Action Canada for Sexual Health & Rights

Submission to the UN Committee on the Elimination of Discrimination Against Women

65th Pre-Sessional Working Group (March 7-11 2016)

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

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Introduction

1. This report is submitted by Action Canada for Sexual Health and Rights in advance of Canada's review during the 65th Pre-Sessional working group of the UN Committee on the Elimination of Discrimination Against Women, taking place March 7 to 11 2016, during which the List of Issues will be adopted. The report examines violations of articles 10 and 12 of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) with respect to ensuring access to safe abortion services without discrimination, providing young people with access to accurate, evidence-based sexuality education, incidences of forced sterilization and the denial of sexual and reproductive health care on moral or religious grounds.

Article 10 – Right to education

BACKGROUND: Comprehensive sexuality education

2. Article 10 of CEDAW requires that State parties "take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education."[1] It must do so in part by eliminating "any stereotyped concept of the roles of men and women at all levels…by encouraging…types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programmes and the adaptation of teaching methods," and by ensuring "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."

3. The Committee on the Elimination of Discrimination Against Women (herein referred to as "the Committee") in its General Recommendations 21 and 24 states that the ability to make informed decisions about safe and reliable contraceptive measures requires information about such contraceptive measures through guaranteed access to sex education and family planning services.[2]

4. The Committee has, on numerous occasions, further clarified governments' obligation to provide sexuality education, not only as a requisite for the realization of the right to education, but also the rights to health and non-discrimination, among others. In its Concluding Observations to Chile in 2012, it recommended the government "include comprehensive programmes on sexual and reproductive health and rights as a regular part of the school curriculum, targeting adolescent girls and boys."[3] Similarly, during Mozambique's review in 2007, the Committee recognizes that adequate sex education is essential for a healthy view of sexuality and therefore must be sufficiently covered in school curricula. In order to integrate healthy views of sexuality into school curricula, the Committee urges the State guarantee adequate age-appropriate sex education to boys and girls.[4] In Ecuador, the Committee expressed concern regarding the implementation of legislation in the realm of sexuality education which has resulted in limited

[1] Convention on the Elimination of All forms of Discrimination Against Women. 1979.
[2] Committee on the Elimination of Discrimination Against Women. (CEDAW) General Recommendation 21 on equality in marriage and family relations, 1994 and 24 on women and health, 1999.
[3] CEDAW.. CEDAW/C/CHL/CO/5-6, 2012.
[4] CEDAW. CEDAW/C/MOZ/CO/2, 2007.

awareness of women's right to sexual and reproductive health.[5] To address the situation, the Committee urged the State to take steps to implement the legislation in conjunction with strengthening sexual and reproductive health programmes so as to provide "women and men with adequate and reliable information on available contraceptive methods and methods that can enable them to exercise their right to make a free and informed decision concerning the number and spacing of their children and to strengthen methods for preventing sexually transmitted diseases and HIV/AIDS, including the availability of condoms."[6]

5. Further, in its statement on sexual and reproductive health and rights within the context of the 2014 review of the Programme of Action of the International Conference on Population and Development (ICPD), the Committee states that "special attention is needed to ensure that adolescents have access to accurate information about their sexual and reproductive health and rights, including responsible sexual behaviour, prevention of early pregnancies and sexually transmitted diseases. Age-appropriate education on sexual and reproductive health should, therefore, be integrated in school curricula. States parties should further address negative stereotypes and discriminatory attitudes with regard to the sexuality of adolescents, with a view to ensuring that these do not interfere with access to information and education on sexual and reproductive health and rights."[7]

6. Sexuality education is recognized as a basic human right of all children and youth in both the Annual Report of the Special Rapporteur on the right to education to the UN General Assembly in 2010[8] and General Comment No. 4 of the Committee on the Rights of the Child.[9] Effective sexuality education must go beyond biology. It must educate children and youth about gender equality, sexual and reproductive health, relationships, gender-based and sexual violence, sexual and gender diversity, healthy emotive processes, informed consent and human rights, and should promote empowerment and autonomy. Such education must be free of and aim to eliminate stereotypes, discrimination, and stigma; respect the evolving capacities of children and youth; and be tailored to meet the specific needs of particular groups e.g. young people with disabilities and those living on the streets. When effectively implemented, comprehensive sexuality education contributes to reducing the transmission of sexually transmitted infections, gender-based violence, stigma and discrimination, unwanted pregnancies, and developing healthy sexual and non-sexual relationships, among other outcomes.[10]

