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Founded in 2014, 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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Formed in 2006, the Sexual Rights Initiative (SRI) is a coalition of organisations including Action Canada for Sexual Health and Rights (Canada), Akahata (Argentina), CREA (India), Coalition of African Lesbians (South Africa), Egyptian Initiative for Personal Rights (Egypt) and the Federation for Women and Family Planning (Poland). The SRI partners advocate together for the advancement of human rights related to sexuality, gender and reproduction at UN Human Rights Council.

This report is also endorsed by:

Canadian Alliance for Sex Work Law Reform <http://sexworklawreform.com>

Abortion Rights Coalition of Canada <http://www.arcc-cdac.ca>

Key words

1. Sexual and Reproductive Health and Rights; Abortion; Comprehensive Sexuality Education; Criminalization of Sex Work.

Executive Summary

2. The federal government of Canada is responsible for ensuring the fulfillment of Canada's international human rights treaty obligations. Specific barriers to the realization of human rights related to sexuality, gender and reproduction persist throughout Canada and must be resolved. This submission addresses three main issues that prevent individuals from exercising their sexual and reproductive rights including: the criminalization of sex work, unequal access to safe abortion services, and inconsistent implementation of curricula/school-based comprehensive sexuality education.
3. The laws effectively criminalizing **sex work** in Canada were ruled unconstitutional and struck down by the Supreme Court of Canada in 2013. The laws enacted in 2014 to replace those sections of the criminal code have replicated and exacerbated the harms caused by previous laws, in contravention of the letter and spirit of the Supreme Court decision. Since taking office in 2015, the current Government of Canada has taken no action to repeal these dangerous and discriminatory laws.
4. Since 1988, **abortion** is unrestricted by criminal law in Canada. However, persistent barriers are in place that inhibit the accessibility, availability, affordability and quality of abortion services for all who need them. Policy options available to the federal government to overcome these barriers, including improved access to medical abortion medication (as recommended by the World Health Organization and approved by Health Canada in 2016) and regulation of health information, have not been adequately evaluated or implemented to ensure Canada's compliance with international human rights law.
5. The content and implementation of **comprehensive sexuality education** curricula in Canada has not been consistent, effective, or delivered in a manner that supports young people's rights to information, non-discrimination, health, education, and to be free from gender-based violence. The Government of Canada has taken no action to address this situation since its last universal

periodic review in 2012 and no accountability mechanisms are in place to ensure that provincial/territorial governments are developing and implementing the highest standard of comprehensive sexuality education.

Criminalization of Sex Work

6. All sex workers and people who sell or trade sex in Canada are entitled to the full range of human rights and protections guaranteed under international law and the Constitution of Canada. The decades-long fight for the decriminalization of sex work in Canada is part of a struggle to realize sex workers' human and labour rights and to end exploitation and violence against sex workers.
7. In 2007, three Ontario sex workers, Terri-Jean Bedford, Amy Lebovitch and Valerie Scott, initiated a constitutional challenge to the provisions of the Criminal Code that criminalized certain aspects of sex work in Canada. These included s. 210 keeping or being found in a bawdy house, s. 212 (1)(j) living on the avails of prostitution, and s.213 (1)(c) communicating in public for the purpose of prostitution.
8. It took close to seven years for the case to move through three courts. The case was built on tens of thousands of pages of evidence as well as countless hours of expert testimony from sex workers, researchers and key stakeholders. In December of 2013, Canada's Supreme Court struck down three of the major provisions that effectively criminalized sex work in Canada. The decision held that all three provisions infringed upon the rights of the sex workers by depriving them of security of the persons guaranteed under section 7 of the Canadian Charter of Rights and Freedoms. The Court found that the existing Criminal Code provisions prevented sex workers from protecting themselves from risks and that the violence from clients or pimps does not diminish the role of the state in making sex workers more vulnerable to that violence. The Court further found the provisions to be overly broad, grossly disproportionate and to have arbitrary effects.¹
9. This decision marked a huge step forward in the recognition of sex workers' human rights. For thirty years, sex workers had been calling on Canada to repeal laws that targeted them, their

¹ Canada (Attorney General) v. Bedford, [2013] SCC 72.

clients and the people they work with, pointing to the inability of criminal prostitution laws to protect them from violence and to the harms caused by making elements of sex work a crime.

