Alternative Report on Canada's seventh periodic report before the Committee Against Torture
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SUMMARY

This submission outlines two interconnected violations of human rights found in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT): (1) involuntary sterilizations of women in Canada and (2) the lack of access to consistent and quality Comprehensive Sexuality Education (CSE) by the Canadian government.

Involuntary sterilization has been recognized by several international human rights and ethical standards as a gender-based human rights violation that can amount to torture or CIDT. Involuntary sterilization represents a failure on duty-bearers to respect, protect and fulfill the full range of sexual and reproductive rights, including through the denial of provision of a full range of available, accessible, acceptable and quality sexual and reproductive health services, and is a violation of the CAT in itself as it causes physical and mental pain and suffering. As indigenous women and women with disabilities in Canada have been targeted by a sexist, racist, ableist, and colonialist eugenic sterilization practices, the State has the obligation to:

- Ensure that all sterilizations of women are performed only on the basis of their prior, free and informed consent.
- Provide a full range of sexual and reproductive health services to Indigenous women and women with disabilities, with their free, prior and informed consent.
- Initiate a national inquiry into forced sterilization across Canada towards ensuring the non-repetition of involuntary sterilization.

The Government of Canada is not fulfilling its obligations under Article 10 of the Convention through its failure to implement a national set of standards and guidelines for the delivery of CSE and its failure to collect relevant and robust data on sexual health programming necessary for effective monitoring and evaluation. As a consequence, the quality and delivery of CSE curricula across Canada is inconsistent and young people and adolescents are unable to exercise their right to education under the Convention.

- Establish standards through which the federal government can monitor and hold provinces and territories accountable to the implementation of CSE, in line with human rights obligations.
- Allocate funds to the Public Health Agency of Canada to raise awareness to the forthcoming Revised Canadian Guidelines for Sexual Health Education, and support provinces and territories towards strengthened implementation of CSE, including campaigns on positive sexuality, consent, sexual and reproductive health information and eliminating stigma and discrimination on the basis of gender, sexuality and reproduction.
- Conduct regular national monitoring, through inter alia broad-based surveys, of a robust set of sexual health indicators disaggregated by relevant factors including gender, age, location, ethnicity and others.

Action Canada for Sexual Health & Rights (Action Canada) is a progressive, pro-choice charitable, human rights organization, based in Ottawa Canada that seeks to advance and uphold sexual and reproductive rights, globally and in Canada.

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

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I. Introduction

1. This submission outlines two violations of human rights found in the Convention Against Torture (CAT), involuntary sterilizations of women in Canada and the lack of consistency, quality and implementation of Comprehensive Sexual Education (CSE) by the Canadian government to prevent similar and other human rights violations. The right to bodily autonomy is both a fundamental and increasingly recognized rights claim and a concept that interconnects and underlies the full range of sexual rights to which all individuals and groups are entitled. Hence, the right to bodily autonomy includes not only the right to decide on treatments like contraception and sterilization, but it also includes the right to have CSE to make those decisions informed and meaningful and to prevent discrimination-based violence.

2. Bodily autonomy is linked to self-determination over not only bodies, but also lives, and is composed of the right of everyone to make decisions over their own bodies and lives without discrimination. It is a fundamental aspect of the right to life, including the right to be free from all forms of discrimination, violence and torture. It obligates States to ensure that these rights are respected, protected and fulfilled, so that every person can exercise their right to decide for themselves over their body and life without interference from the State, family, society and other external elements.

3. This submission first outlines rights violations when Indigenous women, as well as women with disabilities, are denied informed consent for reproductive health services. This report argues, as the CAT Committee has recognized in the past,1 that involuntary medical procedures are violations of both physical integrity and bodily autonomy that can cause physical or mental pain and suffering. Involuntary medical procedures are often the result of the denial of sexual and reproductive health (SRH) services, which is in itself a violation of the Convention. Secondly, the submission outlines the lack of compliance of Canada of effective implementation of CSE as means of preventing discrimination-based violence, as well as torture and CIDT in sexual and reproductive healthcare settings. Each section concludes with recommendations that the Committee should make to the State of Canada to address these violations to articles 2, 10, 12, 13, 14, 15 and 16 of the Convention.

