SUBMISSION FOR CANADA'S REVIEW BEFORE THE UN COMMITTEE ON THE RIGHTS OF PERSONS WITH DISABILITIES, 17th SESSION

February 27, 2017

Key words: right to education, right to health, right to live free from violence, forced sterilization, sexual abuse of people with disabilities, inclusive comprehensive sexuality education for people with disabilities, access to sexual and reproductive health for people with disabilities.

Contact: Sandeep Prasad, Executive Director
613 241 4474 ext. 3 sandeep@sexualhealthandrights.ca

Action Canada
for Sexual Health & Rights

TABLE OF CONTENTS

Introduction

1. This report is submitted by Action Canada for Sexual Health and Rights[1] for Canada's review during the 17th session of the Committee on the Rights of Persons with Disabilities (herein referred to as the 'Committee'), taking place March 20th to April 17th 2017. The report examines violations of Articles 16, 17, 24 and 25 of the Convention on the Rights of Persons with Disabilities (the Convention) with respect to sexual abuse, forced sterilization, the right to health, specifically sexual and reproductive health, and the right to education, specifically inclusive comprehensive sexuality education.

2. The List of Issues[2] prepared by the Committee in September 2016 requests that Canada:
    - Update the Committee on programmes designed and implemented to assist women and girls with disabilities…in particular…protection from violence, including sexual violence, and in gaining access to sexual health, reproductive and parental rights.
    - Inform the Committee about violence against women and children with disabilities, including Indigenous women and children with disabilities, and about measures to prevent and eliminate all forms of violence.
    - Elaborate on measures taken to assist children with disabilities to enjoy their human rights on an equal footing with others, including specific budgetary lines and programmes.
    - Explain in detail how the State Party is working towards inclusive education, in particular for children with high-level support needs across all provinces and territories; please also provide information about reasonable accommodation and support measures for students with disabilities…at all levels of the mainstream education system.
    - Provide details on sterilization without consent.
    - Inform the Committee about measures taken to ensure that women with disabilities, including Indigenous women with psychosocial impairments, can equally exercise their sexual and reproductive health rights and adopt children.

Article 16 – Freedom from exploitation, violence and abuse

Background: Sexual abuse of people with disabilities

3. Article 16 of the Convention requires that State Parties "take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects."[3] Violations of Article 16 entail violations of additional rights recognized under the Convention – including those related to Articles 5 (right to equality and non-discrimination), 6 (women with disabilities), 9 (right to accessibility), 14 (right to liberty and security of the person), 15 (freedom from cruel and inhuman or degrading treatment), among others.

4. Article 6 requires that State Parties "recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms." Article 9 requires that State Parties "take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment... [through the] elimination of obstacles and barriers to accessibility," State Parties shall do this by taking appropriate measures to "develop,

[1] This report was authored by Abigail Kidd, disability rights and anti-violence activist, researcher, and sexual health educator.
[2] Committee on the Rights of Persons with Disabilities. List of issues in relation to the initial report of Canada. CRPD/C/CAN/Q/1. 22 September 2016.
[3] Convention on the Rights of Persons with Disabilities (CRPD). Adopted December 13 2006.

promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public," "ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities," "provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms," and train "stakeholders on accessibility issues facing persons with disabilities." Article 14 requires State Parties to "ensure that persons with disabilities, on an equal basis with others: (a) Enjoy the right to liberty and security of person; (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty." Article 15 requires that State Parties ensure that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment," and requires that State Parties "take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment."[4]

5. The Committee's General Comment No. 3 on women and girls with disabilities recognizes that women with disabilities are at a heightened risk of violence, exploitation and abuse compared to other women. Such violence may be:

> …violence may be interpersonal or institutional and/or structural. Institutional and/or structural violence is any form of structural inequality or institutional discrimination that keeps a woman in a subordinate position, whether physically or ideologically, compared with other people in her family, household or community…Enjoyment by women with disabilities of the right to freedom from exploitation, violence and abuse can be hindered by harmful stereotypes that heighten the risk of experiencing violence. Harmful stereotypes that infantilize women with disabilities and call into question their ability to make judgments, perceptions of women with disabilities as being asexual or hypersexual and erroneous beliefs and myths heavily influenced by superstition that increase the risk of sexual violence against women with albinism all stop women with disabilities from exercising their rights as set out in Article 16, [and] sexual violence against women with disabilities includes rape. Sexual abuse occurs in all scenarios, within State and non-State institutions and within the family or the community. Some women with disabilities, in particular deaf and deafblind women and women with intellectual disabilities, may be at an even greater risk of violence and abuse because of their isolation, dependency or oppression.[5]

General Comment No. 3 calls on State Parties to collect and analyse "data on the situation of women with disabilities in all areas relevant to them in consultation with organizations of women with disabilities with a view to guiding policy planning…and to eliminating all forms of discrimination, especially multiple and intersectional discrimination," adopt "affirmative action measures for the development, advancement and empowerment of women with disabilities, in consultation with organizations of women with disabilities, with the aim of immediately addressing inequalities and ensuring that women with disabilities enjoy equality of opportunity with others. Such measures should be adopted in particular with regard to access to justice, the elimination of violence, respect for home and the family, sexual health and reproductive rights, health, education, employment and social protection…" and train and educate "public and private service providers…on applicable human rights standards and on identifying and combating discriminatory norms and values so that they can provide appropriate attention, support and assistance to women with disabilities."[6]

[4] CRPD. Adopted December 13 2006.
[5] Committee on the Rights of Persons with Disabilities. 2016. "General Comment No. 3: Women and girls with disabilities." CRPD/C/GC/3.
[6] Ibid.

6. The Committee's General Comment No. 2 on accessibility calls on State Parties to ensure that safe houses, support services and procedures be accessible "in order to provide effective and meaningful protection from violence, abuse and exploitation to persons with disabilities, especially women and children."[7]

Situation in Canada: Sexual abuse of people with disabilities

7. The Government of Canada is not fulfilling its obligations under Article 16 of the Convention through its failure to prevent the high rates of abuse experienced by people with disabilities. It is further failing to meet its obligations under Article 9 through its failure to ensure that all services provided to the public, including women's shelters and counselling services, are accessible to people with disabilities.

