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Joint Stakeholder Report

Joint Stakeholder Submission by:

Action Canada for Sexual Health and Rights
Action Canada for Sexual Health and Rights is a charitable human rights organization committed to advancing sexual and reproductive health and rights (SRHR) in Canada and globally through policy advocacy, research, and health promotion.

Website: www.actioncanadashr.org
Address: 240 Bank St #501, Ottawa, ON K2P 1X4 Canada
Contact: Lona Lauridsen Burger, Public Engagement Officer
Email: lona@actioncanadashr.org

Barbra Schlifer Commemorative Clinic
Barbra Schlifer Commemorative Clinic offers legal services and representation, trauma-informed counselling and multilingual interpretation to marginalized and racialized women (self-identified), non-binary, intersex, and Two-Spirit people who have experienced violence.

Website: www.schliferclinic.com
Address: 489 College Street, Suite 503, Toronto, ON M6G 1A5 Canada
Contact: Deepa Mattoo, Executive Director
Email: dmattoo@schliferclinic.com, Tel: +1 647-278-4744

Justice for Migrant Workers (J4MW)
J4MW is an award-winning BIPOC led grassroots organization that supports the rights of racialized migrant farmworkers and their families within Canada and transnationally.

Website: www.harvestingfreedom.org
Address: Justicia for Migrant Workers, PO Box 34001, Rosedale Post Office Toronto, ON M4S 0C4
Contact: Evelyn Encalada Grez
Email: j4mw.on@gmail.com Tel: +1 778-782-3657

Sexual Rights Initiative
The Sexual Rights Initiative is a coalition of national and regional organizations based in Canada, Poland, India, Argentina, and Southern Africa that work together to advance human rights related to sexuality at the United Nations.

Website: www.sexualrightsinitiative.com
Address: Rue de Monthoux 25, Geneva, 1201 Switzerland
Contact: Anthea Taderera, Advocacy Advisor - UPR
Email: anthea@srigeneva.org, Tel: +41767656477

YWCA Hamilton

YWCA Hamilton strengthens women's and girls' voices, broadens their choices, builds dynamic leadership and provides essential and meaningful services that promote safe, inclusive, and equitable communities.

Website: www.ywcahamilton.org
Address: 75 MacNab St. South, Hamilton, ON
Contact: Mary Vaccaro
Email: vaccarm@mcmaster.ca Tel: +1 905-933-9150

The Community Research Platform at McMaster University
The Community Research Platform at McMaster University is a collaborative initiative between the Faculty of Social Sciences and local community organizations designed to foster ongoing, mutually beneficial research partnerships.

Website: crp.mcmaster.ca
Address: 1280 Main Street West. Hamilton, ON L8S 4L8
Contact: Mary Vaccaro
Email: vaccarm@mcmaster.ca Tel: +1 905-933-9150

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Executive Summary

1. This report examines gaps in Canada's obligation to respect, protect, and fulfil the right to abortion. Abortion is a decriminalized healthcare procedure and is enshrined in numerous human rights instruments and ratified conventions. Despite this, many people in Canada face barriers when seeking abortion services and some are ultimately unable to access care.

2. These barriers do not fall equally and are magnified for those who experience marginalization rooted in systemic racism, classism, ableism, and heterosexism, thus engaging the right to non-discrimination based on race, national and social origin, and other statuses. Set within this context, this report outlines generalized barriers and focuses on two areas: a) the impact of precarious migration status and resulting barriers to abortion access and b) the multiple and intersecting barriers faced by people experiencing homelessness.

3. Despite some advances, efforts to address unequal access have been inadequate. The gaps outlined in this report represent incomplete fulfillment of previous UPR recommendations and non-compliance with international human rights law.

4. The submitting organizations recommend a pillared approach to address these inequities through 1) a sustained commitment to a well-resourced sexual and reproductive health and rights (SRHR) sector, 2) targeted measures to eliminate barriers and facilitate low-barrier care, and 3) a broader framework for health equity grounded in human rights.

