

SUBMISSION FOR CANADA'S REVIEW BEFORE THE UN COMMITTEE ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN, 65th SESSION

September 30, 2016

Key words: right to education, right to health, comprehensive sexuality education, sexual and reproductive health and rights, access to abortion information and services, conscientious objection, health and safety of sex workers, criminalization of the non-disclosure of HIV.

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Introduction

1. This report is submitted by a coalition¹ of organizations working to advance sexual and reproductive health and rights for Canada's review during the 65th Session of the UN Committee on the Elimination of All Forms of Discrimination Against Women (herein referred to as the 'Committee'), taking place October 25th 2016. The report examines violations of articles 10 and 12 of the Convention on the Elimination of All forms of Discrimination Against Women (the Convention) with respect to comprehensive sexuality education, access to a comprehensive package of sexual and reproductive health information and services (including safe abortion services), the denial of sexual and reproductive health care on moral or religious grounds, the health and safety of sex workers and the criminalization of the non-disclosure of HIV. The List of Issues² prepared by the Committee in March 2016 requests that Canada provide information on a number of issues outlined in this report. Specifically, the Committee requested that Canada provide information on:
 - a. the provision of age-appropriate sexual and reproductive education in all schools,
 - b. access to a comprehensive and integrated package of quality sexual and reproductive health information and services across all provinces and territories, consistent with international human rights standards,
 - c. measures taken to ensure that the exercise of conscientious objection by health professionals does not impede effective access for women to reproductive health-care services, including access to legal abortion and post-abortion services,
 - d. number of investigations, prosecutions and convictions and the type of sanctions imposed for trafficking and exploitation of prostitution, and
 - e. measures planned to ensure full and unhindered access to health care for women affected by sexually transmitted infections, including HIV/AIDS.

Article 10 – Right to education

Background: comprehensive sexuality education

2. Article 10 of the Convention 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.” It must do so 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 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
3. The United Nations Educational, Scientific and Cultural Organization (UNESCO) defines comprehensive sexuality education (CSE) as “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality.”⁴ Through its jurisprudence, Concluding Observations and General Recommendations, the Committee has affirmed State obligations to deliver CSE in fulfillment of the rights to education, health and non-discrimination.⁵ In its

¹ Action Canada for Sexual Health and Rights, Alberta Society for the Promotion of Sexual Health, Calgary Sexual Health Centre, Pictou County Centre for Sexual Health, Sexual Health Centre Saskatoon, Sexual Health Nova Scotia, Sexuality Education Resource Centre MB, SHORE Centre.

² Committee on the Elimination of all forms of discrimination against women (CEDAW). List of issues in relation to the eighth and ninth periodic report of Canada. CEDAW/C/CAN/Q/8-9. 16 March 2016.

³ CEDAW. Adopted Dec. 18 1979.

⁴ United Nations Educational, Scientific and Cultural Organization. “Sexuality Education.” <http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/> [Accessed August 12 2016].

⁵ 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.” (CEDAW/C/CHL/CO/5-6, 2012) Similarly, during Mozambique's review in 2007, the Committee recognized 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 urged the State guarantee adequate age-appropriate sex education to boys and girls. (CEDAW/C/MOZ/CO/2, 2007) In Ecuador, the Committee expressed concern regarding the implementation of legislation in the realm of sexuality education which has resulted in limited awareness of women's right to sexual and reproductive health. (CEDAW, A/58/38 (SUPP), 2003). 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.” (CEDAWA/58/38 (SUPP), 2003.) In its Concluding Observations to Paraguay in 2011,

General Recommendations 21 and 24, the Committee 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.⁶ 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 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

4. The Special Rapporteur on the Right to Education,⁸ the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Rights of the Child⁹ have also affirmed the right to CSE in annual reports to the General Assembly, through its jurisprudence and its General Comments. CESCR General Comment 22 articulates States Parties’ core obligation to provide CSE so as to “ensure all individuals and groups have access to comprehensive education and information on sexual and reproductive health that are non-discriminatory, non-biased, evidence-based, and that take into account the evolving capacities of children and adolescents.”¹⁰

Situation in Canada: comprehensive sexuality education

5. The Government of Canada is not fulfilling its obligations under Article 10 of the Convention through its failure to implement a national set of standards and guidelines for the delivery of CSE and its failure to collect relevant and robust data on sexual health programming necessary for effective monitoring and evaluation. As a consequence, the quality and delivery of CSE curricula across Canada is inconsistent and young people and adolescents are unable to exercise their right to education under the Convention.
6. In 2008, the Public Health Agency of Canada (PHAC) revised its *Canadian Guidelines for Sexual Health Education* to provide a “framework that outlines principles for the development and evaluation of comprehensive evidence-based sexual health education.”¹¹ However, due to the division of power between federal and provincial jurisdictions, with provincial governments responsible for education, the guidelines have not been consistently implemented across Canada in a manner that recognizes young people’s rights. Additionally, there are no national standards through which sexuality education curricula can be monitored and evaluated.
7. Provinces and territories are left to develop their own CSE curricula, implementation, monitoring and evaluations strategies, thereby creating severe discrepancies in content and delivery across the country. For example, in the province of 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.¹² In the province of Ontario, despite a recent update to the curriculum,¹³ non-governmental organizations have had to step in to

the Committee requested consideration for the reinstatement of the “Pedagogical Framework for comprehensive education on sexuality and adopt the necessary measures towards implementing it.” (CEDAW/C/PRY/CO/6)

⁶ CEDAW. General Recommendation 21 on equality in marriage and family relations, 1994 and 24 on women and health, 1999.

⁷ CEDAW. 57th session. Statement against women on sexual and reproductive health and rights: Beyond 2014 ICPD review. 2014.

⁸ <http://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/SRHR26Feb2014.pdf>

⁹ United Nations Special Rapporteur on the right to education. Annual report to the General Assembly on the human right to comprehensive sexual education. 2010.

¹⁰ 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.