High Rates of Sexual Abuse and Assault

8. Canada's federal government is in the process of developing a 'Federal Strategy to Address Gender-based Violence.' The final report on the engagement process for the strategy acknowledges that women with disabilities are among the groups that experience higher rates of violence. It also specifically mentions the need for accessible shelters for women with disabilities. However, specific details about the exceptionally high rates of violence women with disabilities experience, the factors that need to be addressed to reduce those rates, and the unique gendered violence women with disabilities experience from service providers and support workers is absent from the report.[8]

9. The Canadian Charter of Rights and Freedoms states that all individuals in Canada have "the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice…the right not to be subjected to any cruel and unusual treatment or punishment, …[equality] before and under the law and…the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."[9] Yet, women with disabilities experience significantly higher rates of sexual assault and abuse than women without disabilities. Eighty-five percent of women in Canada will be sexually assaulted or abused in their lifetimes[10], and women with disabilities experience three to four times higher rates of sexual assault than non-disabled women.[11] Persons with disabilities are also between 50% and 100% more likely to experience intimate partner violence. [12] Men with disabilities, particularly men with intellectual disabilities, also experience significantly higher rates of sexual assault than men without disabilities.[13] Caregivers both in residential and institutional settings are often the perpetrators of sexual violence against people with disabilities,[14] as well as professionals who offer services relevant to the individual's disability, such as transit drivers, doctors and support workers.[15]

---

[7] Committee on the Rights of Persons with Disabilities. 2014. "General Comment No. 2: Accessibility." CRPD/C/GC/2.
[8] Status of Women Canada. 2016. "Breaking the Silence: final report on the engagement process for the federal strategy to address gender-based violence." http://www.swc-cfc.gc.ca/violence/strategy-strategie/breaking-briser-en.html
[9] The Constitution Act, 1982, Schedule B to the Canada Act 1982 (UK), 1982, c 11
[10] While this statistic uses Canadian data from 2004, the more widely used statistic of 83% uses data from a 1991 study by Stimpson and Best. More recent data collection in adherence to Article 31 is needed. Douglas Brownridge, Violence Against Women: Vulnerable Populations (New York: Routledge, 2009) in Odette, Fran. 2012 "Sexual Assault and Disabled Women Ten Years after Jane Doe" in *Sexual Assault in Canada: Law, Legal Practice and Women's Activism*. Elizabeth A Sheehy (Ed.). Pp. 173-189. Ottawa, ON: University of Ottawa Press.
[11] Ibid and Disabled Women's Network of Canada. 2014. "Factsheet: Women with Disabilities and Violence." http://www.dawncanada.net/main/wp-content/uploads/2014/03/English-Violence-January-2014.pdf [Accessed February 20, 2017]
[12] Disabled Women's Network of Canada. 2014. "Factsheet: Women with Disabilities and Violence." http://www.dawncanada.net/main/wp-content/uploads/2014/03/English-Violence-January-2014.pdf [Accessed February 20, 2017].
[13] Davis, Leigh Ann. 2011. "People with Intellectual Disabilities and Sexual Violence." The Arc. http://www.thearc.org/document.doc?id=3657 [Accessed February 20, 2017]
[14] Sheehy, Elizabeth A. 2012. "Introduction." in *Sexual Assault in Canada: Law, Legal Practice and Women's Activism*. Elizabeth A Sheehy (Ed.). Pp. 7-22. Ottawa, ON: University of Ottawa Press.
[15] Davis, Leigh Ann. 2011. "People with Intellectual Disabilities and Sexual Violence." The Arc. http://www.thearc.org/document.doc?id=3657 [Accessed February 20, 2017]

10. Statistics Canada's General Social Survey on Victimization found that Indigenous women were almost three times as likely to be a victim of a violent crime as non-Indigenous women.[16] Indigenous people in Canada experience a rate of disability that 2.3 times the national average.[17] Pervasive sexual abuse is also a significant factor in the issue of Missing and Murdered Indigenous Women in Canada.[18] While there is a lack of data on the rates of sexual assault and abuse experienced by Indigenous women with disabilities, consideration of the rates of sexual assault and abuse for non-Indigenous women with disabilities alongside the significant rates of disability suggests that rates of sexual violence and abuse experienced by Indigenous women are considerably high.

11. Sexual assault and abuse, and intimate partner violence, can also be the cause of disability.[19] Physical trauma alongside sexual abuse can result in cognitive disabilities, chronic pain, and physical limitations.[20] Trauma from sexual assault may impact mental health through the development of post-traumatic stress disorder, anxiety, depression, and other mental illnesses.[21] Sexually transmitted infections, including HIV, may also be acquired as a result of sexual abuse.[22]

12. Poverty and reliance on care givers makes it difficult for people with disabilities to leave abusive partners, caregivers, and service providers. Women with disabilities with low incomes are more likely to report having been abused.[23] Similarly, women with disabilities report that their low income or complete lack of money prevents them from leaving abusive situations.[24] Because their abusers are often either family members, spouses, or services providers, women with disabilities may risk institutionalization, loss of caregivers, and loss of services if their accusations are not believed by the police, violence against women service providers, or the courts.[25] A lack of access to financial resources and service options lead to women often having no alternative to the abusive care situations they are in.[26]

---

[16] Brennan, Shannon. 2011. "Violent victimization of Aboriginal women in the Canadian provinces, 2009." Statistics Canada. http://www.statcan.gc.ca/pub/85-002-x/2011001/article/11439-eng.pdf

[17] Durst, Douglas, Mary Bluechardt, Georgina Morin, and Melissa Rezansoff. 2001. "Urban Aboriginal Persons with Disabilities: Triple Jeopardy!" University of Regina. http://www2.uregina.ca/spr2/wp-content/uploads/2011/12/triple.pdf

[18] Kirkup, Kristy. November 20, 2016. "Sexual abuse likely to dominate inquiry into murdered, missing Indigenous women." The Canadian Press in CTVNews. http://www.ctvnews.ca/canada/sexual-abuse-likely-to-dominate-inquiry-into-murdered-missing-indigenous-women-1.3169212

[19] Odette, Fran. 2012 "Sexual Assault and Disabled Women Ten Years after Jane Doe" in *Sexual Assault in Canada: Law, Legal Practice and Women's Activism*. Elizabeth A Sheehy (Ed.). Pp. 173-189. Ottawa, ON: University of Ottawa Press and Learning Network. 2013. "Newsletter: Violence Against Women with DisAbilities and Deaf Women." Issue 7. http://www.vawlearningnetwork.ca/sites/vawlearningnetwork.ca/files/LN_Newsletter_Issue_7_2013_e-version_2.pdf and Rajan, Doris. 2011. "Women with Disabilities and Abuse: Access to Supports - Report on the Pan-Canadian Focus Groups." DisAbled Women's Network (DAWN) Canada. http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resource%20-%20DAWN-RAFH%20Canada%20-%20Focus%20Groups%20WWD_201.pdf

[20] Learning Network. 2013. "Newsletter: Violence Against Women with DisAbilities and Deaf Women." Issue 7. http://www.vawlearningnetwork.ca/sites/vawlearningnetwork.ca/files/LN_Newsletter_Issue_7_2013_e-version_2.pdf and Rajan, Doris. 2011. "Women with Disabilities and Abuse: Access to Supports - Report on the Pan-Canadian Focus Groups." DisAbled Women's Network (DAWN) Canada. http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resource%20-%20DAWN-RAFH%20Canada%20-%20Focus%20Groups%20WWD_201.pdf

[21] Rajan, Doris. 2011. "Women with Disabilities and Abuse: Access to Supports - Report on the Pan-Canadian Focus Groups." DisAbled Women's Network (DAWN) Canada. http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resource%20-%20DAWN-RAFH%20Canada%20-%20Focus%20Groups%20WWD_201.pdf and Davis, Leigh Ann. 2011. "People with Intellectual Disabilities and Sexual Violence." The Arc. http://www.thearc.org/document.doc?id=3657 [Accessed February 20, 2017]

[22] Davis, Leigh Ann. 2011. "People with Intellectual Disabilities and Sexual Violence." The Arc. http://www.thearc.org/document.doc?id=3657 [Accessed February 20, 2017]

[23] "Those with an annual household income less than $20,000 (OR = 3.21, 95% CI = 1.97–5.25) or between $20,000 and $49,999" were more likely to have reported experiencing physical and/or sexual violence. From: Karen Yoshida, Janice DuMont, Fran Odette, and Daria Lysy. 2011. "Factors Associated With Physical and Sexual Violence Among Canadian Women Living With Physical Disabilities" Health Care for Women International: Vol 32, No 8.