7. Canada played an instrumental role establishing the position of UN Special Rapporteur on violence against women and leading the annual resolution on the same topic at the UN Human Rights Council. In 2015, Canada played a leadership role along member states adopting a strong resolution on violence against women, which includes for the

[5] CEDAW, A/58/38 (SUPP), 2003.
[6] CEDAWA/58/38 (SUPP), 2003.
[7] CEDAW 57th session. Statement against women on sexual and reproductive health and rights: Beyond 2014 ICPD review. 2014. http://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/SRHR26Feb2014.pdf
[8] United Nations Special Rapporteur on the right to education. Annual report to the General Assembly on the human right to comprehensive sexual education. 2010.
[9] Committee on the rights of the child. General Comment 4 on adolescent health and development in the context of the Convention on the rights of the child. 2003.
[10] Upworthy. "Oh kindergarten. Finger painting, ABCs, and sexuality education." June/July 2015. http://www.upworthy.com/kids-dont-usually-learn-about-the-birds-and-bees-in-kindergarten-unless-of-course-theyre-dutch

first time at the council reference to 'comprehensive sexuality education,'[11] recognizing its linkages with efforts to prevent violence against women.

COMPREHENSIVE SEXUALITY EDUCATION IN CANADA

8. Documented discrepancies in the quality and delivery of comprehensive sexuality education curriculums in Canada represent violations of article 10 as interpreted within this cited work of the Committee. Specifically, the Government of Canada has failed to implement a comprehensive set of national guidelines for sexual health education resulting in severe discrepancies between provinces in related curricula.

9. In 2008, the Public Health Agency of Canada revised its guidelines for sexual health education, developed to provide a "framework that outlines principles for the development and evaluation of comprehensive evidence-based sexual health education. Guideline statements support each principle and provide the context for effective and inclusive sexual health education programs and policies in Canada."[12] Due to the division of power between federal and provincial jurisdictions, the guidelines have not been consistently implemented across Canada in a manner that recognizes young people's rights. This can reinforce the stigma associated with their sexual activity, can lead to discrimination and 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.[13]

10. Despite the federal government having a role to play both in fulfilling young people's sexual and reproductive rights (in part through the implementation of comprehensive sexuality education) and in gathering and analyzing data on trends in relation to the sexual and reproductive health of all people in Canada, there are no standards through which sexual health education curricula can be monitored and evaluated. Regular national studies are required in order to determine the effectiveness of sexuality education and ultimately to determine if curriculums are contributing to positive health outcomes and reductions in stigma and discrimination, among other outcomes.

11. In Ontario, the curriculum was only recently updated to reflect sexual orientation and gender identity, among other issues, following criticism that it was the most outdated curriculum in the country.[14] In response, in 2010, the Ontario Ministry of Education released a revised Health and Physical Education curriculum covering a range of issues related to health, physical activity and sexual health based on the gathering of evidence and best practices and in consultation with relevant stakeholders. While this represents a positive step forward, there remains significant work to be done in terms of implementation. Since the integration of the new sexuality education curriculum into the broader provincial

[11] UN Human Rights Council. Resolution: Accelerating efforts to eliminate all forms of violence against women: eliminating domestic violence. June 2015. A/HRC/RES/29/14.
[12] *Canadian Guidelines for Sexual Health Education*. Ottawa: Public Health Agency of Canada, 2003.
[13] Public Health Agency of Canada. 2010. Population Specific Status Report: HIV/AIDS and other sexually transmitted and blood born infections among youth in Canada. http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/youth-jeunes/chapter-chapitre-3-eng.php#footnotei
[14] Rushowy, Kristin. "Sex education in Ontario schools outdated, teachers say." *The Toronto Star*, October 10, 2013.

curriculum, some vocal opponents have removed their children from school and publically protested the new curriculum.[15]

12. 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.[16] In 2014, an Edmonton student launched a human rights complaint with the Alberta Human Rights Commission providing evidence that religious groups were delivering misleading information to students on issues related to contraception and sexually transmitted infections, within an *abstinence*-based approach. Research shows the correlation between the implementation of *abstinence-based* approaches and rises in sexually transmitted infections, unwanted pregnancies and other negative health outcomes,[17] as it limits young people's access to comprehensive, evidence-based and scientific information related to sexual and reproductive health.

