereotypes, discrimination and stigma while embracing diversity and respect for the evolving capacities of children and youth. It is a key intervention for gender transformative approaches that seek to address gender stereotypes and norms that perpetuate gender-based violence and harmful practices including early and forced marriage and female genital mutilation. Resources are required not only to implement comprehensive sexuality education curricula across all age groups, in and out of school, but also to support advocates in engaging in curriculum reform and in holding governments accountable to their commitments.

Through this Policy, the Government can play a role in advancing international norms and standards by advocating for the creation of a technical guidance for states to use in the application of a human rights-based approach to the implementation of policies, programs and curricula on comprehensive sexuality education and sharing best practices.

Engaging in bilateral human rights dialogue

The Government of Canada is well positioned to mobilize its experienced and seasoned diplomats at local and regional levels for the advancement of sexual and reproductive rights, beyond the implementation of development initiatives. The Policy can guide this by establishing a framework and allocating resources for this work. Work in this regard could include engaging in policy dialogue with national counterparts in relevant Ministries regarding laws, policies and programs related to sexuality and reproduction with a view to ensuring that those inconsistent with human rights[14] are removed or reformed. Work in this area could also include consultation with civil society organizations, including women's rights organizations and women human rights defenders, on their priorities for the advancement of sexual and reproductive rights.

Ensuring effective and appropriately resourced accountability mechanisms

Accountability is central to every stage of a human rights-based approach and includes transparency as well as meaningful participation by all affected populations and civil society groups at all levels of decision-making, implementation and review, and access to justice.[15] UN guidance emphasizes that it is also essential that rights-holders are aware of their entitlements and are empowered to claim their sexual and reproductive rights, including rights to sexual and reproductive health. The Policy should therefore pay particular attention to marginalized groups, such as adolescents, ethnic and racial minorities, Indigenous women, persons with disabilities, sex workers, persons living with HIV, transgender persons, men who have sex with men, women who have sex with women, migrant and displaced persons and rural women, by carrying out participatory consultations and reviews of legal frameworks.[16]

The Policy must similarly support initiatives that strengthen administrative, political and national legal accountability,

which together create stronger health systems, greater alignment with international human rights norms and standards, and mechanisms for individuals to hold their governments accountable when failing to meet their human rights obligations.

Collaborating with multilateral institutions working to advance sexual and reproductive rights, gender equality and human rights

The Policy must complement the existing initiatives and evidence base of multilateral institutions working in the area, which include: the United Nations Population Fund (UNFPA), UN Women and the Office of the High Commissioner for Human Rights (OHCHR). These agencies possess the technical experience and local, regional and global offices and partners to strengthen the implementation of sexual and reproductive rights-related initiatives. They are also highly engaged in efforts to advance sexual and reproductive rights at local, regional and global levels; in the production of evidence to defend and support initiatives aimed at eliminating discriminatory laws and policies; in supporting the establishment and strengthening of mechanisms to provide redress of human rights violations; in coordinating donor efforts at local levels; and in producing expert opinions on a range of sexual and reproductive rights-related issues, among other activities.

From vision to action

Specific processes for the Policy's development, implementation, monitoring and evaluation could include: regular and ongoing consultation with a range of stakeholders; accountability mechanisms; a regular reporting schedule with quantitative and qualitative targets and indicators; and resources for its effective implementation. Within this, specific individuals, including the Minister of International Development and the Minister of Foreign Affairs, would be identified as responsible for reporting on the implementation of the Policy in the annual Report on Plans and Priorities. A range of stakeholders should be involved in the development of the Policy and its regular review. They should include civil society organizations in Canada and globally working to advance sexual and reproductive rights, young people and adolescents, women human rights defenders, government development and foreign policy experts, academics, and UN officials, among other experts. Funding for the implementation of the Policy must expand beyond existing funding commitments[17] to include resources specifically allocated for effective implementation.

We call on the Government to:

Task the Minister of International Development and the Minister of Foreign Affairs to initiate the creation of a Canadian Global Policy on sexual and reproductive Rights with support from a range of diverse stakeholders for its development, implementation and evaluation.

Meet the international commitment of 0.7% GNI to official development assistance, which includes adequate funds for the implementation of the Policy.

Meet and exceed the commitment of 10% of official development assistance for sexual and reproductive health information and services, as agreed to during past International Parliamentarians Conferences on the Implementation of the International Conference on Population and Development.

Build the capacities of all diplomatic and development officials to effectively implement the Policy, ensuring they possess the skills required to do so working with actors across all sectors.

Apply the Policy to transform the Muskoka Initiative on Maternal, Newborn and Child Health, by integrating a strong focus on human rights, gender equality and sexual and reproductive health and rights.

Endnotes

[1] Some of which include the 1999 CIDA Gender Equality Policy, existing development priorities such as: Children and Youth, Gender Equality, and Maternal, Newborn and Child Health and the 2015 International Development and Humanitarian Assistance Civil Society Partnership Policy.