[24] Rajan, Doris. 2011. "Women with Disabilities and Abuse: Access to Supports - Report on the Pan-Canadian Focus Groups." DisAbled Women's Network (DAWN) Canada. http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resource%20-%20DAWN-RAFH%20Canada%20-%20Focus%20Groups%20WWD_201.pdf

[25] Odette, Fran. 2012 "Sexual Assault and Disabled Women Ten Years after Jane Doe" in *Sexual Assault in Canada: Law, Legal Practice and Women's Activism*. Elizabeth A Sheehy (Ed.). Pp. 173-189. Ottawa, ON: University of Ottawa Press.

[26] Learning Network. 2013. "Newsletter: Violence Against Women with DisAbilities and Deaf Women." Issue 7. http://www.vawlearningnetwork.ca/sites/vawlearningnetwork.ca/files/LN_Newsletter_Issue_7_2013_e-version_2.pdf

13. Failings in disability income support programs leave many people with disabilities living in poverty. In 2006, 14.4% of people with disabilities were living in poverty in Canada, these numbers increase when considering people with learning, memory, or developmental and intellectual disabilities or psychiatric diagnosis (22.3%), those who live alone (31%), and those in shared living arrangements with non-family members (53.7%).[27] Provinces and territories offer varying disability support programs resulting in significant discrepancies in access to financial supports depending where you live. Many programs do not provide the financial support to keep people with disabilities out of poverty. For example, the maximum amount a single person can receive from the Ontario Disability Support Program is $1,110.00 per month (way below the poverty line)[28] and under the British Columbia disability assistance program the maximum amount a single person can receive is $983.42 per month.[29] Due to restrictions on additional income under the disability support program in Ontario, there are frequent situations where people with intellectual disabilities are required to accept jobs that pay well-below the provincial minimum wage ($1.15/hr)[30] or risk losing their health benefits and income supports.[31]

14. The federal Canadian Pension Plan Disability (CPPD) Benefit also keeps recipients below the poverty line with an average payment of $933.82 per month in 2016, and requires people with disabilities to have worked and contributed to the plan to access it.[32] Even when people with disabilities are employed full time and not using disability support programs for income, they make significantly less than people without disabilities. In 2011, the average employment income of men who worked full time was only $49,200 for those with a severe or very severe disability, compared to $67,600 for those without a disability.[33] When additional factors including gender and race are factored in, this average income decreases further.

Accessibility of services for survivors of violence and abuse

15. The Minister of Sport and Persons with Disabilities is in the process of consulting on a federal accessibility legislation. While some provinces and territories have accessibility legislation, such as the Accessibility for Ontarians with Disabilities Act in Ontario, the lack of federal accessibility legislation results in discrepancies in legal protections and access to support services depending where you live. The result is that people with disabilities experience barriers in physical or attitudinal access to the support and counselling services available for those who have experienced violence or sexual abuse, or are currently attempting to leave an abusive situation. For example, shelters, support services, and counselling services are not always physically accessible. Many do not have TTY/TDD (Telecommunication Device for the Deaf) equipment, Braille materials, language or interpretation services, large print materials, wheelchair or

---

[27] Council of Canadians with Disabilities. "As a Matter of Fact: Poverty and Disability in Canada." http://www.ccdonline.ca/en/socialpolicy/poverty-citizenship/demographic-profile/poverty-disability-canada [Accessed February 20, 2017]

[28] In 2016. Special Needs Planning Group. "Ontario Disability Support Program." http://www.specialneedsplanning.ca/odsp.html [Accessed February 20, 2017] and Canadian Centre for Policy Alternatives. 2016. "Ontario's Social Assistance Poverty Gap." https://www.policyalternatives.ca/sites/default/files/uploads/publications/Ontario%20Office/2016/05/CCPA%20ON%20Ontario's%20social%20assistance%20poverty%20gap.pdf [Accessed February 26 20217].

[29] Government of British Columbia. "On Disability Assistance." http://www2.gov.bc.ca/gov/content/family-social-supports/services-for-people-with-disabilities/disability-assistance/on-disability-assistance [Accessed on February 20, 2017]

[30] This is in violation of Article 27. Additionally, many people with intellectual disabilities work for free for years under the pretense of employment training, which may never lead to paid work. Cobb, Chris (March 20, 2015) "Making sense of $1.15/hour: Disabled workers stuck in flawed system, say critics (with video)." Ottawa Citizen. http://ottawacitizen.com/news/local-news/making-sense-of-1-50hour-disabled-workers-stuck-in-flawed-system-critics-say

[31] Individuals will have their income support reduced after earning $200/month and can only have $5000 in assets, which prevents them from accessing work without penalty and from saving money to escape poverty. Government of Ontario. "Treatment of income: When you work and earn money." http://www.mcss.gov.on.ca/en/mcss/programs/social/odsp/income_support/odsp_workearn.aspx [Accessed on February 20, 2017] and Government of Ontario. "Income Support: Treatment of assets." http://www.mcss.gov.on.ca/en/mcss/programs/social/odsp/income_support/assets.aspx [Accessed February 20, 2017]

[32] Government of Canada. "Canada Pension Plan Disability Benefit – How much could you receive." https://www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-disability-benefit/benefit-amount.html [Accessed February 20, 2017]

[33] Martin Turcotte. "Persons with disabilities and employment." Statistics Canada. http://www.statcan.gc.ca/pub/75-006-x/2014001/article/14115-eng.htm [Accessed February 20, 2017]

walker access, and attendant services. [34] As a result, many people with disabilities cannot physically access services and shelters when trying to leave abusive situations. The lack of funding for counselling services results in women with disabilities who have low incomes being unable to access support because of financial barriers.[35]

16. Women with disabilities also experience attitudinal barriers when attempting to access support. A lack of education and stereotypes about women with disabilities results in women feeling "re-abused" by shelter workers, counsellors, and welfare workers when they attempt to access supports.[36] The lack of understanding is significantly worse for women with intellectual disabilities or mental health disabilities.[37] It is also more challenging for women with disabilities who are immigrants or Indigenous as they also experience intersecting forms of discrimination, including racism, from service providers.[38]

Recommendations to the Government of Canada relating to Article 16 of the Convention

17. In continuing discussions towards the development of federal accessibility legislation, ensure the explicit inclusion of services to meet the needs of survivors of violence,[39] including shelters and counselling services and attitudinal accessibility (including mandated education and human rights training that seeks to reduce disability stigma and sensitize health care staff, police,[40] service providers, and frontline workers to the needs of women with disabilities,) accompanied by appropriate funding to provinces and territories to ensure they meet these accessibility expectations.

18. Develop federal disability rights legislation, which mandates protections for people with disabilities and protects them from discrimination in housing, employment, services to address violence against women, among other sectors to ensure they have autonomy over living and self.