10. The Supreme Court suspended its decision for one year to allow Parliament to implement new legislation if it so decided, "...as long as it does so in a way that does not infringe the constitutional rights of prostitutes."² On June 4th 2014, Canada's then Justice Minister introduced Bill C-36, entitled the *Protection of Communities and Exploited Persons Act (PCPEA)*. The new bill proposed to make sex work itself illegal for the first time in Canada via the blanket prohibition of the purchase of sexual services.

11. Facing the prospect of this new legislation, sex workers and their allies banded together and worked hard to be included in the consultation process which was, from the beginning, based on the perspective of prostitution as violence and, more covertly, as nuisance. During the Justice Committee hearings in July of 2014 and the Senate's Legal and Constitutional Affairs Committee hearings in September 2014, sex workers, sex worker rights organizations and allies of sex workers appeared as witnesses to speak to Bill C36. However, the majority of witnesses invited to appear before the committee were in support of the criminalization of sex work despite the fact that the majority of written submissions (63%) were critical of the proposed legislation.³ Out of 91 individuals and organization invited to testify before the committees, 61 spoke in support of the draft bill. 25 percent of the organizations invited to appear had strong ties to the Evangelical Church, a percentage that is not representative of the Canadian society as a whole.⁴

12. Those in opposition to the bill were treated with thinly veiled hostility during the sessions. In one telling moment at the hearings, Senator Donald Plett stated "Of course we don't want to make life safe for prostitutes, we want to do away with prostitution. That's the intent of the bill."⁵ The consultation process clearly did not meet the threshold of meaningful consultation with those most affected by the proposed law as was confirmed by quantitative and qualitative

² ibid

³ Genevieve Fuji Johnson, Mary Burns, and Kerry Porth, (forthcoming, December 2017). "A Question of Respect: A Qualitative Text Analysis of the Canadian Parliamentary Committee Hearings on *The Protection of Communities and Exploited Persons Act*," Canadian Journal of Political Science.

⁴ ibid

⁵ Canada. Parliament. Senate. Standing Senate Committee on Legal and Constitutional Affairs. Evidence, 2nd Session, 41st Parliament, Meeting No. 35, September 9, 2014.

research that studied the consultation process.

13. The *PCPEA* became law on December 6 2014, effectively recriminalizing sex work despite testimony from sex workers about its potential harms, the Supreme Court's findings, and research conducted over the past thirty years that has demonstrated the negative effects of criminal law on the health and safety of sex workers. Human rights experts and UN bodies have affirmed these findings and concluded that criminalization of the sex industry and the application of other punitive regulations fosters discriminatory practices and stigmatizing social attitudes and drives sex work underground.⁶

14. Since the new laws took effect in 2014, human rights advocacy organizations, including Pivot Legal Society, Downtown Eastside Sex Workers United Against Violence (SWUAV), PACE Society, Butterfly - The Asian and Migrant Sex Workers Network, and the Canadian Alliance for Sex Work Law Reform have recorded testimonies of sex workers from across the country. These groups have reported that the new laws have: displaced and isolated sex workers; seeded fear of police and other law enforcement; increased targeted violence against sex workers; disproportionately affected Indigenous women, Black sex workers, youth, people who are immigrants (particularly racialized women) and trans people (especially trans women); interfered with safety mechanisms that sex workers use to stay safe on the job; increased police profiling and surveillance of racialized, Black and Indigenous sex workers; increased the misuse of human trafficking laws across Canada resulting in the profiling, detention, and deportation of migrant sex workers and third parties; and increased stigma and discrimination against sex workers and their clients.⁷ Further, evidence has demonstrated that predators are aware that in a criminalized regime, sex workers actively avoid police for fear of detection, apprehension, and in the case of immigrant women, deportation.⁸ The *PCPEA* replicates the harms of the former laws that the Supreme Court of Canada found violated sex workers' Charter right to security of person.

