



Action Canada for Sexual Health & Rights

Submission to Pre-Budget Consultation 2016

Action Canada for Sexual Health & Rights¹ is a progressive, pro-choice charitable organization committed to advancing and upholding sexual and reproductive health and rights in Canada and globally.

Recommendations in response to the Standing Committee on Finance invitation to share priorities for the 2016 budget

In Canada

Increase provincial and territorial transfers to improve access to sexual and reproductive health services, including abortion services, and establish a national drug plan

The federal government has constitutional spending power through which it funds health systems subject to the 1984 *Canada Health Act*. According to the *Act*, provinces/territories must provide universal coverage to all insured persons for all medically necessary hospital and physician services, which include abortions. Ongoing decreases in health transfers can hinder the ability to meet such requirements. As a result, access to healthcare services can become limited, as is the case with access to abortion services.

Nationwide, only 1/6 of hospitals provide abortions, the majority of which, like free standing sexual health clinics, are disproportionately dispersed and located in urban areas.² 20% of people in Canada live in rural areas where they must travel sometimes thousands of kilometres to access abortion services at their own expense. Moreover, there are few locations that offer services beyond 16 weeks gestation.³ Travel often results in unforeseen monetary expenses for transportation, accommodation, lost wages, childcare, eldercare, and possible procedural costs (for clinic procedures or in Québec which doesn't participate in reciprocal billing).

Decreases in health transfers to provinces and territories also create discrepancies in access to a range of other sexual and reproductive health services. For example, every province has a different system for covering HIV drug costs and care for trans individuals resulting in variations in the quality of care received. This results in some people relocating to another province in order to receive the care they need, sometimes severing important support networks. Ultimately,

¹ For more information, visit: www.sexualhealthandrights.ca. For inquiries, contact: Sarah Kennell, Public Affairs Officer, sarah@sexualhealthandrights.ca

² Sethna, C. 2012. "Travel to Access Abortion Services in Canada." University of Ottawa.

http://socialsciences.uottawa.ca/sites/default/files/public/research/eng/documents/CSethna_WorldIdeas.pdf

³ 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.



those with greater financial resources are better able to meet their health needs than those with lesser means, in contradiction to the principle of universality that is the foundation of our health-care system.

The lack of a national drug plan adds to the barriers associated with accessing comprehensive sexual and reproductive healthcare, particularly for those without insurance coverage. 24% of the population report that they have no drug coverage and are forced to pay out of pocket for pharmaceutical products, including contraceptive drugs and devices.⁴ 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 commodities across provinces and territories – particularly for those with limited financial resources. Sexual and reproductive health-related drugs are required to live healthy, productive lives; yet many people in Canada lack affordable access to them. For example, people in Canada have a narrower range of birth-control options than people in other developed countries and cost-related barriers for those seeking to end their pregnancies through medical abortion will be significant.⁵

Increase funding to improve settlement services, including sexual and reproductive health services, that meet the needs of all migrants, regardless of status

Depending on the type of coverage, some refugees lack coverage for sexual and reproductive health, including labour and delivery, which puts refugee women at particular risk as it bars some claimants from getting pre/post-natal and delivery care, as well as limits access to contraception, cancer screenings, abortion services, and supports in cases of intimate partner violence.⁶

Supporting equitable access to healthcare for migrants regardless of refugee, immigration or marital status, is paramount in addition to developing policies and programs that are grounded in human rights and uphold the principle of universality in the Canada Health Act.

Allocate funds to PHAC for public awareness campaigns and training for government officials on positive sexuality and consent, sexual and reproductive health, and stigma and discrimination

There is an overall lack of knowledge on sexual and reproductive health among youth populations in Canada, which can reinforce stigma associated with sexual activity, lead to discrimination and have negative health outcomes.

⁴ 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>.

⁵ Packaged under the name Mifegymiso, the newly-approved medical abortion drug is expected to cost a \$270.00 per package which is significantly more expensive than the previous regimen.

⁶ Women's College Hospital. 2012. "Impacts of changes to Interim Federal Health Programme for Refugees." <http://www.womenscollegehospital.ca/pdf/WCH%20Impact%20of%20changes%20to%20IFHP%20for%20Refugees.pdf>



- **In 2011, 25% of positive HIV tests were attributed to young people ages 15 to 29.⁷ Women are overrepresented in the younger age group (56.5% among ages 15-19).⁸**
- **Young Canadians have the highest reported STI rates. Reported rates of chlamydia, gonorrhea and syphilis have been steadily rising since the late 1990s.⁹**
- **Over ¾ of transgender youth report verbal harassment in school and 1/3 report physical violence.¹⁰**
- **Young women are 8 times more likely than boys to be victims of a sexual offence;¹¹ 46% of Ontario high school girls are victims of sexual harassment.¹² High rates of violence against young women and girls further demonstrate a lack of awareness regarding gender norms and stereotypes and respectful behaviour and relationships.**
- **Indigenous girls face more frequent incidents of violence than non-indigenous girls and 17% of missing and murdered indigenous women are under 18.¹³**

Positive outcomes of public awareness raising in the context of health include better health outcomes as well as changes in attitudes and behaviours.¹⁴ Together these can lead to decreased demand on the health system. Such campaigns must be accompanied by human rights training programs for all federal government who engage with the public to ensure persons with diverse sexual orientations, gender identities and expressions are treated with respect.