Introduction

5. This report is jointly submitted by Action Canada for Sexual Health and Rights, Justice for Migrant Workers (J4MW), YWCA Hamilton, the Community-based Research Platform at McMaster University, the Barbra Schlifer Commemorative Clinic, and the Sexual Rights Initiative (SRI).

6. Abortion is a common and essential healthcare procedure. About half of all confirmed pregnancies in Canada are unintended[i] and around one third of people who can become pregnant will have an abortion in their lifetime.[ii] Abortion access is a crucial component of a broader sexual and reproductive rights framework, which encompasses "the right to a pleasurable, satisfying and safe sex life free from discrimination, coercion and violence; and the freedom to decide whether, when and how often to reproduce, as well as the right to have the information and means to make this decision."[iii]

7. We welcome the advances that have been made since Canada's last Universal Periodic Review, including vocal leadership on SRHR, new and expanded funding, and the facilitation of greater access to medication abortion.

8. Although abortion is a decriminalized healthcare service, many people lack access to the public health system entirely and others face prohibitive barriers to abortion care. We assert that Norway's third cycle recommendation to "**[t]ake action to ensure equal access to abortion and comprehensive sexuality education across provinces and territories**" (142.169 Norway; Accepted)[iv] has not been adequately implemented and must be reiterated and fully actualized.

9. Quality abortion care can be understood as that which is "effective, efficient, accessible, acceptable/patient centred, equitable and safe."[v] Ensuring quality abortion care for all means building and nurturing an *enabling environment*, encompassing the three pillars of a human rights-based law and policy framework, accessible information, and a supportive and universally accessible health system.[vi] Since Canada's last UPR, major access gaps persist across all three pillars.

10. These protection gaps do not impact individuals and groups equally, and are structural, meaning they are driven and sustained by bias embedded within Canada's social institutions. They fall disproportionately on those who experience oppression rooted in racism, classism, ableism, sexism, heterosexism, and other factors including exposure to gender-based violence, stigmatization, or criminalization.

11. The Government of Canada is obliged to respect, protect, and fulfill the rights of all people within its jurisdiction. This explicitly includes guaranteeing substantive and equal access to abortion care in all provinces and territories,[vii] the absence of which engages other rights, including that of non-discrimination based on sex, gender, age, race, national and social origin, and other statuses.

12. General Comment 22 (2016) of the Committee on Economic, Social and Cultural Rights (CESCR) affirms that "[p]hysical accessibility [of abortion care] should be ensured for all, especially persons belonging to disadvantaged and marginalized groups, including, but not limited to, persons living in rural and remote areas, persons with disabilities, refugees and internally displaced persons, stateless persons and persons in detention."[viii] It is Canada's obligation to ensure that care is "timely, affordable, geographically reachable," respectful of and responsive to "the preferences and values of individual service users and the cultures of their communities," and of equal quality regardless of gender, race, socioeconomic status and other characteristics.[ix] To accomplish this, Canada must commit to a comprehensive and interconnected strategy and dedicate the appropriate administrative, budgetary, and promotional resources.[x]

Abortion in Canada: Legal and Policy Landscape

13. Canada is one of few countries in the world where abortion is entirely decriminalized. There are no laws restricting abortion access based on gestational limits, external approval, or any other factor. In 1988, the Supreme Court held in *R. v. Morgentaler*[xi] that the criminal standing of abortion violated the right to personal security and in 1991 in *Dobson v. Dobson*[xii] that defining legal standards of conduct during pregnancy would violate the privacy, autonomy, and rights of women.[xiii]