¹¹ Committee on Economic, Social, and Cultural Rights (CESCR). General Comment 22 on the right to sexual and reproductive health. 2016.

¹² Canadian Guidelines for Sexual Health Education. Ottawa: Public Health Agency of Canada, 2003.

¹³ “Teen, mother launch complaint against abstinence-based sex ed.” CBC News, July 10, 2014.

¹⁴ Rushow, Kristin. “Sex education in Ontario schools outdated, teachers say.” *The Toronto Star*, October 10, 2013.

create supplemental resources to meet the sexual health education needs of transgender students.¹⁴

8. The Committee reminded Canada in 2008 of the federal government's legal responsibility and leadership role in the implementation of the Convention, and reiterated its previous recommendation of 2003 that the "...State party use its leadership and funding power to set standards and establish an effective mechanism aimed at ensuring accountability and the transparent, coherent and consistent implementation of the Convention throughout its territory in which all levels of government can participate."¹⁵
9. In the absence of federal standards on comprehensive sexuality education, young people and adolescents often lack the knowledge and skills required to lead healthy sexual and reproductive lives. Marginalized young people, particularly young women and girls, are at a heightened risk of experiencing intersecting forms of discrimination which can limit their access to education, health, the judicial system, among other services. Young people in Canada have the highest reported rates of STIs and reported rates of chlamydia, gonorrhoea and syphilis have been steadily rising since the late 1990s.¹⁶ Persistent rates of violence against young women and girls further demonstrate a lack of awareness regarding gender norms and stereotypes and respectful behaviour and relationships, which often carries through into adulthood.¹⁷ Young women are eight times more likely than boys to be victims of a sexual offence;¹⁸ nearly half (46%) of high school girls in Ontario are victims of sexual harassment.¹⁹ Indigenous young women and girls face more frequent incidents of violence than non-Indigenous girls.²⁰ The draft update to General Comment 19 by the Committee calls for the implementation of comprehensive sexuality education as a key prevention strategy for violence against women.²¹
10. The federal government has a role to play in addressing these realities through the regular collection of data on sexual health indicators and the roll-out of evidence and rights-based campaigns (in and out of school) that comprehensively address sexual and reproductive health and rights. Regular national studies are required in order to determine the effectiveness of sexuality education and campaigns, and ultimately determine if such initiatives 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 qualitative measures including young people's satisfaction with the curriculum, their ability to access youth-friendly services and information, violence-related outcomes, satisfaction during sexual intercourse and shifts in public perceptions, among other factors. A 2010 report by Canada's own public health agency noted that Canada "lags behind several other countries in its ability to collect national comprehensive data on this important aspect of the health of youth."²² The same report also examined results from a pilot study to assess the sexual health of young people across Canada and confirmed the validity and reliability of the indicators, concluding that it would be feasible for the study to be replicated at the national level.²³

Recommendations to the Government of Canada relating to Article 10 of the Convention:

- ii. Establish standards through which the federal government can monitor and hold provinces and territories accountable to the implementation of the Guidelines for sexual health education, in line with human rights obligations. This must include

¹⁴ Planned Parenthood Toronto. 2016. "Trans and non-binary youth inclusivity in sexual health: guidelines for sexual health services providers and educators."

<http://ppt.on.ca/previewmysite.com/ppt/wp-content/uploads/2016/04/Trans-and-non-binary-youth-inclusivity-in-sexual-health-guidelines-FINAL.pdf>

¹⁵ CEDAW. 2008. Concluding Observations to Canada. (CEDAW/C/CAN/CO/7).

¹⁶ In 2011, one quarter of positive HIV tests were attributed to young people between the ages of 15 and 29. Public Health Agency of Canada. 2014. 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/assets/pdf/youth-jeunes-eng.pdf>

¹⁷ Wekerle, C., and Wolfe, D. A. 1999. Dating violence in mid-adolescence: Theory, significance, and emerging prevention initiatives. "Clinical Psychology Review," 19 (4), 435-456.

¹⁸ Statistics Canada. 2013. Measuring violence against women: statistical trends. <http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11766-eng.pdf>

¹⁹ D. Wolfe and D. Chiodo. 2008. Sexual Harassment and Related Behaviors Reported Among Youth from Grade 9 to Grade 11. Toronto: Centre for Addiction and Mental Health.

²⁰ Native Women's Association of Canada. Fact Sheet: Violence Against Aboriginal Women. https://nwac.ca/wp-content/uploads/2015/05/Fact_Sheet_Violence_Against_Aboriginal_Women.pdf

²¹ CEDAW. 2016. General Recommendation No. 19: Violence against women - Draft General Recommendation No. 19 (1992): accelerating elimination of gender-based violence against women. <http://www.ohchr.org/EN/HRBodies/CEDAW/Pages/DraftUpdateGR19.aspx>

²² Public Health Agency of Canada. 2012. Canadian Sexual Health Indicators Survey – Pilot Test and Validation Phase: a report on results from the pilot-testing and validation of the Canadian Sexual Health Indicators Survey. http://publications.gc.ca/collections/collection_2012/aspc-phac/HP40-67-2012-eng.pdf

²³ Ibid.

tasking the Public Health Agency of Canada to engage in a multi-stakeholder revision of the Guidelines for sexual health education, with full and meaningful participation of young people and adolescents.²⁴

12. Conduct regular national monitoring, through inter alia broad-based surveys, of a robust set of sexual health indicators disaggregated by relevant factors.²⁵

Allocate sufficient funds to the Public Health Agency of Canada for education and campaigns, on positive sexuality and consent, sexual and reproductive health information, and eliminating stigma and discrimination, among other issues.