19. Initiate a national inquiry into the sexual assault and abuse of people with disabilities to better understand the factors that are resulting in consistently high rates of abuse/assault in Canada,[41] and conduct regular national monitoring,

---

[34] Disabled Women's Network of Canada. 2014. "Factsheet: Women with Disabilities and Violence." http://www.dawncanada.net/main/wp-content/uploads/2014/03/English-Violence-January-2014.pdf [Accessed February 20, 2017]
[35] Ibid.
[36] Rajan, Doris. 2011. "Women with Disabilities and Abuse: Access to Supports - Report on the Pan-Canadian Focus Groups." DisAbled Women's Network (DAWN) Canada. http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resource%20-%20DAWN-RAFH%20Canada%20-%20Focus%20Groups%20WWD_201.pdf
[37] Ibid.
[38] Ibid.
[39] Ensuring they have TTY/TDD equipment, Braille materials, language or interpretation services, large print materials, wheelchair or walker access, and attendant services.
[40] Police are often dismissive of women with disabilities when they report abuse and women with disabilities are seen as unreliable witnesses especially if they have an intellectual/developmental/cognitive disability, speech or communication-based disability, mental illness, or are racialized. Rajan, Doris. 2011. "Women with Disabilities and Abuse: Access to Supports - Report on the Pan-Canadian Focus Groups." DisAbled Women's Network (DAWN) Canada. http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resource%20-%20DAWN-RAFH%20Canada%20-%20Focus%20Groups%20WWD_201.pdf and Odette, Fran. 2012 "Sexual Assault and Disabled Women Ten Years after Jane Doe" in *Sexual Assault in Canada: Law, Legal Practice and Women's Activism*. Elizabeth A Sheehy (Ed.). Pp. 173-189. Ottawa, ON: University of Ottawa Press.
[41] While the inquiry into Missing and Murdered Indigenous Women is a strong start, given the high rates of disability Indigenous women experience, the State needs to take seriously the exceptionally high rates of abuse and assault people with disabilities in Canada are experiencing. In accordance with General Comment 3 on women and girls with disabilities, Canada should "reach out directly to women and girls with disabilities and establish adequate measures to guarantee that their perspectives are fully taken into account and that they will not be subjected to any reprisals for expressing their points of view and concerns, especially in relation to sexual and reproductive health and rights, as well as gender-based violence, including sexual violence," when forming and conducting this inquiry. The inquiry must lead to strong data on the rates of abuse and assault people with disabilities are experiencing, the protections that are required to prevent disability service providers from perpetrating abuses, and on the barriers service providers, including shelters and counselling services, are imposing on women with disabilities. It must explore accessibility as both physical and attitudinal. It must also lead to policy recommendations that will actively decrease the rates of abuse and assault experienced by people with disabilities and increase their access to violence against women and disability support services in Canada.

through inter alia broad-based surveys, of a robust set of sexual violence and abuse indicators disaggregated by relevant factors, including disability, age, etc..

20. Increase federal transfers to provinces and territories for disability supports that allows people with disabilities to live above the poverty line and earn extra income without penalty.[42]

21. Establish an emergency fund for people with disabilities escaping sexually violent/abusive situations, with specific funding available for costs associated with medication, services, etc. [43]

Article 17 – Protecting the integrity of the person

Background: Forced sterilization

22. Article 17 states that "every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others."[44] On the issue of sterilization and parenting, the Committee's General Comment No. 3 on women and girls with disabilities states that "all women with disabilities must be able to exercise their legal capacity by taking their own decisions, with support when desired, with regard to medical and/or therapeutic treatment, including by taking their own decisions on retaining their fertility and reproductive autonomy," and, "harmful gender and/or disability stereotypes based on such concepts as incapacity and inability can result in mothers with disabilities facing legal discrimination, which is why these women are significantly overrepresented in child protection proceedings and disproportionately lose contact and custody of their children, who are subject to adoption proceedings and/or to being placed in an institution."[45] The General Comment calls on States to ensure "that the legal capacity of women with disabilities…be recognized on an equal basis with that of others and that women with disabilities have the right to found a family and be provided with appropriate assistance to raise their children," and that discrimination laws, policies and practices, including forced sterilization of women with disabilities be repealed.[46]

23. Article 23 requires State Parties to "take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others" and that "persons with disabilities, including children, retain their fertility on an equal basis with others."

24. A joint statement titled 'Eliminating forced, coercive and otherwise involuntary sterilization' prepared by the Office of the High Commissioner for Human Rights, UN Women UNAIDS, the United Nations Development Programme, the United Nations Population Fund, UNICEF and the World Heath Organization, recognizes sterilization as a violation of fundamental human rights, and a form of discrimination and violence against women.[47] The statement recognizes State obligations to protect persons from such treatment by health-care professionals. [48] In the context of people with disabilities "various forms of control over sexual behaviour and reproduction, including coercive and involuntary sterilization, are used as methods of fertility regulation for persons with disabilities, often without their

---

[42] In line with Concluding Observation to Canada from the Committee on Economic, Social and Cultural Rights during its review in 2016. E/C.12/CAN/CO/6.
[43] Rajan, Doris. 2011. "Women with Disabilities and Abuse: Access to Supports - Report on the Pan-Canadian Focus Groups." DisAbled Women's Network (DAWN) Canada. http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resource%20-%20DAWN-RAFH%20Canada%20-%20Focus%20Groups%20WWD_201.pdf
[44] CRPD. Adopted December 13 2006.
[45] Committee on the Rights of Persons with Disabilities. 2016. "General Comment No. 3: Women and girls with disabilities." CRPD/C/GC/3.
[46] Ibid.
[47] Including the right to health, the right to information, the right to privacy, the right to decide on the number and spacing of children, the right to found a family and the right to be free from discrimination, among others. World Health Organization. 2014."Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO." http://www.unaids.org/sites/default/files/media_asset/201405_sterilization_en.pdf
[48] Ibid.

informed consent. Women with intellectual disabilities are particularly vulnerable to coercive and involuntary sterilization...[they] are often treated as if they have no control, or should have no control, over their sexual and reproductive choices; they may be forcibly sterilized or forced to terminate wanted pregnancies, based on the paternalistic justification that it is "for their own good.""[49]

25. The statement also addresses the issue of parents/guardians persuading or manipulating individuals with disabilities into consenting to sterilization, "parents or guardians may have different motivations for persuading persons with disabilities, including those aged under 18 years, to opt for sterilization, often in the absence of full, free and informed consent. Parents or guardians may be concerned about avoiding unwanted pregnancy, because of vulnerability to sexual abuse. However, sterilization does not protect against sexual abuse, and does not remove the obligation to provide protection from such abuse. Furthermore, enabling persons with disabilities to retain their fertility is rarely prioritized, even though less permanent contraceptive options are available. Instead of providing persons with intellectual disabilities with the necessary support to look after any children they may have, sterilization is offered to them as a way of avoiding the distress of having any potential children removed from their care."[50]