14. As an insured health service, abortion is protected under the Canada Health Act (the Act), the federal legislation which governs publicly funded healthcare insurance and the primary objective of which is to set standards for "reasonable access to health services without financial or other barriers."[xiv] Responsibilities related to healthcare are shared between Canada's federal and provincial governments. Rather than a single, federally administered system, Canada's thirteen provinces and territories have separate healthcare insurance plans, and each holds jurisdiction over their administration and the delivery of healthcare services. Federal responsibilities include defining and administering healthcare standards through the Act and providing funding to provinces and territories through fiscal transfers, including the Canada Health Transfer. Over 70 percent of spending on healthcare is publicly funded through tax revenues; provinces and territories fund around 78 percent of these costs while the Canada Health Transfer accounts for around 22 percent.[xv] In order to receive these funds, provinces must comply with the Act, including the principles of public

administration, comprehensiveness, universality, portability, and accessibility. This means that, amongst other criteria, healthcare plans must be operated by a public authority and must provide reasonable access to all residents. Although many elements of healthcare fall under provincial and territorial jurisdiction, the federal government has ultimate responsibility for the fulfillment of human rights of all people in Canada.

15. In some provinces, there has been historical resistance to the requirement to fund and make abortion readily available.[xvi] One province, New Brunswick, maintains an unlawful regulation inhibiting access, and in other provinces those accessing care must pay administrative fees, conflicting with the standards of the Act.

16. The ongoing privatization of some healthcare services poses a threat to health equity and goes against the standards of the Act.[xvii] This includes provincial government contracts with for-profit companies for the provision of services and outsourcing of surgical procedures to private entities. Furthermore, health institutions focus and rely on fundraising efforts from foundations and research wings attached to institutions, which means wealthier neighborhoods and communities end up with better access to health resources.

17. In the last several years, Canada has imposed fines on provinces for violations of the Act,[xviii] but these actions have not created equal access. Compliance can be strengthened through the establishment of benchmarks for the availability and accessibility of abortion care and increased Federal Health Transfers with specific conditions to ensure that provinces are taking action on abortion access.

18. The federal government is also responsible for the healthcare needs of federal patients, a jurisdictional category which includes Indigenous peoples and people who are incarcerated. Jurisdictional limitations and bureaucratic complexities have resulted in fragmented, culturally inappropriate, and unequal care. In 2018, the Special Rapporteur on the right to health noted particular concern over the sexual and reproductive rights of incarcerated women, including abortion access.[xix]

19. The 2021 Federal Budget included a historic announcement of CAD 45 million dedicated to expanding access to sexual and reproductive health services by supporting abortion travel and educating healthcare providers on systemic barriers to care. The Health Canada Sexual and Reproductive Fund was rolled out in 2022 and is set to expire in 2024, despite the continued need for services, including travel for abortion care.

Abortion care in context

20. The right to abortion goes hand in hand with the rights to safely carry a pregnancy to term and to parent in safety.[xx] In situating abortion within a broader rights framework, we acknowledge with gratitude and admiration the leadership of Black, Indigenous, and racialized women, trans, and non-binary people in developing the ethos of reproductive justice which underlies this submission. Reproductive justice is a feminist framework, developed in 1994 by the Women of African Descent for Reproductive Justice, which centres "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[xxi] The framework addresses the forces that obstruct these rights and demands the fulfillment of a holistic infrastructure of economic rights, adequate housing, access to public goods, and freedom from fear of violence and coercion. A reproductive justice framework asserts that there is no real choice without meaningful access.

21. In many cases, those who face disproportionate barriers to abortion access also face violent and coercive efforts to control their sexuality, reproduction, and parenthood.[xxii] Ensuring equal access to healthcare services necessitates freedom from violence and discrimination and is incompatible with punitive approaches that further entrench marginalization.

22. Canada's social and medical institutions have been built upon ongoing colonial, white supremacist legacies and racism continues to permeate policy and affect access to healthcare. Systemic racism must be recognized as central to all health access issues.[xxiii] Canada has received and accepted numerous related recommendations,[xxiv] including on gendered racism against Indigenous women, urging Canada to "tackle discrimination against Aboriginal women in all sectors of society, including employment, housing, education and health care."[xxv] Black, Indigenous, and racialized people continue to face intensified and discriminatory barriers, which are often amplified in the context of sexual and reproductive health. Canada has also supported recommendations to "implement all of the 'calls to action' from the Truth and Reconciliation Commission" (142.250), which it has not delivered on, with only three of the 94 calls complete.[xxvi]

23. Barriers to care are felt acutely by those who experience multiple and intersecting types of marginalization, including those living in poverty, persons with disabilities, young people, lesbian, gay, bisexual, transgender, and intersex persons, people living with HIV, people who use drugs, sex workers, and people who are incarcerated or otherwise face criminalization or the threat thereof. Experiences of gender-based violence further obstruct access.

