Action Canada for Sexual Health and Rights (joint submission)

Submission to the UN Committee on Economic, Social and Cultural Rights

66th Pre-Sessional Working Group (March 9-13 2020)

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

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

Key words: right to education, comprehensive sexuality education, right to health, access to abortion, forced sterilization, sex work.

Introduction

This report is submitted by Action Canada for Sexual Health and Rights and the Sexual Rights Initiative in advance of Canada's review during the 66th Pre-Sessional working group of the UN Committee on Economic, Social and Cultural Rights (CESCR), taking place March 9 to 13 2020, during which the List of Issues will be adopted. The report examines violations of articles 12 and 13 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) with respect to ensuring young people have access to accurate, evidence-based comprehensive sexuality education, access to safe abortion services, incidences of forced sterilization, and the health and safety of sex workers.

Article 12 – Right to health

BACKGROUND: Right to access to safe abortion services

Article 12 of ICESCR, as developed by General Comment No. 14 (2000) requires State parties to take measures to ensure women have access to access to safe, effective, affordable, and acceptable methods of family planning and appropriate services in connection with pregnancy. Furthermore, General Comment No. 22 (2016) asserts that the fulfilment of obligations derived from article 12 requires States to "adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to ensure safe abortion care." The Committee has, on numerous occasions, outlined governments' obligation to ensure access to safe abortion services under all circumstances as part of the right to sexual and reproductive health.

In 2016, the CESCR examined barriers in access to abortion and contraception in Canada, expressing concern regarding the stark disparities in access to both. These disparities were most significant for poor women and those living in remote areas. In addressing barriers in access to services, the Committee recommends that states: ensure "physical accessibility […] 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" and that difficulties providing services in remote areas requires "positive measures to ensure that persons in need have communication and transportation to such services."

In recent years, Canada has received numerous recommendations from human rights accountability frameworks calling for immediate steps to realize young peoples' right to comprehensive sexuality education. Namely, the Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW) Concluding Observation 40 (a) in 2016 called on Canada to ensure equal access to abortion services in all provinces and territories. In 2016, the UN CESCR Concluding Observation 52 called on Canada to ensure access to legal abortion services in all provinces and territories. In 2018, Canada received and accepted a recommendation as part of its UN Universal Periodic Review (UPR) to take action to ensure equal access to abortion. The Government of Canada has failed to take meaningful steps to address abortion inequalities across jurisdictions.

Access to safe abortion in Canada

The barriers that exist to safe abortion services in Canada represent violations of article 12 as interpreted by the work of the Committee. The Government of Canada, despite having the responsibility and authority to address these barriers, has failed to take action to address discriminatory policies and the barriers that are created as a result.

In Canada, the provincial governments are responsible for the administration, organization and delivery of health care. The federal government has constitutional “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 CHT) cash contribution. If any of the provinces or territories fails 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.

Despite the legal context, women seeking abortion services in Canada experience significant barriers due to lack of financial resources, geographic location, age, and race, among other factors. Only one out of every 6 hospitals provide abortion services, the majority of which, along with free standing sexual health clinics, are disproportionately dispersed across Canada, with most located in urban areas. For example, the majority of sexual health centres are located within 150km from the US border in major urban centres. 20% of people in Canada live in rural areas, where they must travel sometimes thousands of kilometres to access abortion services, which often require timely care. Adding to this, there are few providers that offer services beyond 16 weeks gestation. This makes it particularly difficult for individuals living in areas with only one service provider (where the provider may only offer services until 10 or 12 weeks gestation, for example) or those living thousands of kilometers away from major urban centres where there are multiple service access points.

The overall limited availability of abortion services is compounded by other barriers. Unexpected travel time is a factor since some of the abortion providers put a gestational limit to the termination of the pregnancy, delaying a woman’s right to abortion. In addition, these women face unforeseen monetary expenses such as travel, accommodation, lost wages, childcare, eldercare, and possibly procedural costs (in the case where there is a lack of reciprocal billing within their provincial or territorial health systems), disproportionately impacting low■income women. While there are no laws requiring parental consent or laws imposing restrictions to abortion access based on age, young people seeking abortion services have reported experiencing stigma and discrimination from health care providers.

New Brunswick only has three hospitals in the entire province providing abortion services. In contravention to the Act, New Brunswick is the only province that refuses to pay for, or reimburse women for, abortion services performed outside of hospitals; hence, this province refuses to fund clinic abortions. This policy can be especially difficult for women in small towns. If a woman in unable to travel to one of the three hospitals, or if she fears stigma and discrimination in accessing services in such environments, she may be forced to travel out-of-province in order to obtain abortion care, pay $700 or more to have the abortion at the one clinic in the province, or continue with the pregnancy and birth against her will. With such limited access, it has been reported that women are increasingly seeking abortion services out-of-country, and in some cases, engaging in unsafe practices to terminate unwanted pregnancies.