Article 12 – Right to health

Background: access to a comprehensive and integrated package of sexual and reproductive health information and services

13. Article 12 of the Convention requires State parties 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.”²⁶
14. The Committee has, on numerous occasions, outlined States Parties’ 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 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.”²⁷ State Parties must “report on measures taken to eliminate barriers that women face in access to health-care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women’s access, such as high fees for health-care services...distance from health facilities and the absence of convenient and affordable public transport.”²⁸
15. 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 good quality.²⁹ 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 [is] part of the right to sexual and reproductive health.”³⁰
16. 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 the costs incurred for 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.³¹ In addressing barriers in access

²⁴ Young people and adolescents must be involved in the design, development, implementation and evaluation of policies and programs that affect their lives This should also include: 1) seeking the views of adolescents and young people as to how they feel the sexuality education they received prepared them for their early sexual lives, and 2) integrating this subjective data into curriculum alterations and redesign.

²⁵ Including gender, age, location, ethnicity and others. One approach to doing this could involve requiring PHAC to regularly implement the Canadian Sexual Health Indicators Survey. Another approach to doing this could involve substantially expanding the Sexual Behaviours Module of the Canadian Community Health Survey by adding further questions including in relation to contraception and pregnancy intention.

²⁶ CEDAW. General Recommendation 24 on women and health. (1999).

²⁷ CEDAW Concluding Observations to Slovakia. (CEDAW/C/SVK/CO/4), 2009, and CEDAW General Recommendation 24. 1999.

²⁸ CEDAW General Recommendation 24. 1999.

²⁹ CEDAW. General Comment 14. 2000. Paragraphs 8 and 12.

³⁰ 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>

³¹ CEDAW. CEDAW/C/AUT/CO/7-8, 2013.

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.³²

17. In response to an individual complaint filed against Peru under Article 7 of the Optional Protocol to the Convention, 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.”³³
18. The World Health Organization (WHO) Safe Abortion Guidelines recommend women have access to both surgical and medical abortion services.³⁴ Mifepristone is considered to be the ‘gold-standard’ for medical abortions, and is listed in the WHO list of essential medicines.³⁵ In delivering quality medical abortion services, the WHO recently released guidelines for health worker roles in providing safe abortion care which include recommendations to ensure appropriate task-shifting in the provision of medical abortion, allowing and training other health professionals, such as nurse practitioners and midwives, to provide these services.³⁶
19. In meeting their obligations under the right to health, States are obligated to fulfill the conditions of availability, accessibility, acceptability and quality. As articulated in General Comment 14 by the Committee on Economic, Social and Cultural Rights, the condition of accessibility includes economic accessibility (affordability). In meeting this condition, “health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.”³⁷ Similarly, in General Recommendation 24, the Committee states that “States parties should report on measures taken to eliminate barriers that women face in access to health-care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women’s access, such as high fees for health-care services...”³⁸ Further, the Committee states that “States and parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women’s health.”³⁹

³² CEDAW Concluding Observations to Mexico. (CEDAW/C/MEX/CO/7-8), 2012.

³³ 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

³⁴ World Health Organization. “Safe abortion: technical and policy guidance for health systems.” 2nd Ed. 2012.

http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1

³⁵ http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_AUG2015.pdf?ua=1

³⁶ World Health Organization. 2015. “Health care worker roles in providing safe abortion care and post-abortion contraception.”

http://apps.who.int/iris/bitstream/10665/181041/1/9789241549264_eng.pdf?ua=1&ua=1

³⁷ CESCR. 2000. “General Comment No. 14: the right to the highest attainable standard of health (article 12 of the Covenant on Economic, Social and Cultural Rights). E/C.12/2000/4.

³⁸ CEDAW. 1999. “CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health).

<http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GR24.pdf>

³⁹ CEDAW. 1999. “CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health).

<http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GR24.pdf>

Situation in Canada: access to a comprehensive and integrated package of sexual and reproductive health information and services

Accessibility of safe abortion services in Canada, including medical abortion

20. The barriers 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. No other medically necessary service faces these administrative restrictions.
21. In accordance with the 1988 Supreme Court of Canada decision *R. v. Morgentaler*, there are no criminal laws restricting access to abortion in Canada. In Canada, the provincial governments are responsible for the administration, organization and delivery of health care. The federal government has constitutionally granted “spending power,” which enables it to fund the health systems under provincial jurisdiction, subject to provincial compliance with certain requirements set out in the 1984 *Canada Health Act* (herein the Act). It regulates the conditions to which provincial and territorial health insurance programs must adhere in order to receive the full amount of the Canada Health Transfer (herein the CHT) cash contribution. If any of the provinces or territories fail to meet any one of the criteria set out in section 13 of the Act, or if the province allows extra billing by medical 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 includes abortion.
22. Lack of access to safe abortion services continues to be an obstacle and a barrier for women who choose to terminate their pregnancies, particularly those in rural or remote regions.⁴⁰ Only 1/6th of hospitals provide abortion services,⁴¹ the majority of which (both hospitals and free standing sexual health clinics) are disproportionately dispersed across Canada and located in urban areas.⁴² Twenty percent of people in Canada live in rural areas where they must travel sometimes thousands of kilometres to access abortion services, which in particular often require timely care, placing a further impediment to access. Adding to this, there are few points of services that offer services beyond 16 weeks’ gestation.⁴³ This is particularly difficult for women living in areas with only one service provider (where the provider may only offer services until 10 or 12 weeks’ gestation, for example). These realities are compounded by other barriers including significant wait times, financial burdens,⁴⁴ required doctor referrals, and geographic location. While there are no laws requiring parental consent or laws imposing restrictions to abortion access based on age, young women seeking abortion services have reported experiencing stigma and discrimination from health care providers.⁴⁵
23. In addition to these barriers, women in Canada lack access to the gold-standard⁴⁶ of medical abortion, known as the drug ‘Mifepristone.’ Approved for use in Canada in July 2015, roll-out of the drug (labelled ‘Mifegymiso’) is only expected in November 2016, under strict regulations imposed by Health Canada. Regulations include: limiting prescribing abilities to physicians only, creating a confidential registry of prescribing physicians, mandatory 6-hr training for prescribing

⁴⁰ 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).

⁴¹ 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.]

⁴² Most located within 150 KM of the US border.