II. Women in Canada are still being involuntarily sterilized as a result of systemic and historical policies and stigma

4. The Committee has recognized that women under several forms of structural violence are more often subjected to involuntary medical procedures, including forced or coerced sterilizations.2 Medicine and science have been the main method of tagging and selecting those who were considered socially undesirable, following eugenicist ideologies.3 Biased scientific techniques like IQ and craniometry have been used historically to justify that some are superior than others4 in a way that reinforces and interweaves structural violence like racism, ableism and sexism. In Canada, afro-descendants, immigrants, indigenous people, poor people, “promiscuous” women, among others, have all been called “feebleminded” and have been sterilized as a result.5 The current situation in Canada is the direct outcome of this history of structural violence.

5. The 1980 Supreme Court of Canada (SCC) Hopp v. Lepp6 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,7 and solidified that parents/guardians of people with disabilities cannot force their consent or consent on their behalf. However, involuntary sterilizations are still being practiced because of the historical legacy of ableist, racist and colonial state policies which position Indigenous women and women with disabilities

as vulnerable and without agency which can in turn create situations where guardians, doctors, and third parties influence and coerce women's consent.

6. Despite the observations issued by the Committee, it has yet to clearly recognize that the denial of adequate and accessible SRH services8 can lead on its own to severe physical or mental suffering. Hence, there are two powerful reasons to recognize that the denial of SRH services is as important as involuntary sterilizations:
    a. It causes severe physical or mental suffering
    b. It is part of the path drawn by systemic policies and social stigma for Indigenous women, as well as for women with disabilities.

7. The Committee is long overdue on issuing observations recognizing the involuntary sterilization of Indigenous women as it has done in the past with women with disabilities,9 HIV-positive women,10 Roma women,11 and intersex persons.12

a. Standards for informed consent require that the woman herself consents to reproductive health procedures and the provision of a full range of SRH services.

8. Informed consent is an essential component of any SRH-related medical intervention, based on the fundamental precept that patients are the best judge of their own interests.13 Informed consent requires, at the minimum:
    1. Professional disclosure of the risks, benefits and alternatives surrounding the medical procedure;14
    2. patient understanding of that disclosure; 15 and
    3. voluntary patient decision. 16

9. The UN Interagency statement aimed at eliminating forced and involuntary sterilization clearly states that **"[s]terilization for prevention of future pregnancy cannot be justified on grounds of medical emergency"**.17 Even when future pregnancy might pose a risk for life or health, existing alternative contraceptive methods must be offered and provided.18 As a result, "the individual concerned must be given the time and information needed to make an informed choice about sterilization."19 Access to full range of sexual and reproductive health information, services, goods, and facilities is encompassed in SRHR,20 as it is essential to informed consent.

10. Different UN mechanisms have addressed involuntary medical practices in general and involuntary sterilizations in particular. For instance, the Committee on the Elimination of All forms of Discrimination Against Women (CEDAW) has expressed that involuntary medical practices are forms of gender-based violence that can amount to torture or CIDT.21 The Committee on the Rights of People with Disabilities (CRPD) has reiterated that women with disabilities have the right "to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."22 Further, it has expressed concern about a lack of data on involuntary sterilization and has recommended gather such data and report it to the Committee.23

11. UN Special Procedures Mandates have also addressed this issue.24 Abuse and mistreatment of women seeking reproductive health services can cause permanent and severe physical and emotional suffering, including in the form of forced sterilization, and has severe impacts on women's personal integrity, physical and mental wellbeing, and family life, as recognized by the Special Rapporteur on violence against women25 and the Special Rapporteur on torture.26 The UN Special Rapporteur on torture has therefore held that forced sterilization may constitute torture or ill-treatment,27 especially when it targets women because of multiple forms of discrimination,28 including when "ethnic and racial minorities, women from marginalized communities and women with disabilities [are targeted] for involuntary sterilization because of discriminatory notions that they are "unfit" to bear children."29 The Special Rapporteur on the rights of the rights of Indigenous peoples similarly expressed concern about the forced sterilization of Indigenous women, among other severe violations of their

sexual and reproductive rights committed in parallel with the historical denial of their rights to self-determination and cultural autonomy.30

b. Sterilizations of women persist in Canada and victims of these policies have not received reparations or appropriate comprehensive assistance