In recent years, Canada has experienced an increase in actions taken by a small, vocal, and well-funded groups dedicated to curtailing and violating women’s reproductive rights through the activities of anti-choice organizations (often known as Crisis Pregnancy Centres (CPCs), of which there are approximately 180 in Canada). Many of these organizations actively interfere with people’s access to abortion care by, for example, sharing misleading information, and gatekeeping or picketing abortion clinics or hospitals. They deceive people into thinking they are abortion clinics – and in many cases, they open as geographically close to abortion clinics as possible. In many cases, a town or city that does not have abortion clinics will have a CPC, and it has been found that some CPCs are receiving public funding to operate. CPCs often do not employ health care providers yet provide health care services (including ultrasounds) and therefore operating in unregulated contexts. As a result, CPCs are not held to the same regulatory standards that require client confidentiality and privacy, adherence to health care standards. Some of these tactics result in delayed access to health care. Abortion is a time-sensitive procedure and the more a person is delayed, the more trouble they can have accessing the service. Delaying access jeopardizes people’s ability to make important decisions about pregnancy as early as possible and to access the appropriate care. The harmful activities of Canadian anti-choice groups go well beyond the safe expression of political positions and lobbying, as they often involve the dissemination of false health information.

BACKGROUND: Forced sterilization

General Comment No. 22 of the Committee states that “measures to guarantee non-discrimination and substantive equality should be cognizant of and seek to overcome the often exacerbated impact that intersectional discrimination has on the realization of the right to sexual and reproductive health.” For Indigenous women, women with disabilities, and poor women, discrimination in the exercise of the right sexual and reproductive health often means violations of their bodily autonomy through the practice of involuntary, coercive, or forced medical procedures, including forced sterilization. The Committee has called for full and transparent investigation and adequate redress in cases of forced sterilization.

UN Special Procedures have also addressed this issue. 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 women and the Special Rapporteur on torture. 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.

Indigenous rights groups in Canada, and globally, have advocated for the application of the principle of free, prior and informed consent (FPIC) in line with the UN Declaration on the Rights of Indigenous Peoples and international human rights law. FPIC empowers Indigenous peoples and communities to meaningfully engage in decision-making that affects them, which includes decision-making around health laws, policies and programmes in the realm of sexual and reproductive rights. The Government of Canada has repeatedly denied the validity of FPIC in international fora, stating that the concept could be applied as a "veto" to Indigenous groups.

In 2018, the UN Committee Against Torture's Concluding Observations 51 (a) and (b) called on Canada to ensure that all allegations of forced or coerced sterilization are impartially investigated, that the persons responsible are held accountable and that adequate redress is provided to the victims, and adopt legislative and policy measures to prevent and criminalize the forced or coerced sterilization of women, particularly by clearly defining the requirement for free, prior, and informed consent with regard to sterilization and by raising awareness among Indigenous women and medical personnel of that requirement. The Committee further requested that Canada provide information on follow-up to the recommendations pertaining to forced sterilization by December 9, 2019. The Government of Canada has yet to follow-up. Recently, the CEDAW Committee asked Canada about the persistence of forced sterilization of Indigenous women.

Forced sterilization in Canada

The 1980 Supreme Court of Canada (SCC) Hopp v. Lepp 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, 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.

In November 2015, media outlets released reports of women in the province of Saskatchewan having undergone forced sterilization in the last five years. 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. Many advocates believe there are other women in Canada, particularly Indigenous women, who have had similar experiences within the health care system.

A 2017 report confirmed that many women had similar experiences of being forced or coerced towards tubal ligation within the health care system. 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. In October 2017, a class action suit representing 55 Indigenous women was filed against the province of Saskatchewan, 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. According to recent information from the attorneys representing forcibly sterilized Indigenous women in class actions, occurrence persists even after and despite recommendations and concerns issued by UN treaty bodies, Special Procedures, and the Inter-American Commission. New amends are being made to the existing class action to include more women and new class actions are being prepared for different jurisdictions.