Recommended Questions to be included in the List of Issues

Recognizing the division of powers outlined in the Constitution of Canada as it relates to legislation respecting education,

- What steps has the Government of Canada taken to systematically ensure that all individuals across all jursidictions receive comprehensive, evidence-based, and scientifically accurate sexuality education at all levels of education?
- What steps has the Government of Canada taken to regularly monitor and evaluate the effectiveness of sexuality education in Canada, and sexual health broadly?
- What steps has the Government of Canada taken to consult with a broad range of stakeholders, including young people and adolescents, in the design, delivery and implementation of national sexual health education guidelines?

Article 12 – Right to health

BACKGROUND: Right to access to safe abortion services

13. Article 12 of CEDAW requires State parties to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning," and to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary."[18]

14. The Committee has, on numerous occasions, outlined governments' obligation to ensure access to safe abortion services, as part of the right to health. In General Recommendation 24 on women and health the Committee states

[15] Canadian Broadcasting Corporation. "Ontario parents opposed to sex ed changes threaten to pull kids from school." May 2015. http://www.cbc.ca/news/canada/toronto/ontario-parents-opposed-to-sex-ed-changes-threaten-to-pull-kids-from-school-1.3059455
[16] "Teen, mother launch complaint against abstinence-based sex ed." CBC News, July 10, 2014.
[17] Guttmacher Institute "Comsequences of Sex Education on Teen and Young Adult Sexual Behaviors and Outcomes." (2012). https://www.guttmacher.org/pubs/journals/j.jadohealth.2011.12.028.pdf and Advocates for Youth. "Abstinence-Only-Until-Marriage Programs: Ineffective, Unethical, and Poor Public Health." (2007) http://www.advocatesforyouth.org/publications/publications-a-z/597-abstinence-only-until-marriage-programs-ineffective-unethical-and-poor-public-health
[18] Committee on the Elimination of Discrimination Against Women. General Recommendation 24 on women and health. (1999).

that it is "discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women" and "urges states increase the access of women and adolescent girls to affordable health-care services, including reproductive health care."[19] The Committee on Economic, Social and Cultural Rights has established that the right to health comprises the right to control one's health and body, including sexual and reproductive health, which includes safe abortion services. In meeting their human rights obligations in this regard, states are required to ensure sexual and reproductive health services are available, accessible, acceptable, and of quality.[20] In its own statement on sexual and reproductive health and rights within the context of the 2014 review of the Programme of Action of the ICPD, the CEDAW Committee stated that "provision of…safe abortion…care are all part of the right to sexual and reproductive health."[21]

15. In its concluding observations to state parties, the Committee has expressed concern regarding access to safe abortion services. In 2013, the Committee examined barriers related to cost, expressing concern in cases where legal abortions are not reimbursed by state-provided medical insurance, combined with non-existent data to demonstrate the impact of such barriers on women who are economically disadvantaged.[22] In addressing barriers in access to services, the Committee recommends that states: "**provide financial support to economically disadvantaged women and girls needing an abortion who cannot afford it**." The Committee has also expressed concern regarding legal discrepancies in access to safe abortion services across jurisdictions. In response the Committee **recommended the state "harmonize the federal and state legislations relating to abortion with a view to eliminating the obstacles faced by women seeking legal abortions**" and to "**inform medical care providers and social workers…of their responsibilities**" to provide abortion services.[23]

16. In response to a complaint filed by an alleged victim in Peru under article 7 of the Optional Protocol to the CEDAW, the Committee recognized that in contexts where the state has legalized abortion, "it must establish an appropriate legal framework that allows women to exercise their right to it under conditions that guarantee the necessary legal security…It is essential for this legal framework to include a mechanism for rapid decision-making, with a view to limiting to the extent possible risks to the health of the pregnant mother." In doing so, it must "review its laws with a view to establish a mechanism for effective access to therapeutic abortion under conditions that protect women's physical and mental health."[24]