24. Fear of violence, surveillance, discrimination, deportation, and incarceration represent major barriers to accessing information and care.[xxvii] Collaboration between law enforcement and other state institutions, including police and border control, continues to

drive harmful and racist practices including forced sterilization, birth alerts, child apprehension, immigration detention, and deportation.

25. Canada's actions must demonstrate a commitment to reconciliation and uphold and deliver upon the unanswered Truth and Reconciliation Committee Calls to Action. We affirm that racialized, gendered, and all other systems of oppression mutually uphold one another and that
they must be fought together.[xxviii]

Overview of access issues

26. Access to abortion in Canada is profoundly unequal. It varies widely by province, is further obstructed by geographic and administrative barriers, and is intertwined with a legacy of ongoing colonialism, racism, and institutional neglect which condition access.

27. Across the country, abortions are frequently only available in urban centres, and access is sparse or absent in rural and Northern communities. As gestational terms increase so too do barriers; medical abortion is approved only until nine weeks and in many jurisdictions surgical abortion is only available in limited hospital settings, sometimes only until twelve to thirteen weeks. Very often, people must travel to access abortion, which entails additional expenses related to transportation, accommodation, food, childcare, and lost wages.

28. Costs associated with accessing care can inhibit access, especially for those who are "uninsured." Residents must register with the healthcare insurance plan in their province, but the criteria of residency and requirements for coverage vary. Recent immigrants, undocumented migrants, and international students are frequently ineligible for these plans. Those without active health cards in their province of residence, which can include people experiencing homelessness or intimate partner violence, are eligible but may face difficulties registering or be turned away from services. For people experiencing homelessness, lack of a health card or other identification is often cited as the largest barrier to care.[xxix] For those without access to the public health system, who disproportionately already experience financial strain, out-of-pocket procedure costs alone can vary from CAD 500 to 3200. This often culminates in prohibitive financial hardship, undermining the principles of universal accessibility and affordability, and represents non-compliance with Canada's human rights obligations.

29. Existing barriers are further aggravated when coupled with the overlapping harms of stigma and criminalization[xxx] which often accompany drug use,[xxxi] involvement in sex work,[xxxii] and experience of incarceration.[xxxiii] Many people face challenges because they lack a fixed address, internet access, a telephone, or meaningful access to accessible, stigma-free, and

culturally relevant information. These factors can inhibit access to provincial health insurance plans as well as services once insured.

30. A lack of adequate and accessible information about how to access abortion care remains a persistent barrier in the experiences of homeless people, migrants, and other marginalized people. These barriers are exacerbated by the proliferation of organized anti-choice groups that create and disseminate intentionally misleading information and operate anti-abortion centres (known as "crisis pregnancy centres") targeting people seeking information on pregnancy options. Disinformation has a detrimental public health impact and fuels abortion stigma, inhibiting access to care. Comprehensive sexuality education, in and out of schools, is a crucial protective force against harmful disinformation.

31. There is a need to work towards establishing low-barrier pathways to abortion care. This involves working in collaboration with health and social service partners to map pathways into abortion care for people who face barriers when navigating complex healthcare systems.

32. There is a need for better information on reproductive health needs and experiences of people who face intensified systemic barriers.[xxxiv] This is vital to inform effective resourcing, planning, and service delivery by healthcare and civil society organizations working in the areas of SRHR and reproductive justice. Identifying barriers and facilitators to care can enhance understanding and assist in the development of policy, programs, and services to ensure equitable access.

Evidence of persisting access issues and discriminatory gaps

Evidence from Action Canada's Access Line and Support Fund

33. **Action Canada for Sexual Health and Rights** runs the Access Line, a national informational telephone and text service for those seeking information and services related to sexual and reproductive health. We also manage the Norma Scarborough Emergency Fund (NSEF), which helps people facing financial barriers in accessing abortion. These services provide unique insights into the barriers people face when seeking healthcare information.