12. Sexist, racist, ableist, and colonialist sterilization practices in the Canadian context have disproportionately impacted Indigenous women.31 For Indigenous women, involuntary sterilization was practiced through legislative frameworks and informal practices which targeted and/or failed to protect Indigenous women. While the literature on this topic tends to treat women with disabilities and Indigenous women as separate categories, it is important to recognize that some women targeted through these practices have identified in multiple ways and were targeted by multiple policies.

Indigenous women

13. Systemic racist policies and attitudes32 are violent effects of colonization that have targeted and victimized Indigenous women. For decades Canada's federal, provincial and territorial governments have been conducting studies and inquiries into the effects of colonization on intersecting violence and enforced poverty for Indigenous women, who are 3.5 times more like to experience violence than non-Indigenous women.33 They are ten times more likely to be murdered or to go missing.34 There is an over-representation of Indigenous peoples in federal prisons: "[While] Aboriginal people in Canada comprise just four per cent of the population, in federal prisons nearly one in four is Métis, Inuit, or First Nations."35 Indigenous women make up 36% of all young women incarcerated.36 Reports indicate human rights violations of incarcerated Indigenous women, including through the "shackling of pregnant women also while in labor, coerced sterilization and sexual violence from prison staff and guards"37 and the absence of effective facilities for incarcerated mothers.38

14. International and regional human rights systems have addressed rights violations of Indigenous women in Canada. In 2010, evidence of the systemic causes of violence against Indigenous women, and specifically the phenomenon of Missing and Murdered Indigenous Women, was raised by the CEDAW's optional protocol that resulted in the CEDAW Inquiry procedure on this issue and a resulting report condemning Canada for their failure to act to ensure the safety and wellbeing of Indigenous women. 39 The Inter-American System has also highlighted in several reports the human rights violations of indigenous women in the Americas and in the province of British Columbia.40 The Inter-American Commission of Human Rights did not address sterilizations but recognized that Indigenous women face barriers in their access to services and information about health and SRH.41

15. Since then Canada has received numerous condemnations and recommendations to redress the endemically high rates of violence against Indigenous women through multiple UN Universal Periodic Reviews (UPR), commissions, committees, inquiries and treaty monitoring bodies including the 2012 Committee Against Torture.42 However, these reports and recommendations have concentrated their attention on murders and forced disappearances, without addressing other violations that are a result of the same systemic causes. Only recently, during Canada's third UPR the State of Argentina recommended the State to investigate forced sterilization of women from discriminated groups, punish such acts, and assist the victims.43

16. In November 2015, media outlets released reports of women in the province of Saskatchewan having undergone forced sterilization in the last five years.44 The women reported being pressured by health professionals and social workers to undergo tubal ligation surgeries. In response, the regional health authority committed to launching an independent investigation to examine the issue. In 2017, the Saskatoon Health Authority published a report highlighting the experiences of Indigenous women being coerced into tubal ligations45 (a method of permanent birth control).

17. The 2017 report46 confirmed that many women had similar experiences of being forced or coerced towards tubal ligation within the health care system.47 This is despite the elimination of policies which permitted and promoted forced sterilization in the 1970s.48 The report proposed a number of concrete recommendations to

be acted upon by the province and the federal government, including a recommendation to launch a national inquiry into forced tubal ligation among across the country.