[2] Programme of Action of the 1994 International Conference on Population and Development. http://www.unfpa.org/icpd

[3] 1995 Beijing Declration and Platform for Action. http://www.un.org/womenwatch/daw/beijing/platform/

[4] UN Human Rights Council. 2012. "Technical Guidance on the application of a human rights-based approach to the implementation of programmes to reduce preventable maternal mortality and morbidity." http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf. The guidance asserts that a human rights-based approach views health holistically. Health systems must be just and particular attention must be paid to marginalized groups. Meaningful participation of marginalized groups is required in the identification of problems, policy design and budget allocation, and the evaluation of programmes and policy implementation. Simultaneous attention must be paid to health interventions and social transformation in order to guarantee rights to sexual and reproductive health. Gender-based discrimination and violence must be eliminated as well as other social inequalities. Duty-bearers are required to use maximum available resources, including resources from international cooperation, for the progressive realization of rights to sexual and reproductive health. Related to this, the Policy would integrate the principles outlined in the UN's Guiding Principles on Business and Human Rights, which in the context of sexual and reproductive rights includes the application of human rights principles to partnerships with pharmaceutical companies and other actors involved with the delivery of sexual and reproductive health services. http://www.ohchr.org/Documents/Publications/GuidingPrinciplesBusinessHR_EN.pdf

[5] Information and services include contraception and family planning; safe abortion services and post-abortion care; pregnancy care (antenatal and post-natal care, skilled birth attendance, referral systems, and emergency obstetric care); assisted reproductive technologies; prevention, treatment, and care of sexually transmitted infections and HIV; prevention and treatment of infertility; and prevention, treatment and care of reproductive cancers, provided in an integrated manner.

[6] High Level Task for ICPD. 2013. "Policy Recommendations for the ICPD Beyond 2014: sexual and reproductive health for all." http://icpdtaskforce.org/resources/policy-recommendations-for-the-ICPD-beyond-2014.pdf

[7] Young people and adolescents are often denied their sexual and reproductive rights because they are not seen as sexual beings. They can experience stigma and discrimination at the hands of services providers, face legal and regulatory barriers that require parental consent, and other barriers. Those with non-conforming gender identities, expressions and sexual orientations can face similar barriers in health settings which can limit their access to health services and information which can lead to poor health outcomes.

[8] Evidence to Policy Initiative. 2012. "What is the Impact of Integrating HIV with Maternal, Neonatal, and Child Health Services?" http://globalhealthsciences.ucsf.edu/sites/default/files/content/ghg/e2pi-hiv-mnch-integration-policy-brief-may-2012.pdf

[9] Office of the High Commissioner for Human Rights. 2012. "Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity." http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

[10] Office of the High Commissioner for Human Rights. 2012. "Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity." http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

[11] Such laws and policies include third-party authorization requirements for adolescents' access to contraception, abortion and HIV testing and counselling; laws criminalizing abortion or imposing restrictions on the conditions under which an abortion can be sought; laws criminalizing adult consensual sexual activity; laws criminalizing unintentional transmission of HIV; and laws and policies allowing conscientious objection of a provider to hinder women's access to a full range of services.

[12] Comprehensive sexuality education is recognized as a basic human right of all children and youth in the annual report of the UN Special Rapporteur on the right to education to the UN General Assembly in 2010, General Comment No. 4 of the UN Committee on the Rights of the Child, and General Comment 14 of the UN Committee on Economic, Social and Cultural Rights. (UN General Assembly. 2010. Report of the United Nations Special Rapporteur on the right to education. http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/462/13/PDF/N1046213.pdf?OpenElement, UN Committee on the Rights of the Child. 2003. General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child. http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G03/427/24/PDF/G0342724.pdf?OpenElement, and UN Committee on Economic, Social and Cultural Rights. 2000. General Comment No. 14: The right to the highest attainable standard of health.) Both Committees recognize that young people's and adolescents' right to access education and information is essential for their health, including sexual and reproductive health.

[13] High Level Task Force for the International Conference on Population and Development. 2013. "Policy recommendations for the ICPD beyond 2014: sexual and reproductive rights for all." http://icpdtaskforce.org/resources/policy-recommendations-for-the-ICPD-beyond-2014.pdf

[14] For example, those which criminalize specific types of consensual sexual activity or impose barriers for specific groups such as adolescents or women on access to sexual and reproductive health services and information.

[15] Office of the High Commissioner for Human Rights. 2012. "Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity." http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

[16] Office of the High Commissioner for Human Rights. 2012. "Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity." http://www2.ohchr.org/english/issues/women/docs/A.HRC.21.22_en.pdf

[17] For example, 'Saving Every Women, Every Child,' 'Global Financing Facility, in support of 'Every Women, Every Child,' among others.