⁴³ There are approximately 20 points of service for those beyond 16 weeks’ gestation. The majority are located in Québec and Ontario. There are no providers offering services beyond 16 weeks in Manitoba, New Brunswick, Newfoundland, Nova Scotia, Nunavut, and Yukon. There are some cases in which women can access services beyond 23 weeks in Canada, however, this is mainly in cases of foetal abnormality. There are no physicians or clinics that publically advertise such services after 24 weeks.

⁴⁴ Which include: unforeseen monetary expenses incurred for things such as travel, accommodation, lost wages, childcare, eldercare, and possibly procedural costs (see paragraph 22). These disproportionately impacting low-income women.

⁴⁵ The Guardian. “Women turning to desperate measures due to lack of abortion services.” November 2011. <http://www.theguardian.pe.ca/News/Local/2011-11-10/article-2802198/Women-turning-to-desperate-measures-due-to-lack-of-abortion-services/> and for examples of stigma-related barriers facing young women in PEI, visit: http://projects.upei.ca/cmaccuarrie/files/2014/01/trials_and_trails_final.pdf

⁴⁶ World Health Organization. 2015. List of Essential Medicines (19th, list, April 2015). http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_AUG2015.pdf?ua=1

physicians and dispensing pharmacists, limiting use up to 7 weeks gestation,⁴⁷ and cost-related barriers (the regimen will not be covered through health insurance, meaning women will have to pay \$300/regimen out-of-pocket).⁴⁸ These regulations will limit the availability of Mifegymiso because: there are many areas throughout Canada where there is a shortage of physicians; many physicians refuse to provide certain sexual and reproductive health services on moral or religious grounds; women with limited access to resources will not be able to afford the high cost of the regimen; women will lack knowledge of how, when and where to access medical abortion; and most physician clinics are not equipped to stock and dispense medication, among others. These regulations are not based in scientific evidence, they will contribute to stigma related to abortion and will not result in improved access to abortion services in Canada.

24. 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. Despite this, women seeking abortion services in clinics,⁴⁹ are not eligible for reciprocal billing.⁵⁰ Women in these situations must incur the expense for the procedure up front, without opportunity for reimbursement. In some areas, standalone clinics or non-hospital affiliated 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 women who are unable to pay for the service out-of-pocket must travel significant distances and incur additional travel and accommodation expenses.⁵¹ This disproportionately impacts low-income individuals. This reality also reduces choices and options in terms of treatments available.⁵²
25. In the province of Prince Edward Island (PEI) there are currently no abortion providers. Facing a legal challenge in 2016, the PEI government agreed to establish one clinic in the provincial capital that will provide abortion services.⁵³ Until this clinic is established, women seeking abortion services funded by the government must travel to either Nova Scotia or New Brunswick where they can obtain services in hospital⁵⁴ prior to 16 weeks' gestation. Costs associated with travel and accommodation are to be paid out-of-pocket.⁵⁵ Due to stigma related to abortion, women seeking referrals to travel out of province are deterred from seeking them,⁵⁶ and there are doctors on PEI who refuse to provide referrals.⁵⁷ In the neighboring province of New Brunswick, there is an 8% access rate, with only two hospitals in the entire province providing abortion services.⁵⁸ 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. If unable to travel to one of the two hospitals, or fearing stigma and discrimination, women may either be forced to travel out-of-province, pay over \$700 to have the abortion at the one clinic in the province, or continue with the pregnancy against her will. With such limited access, women have reported seeking abortion services out of country and, in some cases, engaging in unsafe practices to terminate unwanted pregnancies.⁵⁹ Recourse to unsafe abortion is a clear violation of the right to life under article 6 of the Covenant on Civil and Political Rights.

⁴⁷ The WHO Safe Abortion Guidelines allows for up to 9 weeks gestation. The US Federal Drug Agency recently extended use of Mifepristone to 10 weeks' gestation. World Health Organization. 2012. Safe abortion: technical and policy guidance for health systems, 2nd ed. http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 Federal Drug Agency. 2016. Mifeprex (Mifepristone) information. <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm11323.htm>

⁴⁸ Mifegymiso is expected to cost a \$270.00 per package which is significantly more expensive than the previous regimen.

⁴⁹ 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

⁵⁰ 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.

⁵¹ Costs associated with travel and accommodation are often doubled because hospitals won't allow women to leave without a support person (which hospitals do not provide).

⁵² I.e.: if the hospital only offers to perform abortions under general anesthetic or if someone would prefer to access services in a less institutional setting.

⁵³ <http://www.gov.pe.ca/newsroom/index.php3?number=news&newsnumber=10693&dept=&lang=E>

⁵⁴ Abortion services provided in clinics are not eligible for funding by PEI.

⁵⁵ 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>

⁵⁶ Research suggests that physicians on Prince Edward Island create and maintain stigma surrounding access to abortion on the Island. For example, many believe that the procedure is illegal which deters them from requesting a referral (MacQuarrie, C., MacDonald, J., Chambers, C. January 2014. "Trials and Trails of Accessing Abortion on PEI: reporting on the impact of PEI's abortion policies on women." http://projects.uepi.ca/cmaccuarrie/files/2014/01/trials_and_trails_final.pdf).