⁶ See for example Report of the UN Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Mental and Physical Health (2010) A/HRC/14/20 available from <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G10/131/18/pdf/G1013118.pdf?OpenElement>; WHO (2015) *Sexual health, human rights and the law* available from http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf; Global Commission on HIV and the Law (2012) *Risks, rights and health* available from <https://hivlawcommission.org/report>; Amnesty International (2016) *Policy on state obligations to respect, protect and fulfil the human rights of sex workers* available from <https://www.amnesty.org/en/documents/pol30/4062/2016/en/>

⁷ See Canadian Alliance for Sex Work Law Reform *Sex Work and Changes to the Criminal Code after Bill C-36: What does the evidence say?* (2015) available from <http://sexworklawreform.com/infosheets-impacts-of-c-36/>

⁸ Lowman, John. (2000). *Violence and the Outlaw Status of (Street) Prostitution in Canada*. Violence Against Women. 6. 987-1011.

15. Recent police tactics have led to more surveillance of sex workers. In several cities, police forces have conducted raids under a federally coordinated operation called Northern Spotlight which targets sex workers through their on-line advertisements and then visits or raids their workplaces under the guise of looking for trafficking victims. Many police forces seem to have shifted from investigating suspected cases of exploitation to targeting all sex workers indiscriminately, undermining the relationship between law enforcement and sex working communities.⁹
16. Police services are also increasingly working in collaboration with municipal by-law officers and the Canadian Border Service Agency (CBSA) to conduct raids on locations where they believe sex work to be taking place. In May 2015, the Ottawa Police Service instituted such a raid as part of a joint investigation with by-law officials and CBSA into commercial massage parlours and body rub facilities. Although no crimes were found to be committed at the time, eleven women were detained by the CBSA for not having valid work permits and were issued deportation orders.¹⁰ The threat of deportation added to criminal and/or municipal investigations significantly limits sex workers' ability to report experiences of violence and/or exploitation.
17. 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."¹¹ This means that human trafficking frameworks are being used to understand sex work. Because migrant sex workers are often identified as "trafficked victims" and because their work is often referred to as "sexual exploitation," laws and policies criminalizing both sex work and migration lead to both racialized and sex workers of colour being specifically targeted. This puts already vulnerable populations at higher risk of criminalization and violence. Indigenous sex workers are also particularly targeted and assumed to be trafficked when selling sex for money, while the legacy and impact of colonisation on homelessness, poverty and mental health receives less attention.

⁹ See <http://www.nswp.org/news/operation-northern-spotlight-targets-sex-workers-canada>

¹⁰ See <http://ottawacitizen.com/news/local-news/massage-parlours-charged-after-police-investigation>

¹¹ Protection of Communities and Exploited Persons Act R.S., c. C-46 Summary (f) <http://www.parl.ca/DocumentViewer/en/41-2/bill/C-36/royal-assent/page-4>

18. Canada has an obligation to show due diligence in the protection of sex workers' human rights. Laws and policies must be evidence-based and address the intersecting and layered systems of oppression impacting sex workers' experiences. The new criminal laws have only recreated the harms of the previous laws that were struck down by the Supreme Court of Canada. Since taking office in 2015, the current government has taken no action towards reviewing, repealing or replacing this harmful law or taking the necessary steps to ensure the constitutionally protected rights of sex workers to security of the person are upheld. Nor has it taken a holistic approach to law reform which involves repealing damaging federal law, and looking to how provincial laws and programs can address housing, education, poverty and other structural inequalities that sex workers face.

Abortion

Barriers to Accessing Safe Abortion Services

19. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) guarantees the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This right obliges governments to ensure the availability, accessibility, acceptability and quality of comprehensive and integrated sexual and reproductive health information and services, including abortion, and to remove any barriers that impede access to such services.
20. In accordance with the 1988 Supreme Court of Canada decision *R. v. Morgentaler*, there are no criminal laws restricting access to abortion in Canada. However, abortion services are not available or accessible in many parts of Canada. The overwhelming majority of abortion facilities are in major urban centres which forces individuals outside of these areas to travel long distances at great personal and financial expense to access safe abortion services.
21. Action Canada for Sexual Health and Rights runs a national toll-free 24-hour access line that provides information on sexual and reproductive health and referrals for pregnancy options. This work offers us privileged insight and information on the specific barriers individuals experience when seeking safe abortion services. The access line receives over 2400 calls per year from individuals seeking support from across the country. In 2016, 97% of the calls related to difficulties in accessing safe abortion. Barriers individuals reported include but are not limited