18. In October 2017 a class action suit representing fifty-five Indigenous women was filed against the province of Saskatchewan49, the federal government, regional health authorities and individual physicians regarding recent incidents of forced sterilization of women in Saskatchewan. Intergenerational trauma on mental and sexual health as well as the history of how accessing reproductive health care has impacted Indigenous people (and other marginalized communities) and show that can impact the trust between patients/clients and providers.50

19. According to the Native Youth Sexual Health Network (NYSHN), forms of sterilization persist in the treatment of Indigenous Communities.51 NYSHN writes that 'modern forms of forced sterilization' occur through the "over-prescription of Depo-Provera to Indigenous youth, which has been proven to cause signs of infertility when over-used."52 NYSHN has also reported incidences of forced sterilization in Canadian prisons.53 At an institutional level, "the ideology that justified historical coerced sterilization continues to shape state and medical interventions in the reproductive lives of women, (especially) marginalized, racialized and Indigenous women, pressuring them to get sterilized for their own good, to save them and society from having to care for additional children."54 This speaks to the longstanding forms of systemic racism, and other types of discrimination, that have contributed to the marginalization of Indigenous people in Canada. Such forms of marginalization and discrimination can lead to barriers in access to health care and negative health outcomes.

Women with disabilities

20. People with intellectual, developmental, and cognitive disabilities experience forced sterilization through the manipulation of their consent.55 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.56

21. 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.57 The absence of formal federal strategies for supporting people with disabilities in raising their children leaves people with disabilities, particularly those with intellectual/developmental/cognitive disabilities, frequently losing custody of their children to social services.58 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.59 This manipulated consent is not free consent, and results in bioethics committees approving sterilizations that are arguably involuntary.60 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.

22. According to a forthcoming research report written by Jihan Abbas for the DisAbled Women's Network (DAWN): "… in our research we spoke to one woman with a disability who shared that her parents had made reproductive health choices on her behalf, without her consent, and against her will. Sadly, the power and influence many

parents and guardians hold likely indicates that these unofficial forms of reproductive coercion persist in many ways."

Recommendations:

- Ensure that all sterilizations of women are performed only on the basis of their free, prior and informed consent.
- Take steps to ensure the non-repetition of involuntary sterilization and contraceptive practices, especially against Indigenous and Disabled individuals.
- Provide a full range of discrimination free sexual and reproductive health services to Indigenous women girls and women and girls with disabilities.
- Initiate a national inquiry into involuntary sterilization across Canada, which would include a process to gather, compile and analyze data to assess the extent to which the practice of involuntary sterilization of women has occurred
- Apply the principle of free, prior and informed consent to affected Indigenous peoples and communities, beginning with the empowerment of Indigenous and other women and youth to participate in decision-making related to laws and policies that affect them.
- Ensure that Health Canada, the Public Health Agency of Canada, Indigenous Services Canada, Crown-Indigenous Relations and Northern Affairs Canada and Employment and Social Development Canada prioritize awareness raising around cultural competency, accessibility, training and information regarding laws and standards regarding tubal ligation and forced sterilization for healthcare providers.
- Develop federal disability rights legislation and ensure that Health Canada and Employment and Social Development Canada prioritizes programs and services that promote the social, physical and financial wellbeing and independence of persons with disabilities, ensuring that women and girls with disabilities are directly and meaningfully consulted in this process in accordance with General Comment 7 of the CRPD Committee.

III. Canada must implement Comprehensive Sexual Education to prevent discrimination-based violence that can amount to torture or CIDT

a. Education is a method to prevent torture and CIDT

Comprehensive Sexual Education is a mandatory human rights standard developed by several treaty bodies.