ACCESS TO SAFE ABORTION SERVICES IN CANADA

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

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[19] CEDAW CEDAW/C/SVK/CO/4, 2009, and CEDAW General Recommendation 24. 1999.
[20] CEDAW. General Comment 14. 2000. Paragraphs 8 and 12.
[21] CEDAW. 57th session. Statement against women on sexual and reproductive health and rights: Beyond 2014 ICPD review. 2014. http://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/SRHR26Feb2014.pdf
[22] CEDAW. CEDAW/C/AUT/CO/7-8, 2013.
[23] CEDAW, CEDAW/C/MEX/CO/7-8, 2012.
[24] CEDAW, Communication no. 22/2009. Views of the Committee under article 7, paragraph 3, of the Optional Protocol to CEDAW. http://www.ohchr.org/Documents/HRBodies/CEDAW/Jurisprudence/CEDAW.C.50.D.22.2009_en.pdf

18. In accordance with the 1988 Supreme Court of Canada decision R. v. Morgentaler, there are no criminal laws restricting access to abortion in Canada. In Canada, the provincial governments are responsible for the administration, organization and delivery of health care. The federal government has 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 (herein the Act). It regulates the conditions to which provincial and territorial health insurance programs must adhere in order to receive the full amount of the Canada Health Transfer (herein CHT) cash contribution. If any of the provinces or territories fails to meet any one of the criteria set out in section 13 of the Act, or if the province allows extra billing by medical practitioners or permits user charges for insured health services, the province will face as the penalty a reduction or withholding of the cash contribution. The Act states that provinces and territories must provide universal coverage for all insured persons for all medically necessary hospital and physician services, which abortion is considered to be.

19. Lack of access to safe abortion services continues to be an obstacle and a barrier for women who choose to terminate their pregnancies, particularly for women living in rural or remote regions.[25] A 2006 study found that only 1/6 of hospitals provide abortion services,[26] the majority of which, both hospitals and free standing sexual health clinics, are disproportionately dispersed across Canada, with most located in urban areas. For example, the majority of sexual health centres are located within 150km from the US border in major urban centres. Twenty percent of people in Canada live in rural areas where they must travel sometimes thousands of kilometres to access abortion services, which often require timely care. Adding to this, there are few providers that offer services beyond 16 weeks gestation. This makes it particularly difficult for individuals living in areas with only one service provider (where the provider may only offer services until 10 or 12 weeks gestation, for example) or those living thousands of kilometers away from major urban centers where there are multiple service access points.

20. The overall limited availability to abortion services through clinics and hospitals is compounded by other barriers including significant wait times, age, financial and geographic location. Unexpected travel time is a factor since some of the abortion providers put a gestational limit to the termination of the pregnancy, delaying a woman's right to abortion. In addition, these women face unforeseen monetary expenses such as travel, accommodation, lost wages, childcare, eldercare, and possibly procedural costs (in the case where there is a lack of reciprocal billing within their provincial or territorial health systems), disproportionately impacting low-income women. While there are no laws requiring parental consent or laws imposing restrictions to abortion access based on age, young people seeking abortion services have reported experiencing stigma and discrimination from health care providers.[27]

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[25] Norman WV, Soon JA, Maughn N, Dressler J (2013). *Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS).* PLoS ONE 8(6).

[26] Shaw, Jessica (2006). *Reality Check: A Close Look At Accessing Hospital Abortion Services In Canada.* Ottawa: Canadians for Choice. [This qualitative study has not been updated thus this data has not been validated since 2006 –but to our knowledge, a number of hospitals have ceased offering abortion services since that time, and as a result we would expect the current picture to reflect an even more significant disparity.]

[27] The Guardian. "Women turning to desperate measures due to lack of abortion services." November 2011. http://www.theguardian.pe.ca/News/Local/2011-11-10/article-2802198/Women-turning-to-desperate-measures-due-to-lack-of-abortion-services/1 and http://projects.upei.ca/cmacquarrie/files/2014/01/trials_and_trails_final.pdf

21. Reciprocal billing states that individuals who are not present (either travelling or changing their residence) within their province or territory of residence at the time of needing a specific medically necessary service or procedure are to be either covered or reimbursed in full of the monetary costs by their provincial or territorial health system. Up until June 2015, abortion was on the List of Excluded Services under the Reciprocal Billing Agreement. While some provinces had developed bilateral agreements allowing abortion services to be covered under reciprocal billing in certain points of service, five provinces and one territory continued to exclude abortion from their list of services to be covered under reciprocal billing. Individuals coming from such provinces or territories who were in need of an abortion had to incur the expense of paying up front for the procedure, without an opportunity for reimbursement. This disproportionately impacted low-income individuals. No other medically necessary service faced these administrative restrictions. Despite the impact of such restrictions and having the necessary power, responsibility and authority to ensure that abortion services were provided without financial or other barriers, the Government of Canada had not taken any action to address the discriminatory abortion policies of provinces that contravene the Act, until very recently. [28] In June 2015, the Interprovincial Health Insurance Agreements Coordinating Committee, chaired by the federal department of Health, removed abortion services from the list of excluded services.