to: needing to travel, sometimes hundreds of kilometers to the nearest urban centers, because one has exceeded the gestational limit of the service provider(s) in their communities or live in an area where there are no services at all; having to cover the costs incurred by traveling which can include childcare, eldercare, missed work, plane tickets, gas money, accommodations and food; having to cover the costs of the procedure itself due to issues with reciprocal billing between certain provinces, being an international student, or being in a precarious immigration situation meaning that cost coverage may be delayed, providers being unsure about how to bill for their services, or people being unaware of where to safely access services when in irregular immigration situations; being delayed by anti-choice health care providers or staff acting as gate keepers; being delayed by the wait times that can come from mandatory ultrasounds and mandatory doctor's referrals and tests, etc. Barriers to abortion disproportionately affect young people and marginalized people, especially those who are low-income, people of color, migrants or refugees, people with precarious immigration status and those who do not speak English or French. These barriers are compounded for those living in rural or remote areas.

22. While there has been some welcome progress on abortion access such as the introduction of abortion services on Prince Edward Island in 2017 following decades of advocacy by reproductive rights activists, several provinces continue to uphold unnecessary administrative policies and regulations that impede reasonable and timely access to abortion services. For example, New Brunswick is the only province in Canada to refuse to fund abortion services and ultrasounds performed outside of hospitals. This situation creates unreasonable and unnecessary delays by limiting the points of services to three hospitals in two cities which can be particularly onerous for people, including young people, who must travel to Moncton or Bathurst to access abortion services, or for uninsured patients who face significantly steeper fees to access services in a hospital.

23. There have been some modest advancements in addressing the barriers caused by physicians' unwillingness to provide care on moral or religious grounds, however, official responses to abuses of conscientious objection has been weak overall. Robust national leadership is necessary to ensure colleges in all provinces review their policies to require: effective and timely referrals if conscientious objection is invoked, the provision of emergency care notwithstanding any conscientious objections, and the establishment of effective remedies for persons denied

abortion care for reasons of conscientious objection.

24. Another major barrier that has yet to be addressed by all levels of government is the dissemination of false and misleading information to prevent individuals from accessing abortion services. Anyone accessing health-care services has the right to receive comprehensive, unbiased, medically and factually accurate information, including people seeking information on pregnancy options. To deter people from choosing to terminate pregnancies, groups that oppose people's rights to access safe abortion services¹² have created resources, including misleading postcards, ads, pamphlets and billboards, as well as networks of facilities referred to as 'Crisis Pregnancy Centers' (CPCs) targeting people seeking information on pregnancy options. These groups intentionally restrict, control, and manipulate information people receive about abortion. Some Crisis Pregnancy Centers even offer ultrasound services¹³, mimicking services offered in medical clinics. People accessing services in those facilities often receive false information on mental and physical health risks abortion carries, how the procedure is performed, and where and when to access abortion services.¹⁴ The impacts of CPCs and misinformation on people's health include, but are not limited to, delays in accessing abortion services, unintended births, perpetuating shame and stigma regarding accessing abortion services and delays in accessing pre-natal care.

25. In 2017, the Abortion Rights Coalition of Canada (ARCC) released a study¹⁵ that examined the tax filings of 112 CPCs that are registered charities. It was found that of the 112 centers, 58 received about \$3.5 million in government funding from 2011 to 2015. CPCs with charitable status do not pay income tax on any of their revenue, and can issue tax receipts that reduce donors' taxable income, incentivizing donations for the spreading of false health information to the Canadian public.

Jurisdictional responsibility for abortion services

26. Provincial governments are responsible for the administration, organization and delivery of health care services within their jurisdictions. However, the federal government has

¹² <http://www.arcc-cdac.ca/CPC-study/list-anti-choice-groups.pdf>

¹³ <http://www.arcc-cdac.ca/postionpapers/83-Crisis-Pregnancy-Centres-and-Sonography.pdf>

¹⁴ <http://www.arcc-cdac.ca/CPC-study/cpc.html>

¹⁵ <http://www.arcc-cdac.ca/CPC-study/cpc.html>

constitutional spending power, which enables it to fund health systems under provincial jurisdiction, subject to provincial compliance with certain requirements set out in the 1984 Canada Health Act. The Act states that provinces and territories must provide universal coverage for all insured persons for all medically necessary hospital and physician services. Abortion has been deemed a medically necessary service. Despite having the appropriate power, responsibility and authority to ensure that abortion services are provided on an equitable basis, the Government of Canada has not taken sufficient action to address inequitable and unnecessary abortion policies of provinces that contravene the Act. An obvious example is how New Brunswick is still able to deny funding the provision of abortion and ultrasound services in clinics.