⁵⁷ GUTS: Canadian Feminist Magazine. April 30, 2015. "Abortion Access on PEI." <http://gutsmagazine.ca/blog/abortion-access-on-pei>

⁵⁸ 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>

⁵⁹ 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-main-abortion-clinics> and <http://rabble.ca/columnists/2014/05/new-brunswick-invites-return-unsafe-abortions>

Affordability of sexual and reproductive health services

26. Canada is the only high income country with publicly funded universal health care and no national drug plan.⁶⁰ While most health services are covered through provincial health insurance plans, prescribed medications are not covered through provincial public insurance plans. According to a survey by Statistics Canada, 24% of the Canadian population report that they have no drug coverage and so are forced to pay out of pocket for pharmaceutical products, including contraceptive drugs and devices.⁶¹ Those most likely to fall through the gaps are people who are working but who have low earnings, as they may not be eligible for public benefits and are less likely to have employer-provided benefits. This results in differential access to essential health commodities across provinces and territories, and in barriers and inequalities in accessing them within each province and territories. Sexual and reproductive health-related drugs and devices are required by many to live healthy, productive lives, yet many people in Canada lack affordable access to them.
27. Access to every province has a different system for covering HIV drug costs, leaving some individuals to pay out-of-pocket for drugs,⁶² resulting in discrepancies in access to quality care. This leads some people in Canada to relocate to another province in order to receive the care they need, sometimes severing important support networks. Similarly, people in Canada have a narrower range of contraceptive options with varying coverage for specific methods. For example, implants are not available in Canada. The monthly price of hormonal oral contraceptives ranges from \$15-\$30 a month, depending on the type. The hormonal Intrauterine Device (IUD) costs \$350, and the non-hormonal IUD ranges from \$50-\$200. The average cost of emergency contraceptive pills ranges from \$35-\$50. This leaves individuals relying on the contraceptive method they can afford (sometimes condoms, which have higher failure rates) rather than the method of their choosing. Cost-related barriers also contribute to low-uptake (reduced demand) of long-acting reversible contraceptive methods, which reduces their availability.⁶³
28. Similarly, while there are existing programs to provide the vaccines for the Human Papilloma Virus (HPV) to cisgender⁶⁴ females of school age, they are not covered for cisgender males or for females who fall outside of the programme's parameters,⁶⁵ or the age range covered by each province. Finally, many people in Canada experience significant barriers in access to assisted reproductive technologies – particularly related to cost.⁶⁶ People in Québec and Ontario are able to seek reimbursement for certain costs associated with assisted reproduction. Such programmes were instituted to equalize access to treatment for people facing infertility as well as to reduce complication rates associated with more cost effective but higher risk practices.⁶⁷

Background: conscientious objection

29. 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, the Committee on Economic, Social and Cultural Rights, and the work of the Special Rapporteur on the Right to Health. The Committee has, on numerous occasions, outlined State Parties' obligation to create the necessary

⁶⁰ Canadian Medical Association. June 2016. "National Pharmacare in Canada: getting to there from here." <https://www.cma.ca/En/Lists/Medias/2016-jun-01-cma-pharmacare-submission-hesa-e.pdf>.

⁶¹ Canadian Centre for Policy Alternatives. 2010. "A public drug insurance plan would save Canada billions." <http://pharmacarenow.ca/wp-content/uploads/2009/11/Monitor-Pharmacare.pdf>

⁶² Among them: where you live, who is eligible for coverage, whether you have a low income, if you have developed resistance to certain types of medications, are newly diagnosed, what caps are imposed on prescriptions payouts in your benefit package, whether you have third-party insurance, and many other factors.

⁶³ Black, A., Yang, Q., Wen, S., Lalonde, A., Guilbert, E., Fisher, W. 2009. "Contraceptive Use Among Canadian Women of Reproductive Age: Results of a National Survey." *Journal of Obstetrics and Gynecology Canada*. July 2009. http://www.sexualityandu.ca/uploads/files/National_Contraception_Survey.pdf

⁶⁴ Cisgender female refers to someone who was female at birth and identifies as a woman. *Cis* is borrowed from chemistry, meaning *same*.

⁶⁵ Those having to pay for the vaccine out-of-pocket must pay upwards of \$400-500.

⁶⁶ Average cost of fertility medication in Canada is \$75-\$1,000, sperm preparation costs \$500, a standard in-vitro fertilization (IVF) is \$7,000, IVF medication costs between \$2,000 and \$5,000 and embryo freezing costs \$750.

⁶⁷ Such as inserting multiple embryos at once during IVF cycles. In the absence of adequate public funding for assisted reproduction, people in Canada with greater financial resources are better able to overcome infertility than those with lesser means, in opposition to the principle of universality that is the foundation of our health-care system and of the recognized human right to health.

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.

30. In its Concluding Observations to States 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. The Committee has made the following recommendations to States:

- Establish a “mechanism for monitoring of the practice of conscientious objection by health professionals.”
- 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.”⁶⁸
- Ensure “effective remedies for contesting refusals of abortion.”⁶⁹

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,”⁷⁰ In General Recommendation 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.”⁷¹ 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.”⁷² International health bodies have outlined further recommendations for the exercise of conscientious objection in the context of reproductive health care, including the provision of services in emergency situations, regardless of the practitioners’ personal objections.⁷³

Situation in Canada: conscientious objection

31. The Code of Ethics of the Canadian Medical Association (CMA) requires physicians to inform patients when “personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants,”⁷⁴ but does not require physicians to provide timely referrals. It is in contravention with not only the FIGO guidelines, but also Committee jurisprudence on the issue. Some provincial Colleges of Physicians and Surgeons have amended their policies regarding conscientious objection in line with human rights obligations, yet many policies lack requirements for effective referrals and mechanisms to seek redress or remedy for violations of the policy.
32. 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 on moral or religious grounds. For example, in January 2014, when attempting to access contraceptive services, an Ottawa woman 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.”⁷⁵ This led to the emergence of evidence of other doctors in the

⁶⁸ This recommendation is in line with the 2005 Ethical Guidelines on Conscientious Objection by the International Federation of Gynecologists and Obstetricians (FIGO) which states that practitioners must “provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients’ health and well-being, such as by patients experiencing unwanted pregnancy.” (International Federation of Gynecology and Obstetrics. 2005. Ethical Guidelines on Conscientious Objection, p. 25-27.)

⁶⁹ CEDAW. Concluding Observations to Hungary (CEDAW/C/HUN/CO/7-8), 2013 and CEDAW Concluding Observations to Poland (CEDAW/C/POL/CO/7-8), 2014.

⁷⁰ CEDAW Concluding Observations to Peru. (CEDAW/C/PER/CO/7-8), 2014. Similarly, the 2012 World Health Organization Safe Abortion Guidelines seek to ensure that conscientious objection does not prevent individuals from accessing services to which they are legally entitled.