22. While the removal of abortion services from the list of excluded services is an important step forward, certain restrictive conditions for reciprocal billing persist. Specifically, the change only applies to abortion services provided in hospital settings.[29] This will continue to present barriers in access for people in Canada as abortion services provided in clinics represent a significant number of the points of service across the country. In some areas, clinics are the only point of service in a city or large area (for example in Edmonton, Alberta or in Fredericton, New Brunswick), meaning that people who need to access abortion services in a hospital are still asked to travel significant distances as well as cover travel and accommodation expenses. At a very basic level, it also reduces choices and options in terms of treatments available if the hospital only offers to perform abortions under general anesthetic or if someone would prefer to access services in a less institutional setting.

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

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[28] In 2001, the Federal Health Minister warned four provinces, Quebec, Manitoba, New Brunswick and Prince Edward Island, that their failure to cover fees charged at private abortion clinics constituted violation of the Act. In August 2006, the Superior Court of Quebec ordered Quebec to refund fees paid by women for abortions in private clinics between 1999 and 2006. Deductions have been made from cash contributions to Newfoundland and Labrador in 1998 and to Nova Scotia in 2003 based on charges made to patients for facility fees at private abortion clinics.

[29] Government of Ontario. Health Services Branch. Bulletin to hospitals. September 8, 2015. "Reciprocal Billing of Abortion Services." http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/na_65/na_65.pdf

24. In the province of Prince Edward Island there are no abortion providers. This is the only province in Canada that is still refusing to offer abortion services in-province, thereby violating the obligations set by the Act. Individuals seeking abortion services funded by the government must travel to either Nova Scotia or New Brunswick where they can obtain the services in hospital. Abortion services provided in clinics are not eligible for funding by Prince Edward Island (or New Brunswick). Costs associated with travel and accommodation are to be paid out-of-pocket.[30] Those seeking the service must do so before 16 gestational weeks. Due to stigma related to abortion, there is a lack of doctors on Prince Edward Island who are willing to make the required referrals and requests for funding. In addition, healthcare providers are unwilling to provide accurate information to women who are seeking information on the procedure itself, where to obtain referrals for an abortion, as well as where they can obtain this medical service. In January 2015, a group initiated a legal challenge against the province on the grounds that the province is violating women's rights by denying them equal access to health care services under section 15 of the Canadian Charter of Human Rights.[31]

25. In 2014, New Brunswick reversed a regulation[32] requiring women to obtain the authorization of two doctors and consent of the gynaecologist who will accept to perform the procedure (in order for the procedure to be fully funded). Despite this, New Brunswick only has an 8% access rate with only two hospitals in the entire province that provide abortion services.[33] In contravention to the Act, New Brunswick is the only province that refuses to pay for, or reimburse women for, abortion services performed outside of hospitals; hence, this province refuses to fund clinic abortions. This policy can be especially difficult for women in small towns and for women who do not have a family doctor. If a woman in unable to travel to one of the two hospitals, or fears stigma and discrimination in accessing services in such environments, she may either be forced to travel out-of-province in order to obtain abortion care, pay over $700 to have the abortion at the one clinic in the province, or continue with the pregnancy and birth against her

[30] The provincial department of health does specify that some individuals may be eligible for support for costs associated with travel and accommodation. http://www.healthpei.ca/abortionservices

[31] Women's Legal Education and Action Fund. Reproductive Justice. Accessed Jan. 8 2016. http://www.leaf.ca/legal/reproductive-justice/

[32] 84-20 of the Medical Services Payment Act.