27. Furthermore, the federal government is responsible for meeting the health needs of Indigenous peoples however jurisdiction limitations and complexities has resulted in fragmented, culturally inappropriate and unequal access to health services, including sexual and reproductive health services.¹⁶

Availability of medical abortion

28. In addition to the right to health as articulated in the ICESCR, all people are entitled to the benefits of scientific progress as set out in Article 15 (1) of the Covenant. While historically most abortion services in Canada have utilized surgical methods, Health Canada's 2016 approval of Mifegymiso (the Canadian brand name for the combination of Mifepristone and Misoprostol used for medical abortion and recommended by the World Health Organization) provides an important opportunity to truly address gaps in access to abortion services across its territory and alleviate some of the barriers to abortion access.
29. The benefits of offering medical abortion include: high acceptability among users, can be offered earlier than surgical abortion, has the potential reduce wait times for surgical abortion procedures by multiplying the possible points of services, may be preferable to surgical abortion, and can be administered by different health care providers including doctors, nurse practitioners and midwives which would greatly improve access in remote, rural and

¹⁶ National Collaborating Centre for Aboriginal Health (2011) *Access to health services as a social determinant of First Nations, Inuit and Métis Health* Available from http://www.nccah-ccnsa.ca/docs/fact%20sheets/social%20determinates/Access%20to%20Health%20Services_Eng%202010.pdf

underserved locations where there is often no regular doctor in residence or the infrastructure necessary to offer surgical abortion.

30. Despite the well documented benefits of utilizing medical abortion as a means of safely and equitably expanding access, the use of Mifegymiso is currently restricted in several ways in Canada. Following two and a half years of review by Health Canada, one of the lengthiest approval processes by Health Canada on record for any drug, Mifegymiso was approved in July 2015 but was not available for use until January 2016. Upon approval, Health Canada imposed medically unnecessary and confusing restrictions and regulations on the prescribing and dispensation of the drug. In its initial approval documents, Health Canada mandated the completion of a 6 hour training course before physicians could prescribe Mifegymiso, registration of all physicians and pharmacists wanting to prescribe and dispense Mifegymiso, mandated ultrasounds, required patients to ingest the medication in front of their health care providers meaning that doctors would have to dispense the drug which is not common practice in Canada, and excluded other health care providers such as nurse practitioners from being able to prescribe Mifegymiso. Following objections from pharmacists, physicians, nurse practitioners and sexual and reproductive rights advocates, Health Canada has since revised its guidance to allow provincial Colleges of Physicians and Pharmacists to regulate the dispensing of Mifegymiso, however, deviations from Health Canada's distribution and administration program are considered "off label"¹⁷. Mandatory training and registration of pharmacists and physicians has also been relaxed. The lack of clarity on prescribing and dispensing protocols and the imposition of medically unnecessary obstacles to access, contributes to the stigma surrounding abortion as being outside the norm of regular health care provision.

31. The cost of Mifegymiso for an individual is between \$300-\$400 CAD. As of September 2017, five provinces, Alberta, New Brunswick, Quebec, Ontario and Nova Scotia, have committed to universal cost-coverage for the drug in recognition of the benefits listed above. Mifegymiso was also added to the federal Non-Insured Health Benefits' formulary which covers eligible federal patients and ensures access to most residents of the North-Western Territory, Yukon and Nunavut. The Interim Federal Health Program also just added it to its supplemental benefits