Multilateral and intergovernmental spaces

Background information

In the past, the Government of Canada was a strong leader on gender equality and women's rights, sexual and reproductive rights and human rights, more broadly. Canada led the creation of the position of the UN Special Rapporteur on violence against women, the Convention on the Rights of the Child, the drafting of the UN Security Council resolution on women, peace and security (1325) and the 1999 Canadian International Development Agency (CIDA) Policy on Gender Equality, which, at the time, received international recognition.

For a number of years, the Government of Canada has been much less engaged in key intergovernmental decision-making spaces.[1] Rather than actively participating in advancing forward-looking global policies on a broad range of sexual and reproductive rights issues, the Government of Canada has stepped back from this approach, often taking a back seat in such discussions. While the Government has championed a few specific sexual and reproductive rights-related initiatives (i.e. child, early and forced marriage, sexual orientation, and maternal health) it has also, in other negotiations, put forward regressive proposals or prevented the advancement of sexual and reproductive rights within intergovernmental negotiations. A key example of this is Canada's role in chairing negotiations of the annual UN Human Rights Council resolution on violence against women. While it is an important annual resolution in which sexual and reproductive rights-related policy is often advanced, in 2013, Canada used its position as chair to block proposals that would reaffirm reproductive rights and include safe abortion where legal among the package of services to which survivors of sexual violence are entitled. Canada's blocking of a number of sexual and reproductive rights proposals in the 2014 negotiations of the same resolution led a group of 18 states, all traditional allies of Canada, to withdraw their co-sponsorship of the resolution.

This trend extends to other negotiation spaces, where the Government has failed to propose constructive and progressive suggestions that seek to advance sexual and reproductive rights and even when asked to endorse such efforts made by traditional allies (including the US, the UK, the Netherlands, and others), the Government of Canada has refused to sign on. One such example is from 2014, when Canada shared a seat with the US and Israel during the preliminary negotiations of the Post-2015 development agenda. Despite the expectation that those sharing a seat would deliver joint statements, when presented the opportunity to endorse statements on issues related to sexual and reproductive rights, Canada withdrew, leaving the US and Israel to deliver joint statements covering these topics, without Canada.[2]

The Government of Canada has an opportunity to again be a leader on sexual and reproductive rights and gender equality by developing a strategy to guide foreign policy efforts in this area. Such a strategy would need to work with partners to ensure the advancement of global policy on these issues by proposing and supporting progressive sexual and reproductive rights language in intergovernmental negotiating spaces. Such a strategy would also need to include elements related to engaging in bilateral human rights dialogue, building the capacities of government officials to be effective advocates for these issues, and seeking the perspective of civil society organizations and Indigenous organizations engaged in local, national and global human rights advocacy by meaningfully engaging them in decision-making processes, among other activities.

Advancing sexual and reproductive rights in intergovernmental spaces includes giving visibility to a broad range of under-addressed issues that include, for example, abortion rights, marital rape, discriminatory laws and policies, harmful traditions rooted in gender norms and stereotypes, comprehensive sexuality education, sexual rights, sexual orientation, gender identity and expression, emergency contraception, positive conceptions

of sexuality and reproduction, adolescents access to sexual and reproductive health services, and stigma and discrimination, among others.

Civil society organizations and Indigenous organizations working on sexual and reproductive rights and other relevant experts can support governments in advancing sexual and reproductive rights by providing technical expertise, offering diverse and unique perspectives and existing stakeholder networks, including service providers, institutions, etc., among others. Governments can take advantage of the strengths that sexual and reproductive rights activists and organizations bring by engaging in regular, meaningful consultation, inviting them to be a part of official governmental delegations, and by supporting an enabling environment for civil society.

Meeting and advancing obligations and commitments

The international human rights framework provides scope for the advancement of sexual and reproductive rights both in Canada and globally. Using intergovernmental forums and processes, such as the Universal Periodic Review,[3] Canada can play an important role in encouraging other governments to meet their human rights obligations, as they relate to sexual and reproductive rights. In Canada, the Government can take action on treaties and protocols that it has yet to ratify, which include: the Convention on the Protection of the Rights of all Migrant Workers and Members of their Families; the Convention on the Protection of All Persons from Enforced Disappearances; the Optional Protocol to the Convention against Torture; the Optional Protocol[4] to the International Covenant on Economic, Social and Cultural Rights; the Option Protocol to the Convention on the Rights of the Child on a communications procedure; and the Optional Protocol to the Convention on the Rights of Persons with Disabilities.

In addition to meeting human rights obligations, the upcoming adoption of the UN Sustainable Development Goals (SDGs), which will set the global development agenda for the next 30 years, represents an opportunity for governments to take stock of what has been achieved and the challenges that remain, and to chart a path forward in the pillars of sustainable development: social, economic and environmental. Unlike its predecessor, the Millennium Development Goals (MDGs), the proposed SDGs are universal in nature and will apply to all countries, regardless of economic, social or political realities. In Canada and globally, the Government must establish SDG implementation plans that: seek to include human rights standards in these substantive areas; operationalize human rights principles;[5] clearly delineate responsibilities among levels of government and specific departments, and across sectors; and include support for monitoring mechanisms involving governmental sectors, parliamentarians, academic experts, development partners and donors, Indigenous organizations and civil society—especially women's, youth and other organizations representative of especially excluded groups and diverse constituencies.