26. The Committee has expressed concern regarding the prevalence of cases of forced sterilization against people with disabilities. In its Concluding Observations to Italy, the Committee expressed concern regarding the lack of "data on medical treatment administered without the free and informed consent of the person, including sterilization" and called for the repeal of "laws that permit medical treatment, including sterilization, consented by a third party (parent or guardian) without the free and informed consent of the person, and that it provide related high-quality training to health professionals."[51]

Situation in Canada: Forced sterilization

27. The 1980 Supreme Court of Canada (SCC) Hopp v. Lepp[52] decision determined the legal importance of fully informed consent. In 1986 SCC decision E. (Mrs.) v. Eve made the practice of forced or compulsory sterilization illegal in Canada,[53] and solidified that parents/guardians of people with disabilities cannot force their consent or consent on their behalf. Still, people with intellectual, developmental, and cognitive disabilities experience forced sterilization through the manipulation of their consent.[54] Some people with disabilities, particularly people with intellectual/cognitive/developmental disabilities, are convinced by parents or guardians to consent to sterilization when they initially wanted to experience fertility and parenthood.[55]

28. Lack of support for parents with disabilities creates a barrier to fertility and violates the right to determine the number and spacing of one's children. While there are models for supporting people with disabilities who need assistance raising children, such as the 'Nurturing Assistance model' of support, only few parents have access.[56] The absence of formal federal strategies for supporting people with disabilities in raising their children leaves people with disabilities,

---

[49] Ibid.
[50] Ibid.
[51] Committee on the Rights of Persons with Disabilities. 2016. "Concluding Observations on the Initial report of Italy." CRPD/C/ITA/CO/1.
[52] Hopp v. Lepp, [1980] 2 SCR 192, 1980 CanLII 14 (SCC), http://canlii.ca/t/1mjv6, [Accessed 2017-02-21].
[53] E. (Mrs.) v. Eve, [1986] 2 SCR 388, 1986 CanLII 36 (SCC), http://canlii.ca/t/1ftqt [Accessed 2017-02-21].
[54] Desjardins, Michel. 2012. "The Sexualized Body of the Child: Parents and the Politics of 'Voluntary' Sterilization of People Labeled Intellectually Disabled." In Sex and disability. Robert McRuer and Anna Mollow (Eds.). Pp 69-88, and Armstrong, Jane. 2002. "Woman embroiled in legal battle for having disabled son castrated." Globe and Mail. http://www.theglobeandmail.com/news/national/woman-embroiled-in-legal-battle-for-having-disabled-son-castrated/article4135738/
[55] Desjardins, Michel. 2012. "The Sexualized Body of the Child: Parents and the Politics of 'Voluntary' Sterilization of People Labeled Intellectually Disabled." In Sex and disability. Robert McRuer and Anna Mollow (Eds.). Pp 69-88.
[56] Centre for Independent Living Toronto. "Nurturing Assistance." http://www.cilt.ca/nurturing.aspx

particularly those with intellectual/developmental/cognitive disabilities, frequently losing custody of their children to social services.[57] This creates the circumstances in which individuals with disabilities being sterilized without their full consent. Anecdotal evidence demonstrates many cases involve parents/guardians being concerned with the burden of raising the child of the individual with the disability, and about the trauma that would result from the individual with the disability having their child taken from them because of the lack of supports available to them – resulting in, over the course of several years, parents/guardians slowly manipulating the individual with the disability in their care to agreeing to sterilization procedures that they do not initially want.[58] This manipulated consent is not free consent, and results in bioethics committees approving sterilizations that are arguably involuntary.[59] Research surrounding the practice is limited to a small group of Canadian parents of teens and young adults with intellectual disabilities. While no national data on the prevalence of this practice exists anecdotal evidence suggests it is likely common.

Recommendations to the Government of Canada relating to Article 17 of the Convention

29. Take steps to ensure the non-repetition of non-consensual sterilization and/or manipulated consent of people with disabilities through the development of federal disability rights legislation, ensuring that women and girls with disabilities are directly and meaningfully consulted in its development.

30. Develop human rights education and training programmes for health-care providers to prevent non non-consensual sterilization and/or manipulated consent of people with disabilities.

31. Develop a federally funded national strategy to build systems capacity to support parents with intellectual disability and promote a healthy start to life for their children.[60]

Article 24– Right to Education

Background: Comprehensive and Inclusive sexuality education

32. Article 24 of the Convention requires State Parties to "recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and life long learning." State Parties must do so by ensuring "persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live," and by "ensuring that the education of persons, and in particular children, who are blind, deaf or deafblind, is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximize academic and social development."[61] Violations of Article 24 entail violations of additional rights recognized under the Convention – including Articles 8 (Awareness-raising) and 16.

---

[57] Tomasi, Patricia. March 11 2015. "Parents With Disabilities: These Moms Live In Fear Of Losing Their Kids." The Huffington Post Canada. http://www.huffingtonpost.ca/2015/05/10/parents-with-disabilities_n_7251484.html and McConnell, David. 2014. "Parenting with intellectual disabilities." [Accessed February 21, 2017] http://eugenicsarchive.ca/discover/connections/535eed3e7095aa0000000245

[58] Desjardins, Michel. 2012. "The Sexualized Body of the Child: Parents and the Politics of 'Voluntary' Sterilization of People Labeled Intellectually Disabled." In Sex and disability. Robert McRuer and Anna Mollow (Eds.). Pp 69-88.

[59] Ibid.

[60] Australia is currently the only country with a federally funded strategy to build systems capacity to support parents with intellectual disability and promote a healthy start to life for their children. See their strategy: www.healthystart.net.au and McConnell, David. 2014. "Parenting with intellectual disabilities." [Accessed February 21, 2017] http://eugenicsarchive.ca/discover/connections/535eed3e7095aa0000000245

[61] CRPD. Adopted December 13 2006.

33. Article 8 requires State Parties to "raise awareness…regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities," and to "combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age," by "fostering at all levels of the education system, including in all children from an early age, an attitude of respect for the rights of persons with disabilities." Article 16 obliges State Parties to "take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring…appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse."[62]

34. In recognizing the right to sexual and reproductive health education and information, the Committee's General Comment No. 3 on women and girls with disabilities recognizes that women with disabilities may be "denied access to information and communication, including comprehensive sexuality education, based on harmful stereotypes that assume that they are asexual and do not therefore require such information on an equal basis with others. Information may also not be available in accessible formats. Sexual and reproductive health information includes information about all aspects of sexual and reproductive health, including maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive cancer," and that, "lack of access to sexual and reproductive health information for women with disabilities, especially women with intellectual disabilities and deaf and deafblind women, can increase their risk of being subjected to sexual violence."[63]

35. The United Nations Educations, 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." In the Special Rapporteur on the Right to Education, the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Rights of the Child 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."

Situation in Canada: Comprehensive and Inclusive sexuality education for persons with disabilities

36. The Government of Canada is not fulfilling its obligations under Article 24 of the Convention through its failure to implement a national set of standards for the delivery of comprehensive sexuality education that is inclusive of the sexual experiences of people with disabilities, and available in all accessible formats. During its review of Canada in 2016, the Committee on the Elimination of Discrimination Against women noted with concern the lack of "a

[62] CRPD. Adopted December 13 2006.
[63] Committee on the Rights of Persons with Disabilities. 2016. "General Comment No. 3: Women and girls with disabilities." CRPD/C/GC/3.

comprehensive set of national guidelines or standards for education on sexual and reproductive health and rights curriculum, which resulted in severe discrepancies among provinces/territories in terms of curricula."[64]

37. 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."[65] 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. They also have not been updated to reflect the last 10 years in sexual health education advancements and knowledge. Additionally, there are no national standards through which sexuality education curricula can be monitored and evaluated.