[33] Action Canada for Sexual Health and Rights. Mapping Abortion Access in Canada. 2015. http://www.sexualhealthandrights.ca/wp-content/uploads/2015/10/Map-Access-CHC-and-AC.pdf

will. With such limited access, it has been reported that women are increasingly seeking abortion services out of country, and in some cases, engaging in unsafe practices to terminate unwanted pregnancies.[34]

Recommended Questions to be included in the List of Issues

Recognizing the existence of discriminatory policies and barriers that prevent individuals in Canada from accessing safe abortion services:

- What steps has the Government of Canada taken to enact penalties against provinces refusing to uphold the criteria set out in section 13 of the Canada Health Act?
- What steps has the Government of Canada taken to initiate the Dispute Avoidance and Resolution process, provided for by the Canada Health Act, with provincial governments that contravene the Canada Health Act with respect to the availability and accessibility of abortion services?
- What steps has the Government of Canada taken to ensure reciprocal billing coverage for abortion services provided in clinics, in addition to in hospital settings?
- What steps has the Government of Canada taken to ensure barrier-free access to abortion services, including medical abortion?
- What steps has the Government of Canada taken to ensure that all women have access to accessible, available, acceptable and quality sexual and reproductive health services, including abortion services?

BACKGROUND: Forced sterilization

26. General recommendation 19 of the Committee on violence against women states that "compulsory sterilization or abortion adversely affects women's physical and mental health, and infringes the right of women to decide on the number and spacing of their children." General recommendation 24, on women and health calls upon states to "ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures…because of lack of appropriate services in regard to fertility control."[35]

27. The Committee has, on numerous occasions, expressed concern regarding incidences of forced sterilization, particularly among marginalized communities. In its Concluding Observations to States, the Committee has called for the elimination of forced sterilization, raising awareness among health professionals of their prejudices towards marginalized women, providing social and health services support to vulnerable women, and developing clear a definition of free, prior and informed consent in cases of sterilization, and to financially compensate victims of coercive or non-consensual sterilizations.[36]

[34] Allen, Tess. October 20 2014. 'Lacking access to abortion access, New Brunswick women head to Main abortion clinics.' http://rabble.ca/news/2014/10/lacking-abortion-access-new-brunswick-women-head-maine-abortion-clinics and http://rabble.ca/columnists/2014/05/new-brunswick-invites-return-unsafe-abortions

[35] CEDAW. General Recommendations 19, 1992, and 24, 1999.

[36] CEDAW. CEDAW/C/CZE/CO/5 (2010), CEDAW/C/JOR/CO/5 (2021) and CEDAW/C/HUN/CO/7-8 (2013).

28. Indigenous rights groups in Canada, and globally, have advocated for the application of the principle of free, prior and informed consent (FPIC) in line with the UN Declaration on the Rights of Indigenous Peoples and international human rights law. FPIC empowers Indigenous peoples and communities to meaningfully engage in decision-making that affects them, which includes decision-making around health laws, policies and programmes in the realm of sexual and reproductive rights. The Government of Canada has repeatedly denied the validity of FPIC in international fora,[37] stating that the concept could be applied as a 'veto' to Indigenous groups.

FORCED STERILIZATION IN CANADA

29. In November 2015, media outlets released reports of women in the province of Saskatchewan having undergone forced sterilization in the last five years.[38] The women reported being pressured by health professionals and social workers to undergo tubal ligation surgeries. In response, the regional health authority committed to launching an independent investigation to examine the issue. Many advocates believe there are other women in Canada, particularly Indigenous women, who have had similar experiences within the health care system. [39] This is despite the elimination of policies which permitted and promoted forced sterilization in the 1970s.[40]

30. According to the Native Youth Sexual Health Network (NYSHN), forms of sterilization persist among Indigenous Communities.[41] NYSHN writes that 'modern forms of forced sterilization' occur through the "over-prescription of Depo-Provera to Indigenous youth, which has been proven to cause signs of infertility when over-used."[42] NYSHN has also reported incidences of forced sterilization in Canadian prisons.[43] At an institutional level, "the ideology that justified historical coerced sterilization continues to shape state and medical interventions in the reproductive lives of women, (especially) marginalized, racialized and Indigenous women, pressuring them to get sterilized for their own good, to save them and society from having to care for additional children."[44] This speaks to the longstanding forms of systemic racism, and other types of discrimination, that have contributed to the marginalization of Indigenous people