Such action plans must recognize relevant substantive human rights obligations and the commitments made under existing development frameworks, including the Programme of Action of the 1994 International Conference on Population and Development, the 1995 Beijing Declaration and Platform for Action, and the 2007 UN Declaration on the Rights of Indigenous Peoples, among other commitments. They must also be accompanied by adequate funding for their effective implementation and to meet existing financing commitments to assist other countries in meeting their human rights obligations.

Support for multilateral institutions

In an ongoing effort, Canada must increase its support for UN agencies and institutions; they remain at the forefront of the advancement of technical guidance, capacity building, intergovernmental negotiations, and development assistance as related to sexual and reproductive rights. And while aid levels continue to increase at the global level, support for multilateral institutions, particularly those working on sexual and reproductive rights, and human rights more broadly, has stagnated. Despite the fact that human rights is recognized as one of the three UN pillars, the human

rights programme receives just 3% of the Secretariat's regular budget.[6]

In recent years, UN agencies have also experienced increases in support for earmarked funding streams (i.e. project-based funding or initiative specific funding) at the expense of support for core-funding. This often prevents agencies from maintaining support for long-term initiatives that are central to the agency's mandate. Stability in core funding also enables the agencies to respond more effectively to the development needs of countries.[7] Agencies working specifically on sexual and reproductive rights, gender equality and human rights, more broadly, receive considerably less funding than other UN agencies. For example, in 2014, the United Nations Population Fund (UNFPA) reported just over one billion in contributions, and UN Women reported $322 million, compared to the United Nations Children's Fund (UNICEF) and United Nations Development Programme (UNDP) each reporting over four billion in 2013.[8]

We call on the Government to:

Constructively re-engage in intergovernmental negotiations at the UN and in other multilateral fora and, working with government and NGO partners, seek to advance a robust and progressive agenda for sexual and reproductive health and rights, gender equality and human rights.

Continue to chair negotiations of the resolution on violence against women at the UN Human Rights Council, ensuring the contents of each resolution progressively integrate relevant gender equality and sexual and reproductive rights issues.

Support the meaningful participation of representatives from civil society and Indigenous organizations in Canada on official governmental delegations, with open and transparent decision-making processes for the selection of such representatives, ensuring adequate participation of traditionally marginalized groups.

Support ongoing capacity-building of DFATD, parliamentarians, and other relevant stakeholders by global experts on a range of thematic issues, including sexual and reproductive health and rights, human rights, gender equality, etc.

Provide leadership in the G7 and G20 to transform the Muskoka Initiative on maternal, newborn and child health such that sexual and reproductive health and rights are central components of the initiative.

Establish action plans and strategies for the implementation of the Sustainable Development Goals both in Canada and globally that operationalize human rights principles and that in doing so, engage a diverse range of stakeholders in consultations, with dedicated resources for the establishment of a human rights-based accountability mechanism to monitor progress with transparent reporting mechanisms.

Ratify the Optional Protocol to the Convention against Torture; the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights; the Convention on the Protection of the Rights of all Migrant Workers and Members of their Families; the Optional Protocol to the Convention on the Rights of the Child; the Optional Protocol to the Convention on the Rights of Persons with Disabilities; the Convention on the Protection of All Persons from Enforced Disappearances; and fully adopt and implement the United Nations Declaration on the Rights of Indigenous Peoples.

Increase funding for multilateral organizations working to advance gender equality, and sexual and reproductive health and rights, and human rights, including: UNFPA, UN Women, and OHCHR.

Endnotes

[1] Globe and Mail. 2014. "Canada's decade of diplomatic darkness." http://www.theglobeandmail.com/globe-debate/canadas-decade-of-diplomatic-darkness/article20745304/

[2] Remarks by Ambassador David Roet, Israel Deputy Permanent Representative to the United Nations, for the US and Israel, 8th Session of the SDG Open Working Group, on Promoting Equality, including Social

Equity, Gender Equality and Women's Empowerment. February 6, 2014. https://sustainabledevelopment.un.org/content/documents/7577us14.pdf; remarks by Ambassador Elizabeth Cousens, U.S. Representative to ECOSOC, for the US and Israel, 4th Session of the SDG Open Working Group, on Health and Population Dynamics. June 19, 2013. https://sustainabledevelopment.un.org/content/documents/7542us7.pdf; and remarks by Ambassador Elizabeth Cousens, U.S. Representative to ECOSOC, for the US/Canada/Israel Team, 10th Session of the SDG Open Working Group, on Consolidation of Focus Areas: Gender Equality and Women's Empowerment, Education, Employment and Decent Work for All, Health and Population Dynamics. April 1, 2014. https://sustainabledevelopment.un.org/content/documents/8462us18.pdf