38. 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. Curriculum often fails to meet the needs of students with disabilities. For example, in the province of Alberta, issues related to disability and stigma are absent from the sexual health curriculum outcomes.[66] In Manitoba, disability is not mentioned in any of the sexual health modules from kindergarten and grade eight.[67] In the province of Ontario, the increased risk of exploitation for people with disabilities, the need to adjust curriculum for learning levels, and the specific stigma experienced by people with disabilities is included in the curriculum; however, people with disabilities are often used as a learning tool rather than treated as equal, present peers in the curriculum.[68] Beyond provincial and territorial curriculums, there are few to no resources specifically geared towards sexual education for people with intellectual disabilities in Canada,[69] meaning that if traditional curriculums fail to address these issues, teachers, parents and other communities members have little access to supplementing learning tools.

39. In order to address the increased risks of sexual abuse and exploitation experienced by people with disabilities, consent-based sexual health education that is geared towards their specific experiences is crucial. This must include validating the right for people with disabilities to access healthy sexual relationships, and ensuring that they understand and can identify what abusive behaviours look like.[70] This is particularly important for people with intellectual and developmental disabilities,[71] and needs to be addressed in sexual health education throughout Canada.

40. Additionally, people with disabilities are often absent from sexual education classes due to the tendency to place the education alongside physical education, for health reasons[72] and due to under resourcing (which may prevent people with disabilities from being in a school setting in general).[73] The assumption that people with disabilities are not

---

[64] Committee on the Elimination of Discrimination Against Women. 2016. "Concluding Observations on the combined eight and ninth periodic reports of Canada." CEDAW/C/CAN/CO/8-9.
[65] Canadian Guidelines for Sexual Health Education. Ottawa: Public Health Agency of Canada, 2003.
[66] Alberta Learning. 2002. "Career and Life Management." https://education.alberta.ca/media/160199/calm.pdf
[67] Government of Manitoba. 2005. "Human Sexuality: A Resource for Kindergarten to Grade 8 Physical Education/Health Education."
[68] Government of Ontario. 2015. Revised. "The Ontario Curriculum Grades 1 to 8: Health and Physical Education." http://www.edu.gov.on.ca/eng/curriculum/elementary/health1to8.pdf
[69] Ramage, Kaylee. 2015. "Sexual Health Education for Adolescents with Intellectual Disabilities: A Literature Review." Saskatchewan Prevention Institute.
[70] Rajan, Doris. 2011. "Women with Disabilities and Abuse: Access to Supports - Report on the Pan-Canadian Focus Groups." DisAbled Women's Network (DAWN) Canada. http://www.canadianwomen.org/sites/canadianwomen.org/files/PDF%20-%20VP%20Resource%20-%20DAWN-RAFH%20Canada%20-%20Focus%20Groups%20WWD_201.pdf
[71] Child and Parent Resource Institute Sexual Behaviour Team. 2016. "Sexuality and Developmental Disability: A Guide for Parents." Government of Ontario. https://www.cpri.ca/files/6014/5278/9389/Talking_to_Your_Delayed_Child_-accessible_Jan2016.pdf
[72] Public Health Agency of Canada. 2014. "Questions and Answers: Sexual Health Education for Youth with Physical Disabilities." [Accessed February 21, 2017] http://www.phac-aspc.gc.ca/std-mts/rp/pd-ip/pd-id-eng.php
[73] Bouevitch, Nelly. February 5, 2016. "Parents resort to pulling special-needs children from resource-starved schools." The Globe and Mail. http://www.theglobeandmail.com/news/national/education/parents-resort-to-pulling-special-needs-children-from-resource-starved-schools/article28541670/

sexual can result in the belief that they do not need extensive sexuality education, resulting in gaps in knowledge,[74] and being at increased risk of for sexually transmitted infections, sexual violence, among other human rights violations.[75] Sexual health education is often the place where respect for persons with disabilities is fostered throughout development as is the case in Ontario's 2015 Sexual Health Guidelines.[76] Unfortunately, in the absence of federal leadership, many provinces and territories have yet adopt this approach meaning that the majority of people in Canada do not receive education that fosters respect and addresses stigma and discrimination against people with disabilities, nor do people with disabilities receive consistent, accessible, quality, inclusive sexuality education.

41. The federal government has a role to play in addressing these realities through the regular collection of data on sexual health indicators (including for people with disabilities) and the roll-out of evidence and rights-based campaigns (in and out of school) that comprehensively address sexual and reproductive health and rights, including disability-specific campaigns that reduce stigma and reinforce access 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 disability 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 the satisfaction with the curriculum for people with disabilities, their ability to access youth-friendly and disability-accessible services and information, violence-related outcomes including rates of sexual assault and abuse experienced by people with disabilities, knowledge of consent and sexual rights, satisfaction during sexual intercourse, and shifts in public perceptions of disabilities, among other factors.

Recommendations to the Government of Canada relating to Article 24 of the Convention

42. 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 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 people with disabilities.[77]

43. Allocate sufficient funds to the Public Health Agency of Canada for education and campaigns on positive sexuality and consent; sexual and reproductive health information that is accessible to people with learning disabilities, intellectual and developmental disabilities, visual impairments, and hearing impairments; and eliminating stigma, stereotypes, and discrimination, among other issues.

44. Hold provincial and territorial governments responsible for ensuring that sexual health education is provided to all students, especially those with disabilities who may be in segregated classroom settings, removed from the relevant courses due to health or physical limitations, and who are otherwise absent from sexual health education settings.

---

[74] Ibid.
[75] Public Health Agency of Canada. 2014. "Questions and Answers: Sexual Health Education for Youth with Physical Disabilities." [Accessed February 21, 2017] http://www.phac-aspc.gc.ca/std-mts/rp/pd-ip/pd-id-eng.php
[76] Government of Ontario. 2015. Revised. "The Ontario Curriculum Grades 1 to 8: Health and Physical Education." http://www.edu.gov.on.ca/eng/curriculum/elementary/health1to8.pdf
[77] In line with the Committee's General Comment Np. 3 on women with disabilities, which calls on State parties to "reach out directly to women and girls with disabilities and establish adequate measures to guarantee that their perspectives are fully taken into account and that they will not be subjected to any reprisals for expressing their points of view and concerns, especially in relation to sexual and reproductive health and rights, as well as gender-based violence, including sexual violence." CRPD. 2016. "General Comment No. 3: Women and girls with disabilities." CRPD/C/GC/3.

45. Conduct regular national monitoring, through inter alia broad-based surveys, of a robust set of sexual health indicators disaggregated by relevant factors, including disability.[78]

Article 25 – Right to health

Background: Access to comprehensive sexual and reproductive health services for people with disabilities without discrimination

46. Article 25 of the Convention requires State Parties "provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health," and to "prevent discriminatory denial of health care or health services."[79] Violations of Article 25 entail violations of additional rights recognized under the Convention – including those related to Articles 6 9 , 23, among others.