34. The majority of those who access our services are from rural and remote areas or live in provinces where access is restricted by anti-choice policies, medically unnecessary regulations, or underfunded services. Most face additional barriers rooted in marginalization. They are, disproportionately, experiencing poverty or homelessness, racialized, young, undocumented or in precarious immigration situations, or face barriers

related to intimate partner violence. Some face challenges related to criminalization based on drug use or other factors.

35. In 2022, the Access Line received an average of 400 calls per month from across Canada, the vast majority of which were related to abortion care. Over 70 percent of callers faced major barriers to abortion, including travel costs, long wait times, precarious housing, immigration status, and intimate partner violence. While Action Canada's Access Line does not ask questions that fall outside of the scope of our services, many callers voluntarily report the barriers they face in accessing care.

36. In 2022, over 45 percent of those receiving our financial and logistical assistance were migrants without documentation or with precarious status. During the COVID-19 pandemic, we found that most people who were ultimately unable to access abortion in Canada had precarious immigration status or were undocumented.[xxxv]

37. Although not part of our advertised services, the line also receives significant calls from people requiring support with navigating healthcare systems. Challenges include not having a family doctor, lack of access to SRHR services in their area, and denial of abortion care by providers, among others. The line also supports people to self-advocate, illustrating further unmet needs.

38. In 2022, Action Canada assisted 219 people in accessing abortion care through our Norma Scarborough Emergency Fund, which supports those needing assistance to pay for abortion services and other costs associated with accessing care. On average, about 40 percent of the people Action Canada supports through our financial assistance program are uninsured.

39. This past year, we have seen a sharp increase in wait times for services which then create complex scenarios where people must travel increasingly far to get the care they need. While travel costs, accommodations, and incidentals for those we support are currently funded through Health Canada's Sexual and Reproductive Health Fund, medical expenses such as surgical abortions, ultrasounds, medication, and other medical costs can only be covered through funds we raise with individual donors.

40. Demand for these services has accelerated, indicating that SRHR organizations are facing increased pressures because of otherwise unmet needs for information and services.[xxxvi] In 2022, the Access Line saw an overall 65 percent rise in calls compared to 2021.[xxxvii] We have also seen a 181 percent increase in the number of people supported by our fund from 2021 to 2022 and a 300 percent increase in the financial support provided. This trend has continued to accelerate, with calls during the first two months of 2023 nearly double those of the previous year.

Migration status as a barrier to abortion access

41. **Justice for Migrant Workers (J4MW)**, a collective based in Ontario and British Columbia and with networks across the country, has been supporting migrant farmworkers' rights for over 20 years, including one-on-one case work with migrants to assert their sexual and reproductive rights in rural Canada. Although the Canadian federal government, farm employers, and farm lobby groups insist that migrant farmworkers have the same rights as Canadian workers, it is clear through the cases that J4MW has witnessed and documented, that migrant workers are denied the basic tenets of bodily autonomy, such as the right to terminate unwanted pregnancies. In this context, migration status is a constitutive determinant for the negation of reproductive justice.

42. Many previously accepted UPR recommendations specifically address the rights of migrants,[xxxviii] including to "[e]nsure that temporary and migrant agricultural workers are covered under the protection of labour legislation and have access to health and employment benefits," (142.264 Trinidad and Tobago; Acceptedh)[xxxix] but have yet to be fully implemented.