[3] The Universal Periodic Review (UPR) mechanism of the UN Human Rights Council has also been effective in raising questions and recommendations to States to address the non-implementation and violation of sexual and reproductive rights. The pressure and review before all Member States by the UN has pushed many States to take steps to affirm sexual rights. For more information, visit http://sexualrightsinitiative.com/universal-periodic-review/upr-toolkit/

[4] Optional Protocols on communications procedures allow individuals to initiate complaints against States who fail to meet their human rights obligations found in the treaty, once domestic remedies have been exhausted. UN Committees that oversee international human rights treaties and associated complaints mechanisms support States in meeting their human rights obligations by providing them with concrete measures to address violations and denials of rights. Optional Protocols support States in maintaining transparent and democratic decision-making at all levels of government.

[5] Operationalize human rights principles that include: non-discrimination, transparency, accountability, participation, empowerment, sustainability, and international cooperation.

[6] OHCHR Management Plan. 2014-2017: Working for your rights. http://www2.ohchr.org/english/OHCHRreport2014_2017/OMP_Web_version/media/pdf/0_THE_WHOLE_REPORT.pdf

[7] UNFPA. 2014. Annual Report. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_annual_report_2014_en.pdf

[8] UNFPA. 2014. Annual Report. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_annual_report_2014_en.pdf UNICEF. 2014. Annual Report. http://www.unicef.org/publications/files/UNICEF_Annual_Report_2013_web_26_June_2014.pdf UN Women. 2015. Annual Report. http://www.unwomen.org/~/media/headquarters/attachments/sections/library/publications/2015/annual%20report%202014-2015%20(1).pdf UNDP. 2014. Annual Report. http://www.undp.org/content/dam/undp/library/corporate/UNDP-in-action/2014/UNDP_AR2014_english.pdf

Access to abortion services

Background information

Ministerial announcements since 2010 have made it clear that Canadian foreign aid will not be put toward safe abortion services. Canada's refusal to fund abortion services abroad is not a written policy, and therefore has not been subjected to Parliamentary scrutiny. The refusal represents an ideological stance that is not guided by medical evidence or best practice.

The World Health Organization (WHO) estimates that 22 million unsafe abortions are performed each year, which account for 13% of maternal deaths worldwide. In the year 2008 alone, 47,000 women died and an estimated 5 million more experienced temporary or permanent disability as a result of unsafe abortions.

Over 14 million girls are forced into marriage each year and an estimated 90% of adolescents who give birth are married. Married girls are twice as likely to experience sexual violence, encounter unwanted pregnancies and seek unsafe abortions.

Despite legal restrictions and social barriers to accessing abortion services and the lack of availability of safe services in developing countries, abortion rates are higher than in other parts of the world. This reality clearly indicates that restrictions on abortion do not reduce abortion rates; they force women to resort to clandestine, illegal and unsafe services putting their health and lives at risk.

The Government of Canada's current practice overseas contradicts Canada's domestic stance on the issue. In accordance with the 1988 Supreme Court of Canada decision in Canada v. Morgentaler, there are no laws restricting access to abortion in Canada. The decision found that the existing legislation surrounding the regulation of abortion violated section 7 of the Canadian Charter of Rights and Freedoms by infringing upon a woman's right to security of the person. The decision clarified that restrictions on access to abortion were discriminatory, particularly against marginalized women, who may experience additional barriers and stigma when attempting to access abortion services.

Canada's current approach to abortion services in its development programming is comparable to the US policy. 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 injuries related to unsafe abortions.[1] The overly broad application of the Amendment has resulted in the denial of lawful care related to abortion. This includes the denial of safe abortions, post-abortion care and referrals, counselling and information with regard to abortion services. The Ministerial statements indicating that Canada will not fund safe abortion services abroad has the potential to be interpreted in a similarly overly broad manner in its implementation and to result in the denial of lawful care to women and girls. Implementing partners or health facilities, for fear of losing Canadian government funding, may simply not provide lawful services and information related to abortion to the detriment of women.

Globally, the majority of countries worldwide permit abortion either in cases of rape or to preserve a woman's physical health.[2] Thirty-one out of fifty of Canada's priority development countries permit abortion without restriction or on the grounds of women's mental health and/or rape. According to the WHO, "ready access to contraception and to early, safe abortion significantly reduces high rates of maternal mortality and morbidity; it prevents the

costs currently imposed by unsafe abortion on health systems and on society and individuals."[3] Given the legal permissibility of abortion in most of these countries, as well as in Canada, there is ample scope for Canadian international cooperation efforts to support increased access to safe and legal abortion services for women and adolescent girls as part of a comprehensive and integrated package of sexual and reproductive health services.