Increase provincial and territorial transfers for nationally standardized income assistance and re-establish a federal minimum wage covering all workers under federal jurisdiction at \$15/hr, indexing to inflation

Poverty is one of the best predictors of poor health.¹⁵ Low levels of socio-economic development facilitate the spread of STIs, including HIV; create challenges in access to prevention, treatment and support; and coincide with an increasing rate in unintended pregnancies.¹⁶ When

⁷ 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>

⁸ Ibid.

⁹ Public Health Agency of Canada. 2010. Population Specific Status Report: HIV/AIDS and other sexually transmitted and blood born infections among youth in Canada. <http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/youth-jeunes/chapter-chapitre-3-eng.php#footnote1>

¹⁰ Egale: Canada Human Rights Trust. 2011. "Every Class in Every School." <http://egale.ca/every-class/>.

¹¹ Statistics Canada. 2013. Measuring violence against women: statistical trends. <http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11766-eng.pdf>

¹² 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.

¹³ Native Women's Association of Canada. http://www.nwac.ca/files/download/NWAC_3D_Toolkit_e_0.pdf

¹⁴ Newbold, K., Campos, S. McMaster Institute of Environment and Health. 2011.

<http://www.mcmaster.ca/mihe/documents/publications/Social%20Media%20Report.pdf>

¹⁵ Feeny D., Kaplan MS, Hugué N, McFarland BH. Comparing population health in the United States and Canada. *Popul Health Metr* 2010 Apr 29; 8:8; Marmot M. and Wilkinson R. 1999. *Social Determinants of Health*. Oxford: Oxford University Press., 2009; Morris JN, Wilkinson P, Dangour AD, Deeming C, Fletcher A. Defining a minimum income for health living (MIHL): older age, England. *Int J Epidemiol*. 2007 Dec; 36(6): 1300-7.; Pickett KE, Wilkinson RG. Greater equality and better health. *BMJ* 2009 Nov 10; 339: b4320.; Raphael D. Public policies and the problematic USA population health profile. *Health Policy*. 2007 Nov; 84(1): 101-11., 2010; Victorina CC, Gauthier AH. The social determinants of child health: variations across health outcomes – a population-based cross-sectional analysis. *BMC Pediatr*. 2009 Aug; Dahlgren G and Whitehead M. 1991. *Policies and Strategies to Promote Social Equity in Health*. Stockholm: Institute for Futures Studies; Evans RG, Stoddart GL. 1994. *Producing Health, Consuming Healthcare*. In: Evans RG, ML Barer, TR Marmor (Eds.) *Why are some people healthy and Others Not? Determinants of the Health of Populations*. New York: Aldine de Gruyter: 77-63.

¹⁶ Guttmacher Institute. 2015. "Unintended Pregnancy in the United States." <http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html>



governments invest in job creation, health services and social assistance, and legislate increases in minimum wage, children and families see improved short and long term outcomes.¹⁷ Measures that can reduce poverty rates in the community lead to better health outcomes, including sexual and reproductive health outcomes, and help to limit the growing costs of treating poor health.¹⁸

Increase provincial and territorial transfer payments for programs that improve the safety of individuals selling sexual services and assist those seeking to transition out of the sex industry, including support for: income assistance, housing, education and training, poverty alleviation, and treatment and support for addictions

The 2014 Protection of Communities and Exploited Persons Act includes \$20 million over five years to be divvied up across the country for support systems for sex workers who wish to exit the industry. A significant portion of it is earmarked for law enforcement purposes. These funds are insufficient to support a comprehensive approach, which would aim to improve the safety of individuals selling sexual services and assist those who wish to transition out of the industry. When social service provision is contingent on sex workers exiting the sex industry, harm reduction activities are curtailed, the safety and security of sex workers are undermined and sex workers' access to information and safer sex supplies is reduced.