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[37] Government of Canada. Permanent Mission of Canada to the UN. "Canada's Statement on the World Conference on Indigenous Peoples Outcome Document." September 2014. http://www.canadainternational.gc.ca/prmny-mponu/canada_un-canada_onu/statements-declarations/other-autres/2014-09-22_wcipd-padd.aspx?lang=eng and Amnesty International Canada. "Free, Prior and Informed Consent." 2013. http://www.amnesty.ca/sites/amnesty/files/fpic_factsheet_nov_2013.pdf

[38] National Post. "Saskatoon Health Region apologizes after aboriginal women felt pressured by staff to have tubes tied." November 2015. http://news.nationalpost.com/news/canada/saskatoon-health-region-apologizes-after-aboriginal-women-felt-pressured-by-staff-to-have-tubes-tied

[39] Radical Criminology. "Art through a birch bark health: an illustrated interview with Erin Marie Konsmo. http://journal.radicalcriminology.org/index.php/rc/article/view/29/html, 2013, and Vice News. "This Woman Says a Hospital in Canada Pushed Her to Undergo Sterilization." November 2015. https://news.vice.com/article/this-woman-says-a-hospital-in-canada-pushed-her-to-undergo-sterilization

[40] Vice News. "This Woman Says a Hospital in Canada Pushed Her to Undergo Sterilization." November 2015. https://news.vice.com/article/this-woman-says-a-hospital-in-canada-pushed-her-to-undergo-sterilization

[41] Radical Criminology. "Art through a birch bark health: an illustrated interview with Erin Marie Konsmo. http://journal.radicalcriminology.org/index.php/rc/article/view/29/html, 2013, and Vice News. "This Woman Says a Hospital in Canada Pushed Her to Undergo Sterilization." November 2015. https://news.vice.com/article/this-woman-says-a-hospital-in-canada-pushed-her-to-undergo-sterilization

[42] Radical Criminology. "Art through a birch bark health: an illustrated interview with Erin Marie Konsmo. http://journal.radicalcriminology.org/index.php/rc/article/view/29/html, 2013.

[43] Native Youth Sexual Health Network. 2013. Presentation during 6th session of the Expert Mechanism on the Rights of Indigenous Peoples July 8-12, 2013; http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf

[44] Saskatoon Star Phoenix. "Saskatchewan women pressured to have tubal ligations." November 17, 2015. http://thestarphoenix.com/news/national/women-pressured-to-have-tubal-ligations

in Canada. Such forms of marginalization and discrimination can lead to barriers in access to health care and negative health outcomes.

Recommended Questions to be included in the List of Issues

Recognizing recent instances of health professionals use of sterilization against the will of the patient,

- What steps has the Government of Canada taken, especially within Indigenous communities, to ensure the non-repetition of non-consensual sterilization?

BACKGROUND: Conscientious objection

31. The Committee has, on numerous occasions, outlined governments' obligation to create the necessary conditions so as to limit the exercise of conscientious objection by doctors and health institutions so that it does not impede effective access by women to reproductive health care services.

32. Explored within the context of women's access to abortion services, the 2011 Report of the UN Special Rapporteur on the Right to Health recognizes conscientious objection as a legal restriction which creates a barrier to access to sexual and reproductive health services and information.[45] In General Recommendations 24 the Committee "states that it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to other accessible health providers." [46]

33. In its Concluding Observations to States under periodic review the Committee has expressed concern regarding health professionals increasingly resorting to conscientious objection without an adequate regulatory framework and the use of conscientious objection particularly as it relates to the delivery of or referral to sexual and reproductive health services and information. In response, the Committee has made the following recommendations to states:
    - Establish a "**mechanism for monitoring of the practice of conscientious objection** by health professionals,"[47]
    - Ensure "that **conscientious objection is accompanied by information to women about existing alternatives** and that it remains a personal decision rather than an institutionalized practice,"[48] and
    - Ensure "**effective remedies for contesting refusals** of abortion,"[49]

    Ultimately, the Committee urges states to ensure that "the **exercise of conscientious objection by health professionals does not impede effective access by women to reproductive health-care services**, including abortion and post-abortion care,"[50]

[45] United Nations. 2011. Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. A/66/254. New York, UN General Assembly; para 24 and para 65 (m).
[46] CEDAW. CEDAW/C/SVK/CO/4, 2009.
[47] CEDAW. CEDAW/C/HUN/CO/7-8, 2013.
[48] CEDAW. CEDAW/C/HUN/CO/7-8, 2013.
[49] CEDAW. CEDAW/C/POL/CO/7-8, 2014.
[50] CEDAW. CEDAW/C/PER/CO/7-8, 2014.