⁷¹ CEDAW Concluding Observations to Slovakia. (CEDAW/C/SVK/CO/4), 2009.

⁷² CESCR Concluding Observations to Poland (E/C.12/POL/CO/5), 2009.

⁷³ International Federation of Gynecology and Obstetrics. 2005. Ethical Guidelines on Conscientious Objection, p. 25-27.

⁷⁴ Canadian Medical Association. 2004. Code of Ethics. <https://www.cma.ca/En/Pages/code-of-ethics.aspx>

⁷⁵ “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>

province refusing to provide women with contraceptive services.⁷⁶ Similarly, in July 2016, a woman was denied a selective abortion at Toronto's Mount Sinai Hospital. According to lawyers, the hospital said it "[didn't] want to be known as a hospital that does abortions."⁷⁷ This case points to the existence of a policy of institutional objection. Institutions do not have human rights, only individuals may exercise their right to conscientious objection. In addition to these examples, there are countless and regular cases of women being denied access to accurate information by administrative gatekeepers across the country, particularly when seeking abortion services in hospital settings.

Background: health and safety of sex workers

33. Laws and policies that criminalize sex work force sex workers, clients and third parties into unsafe and unprotected areas. Such laws restrict access to important safety strategies, resulting in significant and profound negative consequences on sex workers' right to health, security, safety, and equality. Such laws represent violations under Article 12 as interpreted within this cited work of the Committee, the work of the Special Rapporteur on the right to health and the work of the Special Rapporteur on extreme poverty and human rights. States are obligated to show due diligence in the protection of sex workers' human rights through the enactment and reform of evidence and rights-based laws and policies and by addressing the intersecting and layered systems of oppression that impact sex workers' experiences.
34. International human rights organizations and UN agencies, including Amnesty International, Human Rights Watch, UNAIDS, Association of Women's Rights in Development (AWID), among others, support the decriminalization of sex work. In its Concluding Observations, the Committee has called for the decriminalization of sex work and to "take effective steps to ensure that sex workers who are victims of violence, torture or ill-treatment are provided an opportunity for a fair trial and, as appropriate, receive medical and psychosocial services as well as compensation, including reparations and guarantees of non-repetition."⁷⁸ The 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.⁷⁹ During his visit to Vietnam, the Special Rapporteur called for the elimination of stigmatization experienced by sex workers and the creation of "an enabling environment, in which at-risk populations, including injecting drug users, female sex workers and men who have sex with men, are able to effectively access health care, by de-penalizing drug use and sex work."⁸⁰ Similarly, the Special Rapporteur on extreme poverty and human rights has called for the "repeal [of] provisions relating to sex work;...[the provision of] training to all health service providers and law enforcement agents, in relation to their obligations and attitudes towards sex workers;...[ensuring] that law enforcement personnel are held accountable for any act of violence or abuse against sex workers and [improving] mechanisms of legal recourse for sex workers; [developing] support systems (legal and counselling) for sex workers; [... and strengthening] the capacity of organizations representing sex workers by, inter alia, providing a platform for their participation in public decision-making processes that affect them."⁸¹

⁷⁶ Grant, Kelly. "Policy allowing doctors to deny treatment on moral or religious grounds under review." *The Globe and Mail*, July 02, 2014.

⁷⁷ Blackwell, Tom. "Mount Sinai Hospital's refusal to eliminate one fetus from twin pregnancy triggers human rights battle." *National Post*, July 29 2016.

<http://news.nationalpost.com/health/mount-sinai-hospitals-refusal-to-eliminate-one-fetus-from-twin-pregnancy-triggers-human-rights-battle-in-toronto?lsa=65d9-ab0d>

⁷⁸ CEDAW. 2010. Concluding Observations to Fiji. (CEDAW/C/FJI/CO/4)

⁷⁹ UN General Assembly. 2010. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*. Human Rights Council, 14th session. A/HRC/14/20.

⁸⁰ UN General Assembly. 2012. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, Mission to Viet Nam. 2012. A/HRC/20/15/Add.2.

⁸¹ UN General Assembly. 2013. Report of the Special Rapporteur on extreme poverty and human rights, Ms. Magdalena Sepúlveda Carmona, Mission to Nanibia. A/HRC/23/36/Add.1.

Situation in Canada: health and safety of sex workers

35. The criminalization of sex work (including third parties and clients)⁸² in Canada represents 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 human rights violations, has failed to respect and protect the human rights of sex workers through its enactment of Bill C-36, the Protection of Communities and Exploited Persons Act (PCEPA), a discriminatory piece of legislation that puts the health and lives of sex workers – particularly migrant sex workers – at risk.
36. In 2013, the Supreme Court of Canada (SCC) struck down elements of the Criminal Code that were determined to violate the rights of sex workers by undermining their health and safety. The SCC 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 June 2014. The PCEPA, effectively criminalizes 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 approach continues to impose danger, increase criminalization, decrease agency, provide little control over working conditions and reduce safe options for sex workers.
37. The 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.⁸³ In the context of the right to health, the criminalization of both the selling and/or 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 sex work,⁸⁴ reduces sex workers' ability to negotiate safer sex with clients, on the street as well as indoors, or on the phone,⁸⁵ 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 identified as sex workers which could lead to police entrapment,⁸⁶ and 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. According to the Lancet, 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.⁸⁷ The criminalization of sex work increases the likelihood of additional violation of sex workers' human rights, namely the right to live free of violence and the right to bodily autonomy and women's agency.⁸⁸

⁸² Canadian Alliance for Sex Work Law Reform. "Sex work and changes to the Criminal Code after bill C-36: what does the evidence say." www.sexworklawreform.com

⁸³ World Health Organization. 2015. Sexual health, human rights and the law. http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf?ua=1, SWJAV et al. "My Work Should Not Cost me My Life" (Vancouver: Pivot Legal Society, 2014), available at: http://www.pivotlegal.org/my_work and Canada (Attorney General) v. Bedford, 2013 SCC 72 CanLII. 2013. 3 SCR 1101. Available at: <http://canlii.ca/t/g2f56>

⁸⁴ Canadian Alliance for Sex Work Law Reform: factsheet "Why Decriminalization is Consistent with Public Health Goals."