47. Article 6 requires State Parties to "take measures to ensure the full and equal enjoyment by women with disabilities of all human rights and fundamental freedoms." Article 9 requires State Parties to "take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment...[through the] elimination of obstacles and barriers to accessibility," which shall apply to buildings including medical facilities. State Parties shall do this by taking appropriate measures to "develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public," "ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities," "provide training for stakeholders on accessibility issues facing persons with disabilities," and "provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms." Article 23 requires State Parties to "take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others" and that "persons with disabilities, including children, retain their fertility on an equal basis with others."[80]

48. The Committee's General Comment No. 3 on women and girls with disabilities recognizes that "health-care facilities and equipment, including mammogram machines and gynaecological examination beds, are often physically inaccessible for women with disabilities. Safe transport for women with disabilities to attend health-care facilities or screening programmes may be unavailable, unaffordable or inaccessible," and, "attitudinal barriers raised by health-care staff and related personnel may result in women with disabilities being refused access to health-care practitioners and/or services, especially women with psychosocial or intellectual impairments, deaf and deafblind women and women who are still institutionalized."[81] General Comment No. 3 calls on states to adopt affirmative action measures, in consultation with organizations of women with disabilities, "with the aim of immediately addressing inequalities and ensuring that women with disabilities enjoy equality of opportunity with others. Such measures should be adopted in particular with regard to access to…sexual health and reproductive rights, health...Public and private services and facilities used by women with disabilities should be fully accessible in compliance with article 9 of the

[78] Including gender, age, location, ethnicity, disability status, 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.
[79] CRPD. Adopted December 13 2006.
[80] CRPD. Adopted December 13 2006.
[81] CRPD. 2016. "General Comment No. 3: Women and girls with disabilities." CRPD/C/GC/3.

Convention and the Committee's general comment No. 2 (2014) on accessibility, and public and private service providers should be trained and educated on applicable human rights standards and on identifying and combating discriminatory norms and values so that they can provide appropriate attention, support and assistance to women with disabilities."[82]

49. The Committee has, on numerous occasions, called on states to create enabling environments for people with disabilities to fully exercise their sexual and reproductive rights.[83] In its Concluding Observations to Italy, the Committee expressed concern regarding the "lack of physical accessibility and information regarding sexual and reproductive health services, including discrimination and stereotyping, particularly to women and girls with disabilities," and called on the State to "ensure accessibility to facilities and equipment, information and communications regarding sexual and reproductive health services, and that it provide training to health personnel about the rights of persons with disabilities."[84]

50. The Committee on Economic, Social and Cultural Rights, in its General Comment No. 22 stated the requirement that sexual and reproductive health services be both physically and financially accessible. In the context of people with disabilities, "the sexual and reproductive health needs of particular groups should be given tailored attention. For example, persons with disabilities should be able to enjoy not only the same range and quality of sexual and reproductive health services but also those services which they would need specifically because of their disabilities. Further, reasonable accommodation must be made to enable persons with disabilities to fully access sexual and reproductive health services on an equal basis, such as physically accessible facilities, information in accessible formats and decision-making support, and States should ensure that care is provided in a respectful and dignified manner that does not exacerbate marginalization."[85] The same Committee also addresses the affordability of sexual and reproductive health services, stating that "publicly or privately provided sexual and reproductive health services must be affordable for all. Essential goods and services, including those related to the underlying determinants of sexual and reproductive health, must be provided at no cost or based on the principle of equality to ensure that individuals and families are not disproportionately burdened with health expenses. People without sufficient means should be provided with the support necessary to cover the costs of health insurance and access to health facilities providing sexual and reproductive health information, goods and services."[86]

51. In its Concluding Observations to State Parties, the Committee on the Elimination of all Forms of Discrimination Against Women 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. In addressing barriers in access to services, the same Committee recommends that States: "provide financial support to economically disadvantaged women and girls needing an abortion who cannot afford it."[87]

[82] Ibid.
[83] Committee on the Rights of Persons with Disabilities. 2016. "Concluding observations on the initial report of the Plurinational State of Bolivia." CRPD/C/Bol/CO/1.
[84] Committee on the Rights of Persons with Disabilities. 2016. "Concluding Observations on the Initial report of Italy." CRPD/C/ITA/CO/1.
[85] Committee on Economic, Social and Cultural Rights. 2016. "General Comment No. 22: on the right to sexual and reproductive health." E/C.12/GC/22.
[86] Ibid.
[87] CEDAW Concluding Observations to Mexico. (CEDAW/C/MEX/CO/7-8), 2012.

Situation in Canada: Access to comprehensive sexual and reproductive health services for people with disabilities without discrimination

52. The Government of Canada is not fulfilling its obligations under Article 25 through its failure to ensure that people with disabilities have equal access to abortion services, to comprehensive, accessible and affordable sexual health care, and to reproductive health services that allow people with disabilities to retain their fertility on an equal basis with others.

Accessibility of safe abortion services in Canada, including medical abortion

53. 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.

54. 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.[88] Only 1/6th of hospitals provide abortion services,[89] the majority of which (both hospitals and free standing sexual health clinics) are disproportionately dispersed across Canada and located in urban areas.[90] 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.[91] 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,[92] 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.[93] Women with disabilities can experience compounding discrimination given the existing barriers they face in physical and attitudinal access to information and services, stigma, access to financial resources, among other barriers.

---

[88] 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).

[89] 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.]

[90] Most located within 150 KM of the US border.

[91] 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.

[92] Which include: unforeseen monetary expenses incurred for things such as travel, accommodation, lost wages, childcare, eldercare, and possibly procedural costs. These disproportionately impacting low-income women.

[93] The Guardian. "Women turning to desperate measures due to lack of abortion services." November 2011. http://www.theguardian.pe.ca/News/Local/2011-11-10/article-2802198/Women-turning-to-desperate-measures-due-to-lack-of-abortion-services/1 and for examples of stigma-related barriers facing young women in PEI, visit: http://projects.upei.ca/cmacquarrie/files/2014/01/trials_and_trails_final.pdf

55. Women in Canada also lack access to the gold-standard[46] of medical abortion, known as the drug 'Mifepristone.'[94] While it was approved for use in Canada in July 2015, it has only started to become available in 2017, and is 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 physicians and dispensing pharmacists, limiting use up to 7-weeks gestation[95], and cost-related barriers. These regulations 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 lack knowledge of how, when and where to access medical abortion; most physician clinics are not equipped to stock and dispense medication, and physicians are not accessing the training required to prescribe it, among others. These regulations are not based in scientific evidence, they will contribute to stigma related to abortion, will not increase access to abortion for women with disabilities who may struggle to physically access surgical abortions, and will not result in improved access to abortion services in Canada. Mifepristone is not covered under any provincial or territorial health plans.[96] This makes the $300+/regimen financially inaccessible, especially given the financial barriers many people with disabilities face while on social assistance and disability support plans. Many people with disabilities rely on drug coverage through benefit plans associated with their provincial or territorial disability support program.