34. Other treaty monitoring bodies have adopted similar positions. In 2009, in its concluding observations to Poland, the Committee on Economic, Social and Cultural Rights recommended that the government "take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by…implementing a mechanism of timely and systematic referral in the event of conscientious objection."[51]

35. Further, in a statement on sexual and reproductive health and rights within the context of the 2014 review of the Programme of Action of the ICPD, the Committee stated that "States parties should further organize health services so that the exercise of conscientious objection does not impede [patients] effective access to reproductive health care services, including abortion and post-abortion care."[52]

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

CONSCIENTIOUS OBJECTION IN CANADA

37. The Code of Ethics of the Canadian Medial Association (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," but does not require physicians to provide timely referrals. While the Code does include an anti-discrimination clause, including on the grounds of sex, arguing violations on such grounds have not been successful. Following the news that Ottawa-based doctors were refusing to provide sexual and reproductive health services and information on moral and religious grounds, the Ontario College of Physicians and Surgeons is reviewing its policy on the issue.

38. Communities of global medical experts have also established policies and guidelines on this topic. The 2012 World Health Organization Safe Abortion Guidelines seeks to ensure that conscientious objection does not prevent individuals from accessing services to which they are legally entitled. In 2005, the International Federation of Gynecologists and Obstetricians (FIGO) developed its Ethical Guidelines on Conscientious Objection, which state that practitioners have a "duty to abide by scientifically and professionally determined definitions of reproductive health services and to exercise care and integrity not to misrepresent or mischaracterise them on the basis of personal beliefs." The Guidelines state that "the primary conscientious duty of [practitioners] is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty." Practitioners must also "provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardise patients' health and well-being, such as by patients experiencing unwanted pregnancy." Moreover, "In emergency situations, to preserve life or physical or mental health, practitioners must provide the medically indicated care of their patients' choice regardless of the practitioners' personal objections."[53] The CMA Code of Ethics is in contravention with not only the FIGO guidelines, but also Committee jurisprudence on the issue in that it does not require practitioners to provide timely referrals and therefore does not appropriately safeguard the right to health in the face of purported conscientious objection.

[51] Committee on Economic, Social and Cultural Rights. E/C.12/POL/CO/5, 2009.
[52] CEDAW. 57th session. Statement against women on sexual and reproductive health and rights: Beyond 2014 ICPD review. 2014. http://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/SRHR26Feb2014.pdf
[53] International Federation of Gynecology and Obstetricts. 2005. Ethical Guidelines on Conscientious Objection, p. 25-27.

39. In recent years, there have been several reported incidents in which women have been refused sexual and reproductive health information and services as a result of doctors' conscientious objection on moral or religious grounds. In January 2014, when attempting to access contraceptive services, an Ottawa resident received a letter explaining the doctor's decision to refuse to provide "vasectomies, abortions, the morning after pill and any artificial contraception," on the grounds of "medical judgement as well as professional ethical concerns and religious values."[54] This incident resulted in the emergence of evidence of other doctors in the province refusing to provide women with conceptive services.[55]

Recommended Questions to be included in the List of Issues

Taking stock of recent instances of health professional's refusal, on moral or religious grounds, to provide individuals with access to information about their sexual and reproductive health,

- What steps has the Government of Canada taken to ensure that all individuals are able to exercise their right to sexual and reproductive health, free from all barriers, including "implementing a mechanism of timely and systematic referral in the event of conscientious objection"?[1]
- How steps has the Government of Canada taken steps to ensure that conscientious objection exemptions are well-defined in scope and well-regulated in use, and that referrals and alternative services are available in cases where the objection is raised by a service provider?[1]

[54] "It Happened To Me: I Asked For Birth Control And Got A Form Letter Saying 'No.'" *XO Jane*, February 4, 2014. http://www.xojane.com/it-happened-to-me/it-happened-to-me-my-doctor-refused-to-refill-my-birth-control

[55] Grant, Kelly. "Policy allowing doctors to deny treatment on moral or religious grounds under review." *The Globe and Mail*, July 02, 2014.