<https://drive.google.com/folderview?id=0B3mqMOhRg5FeLWpPd2iVYtTidTA&usp=sharing&tid=0B3mqMOhRg5FeNY4ZkxGb2pLaWM>

⁸⁵ Kim Blankenship and Stephen Koester, "Criminal Law, Policing Policy and HIV Risk in Female Street Sex Workers and Injection Drug Users" (2002) 30 Journal of Law, Medicine and Ethics 548, p.550; Annika Eriksson and Anna Gavanas, Prostitution in Sweden 2007 (Socialstyrelsen 2008)

http://www.socialstyrelsen.se/lists/artikkelkatalog/attachments/8806/2008-126-65_200812665.pdf p.48; Ulf Stridbeck (ed.), Purchasing Sexual Services in Sweden and the Netherlands: Legal Regulation and Experiences—An Abbreviated English Version. A Report by a Working Group on the legal regulation of the purchase of sexual services (Justis- og Politidepartementet, 2004) http://www.regjeringen.no/upload/kilde/jd/rap/2004/0034/ddd/pdfv/232216-purchasing_sexual_services_in_sweden_and_the_netherlands.pdf pp.13 and 19;

Petra Östergren, "Sexworkers critique of Swedish Prostitution policy" (2004), http://www.petraostergren.com/pages.aspx?r_id=40716; Rosie Campbell and Merl Storr, "Challenging the Kerb Crawler Rehabilitation Programme" (2001) 67 Feminist Review 94, 102 citing Steph Wilcock, The Lifeline Sexwork Project Report: Occupational Health and Safety Issues and Drug Using Patterns of Current Sexworker: Survey Findings (Manchester: Lifeline, 1998); Pro Sentret, Året 2010/2011, pp.72, 78-79.

⁸⁶ Helseidrettoratet (Norwegian Directorate of Health), UNGASS Country Progress Report Norway: Jan. 2008–Dec. 2009 (Helseidrettoratet, Apr. 2010)

http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/norway_2010.

⁸⁷ The Lancet. 2014. "HIV and Sex Workers." <http://www.thelancet.com/series/HIV-and-sex-workers>.

⁸⁸ The criminalization of both the selling and the 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 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

38. Migrant sex workers are at particularly at risk of experiencing human rights violations, detention and deportation. Recent reports suggest migrant women sex workers are being targeted, creating environments of fear which further limit sex workers' ability to access health services, report incidences of violence, or seek broader support services.⁸⁹ 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." The new laws rests on the incorrect conflation of consensual sex work with coercion or trafficking, which prohibits the former. Human trafficking frameworks are therefore being applied to the context of sex work,⁹⁰ which limits meaningful dialogue about the rights of sex workers and creates the assumption that all sex workers are victims.⁹¹ The new laws therefore uphold misconceptions about sex work and sex workers: that all sex workers are women or that they are inherently victims. It positions all sex workers, and by extension women, as 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. It is also important to consider that Canada has existing 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.

Background: criminalization of the non-disclosure of HIV

39. The criminalization of the non-disclosure of HIV entails violations of the right to health, among other rights, including for women living with HIV. States are obligated to show due diligence in the protection of those living with HIV, including through the elimination of laws that criminalize non-disclosure of HIV status and exposure to and transmission of HIV.⁹² The UN Special Rapporteur on the right to health has stated that criminalizing HIV transmission not only infringes on the right to health but also on other rights, including the rights to privacy, equality and non-discrimination.⁹³

Situation in Canada: criminalization of the non-disclosure of HIV

40. Under current law in Canada, those living with HIV can be criminally charged and prosecuted for failing to disclose their HIV status prior to sexual relations.⁹⁴ To date, more than 180 people have been charged in Canada.⁹⁵ An overly broad interpretation of the law has resulted in charging those living with HIV with aggravated sexual assault (which carries a maximum penalty of life imprisonment and mandatory registration on the Sexual Offender Registry).⁹⁶ SCC rulings from 2012 make clear that those living with HIV are "at risk of prosecution for non-disclosure of their HIV-positive status even if there was no transmission, the person had no intention to harm their sexual partner, and the person used a condom or had an undetectable viral load."⁹⁷ This decision runs counter to international human rights recommendations and medical evidence on HIV.⁹⁸

information for people to protect themselves; and intensifies the social stigma of selling sex. The Criminalization of 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, and rests on the incorrect conflation of consensual sex work with coercion or trafficking, which prohibits the former.

⁸⁹ Butterfly (Asian and Migrant Sex Workers Support Network), *Stop the harm from anti-trafficking policies & campaigns: support sex workers' rights, justice and dignity*, 2016.

⁹⁰ See the *National Action Plan to Combat Human Trafficking* which makes claim that the sexual exploitation of women and girls is the most common manifestation of trafficking in Canada. See Public Safety Canada, *National Action Plan to Combat Human Trafficking*, 2012.

⁹¹ Butterfly (Asian and Migrant Sex Workers Support Network), *Stop the harm from anti-trafficking policies & campaigns: support sex workers' rights, justice and dignity*, 2016.

⁹² CESCR. General Comment 22. 2016, UNAIDS/UNDP, *Policy brief: criminalization of HIV transmission*, August 2008, UN General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*, Human Rights Council, Fourteenth session, Agenda item 3, A/HRC/14/20, April 27, 2010, Global Commission on HIV and the Law (UNDP HIV/AIDS Group), *HIV and the Law: Risks, Rights and Health* (July 2012), 24. Available at www.hivlawcommission.org

⁹³ UN General Assembly. 2010. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*. Human Rights Council, 14th session. A/HRC/14/20, paras. 2, 51.