¹⁷ http://www.ocpinfo.com/library/practice-related/download/Dispensing_Mifegymiso.pdf

though access is still complicated for many of the eligible refugees. The provinces of Manitoba, British Columbia, and Saskatchewan did not pledge universal coverage and instead, Manitoba residents will be able to access Mifegymiso free of charge in a few limited sites located in urban centers while Saskatchewan and British Columbia added Mifegymiso to their provincial formularies which limits accessibility and fuels a two-tiered access to health care depending on geographical and social locations. In addition, two provinces, Prince Edward Island and Newfoundland/Labrador have not yet committed to cost coverage at all for medical abortion and many persons under federal health jurisdiction are also currently without coverage. This patchwork of decisions related to cost coverage leads to unequal access across the country and denies many pregnant individuals without financial means a safe, timely, less invasive and potentially more acceptable method of terminating a pregnancy. Extending from its duty to fulfill its obligations under ICESCR and its responsibility to ensure equal access to health services in accordance with the Canada Health Act, Canada has a duty to actively support the roll out of Mifegymiso as a strategy for increasing access to abortion across the country, remove any medically unnecessary administrative barriers, and encourage every province and territory to guarantee universal cost-coverage to prevent unequal, two-tiered access to health services across the country.

Comprehensive Sexuality Education

32. Comprehensive sexuality education (CSE) refers to age-appropriate education about human rights, human sexuality, gender equality, relationships, and sexual and reproductive health through the provision of scientifically-accurate, nonjudgmental information and the development of decision-making, critical thinking, communication and negotiation skills. Comprehensive sexuality education aims to eliminate gender norms and stereotypes, discrimination and stigma while embracing diversity and respect for the evolving capacities of children and youth.

33. UN Special Procedures and Treaty Monitoring Bodies have repeatedly emphasized that rights to sexual and reproductive health, education and to be free from violence and discrimination on the basis of sexuality and gender obliges States to ensure the delivery of high quality CSE. Moreover, as the lead sponsor of the annual UN Human Rights Council resolution on

accelerating efforts to eliminate violence against women and girls, Canada has championed the need for States to deliver CSE as part of States' gender based violence prevention strategies.

34. Within Canada, the delivery of education falls under provincial/territorial jurisdiction and curricula is overseen by the provinces and territories. The absence of a standardized CSE curricula has resulted in inconsistent implementation of CSE across the country and a lack of information on the content, acceptability and effectiveness of existing curricula.
35. Recent evidence suggests that there are significant gaps in the sexual health knowledge of Canadian youth.¹⁸ In 2011, over one quarter of positive HIV tests were attributed to young people between the ages of 15 and 29.¹⁹ According to 2010 national STI surveillance data, 63% of new cases of chlamydia, 49% of new cases of gonorrhoea and 14.9% of new cases of infectious syphilis were among young people aged 15-24²⁰. Violence against young women and girls persist at alarming rates as evidenced by research that found that young women are eight times more likely than boys to be victims of a sexual offence²¹, nearly half (46%) of high school girls in Ontario are victims of sexual harassment²², Indigenous women and girls are two and half times more likely to be a victim of violence and report more severe instances of violence than non-Indigenous women and girls²³, and 17% of missing and murdered Indigenous women are under the age of 18.²⁴
36. The Federal government has an acknowledged role to play both in fulfilling young people's sexual and reproductive rights. In 2008, the Public Health Agency of Canada (PHAC) revised its *Guidelines for Sexual Health Education* to provide a framework for the development and implementation of evidence-based sexual health education. However, while the guidelines offer evidence to support school-based sexual health education, provincial and territorial education ministries are not required to consult PHAC's guidelines in the creation of new/updated

¹⁸ See for example Kumar, M.M., Lim, R., Langford, C., Seabrook, J.A., Speechley, K.N., and Lynch, T. (2013). Sexual knowledge of Canadian adolescents after completion of high school sexual education requirements. *Pediatric Child Health*; 18(2): 74 – 80; Sarah Flicker, Susan Flynn, June Larkin, Robb Travers, Adrian Guta, Jason Pole, and Crystal Layne (2009). *Sexpress: The Toronto Teen Survey Report*. Planned Parenthood Toronto. Toronto, ON.