Provide sufficient and stable funding for community-based strategies that provide realistic alternatives to imprisonment for Indigenous and racialized offenders¹⁹

Racialized and Indigenous communities in Canada have experienced the negative impacts of systemic racism and discrimination. There is an over-representation of Indigenous peoples and racialized communities in federal prisons,²⁰ increasingly the likelihood of these individuals receiving mandatory minimum sentences, which judges are now required to impose on a range of offences.²¹ Longer sentences can lead to poor health outcomes for those who are incarcerated, especially related to sexual and reproductive health. Those more likely to become incarcerated (Indigenous persons and racialized communities) are more susceptible to contracting an STI, including HIV.²² Rising STI rates can be attributed to the lack of effective harm reduction

¹⁷ Bloch, G. Making Evidence Matter. "How an inadequate minimum wage is linked to poorer health outcomes – for everyone."

<http://umanitoba.ca/outreach/evidencenetwork/archives/17163>

¹⁸ Forget, E. 2011. "The Town with No poverty: using health administration to revisit outcomes of a Canadian guaranteed annual income field experiment." <http://public.econ.duke.edu/~erw/197/forget-cea%20%282%29.pdf>

¹⁹ Truth and Reconciliation Commission of Canada (TRCC). 2015. "Calls to Action."

http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf

²⁰ In 2011, the Correctional Investigator of Canada reported an 80% increase in Black prisoners in federal jails over the last decade, despite Canada's Black population representing just 2.5% of the total population. Native Youth Sexual Health Network,

<http://www.nativeyouthsexualhealth.com/january15172014.pdf> and Rabble. 2014. "Do Black Lives Matter in Canada?"

<http://rabble.ca/columnists/2014/12/do-black-lives-matter-canada> and CBC. 2011. "Prison watchdog probes spike in number of black inmates."

<http://www.cbc.ca/news/politics/prison-watchdog-probes-spike-in-number-of-black-inmates-1.1039210>

²¹ BC Civil Liberties Association. "More than we can afford: the cost of minimum sentencing." <https://bccla.org/wp-content/uploads/2014/09/Mandatory-Minimum-Sentencing.pdf>

²² Public Health Agency of Canada. 2013. "The Chief Public Health Officer's Report on the State of Public Health in Canada, 2013. Infectious Diseases – The never ending threat." <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2013/sti-its-eng.php>.



policies, limited access to comprehensive sexual and reproductive health services, and information in and out of prisons.²³

Invest in the Guidelines for the Implementation of Mother-Child Units in Canadian Correctional Facilities in all federal prisons

Indigenous women make up 36% of all young women incarcerated.²⁴ Reports indicate human rights violations of incarcerated Indigenous women, including through the “shackling of pregnant women also while in labor, coerced sterilization and sexual violence from prison staff and guards”²⁵ and the absence of effective facilities for incarcerated mothers.²⁶

Evidence from British Columbia, where the guidelines were developed and implemented, indicate a range of positive outcomes associated with mother-build units in prisons. Outcomes include reduced rates of re-incarceration of those who have had babies in prison, cost savings by the State (as a result of reduces rates of re-incarceration and reductions in the number of children in foster care), and improved physical and psychological health.²⁷

Foreign Policy & International Development

End freeze on foreign aid, meet the international commitment of 0.7% GNI to official development assistance, and exceed the commitment of 10% of OA for sexual and reproductive health information and services²⁸

Government of Canada spending on aid has plateaued at 0.24% GNI, funding for women’s rights organizations and gender specific projects has decreased significantly, and many partners and countries have criticized Canada for adopting ideological stances on development issues, specifically around sexual and reproductive rights. UK government spending on family planning in one year alone was more than double the total that Canada spent on family planning in the last four years of the Muskoka Initiative, with a mere 1.2% of funding going to family planning.²⁹

Women and girls continue to have their rights violated:

- **1 in 3 women worldwide has experienced sexual violence.**

²³ The Correctional Investigator of Canada has reported delays in inmates’ access to health services, cuts to essential health-related programs, unsupported harm reduction strategies, and the exacerbation of inmates’ existing health conditions. Correctional Investigator of Canada. 2014. “Annual Report 2013-2014 of the Office of the Correctional Investigator.” <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>

²⁴ Native Youth Sexual Health Network, <http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf>.

²⁵ Native Youth Sexual Health Network. 2013. Presentation during 6th session of the Expert Mechanism on the Rights of Indigenous Peoples July 8-12, 2013; <http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf>.

²⁶ Brennan, S. 2014. “Canada’s Mother-Child Program: Examining its emergence, usage and current state.” Canadian Graduate Journal of Sociology and Criminology. <file:///C:/Users/Sarah/Downloads/84-444-1-PB.pdf>.

²⁷ “Bonding through bars: new guidelines for mother-child prison units puts interests of child first.” Peter Wall Institute for Advanced Studies, University of British Columbia. <http://pwias.ubc.ca/media-centre/wall-papers/fall-2015/Bonding-through-Bars-new-guidelines-for-mother-child-units/>

²⁸ As agreed to during past International Parliamentarians Conferences on the Implementation of the International Conference on Population and Development (ICPD).