23. The Committee recognized in its General Comment 2 that methods that have found to be effective in preventing torture and CIDT, explicitly public education and its new approaches, are mandatory under article 2. 61 It also stated that the scope of these measures should expand by building up on the remaining articles of CAT.62 Accordingly, the Committee has observed that education in general (article 10 CAT) is a mean of preventing further violations under CAT, and has warned that failure to implement measures in this regard is a failure of compliance with CAT.63

24. The Committee has recommended States to provide education to address the causes of sexual and gender-based violations of the CAT.64 As part of the obligation to prevent torture, States should also strengthen public educational and awareness-raising programs to combat gender stereotypes.65

25. The Committee on Economic, Social and Cultural Rights (CESCR), CRPD, and CEDAW have all explicitly developed the requirements for CSE. The CESCR Committee has recommended that CSE be mandatory in schools,66 meet medical and educational standards,67 and be based on a human rights perspective.68 The CRPD Committee requires that States provide accessible information and education on sexual and reproductive health.69 The CEDAW Committee requires that CSE includes information about gender relations,70 responsible sexual

behavior,71 gender equality, respect, and combating sexual violence72 and be based on human rights standards and scientific evidence.73

26. The CEDAW Committee found in 2016, as this report also proves, that Canada lacks coherent and comprehensive standards on CSE, allowing for enormous gaps among provinces and territories.74 However, the Canadian government, in its State Report sent to this Committee during the current review, presents as one of its actions to prevent discrimination-based violence the "Violence Prevention Action Plan, in partnership with the Department of Education and Early Childhood Learning, […] a commitment to provide safer and inclusive schools for LBGT youth."75 In order for educational programs, and CSE in particular, to be meaningful as a way to prevent discrimination-based violence that is in violation of CAT, it is crucial to insist on the recommendation to Canada issued by the CEDAW Committee. As a result, Canada should "[e]stablish national guidelines or standards to harmonize education curricula on sexual and reproductive health and rights among provinces and territories and allow the federal Government to hold them accountable for implementing such guidelines or standards."76

Canada is not complying with its obligation to provide CSE according to human rights standards.

27. The Government of Canada is not fulfilling its obligations under Article 10 of the Convention through its failure to implement a national set of standards and guidelines for the delivery of CSE and its failure to collect relevant and robust data on sexual health necessary for effective monitoring and evaluation. As a consequence, the quality and delivery of CSE curricula across Canada is inconsistent and young people and adolescents are unable to exercise their right to education under the Convention.

28. 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."77 However, due to the division of power between federal and provincial jurisdictions, with provincial governments responsible for education, the guidelines have not been consistently implemented across Canada in a manner that recognizes young people's rights. Additionally, there are no national standards through which sexuality education curricula can be monitored and evaluated.

29. Provinces and territories are left to develop their own CSE curricula, implementation, monitoring and evaluations strategies, thereby creating severe discrepancies in content and delivery across the country. For example, in the province of Alberta, some school boards allow religious groups to deliver sexuality education, which can contain inaccurate and misleading information regarding SRH, diverse family formations and scientific evidence.78 In the province of Ontario, despite a recent update to the curriculum,79 non-governmental organizations have had to step in to create supplemental resources to meet the sexual health education needs of transgender students.80

30. In the absence of federal standards on CSE, young people and adolescents often lack the knowledge and skills required to lead healthy sexual and reproductive lives. Marginalized young people, particularly young women and girls, are at a heightened risk of experiencing intersecting forms of discrimination which can limit their access to education, health, the judicial system, among other services. Young people in Canada have the highest reported rates of STIs and reported rates of chlamydia, gonorrhea and syphilis have been steadily rising since the late 1990s.81 Persistent rates of violence against young women and girls further demonstrate a lack of awareness regarding gender norms and stereotypes and respectful behavior and relationships, which often carries through into adulthood.82 Young women are eight times more likely than boys to be victims of a sexual offence; 83 nearly half (46%) of high school girls in Ontario are victims of sexual harassment.84 Indigenous young women and girls face more frequent incidents of violence than non-Indigenous girls.85 General Comment 35 by the CEDAW Committee calls for the implementation of CSE as a key prevention strategy for violence against women.86