¹⁹ 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>

²⁰ *ibid*

²¹ <http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11766-eng.pdf>

²² <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.586.6071&rep=rep1&type=pdf>

²³ <http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11766-eng.pdf>

²⁴ https://www.nwac.ca/wp-content/uploads/2015/05/Fact_Sheet_Missing_and_Murdered_Aboriginal_Women_and_Girls.pdf

curricula. Moreover, these guidelines are almost ten years old and do not reflect the most recent evidence, sexual and reproductive health options and enabling legal developments. Currently, there is no federal mechanism for accountability or standardization to ensure CSE conforms to the highest standards and most recent evidence

37. We are encouraged to learn that PHAC has tasked SIECCAN (Sex Information Education Council of Canada) to engage in a revision process of these guidelines, which are almost ten years old. We would expect that part of this revision process would include the meaningful consultation of a diversity of stakeholders including young people and reflect the most recent evidence, sexual and reproductive health options and enabling legal developments.
38. The federal government does not regularly commission or collect data regarding the state of sexuality education in Canada, including evaluation of curriculum development, delivery, and the effect on adolescent knowledge and health outcomes. Regular national studies are required to determine the effectiveness of each province and territories' curricula and ultimately to determine if they are contributing to positive health outcomes and the fulfillment of young people's human rights.

Recommendations for action

Sex Work

- Uphold sex workers' rights under the Canadian Charter of Rights and Freedoms and international human rights law by repealing the *Protection of Communities and Exploited Persons Act* and other *Criminal Code* sections criminalizing sex workers, their clients and third parties.
- Ensure meaningful, transparent participation of current sex workers and sex worker's rights advocates in all policy and law reform processes that affect their health, safety and human rights.
- Revise existing anti-trafficking policies and programs that equate sex work with human trafficking, remove assumptions that sex work, absent coercion, is a form of trafficking, sexual exploitation, or violence and discourage the targeting of sex workers, especially racialized sex

workers, under the guise of anti-trafficking measures.

Abortion

- Collect data on the accessibility of abortion services across the country to identify gaps in service provision and ensure the prompt development of a national action plan to secure the accessibility, availability, acceptability and quality of both medical and surgical abortion services for all individuals in Canada, regardless of geography and social location. This plan must include a robust access plan for people who need to access abortion services after the first trimester of pregnancy.
- Enforce consumer protection laws that ban false advertising or deceptive practices by service providers to prevent CPCs and anti-choice organizations from spreading false health information about abortion and to require the disclosure that CPCs are not medical facilities.
- Develop and enforce policies to ensure that ‘crisis pregnancy centers’ and organizations that seek to restrict people’s access to health services do not receive funding from government programs.
- Withhold the transfer of federal health contributions to the provinces and territories when governments fail to ensure the availability and accessibility of abortion services and initiate dispute resolution procedures under sections 14-17 of the Canada Health Act as violations of the Accessibility or Universality program criteria established in sections 7, 10 and 12 of the Act.
- Ensure all individuals in Canada have equal access to abortion services, regardless of immigration status, including by removing waiting periods for temporary and permanent residents to access health care, and the provision of health care to undocumented people.
- Remove medically unnecessary restrictions for the prescribing of Mifegymiso and support the availability of medical abortion in remote and rural areas as means of addressing unequal access to abortion services.

- Ensure universal cost-coverage for Mifegymiso to prevent two-tiered, and discriminatory access to health care in Canada for all patients, including federal patients and uninsured patients.

Comprehensive Sexuality Education

- Following the multi-stakeholder revision of the *Guidelines for Sexual Health Education*, the Minister of Health must task the Public Health Agency of Canada with responsibility for disseminating and implementation of the revised guidelines, and creating clear mechanisms of accountability for the provinces/territories to adhere to when creating/updating sexuality education curriculums.
- Conduct regular national monitoring, through *inter alia* broad-based surveys of a robust set of sexual and reproductive health indicators disaggregated by relevant factors including gender identity, sexual orientation, age, location, race, ethnicity and others.
- Meaningfully engage diverse constituencies young people, particularly those that are marginalized, in the design, development, implementation and evaluation of policies and programs that affect their lives, including in relation to comprehensive sexuality education.
- Ratify the Optional Protocol to the Convention on the Rights of the Child on a communications procedure to provide an accountability mechanisms for young people to claim their sexual and reproductive rights.
- Mandate Health Canada to conduct research on the current state of sexuality education across Canada and produce recommendations aimed at strengthening the curriculum development, implementation and accountability of sexuality education everywhere in Canada.