Access to abortion is a recognized component of the right to health in international human rights law. Failing to provide women and adolescent girls, including survivors of sexual violence and married young women and girls, with access to a comprehensive package of sexual and reproductive health services (which include safe abortion) denies them their human rights, including their fundamental right to life, to health, to bodily autonomy, to decide freely about the number and spacing of children, to self-determination, to freedom from torture, and to freedom from discrimination, as well as the right to live free from violence. A policy that restricts Canadian foreign aid from funding access to safe and legal abortion services, Canada is complicit in the continued violation of women's and girls' human rights. This position also alienates Canada from its traditional allies, including the US and the UK, who have expressed grave concern regarding the Government's failure to recognize the linkages between sexual and reproductive health and rights and sexual violence.[4]

According to the Official Development Assistance (ODA) Accountability Act, the Government is responsible for aligning development assistance with international human rights standards. Through the ODA Accountability Act, the Government has a responsibility to promote international human rights standards through the delivery of foreign aid. Failing to take responsibility for inaction on promoting reproductive rights and a full spectrum of reproductive health services leaves the Government in a position to be held accountable in Canadian courts for the denial of reproductive health care to women and girls.

We call on the Government to:

End Ministerial restrictions on funding for safe abortion in Canadian foreign aid.

Transform the Muskoka Initiative on maternal, newborn and child health as well as initiatives on child, early and forced marriage and sexual violence to ensure that sexual and reproductive health and rights are central components of these initiatives, including funding for safe abortion services, accompanied by financial resources for effective advocacy for policy change in countries receiving development assistance from Canada.

Fund and support advocacy initiatives aimed at decriminalizing and increasing access to abortion services.

Develop a comprehensive policy to guide Government of Canada efforts in providing a comprehensive and integrated package of sexual and reproductive health services and information, which includes funding for abortion services and advocacy.

Endnotes

[1] Guttmacher Institute. 2013. "Abortion Restrictions in U.S. Foreign Aid: The History and Harms of the Helms Amendment." https://www.guttmacher.org/pubs/gpr/16/3/gpr160309.html

[2] At the time of publication, 132 countries worldwide permit abortion upon request, to preserve a woman's physical health and/or in cases of rape.

[3] WHO. 2010. "Technical Opinion in response to the request of: Katherine MacDonald, Executive Director, Action Canada for Population and Development." http://www.sexualhealthandrights.ca/who-technical-opinion-2010/ In response to the Canadian Parliamentary committees' concerns regarding Canada's approach, the WHO 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. Access to safe abortion drastically reduces the negative health outcomes and deaths from unsafe abortion, thereby reducing maternal mortality and morbidity rates.

[4] Wells, P. 2011. Macleans. "Abortion: Harper's vigilant global audience." http://www.macleans.ca/politics/ottawa/abortion-harpers-vigilant-global-audience/ and http://www.cbc.ca/news/politics/no-abortion-in-canada-s-g8-maternal-health-plan-1.877257 and CBC. 2010. "No abortion in Canada's G8 maternal health plan." http://www.acpd.ca/index.php/archives/1252

Multilateral and intergovernmental spaces

Background information

In the past, the Government of Canada was a strong leader on gender equality and women's rights, sexual and reproductive rights and human rights, more broadly. Canada led the creation of the position of the UN Special Rapporteur on violence against women, the Convention on the Rights of the Child, the drafting of the UN Security Council resolution on women, peace and security (1325) and the 1999 Canadian International Development Agency (CIDA) Policy on Gender Equality, which, at the time, received international recognition.

For a number of years, the Government of Canada has been much less engaged in key intergovernmental decision-making spaces.[1] Rather than actively participating in advancing forward-looking global policies on a broad range of sexual and reproductive rights issues, the Government of Canada has stepped back from this approach, often taking a back seat in such discussions. While the Government has championed a few specific sexual and reproductive rights-related initiatives (i.e. child, early and forced marriage, sexual orientation, and maternal health) it has also, in other negotiations, put forward regressive proposals or prevented the advancement of sexual and reproductive rights within intergovernmental negotiations. A key example of this is Canada's role in chairing negotiations of the annual UN Human Rights Council resolution on violence against women. While it is an important annual resolution in which sexual and reproductive rights-related policy is often advanced, in 2013, Canada used its position as chair to block proposals that would reaffirm reproductive rights and include safe abortion where legal among the package of services to which survivors of sexual violence are entitled. Canada's blocking of a number of sexual and reproductive rights proposals in the 2014 negotiations of the same resolution led a group of 18 states, all traditional allies of Canada, to withdraw their co-sponsorship of the resolution.