31. The federal government has a role to play in addressing these realities through the regular collection of data on sexual health indicators and the roll-out of evidence and rights-based campaigns (in and out of school) that comprehensively address sexual and reproductive health and rights. Regular national studies are required in

order to determine the effectiveness of sexuality education and campaigns, and ultimately determine if such initiatives are contributing to positive health outcomes and reductions in stigma and discrimination, among other outcomes. Such studies must look beyond objective information related to STI and HIV transmission rates and unwanted pregnancies. They must integrate qualitative measures including young people's satisfaction with the curriculum, their ability to access youth-friendly services and information, violence-related outcomes, satisfaction during sexual intercourse and shifts in public perceptions, among other factors. A 2010 report by Canada's own public health agency noted that Canada "lags behind several other countries in its ability to collect national comprehensive data on this important aspect of the health of youth."87 The same report also examined results from a pilot study to assess the sexual health of young people across Canada and confirmed the validity and reliability of the indicators, concluding that it would be feasible for the study to be replicated at the national level.88

Recommendations:

- Establish standards through which the federal government can monitor and hold provinces and territories accountable to the implementation of CSE, in line with human rights obligations.
- Allocate funds to the Public Health Agency of Canada to raise awareness to the forthcoming Revised Canadian Guidelines for Sexual Health Education, and support provinces and territories towards strengthened implementation of CSE, including campaigns on positive sexuality, consent, sexual and reproductive health information and eliminating stigma and discrimination on the basis of gender, sexuality and reproduction
- Conduct regular national monitoring, through inter alia broad-based surveys, of a robust set of sexual health indicators disaggregated by relevant factors including gender, age, location, ethnicity and others.

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[1] CAT Committee, *Concluding Observations: Slovakia*, ¶ 12, U.N. Doc. CAT/C/SVK/CO/3 (2015); *Czech Republic*, ¶ 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012) ; *Kenya*, ¶ 27, U.N. Doc. CAT/C/KEN/CO/2 (2013); *Peru*, ¶ 19, U.N. Doc. CAT/C/PER/CO/5-6 (2013); *France*, ¶¶ 34-35, U.N. Doc. CAT/C/FRA/CO/7 (2016).

[2] Id.

[3] Natalia Acevedo, The medical discourse and the sterilization of people with disabilities in the United States, Canada and Colombia: From eugenics to the present, (2015), P. 99-101

[4] Id.

[5] Id.

[6] Hopp v. Lepp, [1980] 2 SCR 192, 1980 CanLII 14 (SCC), Available at: http://canlii.ca/t/1mjv6, [Accessed 2017-02-21].

[7] E. (Mrs.) v. Eve, [1986] 2 SCR 388, 1986 CanLII 36 (SCC), Available at: http://canlii.ca/t/1ftqt [Accessed 2017-02-21].

[8] CESCR GC 22

[9] CAT Committee, *Concluding Observations: Kenya*, ¶ 27, U.N. Doc. CAT/C/KEN/CO/2 (2013); *Peru*, ¶ 19, U.N. Doc. CAT/C/PER/CO/5-6 (2013).

[10] CAT Committee, *Concluding Observations: Kenya*, ¶ 27, U.N. Doc. CAT/C/KEN/CO/2 (2013).

[11] CAT Committee, *Concluding Observations: Slovakia*, ¶ 12, U.N. Doc. CAT/C/SVK/CO/3 (2015); *Czech Republic*, ¶ 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012).

[12] CAT Committee, *Concluding Observations: France*, ¶¶ 34-35, U.N. Doc. CAT/C/FRA/CO/7 (2016).

[13] World Health Organization [WHO], A DECLARATION ON THE PROMOTION OF PATIENTS' RIGHTS IN EUROPE, ICP/HLE 121, Art. 3.1 (1994); UN Office of the High Commissioner for Human Rights, Istanbul Protocol, Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ¶ 63, U.N. Doc. HR/P/PT/8/Rev.1 (2004); Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, art. 5, adopted Apr. 4, 1997,

Eur. T.S. No. 164 (entered into force Dec. 1, 2009); INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO), Guidelines regarding informed consent, in ETHICAL ISSUES IN OBSTET & GYNEC. 13-14 (Oct. 2009).

[14] Id.

[15] Id.

[16] Id.

[17] WHO, et. al., Eliminating forced, coercive or otherwise involuntary sterilization: An interagency statement 9 (2014), available at http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325_eng.pdf

[18] Id.