43. While the experience of accessing healthcare in Canada for migrants is varied, many experience generalized precarity rooted in their migration status and poor labour protections. They face intensified barriers related to their exclusion from the public health system, economic marginalization, lack of independent access to transportation or other material supports, lack of accessible information, and the isolated contexts in which many live and work. These barriers intersect with and amplify one another and are further aggravated by racism and xenophobia "embedded in countries' immigration laws, policies, institutions and practices, which often subject migrants to dangerous conditions or impose obstacles to health services and resources."[xl]

44. This is especially true for those that fall under Canada's Temporary Foreign Worker Programs (TFWPs) or who are undocumented. Canada has increasingly been relying on Temporary Foreign Worker Programs (TFWPs) over the last decade to offset labour shortages in key industries such as agriculture, meat processing, construction, and caregiving. In 2020 alone, the Canadian government granted 103,552 temporary work permits.[xli] There is also a significant number of people without legal authorization filling these labour shortages across the country, with conservative estimates ranging from 200,000 to 500,000 people.[xlii] While the experiences of work and life differ among migrant workers, those working in occupations that the Canadian government deems to be "low skill" and overly represented by people from the Global South are structurally prone to precarity and

vulnerability in their overall well-being, working, and living conditions.

45. Migrant farmworkers are among the most disadvantaged in accessing abortion services and support due to reinforcing systemic inequities including rural location, lack of mobility and freedom, and lack of facility of the official languages (English and French). The majority of migrant farmworkers participate in the long-standing Seasonal Agricultural Workers Program (SAWP), which began in 1966. While the government permits employers to hire farmworkers from anywhere in the world through the Agriculture Stream Program, the system is reliant on unequal economic structures and workers from low-income Global South countries. Undocumented migrants also work in agriculture and rely on local recruiters to secure their sporadic employment and often substandard housing. The lack of secure migration status excludes migrants from accessing basic rights and services.

46. The control that Canadian employers are able to assert over the migrant workforce inhibits access to sexual and reproductive healthcare services and support. Migrant workers are bound to a coercive relationship with their Canadian employers, who prioritize production and profit over basic functions of their humanity such as reproduction, intimacy, and sexuality. Although there are frameworks in place which theoretically guarantee the rights of migrant workers,[xliii] the nature of TFWPs render workers particularly vulnerable to rights violations and excludes them from certain standards extended to other migration categories. In these programs, Canadian employers have the power to decide who gets to work in Canada and also have the power to fire workers. Termination of employment contracts results in workers' deportation, as residency permits are tied to employment with a particular employer. While contributing arduous work to key billion-dollar industries, migrant workers are dehumanized, erased, and denied reproductive justice in a country globally acclaimed for "universal healthcare."

47. Given this precarity, migrant workers are known to conceal health issues from their employers, particularly in relation to sexual health and reproduction. Migrant women often conceal health concerns to ensure they are not sent back before the end of their work contracts and gain seasonal employment the following year. When employers become aware of pregnancies, migrant workers are often sent back to their home countries because they are seen as liabilities for production and farm operations. When contending with unwanted pregnancies, migrant workers are left alone to traverse the limited options available to them in rural townships. With rural access already inhibited, migrant workers experience compounding inequities in attaining reproductive justice.

48. Migrant workers are often warned by government officials not to engage in sexual or intimate relations while in Canada. In advance of their departure, some migrant women have been asked to sign contracts to refrain from sexual activities while employed for the

season on Canadian farms. In a project based out of the University of Guelph, called Rural Women Making Change, Jamaican female respondents asserted that before boarding a plane to Canada, they are required to take pregnancy tests. Before leaving to work in Canada, many migrants bring abortion pills in response to the systemic denial of reproductive justice in isolated and coercive contexts.

49. Financial barriers obstruct the right to health for undocumented people, who are not eligible to become insured within the public health system. For temporary workers, provincial health coverage usually begins after three months, before which all medical procedures, including abortion, must be paid out of pocket. It is unacceptable that administrative waiting periods obstruct access to medically necessary services. For those who are already economically marginalized, and especially when coupled with additional expenses, these barriers may be insurmountable.

50. Migrant workers do not have the freedom and privacy to easily leave their workplace without the knowledge and approval of their employers. When workers require medical attention, they must request their often reluctant employers transport them to rural clinics, where employers become privy to their private medical issues when they or other managers interpret for them. Those seeking abortions often must organize a secretive and elaborate plan with private transportation, secure their own interpreter, and find an abortion provider, often far from them. None of this is possible for migrant workers who cannot count on trusted community networks.