This trend extends to other negotiation spaces, where the Government has failed to propose constructive and progressive suggestions that seek to advance sexual and reproductive rights and even when asked to endorse such efforts made by traditional allies (including the US, the UK, the Netherlands, and others), the Government of Canada has refused to sign on. One such example is from 2014, when Canada shared a seat with the US and Israel during the preliminary negotiations of the Post-2015 development agenda. Despite the expectation that those sharing a seat would deliver joint statements, when presented the opportunity to endorse statements on issues related to sexual and reproductive rights, Canada withdrew, leaving the US and Israel to deliver joint statements covering these topics, without Canada.[2]

The Government of Canada has an opportunity to again be a leader on sexual and reproductive rights and gender equality by developing a strategy to guide foreign policy efforts in this area. Such a strategy would need to work with partners to ensure the advancement of global policy on these issues by proposing and supporting progressive sexual and reproductive rights language in intergovernmental negotiating spaces. Such a strategy would also need to include elements related to engaging in bilateral human rights dialogue, building the capacities of government officials to be effective advocates for these issues, and seeking the perspective of civil society organizations and Indigenous organizations engaged in local, national and global human rights advocacy by meaningfully engaging them in decision-making processes, among other activities.

Advancing sexual and reproductive rights in intergovernmental spaces includes giving visibility to a broad range of under-addressed issues that include, for example, abortion rights, marital rape, discriminatory laws and policies, harmful traditions rooted in gender norms and stereotypes, comprehensive sexuality education, sexual rights, sexual orientation, gender identity and expression, emergency contraception, positive conceptions

of sexuality and reproduction, adolescents access to sexual and reproductive health services, and stigma and discrimination, among others.

Civil society organizations and Indigenous organizations working on sexual and reproductive rights and other relevant experts can support governments in advancing sexual and reproductive rights by providing technical expertise, offering diverse and unique perspectives and existing stakeholder networks, including service providers, institutions, etc., among others. Governments can take advantage of the strengths that sexual and reproductive rights activists and organizations bring by engaging in regular, meaningful consultation, inviting them to be a part of official governmental delegations, and by supporting an enabling environment for civil society.

Meeting and advancing obligations and commitments

The international human rights framework provides scope for the advancement of sexual and reproductive rights both in Canada and globally. Using intergovernmental forums and processes, such as the Universal Periodic Review,[3] Canada can play an important role in encouraging other governments to meet their human rights obligations, as they relate to sexual and reproductive rights. In Canada, the Government can take action on treaties and protocols that it has yet to ratify, which include: the Convention on the Protection of the Rights of all Migrant Workers and Members of their Families; the Convention on the Protection of All Persons from Enforced Disappearances; the Optional Protocol to the Convention against Torture; the Optional Protocol[4] to the International Covenant on Economic, Social and Cultural Rights; the Option Protocol to the Convention on the Rights of the Child on a communications procedure; and the Optional Protocol to the Convention on the Rights of Persons with Disabilities.

In addition to meeting human rights obligations, the upcoming adoption of the UN Sustainable Development Goals (SDGs), which will set the global development agenda for the next 30 years, represents an opportunity for governments to take stock of what has been achieved and the challenges that remain, and to chart a path forward in the pillars of sustainable development: social, economic and environmental. Unlike its predecessor, the Millennium Development Goals (MDGs), the proposed SDGs are universal in nature and will apply to all countries, regardless of economic, social or political realities. In Canada and globally, the Government must establish SDG implementation plans that: seek to include human rights standards in these substantive areas; operationalize human rights principles;[5] clearly delineate responsibilities among levels of government and specific departments, and across sectors; and include support for monitoring mechanisms involving governmental sectors, parliamentarians, academic experts, development partners and donors, Indigenous organizations and civil society—especially women's, youth and other organizations representative of especially excluded groups and diverse constituencies.

Such action plans must recognize relevant substantive human rights obligations and the commitments made under existing development frameworks, including the Programme of Action of the 1994 International Conference on Population and Development, the 1995 Beijing Declaration and Platform for Action, and the 2007 UN Declaration on the Rights of Indigenous Peoples, among other commitments. They must also be accompanied by adequate funding for their effective implementation and to meet existing financing commitments to assist other countries in meeting their human rights obligations.

Support for multilateral institutions

In an ongoing effort, Canada must increase its support for UN agencies and institutions; they remain at the forefront of the advancement of technical guidance, capacity building, intergovernmental negotiations, and development assistance as related to sexual and reproductive rights. And while aid levels continue to increase at the global level, support for multilateral institutions, particularly those working on sexual and reproductive rights, and human rights more broadly, has stagnated. Despite the fact that human rights is recognized as one of the three UN pillars, the human

rights programme receives just 3% of the Secretariat's regular budget.[6]

In recent years, UN agencies have also experienced increases in support for earmarked funding streams (i.e. project-based funding or initiative specific funding) at the expense of support for core-funding. This often prevents agencies from maintaining support for long-term initiatives that are central to the agency's mandate. Stability in core funding also enables the agencies to respond more effectively to the development needs of countries.[7] Agencies working specifically on sexual and reproductive rights, gender equality and human rights, more broadly, receive considerably less funding than other UN agencies. For example, in 2014, the United Nations Population Fund (UNFPA) reported just over one billion in contributions, and UN Women reported $322 million, compared to the United Nations Children's Fund (UNICEF) and United Nations Development Programme (UNDP) each reporting over four billion in 2013.[8]

We call on the Government to:

Constructively re-engage in intergovernmental negotiations at the UN and in other multilateral fora and, working with government and NGO partners, seek to advance a robust and progressive agenda for sexual and reproductive health and rights, gender equality and human rights.