⁹⁴ Canadian HIV/AIDS Legal Clinic. 2014. "Criminal Law and HIV Non-Disclosure in Canada." <http://www.aidslaw.ca/site/criminal-law-and-hiv/?lang=en>

⁹⁵ E. J. Bernard and S. Cameron, *Advancing HIV Justice 2: Building momentum in global advocacy against HIV criminalisation* (Brighton/Amsterdam: HIV Justice Network and Global Network of People Living with HIV (GNP+), April 2016).

⁹⁶ Canadian HIV/AIDS Legal Clinic. 2014. "Criminal Law and HIV Non-Disclosure in Canada." <http://www.aidslaw.ca/site/criminal-law-and-hiv/?lang=en>

⁹⁷ Canadian HIV/AIDS Legal Network. 2016. Submission to Committee on the Elimination of Discrimination Against Women.

⁹⁸ Loutfy M., Tyndall M. et al., "Canadian Consensus Statement on HIV and its transmission in the context of the criminal law," *Canadian Journal of Infectious Diseases & Medical Microbiology* 25, 3 (2014): pp. 135-140, and A.J. Rodger et al., "Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is

41. Evidence from Canada demonstrates that the criminalization of the non-disclosure of HIV undermines effective HIV prevention strategies, deters HIV positive women from seeking health and other support services, prevents disclosure of their HIV status to relevant services providers, and can deter HIV positive women who experience violence to report such incidences to legal authorities or relevant services providers.⁹⁹ A 2015 study concluded that: “[t]he threat of HIV non-disclosure prosecution combined with a heightened perception of surveillance may alter the environment within which women engage with healthcare services. Fully exploring the extent to which HIV criminalization represents a barrier to the healthcare engagement of [women living with HIV] is a public health priority.”¹⁰⁰ HIV positive women who experience multiple and intersecting factors of oppression are at heightened risk of experiencing human rights violations fearing criminal charges for failing to disclose their HIV status.

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

42. **Ensure access to abortion services in all jurisdictions in compliance with the requirements of international human rights law,¹⁰¹ and withhold Cash Contributions and initiate dispute resolution procedures** under sections 14-17 of the Canada Health Act as violations of the program criteria established in sections 7, 10 and 12 of the Act **for provinces and territories failing to ensure the availability and accessibility of abortion services.**
43. **Establish a national protocol and funding instrument for individuals having to travel to access abortion services** (in Canada and outside of Canada), with funding to cover costs associated with travel, accommodation and the procedure (prior to the procedure).
44. **Ensure access to medical abortion, inline with international human rights obligations, by:**
- Easing restrictions on access to medical abortion drug Mifegymiso** (including removing restrictions related to: physician-only dispensing, extending gestational limitations, private registry and mandatory ultrasounds),
 - Ensuring cost coverage through either a federal programme or provincial/territorial insurance plans for Mifegymiso,**
 - Engaging in awareness raising activities for service providers and women on the availability of medical abortion, and**
 - Ensuring appropriate task-shifting in the provision of medical abortion, and allowing the training of other health professionals, such as nurse practitioners and midwives, to provide these services.**
45. **Establish a national drug plan in order to eliminate financial barriers to accessing a comprehensive package of sexual and reproductive health services** (including medical abortion, HPV vaccine, assisted reproductive technologies, HIV medications, etc.).
46. **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.¹⁰²

using suppressive antiretroviral therapy,” *JAMA* 316, 2 (12 July 2016): pp. 171–181; Loutfy M., Tyndall M. et al., “Canadian Consensus Statement on HIV and its transmission in the context of the criminal law,” *Canadian Journal of Infectious Diseases & Medical Microbiology* 25, 3 (2014): pp. 135-140.

⁹⁹ http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Women_crim-ENG.pdf and, P. Allard, C. Kazatchkine and A. Symington, “Criminal prosecutions for HIV non-disclosure: Protecting women from infection or threatening prevention efforts? in. J. Gahagan (ed) *Women and HIV Prevention in Canada: Implications for Research, Policy, and Practice* (Toronto: Women’s Press, 2013): 195–218.

¹⁰⁰S. Patterson, et al., “The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence,” *Journal of the International AIDS Society* 18 (2015): 20572.

¹⁰¹ This could form part of a renewed national health accord and 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 and offer remedy and redress for violations of the right to health.

¹⁰² See footnote 21.

47. **Establish effective remedies for the regulation of conscientious objection in all jurisdictions complies with international human rights law requirements and the guidance of international technical and professional bodies,¹⁰³ and withhold Cash Contributions and initiate dispute resolution procedures under sections 14-17 of the Canada Health Act as violations of the program criteria established in sections 7, 10 and 12 of the Act for provinces and territories that fail to prohibit institutional objection or to regulate individual conscientious objection.¹⁰⁴**
48. **Remove all criminal code sections that are specific to sex work, and threaten sex workers' health and safety, including those introduced by the Protection of Communities and Exploited Persons Act, and support concrete measures to improve the safety of individuals selling sexual services and to assist those who wish to transition out of the sex industry, providing significant resources for income support, housing, education and training, poverty alleviation, and treatment and support for addictions.**
49. **Limit the use of criminal law to intentional transmission of HIV, ensuring that under no circumstances is it used against people living with HIV who use a condom, practice oral sex or have condomless sex with a low or undetectable viral load for not disclosing their status to sexual partner(s), and mandate that the offence of sexual assault not be applied to HIV non-disclosure as it constitutes a stigmatizing and harmful misuse of this offence.**

¹⁰³ It would need to ensure appropriate regulation of individual conscientious objection (CO) that would apply to physicians and other health professionals lawfully allowed to provide sexual and reproductive health services. It would need to contain: measures to effectively prohibit any attempted institutional objection to the provision of sexual and reproductive health services, national guidelines for the implementation of appropriate monitoring and accountability mechanisms with respect to CO and remedy and redress for violations of the right to health.

¹⁰⁴ By requiring health professionals to provide accurate and unbiased information about medical options, effective referrals and urgent or emergency care; and by ensuring that they are effectively held accountable for violations of these ethical duties.