[19] Id.

[20] ESCR Committee, *General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 5, U.N. Doc. E/C.12/GC/22 (2016).

[21] CEDAW Committee*, General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, ¶ 18, U.N. Doc. CEDAW/C/GC/35 (2017).

[22] CRPD Committee, *General Comment No. 3: Article 6: Women and girls with disabilities*, ¶ 38, U.N. Doc. CRPD/C/GC/3 (2016).

[23] CAT Committee, Concluding Observations: Czech Republic, ¶ 12, U.N. Doc. CAT/C/CZE/CO/4-5 (2012).

[24] Including the **Special Rapporteur on Torture** (see e.g. UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, ¶¶31-35, 1 February 2013, A/HRC/22/53; UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, ¶38, 15 January 2008, A/HRC/7/3); the **Special Rapporteur on Violence against Women** (see e.g. *Report of the Special Rapporteur on violence against women, its causes and consequences*, ¶¶ 28 & 36, U.N. Doc. A/67/227 (2012)); the **Special Rapporteur on the rights of persons with disabilities** (see e.g. Report of the Special Rapporteur on the rights of persons with disabilities, ¶34, A/72/133, 14 July 2017); the **Special Rapporteur on minority issues** (see e.g. *Report of the Special Rapporteur on minority issues, Rita Izsák: Comprehensive study of the human rights situation of Roma worldwide, with a particular focus on the phenomenon of anti-Gypsyism,* ¶27, A/HRC/29/24, 11 May 2015); the **Working Group on the issue of discrimination against women in law and in practice** (see e.g. *Report of the Working Group on the issue of discrimination against women in law and in practice,* ¶¶ 45, 48, 54, 57, A/HRC/32/44, 8 April 2016); the **Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health** (see e.g. *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* ¶12, A/66/254, 3 August 2011).

[25] UN Special Rapporteur on Violence against Women, Report of the Special Rapporteur on violence against women, its causes and consequences, ¶¶ 28 & 36, U.N. Doc. A/67/227 (2012).

[26] UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, ¶46, 1 February 2013, A/HRC/22/53.

[27] UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, ¶¶31-35, 1 February 2013, A/HRC/22/53; UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, ¶38, 15 January 2008, A/HRC/7/3.

[28] UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, ¶32, 1 February 2013, A/HRC/22/53.

[29] UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, ¶48, 1 February 2013, A/HRC/22/53.

[30] UN Human Rights Council, Report of the Special Rapporteur on the rights of indigenous peoples, Victoria Tauli-Corpuz, ¶34, 6 August 2015, A/HRC/30/41.

[31] Stote, K. (2012). The coercive sterilization of aboriginal women in Canada. American Indian Culture and Research Journal, 36(3), 117-150.

[32] The Truth and Reconciliation Commission's final report begins by explaining: "For more than a century, the central goals of Canada's Aboriginal policies were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the treaties; and through a process of assimilation cause

Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious and racial entities in Canada." Truth and Reconciliation Commission of Canada, Honouring the Truth. (2015). Reconciling for the Future. Available at: http://www.trc.ca/websites/trcinstitution/index.php?p=890

[33] Canadian Women's Foundation. (2011). Violence Against Aboriginal Women: Scan and Report. Available at: https://www.canadianwomen.org/wp-content/uploads/2017/09/PDF-VP-Resources-Lamontagne_CWF_Aboriginal-Women_Final_2011.pdf

[34] Id.

[35] Native Youth Sexual Health Network. (2014). International Expert Group Meeting on Sexual Health and Reproductive Rights Articles 21, 22 (1), 23 and 24 of the United Nations Declaration on the Rights of Indigenous peoples. Available at: http://www.nativeyouthsexualhealth.com/january15172014.pdf.

[36] Native Youth Sexual Health Network. 2013. Presentation during 6th session of the Expert Mechanism on the Rights of Indigenous Peoples July 8-12, 2013. Available at: http://www.nativeyouthsexualhealth.com/emrip2013item5.pdf.

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