Continue to chair negotiations of the resolution on violence against women at the UN Human Rights Council, ensuring the contents of each resolution progressively integrate relevant gender equality and sexual and reproductive rights issues.

Support the meaningful participation of representatives from civil society and Indigenous organizations in Canada on official governmental delegations, with open and transparent decision-making processes for the selection of such representatives, ensuring adequate participation of traditionally marginalized groups.

Support ongoing capacity-building of DFATD, parliamentarians, and other relevant stakeholders by global experts on a range of thematic issues, including sexual and reproductive health and rights, human rights, gender equality, etc.

Provide leadership in the G7 and G20 to transform the Muskoka Initiative on maternal, newborn and child health such that sexual and reproductive health and rights are central components of the initiative.

Establish action plans and strategies for the implementation of the Sustainable Development Goals both in Canada and globally that operationalize human rights principles and that in doing so, engage a diverse range of stakeholders in consultations, with dedicated resources for the establishment of a human rights-based accountability mechanism to monitor progress with transparent reporting mechanisms.

Ratify the Optional Protocol to the Convention against Torture; the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights; the Convention on the Protection of the Rights of all Migrant Workers and Members of their Families; the Optional Protocol to the Convention on the Rights of the Child; the Optional Protocol to the Convention on the Rights of Persons with Disabilities; the Convention on the Protection of All Persons from Enforced Disappearances; and fully adopt and implement the United Nations Declaration on the Rights of Indigenous Peoples.

Increase funding for multilateral organizations working to advance gender equality, and sexual and reproductive health and rights, and human rights, including: UNFPA, UN Women, and OHCHR.

Endnotes

[1] Globe and Mail. 2014. "Canada's decade of diplomatic darkness." http://www.theglobeandmail.com/globe-debate/canadas-decade-of-diplomatic-darkness/article20745304/

[2] Remarks by Ambassador David Roet, Israel Deputy Permanent Representative to the United Nations, for the US and Israel, 8th Session of the SDG Open Working Group, on Promoting Equality, including Social

Equity, Gender Equality and Women's Empowerment. February 6, 2014. https://sustainabledevelopment.un.org/content/documents/7577us14.pdf; remarks by Ambassador Elizabeth Cousens, U.S. Representative to ECOSOC, for the US and Israel, 4th Session of the SDG Open Working Group, on Health and Population Dynamics. June 19, 2013. https://sustainabledevelopment.un.org/content/documents/7542us7.pdf; and remarks by Ambassador Elizabeth Cousens, U.S. Representative to ECOSOC, for the US/Canada/Israel Team, 10th Session of the SDG Open Working Group, on Consolidation of Focus Areas: Gender Equality and Women's Empowerment, Education, Employment and Decent Work for All, Health and Population Dynamics. April 1, 2014. https://sustainabledevelopment.un.org/content/documents/8462us18.pdf

[3] The Universal Periodic Review (UPR) mechanism of the UN Human Rights Council has also been effective in raising questions and recommendations to States to address the non-implementation and violation of sexual and reproductive rights. The pressure and review before all Member States by the UN has pushed many States to take steps to affirm sexual rights. For more information, visit http://sexualrightsinitiative.com/universal-periodic-review/upr-toolkit/

[4] Optional Protocols on communications procedures allow individuals to initiate complaints against States who fail to meet their human rights obligations found in the treaty, once domestic remedies have been exhausted. UN Committees that oversee international human rights treaties and associated complaints mechanisms support States in meeting their human rights obligations by providing them with concrete measures to address violations and denials of rights. Optional Protocols support States in maintaining transparent and democratic decision-making at all levels of government.

[5] Operationalize human rights principles that include: non-discrimination, transparency, accountability, participation, empowerment, sustainability, and international cooperation.

[6] OHCHR Management Plan. 2014-2017: Working for your rights. http://www2.ohchr.org/english/OHCHRreport2014_2017/OMP_Web_version/media/pdf/0_THE_WHOLE_REPORT.pdf

[7] UNFPA. 2014. Annual Report. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_annual_report_2014_en.pdf

[8] UNFPA. 2014. Annual Report. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_annual_report_2014_en.pdf UNICEF. 2014. Annual Report. http://www.unicef.org/publications/files/UNICEF_Annual_Report_2013_web_26_June_2014.pdf UN Women. 2015. Annual Report. http://www.unwomen.org/~/media/headquarters/attachments/sections/library/publications/2015/annual%20report%202014-2015%20(1).pdf UNDP. 2014. Annual Report. http://www.undp.org/content/dam/undp/library/corporate/UNDP-in-action/2014/UNDP_AR2014_english.pdf