51. Migration status remains amongst the largest barriers to health equity in Canada. The provision of permanent residency status is a central demand among the migrant justice movement and is endorsed by dozens of organizations in Canada.[xliv] Although a regularization program was promised by the federal government in 2021, details are vague and it has yet to be delivered upon.[xlv] Ensuring status for all would subdue the marginalization undocumented people face and the imbalance of power between Canadian employers and migrant workers. A regularization program, without caps or exclusions, is a crucial step to fulfill the right to health for all people in Canada and must happen alongside a moratorium on detentions, deportations, and other immigration enforcement.

Homelessness as a barrier to abortion access

52. People who become pregnant while experiencing homelessness face barriers to realizing their inherent rights to make reproductive choices, including to seek abortion care. **YWCA Hamilton** sees firsthand the challenges pregnant people experiencing homelessness face and have heard from those seeking services as well as health and social care providers.

53. Canada has accepted previous UPR recommendations related to the rights of people who are unhoused or living in poverty,[xlvi] including to "[c]ontinue to take all measures necessary to combat poverty more effectively while paying particular attention to groups and individuals who are more vulnerable to poverty such as Indigenous peoples, persons with disabilities, single mothers and minority groups" (142.156 Serbia; Accepted).[xlvii]

54. People living without secure and stable housing, who reside in temporary shelters, unsafe accommodations, on the streets and/or in encampments face multiple barriers when attempting to access both surgical and medical abortion. These can lead to desperate acts, such as attempts at self-inducing abortion, or being forced to carry unintended pregnancies to term. Lack of access to safe, timely, and accessible abortion care poses a significant risk to people who become pregnant while homeless.

55. The pathways into homelessness for women and birthing people are shaped by a myriad of socio-economic factors, including living in extreme poverty, experiencing intimate partner and family violence, immigration and settlement issues, lack of social support, and coping with significant trauma, physical health, mental health, and substance use concerns. Each of these factors have a significant impact on the ways in which people exercise their right to reproductive choice and abortion access.

56. Gender-based homelessness is that which is caused or characterized by gendered experiences of marginalization, including gender-based violence. The most well documented feature of gender-based homelessness in Canada is its hidden and invisible nature, as women are less likely to access mainstream shelters and drop-in spaces and more likely to rely on relational, precarious, and dangerous supports to survive. It is well-recognized that women experiencing homelessness negotiate a number of high-risk survival strategies to obtain shelter and may avoid the dangers of the streets and co-ed shelter spaces, including by staying in unsafe and exploitative relationships and exchanging sex for shelter.[xlviii] The gendered survival strategies that women engage in while homeless position them at a heightened risk for an unintended pregnancy. Accessing abortion care is made difficult by precarious and unstable living conditions and limited access to resources and support.

57. The identities of women who disproportionately experience homelessness mirror the identities of those who already face barriers to accessing healthcare. This is particularly pronounced for Indigenous people, racialized people, people living with disabilities, and people who use substances. Indigenous people are disproportionately represented in the homeless population in both urban and rural settings across Canada. Ongoing colonialization, genocide, and forced sterilization of Indigenous people has created

conditions whereby Indigenous people experiencing pregnancy may be hesitant to seek abortion care through the healthcare system.

58. Research on people experiencing gender-based homelessness in Canada notes that 55 percent of participants identified as having three or more disabilities.[xlix] Experiences of disability may create additional barriers for people when attempting to navigate complex healthcare systems, like abortion care. Pregnant people who use substances while homeless are significantly less likely to access any form of healthcare out of fear of judgement and stigma from service providers.

59. Lack of access to safe, timely, and respectful abortion care poses risks to well-being. Some research suggests that people who experience homelessness present to abortion care later in their pregnancy and face increased risks of complications relating to abortion care.[l] These risks become heightened when people occupy intersecting marginalized identities in addition to homelessness.