²⁹ Euromapping 2013. http://www.dsw.org/uploads/tx_aedswpublication/Euromapping_2013.pdf and McLeod Group. Aid Flows. <http://www.mcleodgroup.ca/topics-3/development-assistance/aid-flows/>



- **By 2020, 142 million girls will be married before they turn 18.**
- **Complications during pregnancy and childbirth are the second leading cause of death among 15-19 year old girls around the world.**

Investing in sexual and reproductive health and rights yields significant returns on investment. Meeting the unmet need for modern contraception and achieving universal access to sexual and reproductive health services by 2030, for example, is estimated to yield US\$120 for every dollar spent, and over US\$400 billion in annual benefits.³⁰ Yet, funding for women’s rights organizations and projects that specifically address their needs and realities continues to fall short.³¹

Increase funding for multilateral organizations working on gender equality, sexual and reproductive health and rights, and human rights more broadly, including: UNFPA, UN Women, and OHCHR. **UN agencies and institutions remain at the forefront of technical guidance, capacity building, intergovernmental negotiations, and development assistance. While aid levels continue to increase at the global level, support for multilateral institutions, particularly those working on human rights, has stagnated. Agencies working specifically on sexual and reproductive rights, gender equality and human rights more broadly receive considerably less funding than other UN agencies.³² Although human rights is recognized as one of the three UN pillars, the human rights programme receives just 3% of the Secretariat’s regular budget.³³ UN agencies have also experienced increases in support for earmarked funding streams at the expense of support for core-funding, which often prevents agencies from maintaining support for long-term initiatives and more effectively responding to development needs.³⁴**

³⁰ ICPD Task Force. 2015. <http://icpdtaskforce.org/wp-content/uploads/2015/01/FinancingBriefSmartInvestments2015.pdf>

³¹ In addition to the Muskoka Initiative, the Government of Canada has prioritized child, early and forced marriage and sexual violence in conflict as development priorities. The Government must allocate funds associated with these initiatives to provide those affected by such practices with a comprehensive package of sexual and reproductive health information and services, support initiatives that seek to address discriminatory laws and policies and strengthen the capacities of women’s rights organizations working to advance sexual and reproductive rights.

³² For example, in 2014, the United Nations Population Fund (UNFPA) reported just over one billion in contributions, and UN Women reported \$322 million, compared to the United Nations Children’s Fund (UNICEF) and United Nations Development Programme (UNDP) each reporting over four billion in 2013. UNFPA. 2014. Annual Report. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_annual_report_2014_en.pdf; UNICEF. 2014. Annual Report. http://www.unicef.org/publications/files/UNICEF_Annual_Report_2013_web_26_June_2014.pdf; UN Women. 2015. Annual Report. [http://www.unwomen.org/~media/headquarters/attachments/sections/library/publications/2015/annual%20report%202014-2015%20\(1\).pdf](http://www.unwomen.org/~media/headquarters/attachments/sections/library/publications/2015/annual%20report%202014-2015%20(1).pdf); and UNDP. 2014. Annual Report. http://www.undp.org/content/dam/undp/library/corporate/UNDP-in-action/2014/UNDP_AR2014_english.pdf

³³ OHCHR Management Plan. 2014-2017: Working for your rights. http://www2.ohchr.org/english/OHCHRreport2014_2017/OMP_Web_version/media/pdf/0_THE_WHOLE_REPORT.pdf

³⁴ Agencies working specifically on sexual and reproductive rights, gender equality and human rights, more broadly, receive considerably less funding than other UN agencies. UNFPA. 2014. Annual Report. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_annual_report_2014_en.pdf

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Fund and support advocacy initiatives aimed at decriminalizing and increasing access to abortion **Despite legal restrictions, social barriers and the lack of available safe services in developing countries, abortion rates are higher than in other parts of the world.³⁵ Restrictions on abortion do not reduce abortion rates; they force women to resort to clandestine, illegal and unsafe services that put their health and lives at risk.**

- **WHO estimates that 22 million unsafe abortions are performed each year, accounting for 13% of maternal deaths worldwide.**
- **In 2008, unsafe abortions resulted in 47,000 maternal deaths and an estimated 5 million more women experienced temporary or permanent disability.**
- **Over 14 million girls are forced into marriage each year³⁶ and an estimated 90% of adolescents who give birth are married. Married girls are twice as likely to experience sexual violence, encounter unwanted pregnancies and seek unsafe abortions.**

³⁵ Guttmacher Institute. 2012. Facts on induced abortion worldwide. http://www.guttmacher.org/pubs/fb_IAW.html

³⁶ UNICEF. 2013. "Joint Press Release: Child marriages: 39,000 every day." http://www.unicef.org/media/media_68114.html