56. Many women in Canada must travel to access abortion services.[97] Women in these situations must incur the expense for the procedure up front, without opportunity for reimbursement. For example, abortions performed in the one clinic in the province of New Brunswick are not covered under the provincial insurance plan meaning that women seeking the service in a clinic setting who are unable to pay for the service out-of-pocket must travel significant distances and incur additional travel and accommodation expenses.[98] Similarly, women seeking services beyond 16 weeks gestation must often travel to the limited number of clinics that provide services beyond this gestational period. There are many health care providers in Canada that refuse to provide information related to abortion and abortion services on moral and religious grounds. This results in many women having to travel in order to find health care they are legally entitled to. The high rates of poverty women with disabilities experience makes traveling to access abortion services into an even more significant barrier. In addition to needing to afford the travel costs, people with disabilities may need to hire an attendant, choose a more expensive form of travel that's accessible, and pay for a more expensive accommodation than most because of limited accessible hotels.

Access to comprehensive, accessible and affordable sexual health care

57. While some provinces and territories have accessibility legislation, such as the Accessibility for Ontarians with Disabilities Act in Ontario, there is no federal accessibility legislation, causing discrepancies in access to information

---

[94] 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

[95] 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/ucm111323.htm

[96] While Celopharma, the Canadian distributer of Mifepristone submitted the drug to the Common Drug Review, the approval of which is required to have the drug covered on provincial health plans, they were unable to afford the high costs of the process and had to withdraw. The Canadian Agency for Drugs and Technologies in Health has refused to wave or defer the high fee associated with process, preventing coverage of the drug. Grant, Kelly. September 26, 2016. "Most provincial drug plans won't cover abortion pills in Canada." The Globe and Mail. http://www.theglobeandmail.com/news/national/most-provincial-drug-plans-wont-cover-abortion-pills-in-canada/article32047302/

[97] Reasons for travel include: seeking services beyond 16 weeks gestation, locating physician willing to provide the procedure (many physicians refuse on moral and religious grounds), among other reasons.

[98] 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).

and services depending where you live. Canada's federal Minister of Sport and Persons with Disabilities in the process of conducting consultations on federal accessibility legislation. Physical and attitudinal barriers in access to sexual health services prevents people with disabilities from accessing testing for sexually transmitted infections (STIs), cancer screenings and PAP smears, gynecological and urologist exams, treatments for STIs, and other sexual and reproductive health services. As a result, women with disabilities are less likely to be screened for cervical cancer.[99] People with disabilities also may be turned away from clinics because they are inaccessible and are often forced to travel long distances to hospitals to access testing.[100] Additionally, a lack of education around the sexual health needs and behaviours of people with disabilities results in people with disabilities being told they do not need sexual health screenings, based on assumptions that they are asexual, and results in the refusal of screenings when they are requested.[101]

58. Cost of sexual and reproductive health medications remains a significant barrier, particularly for people with disabilities who are more likely to have limited access to financial resources.[102] Canada is the only high income country with publicly funded universal health care and no national drug plan. 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.[103] 14.6% of people with disabilities access provincial/territorial/municipal social assistance plans, and so likely have access to the benefits associated with those plans.[104] However, 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. Of people with disabilities, at least 17% work part-time all year, and 19% work part-time part of the year,[105] and so are likely to have no employer-provided drug benefits and no access to social assistance 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.

---

[99] Lofters, Aisha, Sara Guilcher, Richard H. Glazier, Susan Jaglal, Jennifer Voth, and Ahmed M. Bayoumi. 2014. "Screening for cervical cancer in women with disability and multimorbidity: a retrospective cohort study in Ontario, Canada." CMAJ Open 2(4). 240-247. and Angus, Jan, et al. 2011. "Access to Cancer Screening for Women with Mobility Disabilities." Journal of Cancer Education.

[100] Gurza, Andrew. 2016. "I'm a Queer Man with Disabilities & STD Testing Isn't Accessible—Something Needs to Change." Out Magazine. http://www.out.com/lifestyle/2016/5/20/im-queer-man-disabilities-std-testing-isnt-accessible-something-needs-change

[101] Ibid.

[102] The disability income support programs for people with disabilities in Canada leave many people with disabilities living in poverty. In 2006, 14.4% of people with disabilities were living in poverty in Canada, these numbers increased when considering people with learning, memory, or developmental and intellectual disabilities or psychiatric diagnosis (22.3%), those who live alone (31%), and those in shared living arrangements with non-family members (53.7%). Additionally, the provinces and territories are responsible for any disability support programs, so they vary. These programs do not provide the financial support to keep people with disabilities out of poverty. For example, the maximum amount a single person can receive from the Ontario Disability Support Program is $1,110.00 and under the British Columbia disability assistance program the maximum amount a single person can receive is $983.42. Additionally, because of restrictions on additional income under the disability support program in Ontario, there are frequent situations where people with intellectual disabilities are required to accept jobs that pay well-below the provincial minimum wage ($1.15/hr) or risk losing their health benefits and income supports. The Federal Canadian Pension Plan Disability Benefit also keeps recipients below the poverty line, with an average of payment of $933.82 102 per month in 2016, and requires people with disabilities to have worked and earned CPP to access it. are employed full time and not using disability support programs for income, they make significantly less than people without disabilities. In 2011 average employment income of men who worked full time was only $49,200 for those with a severe or very severe disability compared to $67,600 for those without a disability. When additional factors including gender and race are factored in, this average income decreases further.

[103] 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

[104] Turcotte, Martin. 2014. "Persons with disabilities and employment." Statistics Canada.

[105] Additionally, people with disabilities are overrepresented in sales and customer service positions, which often have lower wages and no benefits. Turcotte, Martin. 2014. "Persons with disabilities and employment." Statistics Canada.

59. Every province has a different system for covering HIV drug costs, leaving some individuals to pay out-of-pocket for drugs,[106] 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 between $350-415, 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.[107] Similarly, while there are existing programs to provide the vaccines for the Human Papilloma Virus (HPV) to cisgender[108] females of school age, they are not covered for cisgender males or for females who fall outside of the programme's parameters,[109] 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.[110] 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.[111]

Recommendations to the Government of Canada relating to Articles 25 of the Convention:

60. Establish special measure to ensure people with disabilities have equal access to both surgical and medical abortion services, in compliance with international human rights law, 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.

61. Ensure access to medical abortion, inline with international human rights obligations.[112]

62. 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, disability and others.[113]

---

[106] 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.

[107] 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

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

[109] Those having to pay for the vaccine out-of-pocket must pay upwards of $400-500.

[110] 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.

[111] 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.

[112] This includes: 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.

[113] 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.

63. 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, STI treatments etc.).

64. In continuing discussions towards the development of federal accessibility legislation, ensure the inclusion of provisions for the required physical and attitudinal accessibility[114] of health facilities (including mandated education and human rights training to reduce disability stigma and sensitize health care providers to eliminate the refusal or testing, treatment information, or care for people with disabilities), accompanied by appropriate funding to provinces and territories to ensure they meet these accessibility expectations.

[114] Including: Lifts, TTY/TDD equipment, Braille materials, language or interpretation services, large print materials, wheelchair or walker access, and access to attendant services/knowledge of how to provide basic primary care including toileting.