60. People who experience homelessness face unique barriers to abortion access as a direct result of precarious housing and obstructed access to economic and material resources. Experiencing homelessness puts an undue amount of stress on the body, coupled with lack of sleep and improper nutrition, which can lead to an irregular menstrual cycle. Many people may not find out they are pregnant until late in their pregnancy because of irregular menstrual cycles and lack of access to pregnancy testing. This means that for many people experiencing homelessness, surgical abortion is the only option. Access to surgical abortion is more limited, particularly for people who seek abortions after 12-24 weeks (depending on the gestational limits in their province), and often requires travelling, posing a substantial barrier.

61. Many people experiencing homelessness do not have access to a general practitioner or trusted healthcare provider to make a referral. Not having proper identification or a provincial health card is a common issue impacting homeless populations and can be a barrier to receiving abortion care. Many people lack access to a reliable working telephone, which means they are unable to communicate privately and consistently with abortion care providers.

62. While medical abortion can be a self-managed and safe option, people living outside, in unsafe accommodations, or in shelter or drop-in spaces with limited privacy face major barriers. People need a safe place to stay, rest, and be supported through a medical abortion, which can take up to several days. The requirements of medical abortion and the need for follow up care may mean that providers are hesitant to prescribe medical abortion to patients at high risk of being lost to follow up. This speaks to a broader need for safe and

supported temporary emergency accommodations that attend to the emergency reproductive care needs of people experiencing homelessness in Canada.

Conclusion and recommendations

63. As illustrated by the experiences of the submitting organizations, each of which is uniquely positioned to understand intersecting access barriers, Canada has yet to fulfill its human rights obligations around abortion access. The previous recommendation on "action to ensure equal access to abortion and comprehensive sexuality education across provinces and territories" (142.169 Norway; Accepted) must be reiterated and fully actualized. Abortion access, like all SRHR issues, must be firmly situated within a human rights framework centralizing health, safety, and freedom from violence and discrimination.

64. To facilitate compliance with this overarching recommendation, Canada must build a stronger enabling environment for the fulfillment of all persons' sexual and reproductive rights. We recommend a pillared approach which recognizes the importance of interconnected, rights-based actions to address acute access issues and their systemic roots.

65. This necessitates a framework that recognizes the role of racism, colonialism, poverty, ableism, sexism, heterosexism, and cissexism in conditioning access, and that takes interconnected steps to address them, in alignment with the Truth and Reconciliation Committee Calls to Action.

We call on Canada to:

Pillar 1: A strengthened and well-resourced commitment to SRHR

1. **Make permanent and increase resources to Health Canada's Sexual and Reproductive Health Fund** to address barriers to access and provide essential core funding to civil society organizations.
2. **Strengthen compliance with the Canada Health Act by establishing benchmarks for the availability and accessibility of abortion care** through the public health system, and holding provinces to account.
3. **Increase Federal Health Transfers with ties to the expansion of reproductive and sexual health services,** with emphasis on facilitating equal access to abortion, across the country.

Pillar 2: Dismantling barriers and enhancing pathways to low-barrier care

4. Guarantee the provision of healthcare to undocumented people and migrant workers through a **no-exclusions regularization program** granting **full and permanent immigration status.**
5. Assist provinces and territories in fulfilling access to a full range of health services for all through **new or expanded federal transfers explicitly tied to the provision of care for those who are uninsured**, including undocumented migrants.
6. **Combat the dissemination of false and misleading information through comprehensive sexuality education in and out of schools,** with an emphasis on ensuring equal access to comprehensive, unbiased, widely accessible, and medically and factually accurate information.
7. Ensure **substantive access and the provision of necessary supports, including transportation and safe and private accommodation, for federal patients** seeking abortion care.

Pillar 3: Nurturing a broader framework for equity in healthcare access

8. **Consider and address barriers to access to SRHR in the development and implementation of broader laws and policies**, especially where they inhibit access for people facing marginalization, to ensure the respect, protection, and fulfillment of human rights.
9. Expand **funding to community-based organizations**, building increased capacity to **lead research, programming, and advocacy around health access, including abortion care, in their areas of expertise**.

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