According to the Native Youth Sexual Health Network (NYSHN), forms of sterilization persist among Indigenous communities. 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." NYSHN has also reported incidences of forced sterilization in Canadian prisons. 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." This speaks to the longstanding forms of systemic racism, and other types of discrimination, that have contributed to the marginalization of Indigenous peoples in Canada. Such forms of marginalization and discrimination can lead to barriers in access to health care and negative Recommended Questions to be included in the List of Issues Recognizing recent instances

of health professionals use of sterilization against the will of the patient, What steps has the Government of Canada taken to investigate instances of forced sterilization, provide reparations to the victims of forced sterilization, and ensure the non-repetition of forced sterilization, particularly among Indigenous Women?Recommended Questions to be included in the List of Issues Recognizing recent instances of health professionals use of sterilization against the will of the patient, What steps has the Government of Canada taken to investigate instances of forced sterilization, provide reparations to the victims of forced sterilization, and ensure the non-repetition of forced sterilization, particularly among Indigenous Women?health outcomes.

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BACKGROUND: health and safety of sex workers

The Committee has expressed concern regarding the criminalization of sex work resulting in rights violations, exposure to harassment, and arbitrary arrest and detention, resulting in sex workers not being able to report physical and sexual violence against them. The Committee has called to end the arrests of sex workers, consider decriminalizing sex work, and provide assistance and support to victims of harassment, violence, and exploitations.

Laws that criminalize sex work violate sex workers' right to be free from discrimination, stereotyping, and violence, including in the areas of health, employment, and access to justice. Sex work laws force sex workers, clients, and third parties into unsafe and unprotected areas. They restrict access to important safety strategies, resulting in significant and profound negative consequences on sex workers' right to health, security, safety, and equality. Such laws represent violations under article 12 as interpreted by the Committee, the work of the Special Rapporteur on the right to health and the work of the Special Rapporteur on extreme poverty and human rights. States are obligated to show due diligence in the protection of sex workers' human rights through the enactment and reform of evidence and rights-based laws and policies and by addressing the intersecting and layered systems of oppression that impact sex workers' experiences. The Special Rapporteur on the right to health has condemned the criminalization, full or asymmetrical, of sex work as violating sex workers' right to health by creating barriers to their access to health services, which can lead to poor health outcomes. UN agencies, including UNAIDS, World Health Organization, and the International Organization for Migration, support the decriminalization of sex work.

Sex work in Canada

In 2016, the CEDAW Committee recommended that Canada decriminalize women engaged in sex work. Canada has failed to take any action since then. The criminalization of sex work (including third parties and clients) in Canada represents violations of article 12 of the CEDAW as interpreted by that Committee. The Government of Canada, despite having the responsibility and authority to address these human rights violations, has failed to respect and protect sex workers' human rights.

In 2013 the Supreme Court of Canada (SCC) struck down elements of the Criminal Code that were determined to violate the rights of sex workers by undermining their health and safety. In response, the federal government tabled Bill C-36 in 2014, the Protection of Communities and Exploited Persons Act (PCEPA). PCEPA effectively criminalizes the purchase of sexual services; communicating for the purpose of purchasing and selling sexual services; receiving a material benefit from the crimes of purchasing sexual services or communicating to obtain them; procuring a person to offer or provide sexual services for consideration; and prohibiting advertising of sexual services. With PCEPA, the Federal Government reinstated provisions very similar to those already found by the SCC to be harmful to sex workers' lives, health, and safety. This approach continues to impose danger, increase surveillance and over-policing, decrease agency, provide little control over working conditions, and reduce safety for sex workers.

Evidence from Canada and throughout the world clearly indicates that criminalization forces sex workers into unsafe and unprotected areas restricting access to important safety strategies that can have significant and profound negative consequences on sex workers' health, security, safety, equality, and human rights. In the context of the right to health, the criminalization of both the selling and/or the purchase of sexual services: creates fear among sex workers that they may face legal consequences or harassment if they carry condoms and lubricant, which can be used as evidence of sex work, reduces sex workers' ability to negotiate safer sex with clients, on the street as well as indoors or on the phone, affects the relationship

between sex workers and any service providers (such as those providing condoms and harm reduction supplies), as sex workers may fear being identified as sex workers which could lead to police entrapment, and heightens risks of HIV and other sexually transmitted infections, as sex workers face substantial barriers in accessing prevention, treatment, and care services, largely because of stigma, discrimination, and criminalization. According to the Lancet, decriminalization of sex work was determined to be the single most efficient structural intervention to reduce HIV infections among sex workers through reducing the risk of violence. The criminalization of sex work increases the likelihood of additional violation of sex workers' human rights, namely the right to live free of violence and the right to bodily autonomy and women's agency.

Recommended Questions to be included in the List of Issues Recognizing ongoing violations of sex workers' right to health and safety, What steps has the Government of Canada taken to respect, protect and fulfill sex workers' rights by removing all criminal sanctions against sex work?What steps will the Government of Canada take to ensure that laws, policies, and programs, including those targeting human trafficking, do not infringe on sex workers' fundamental rights to health, labour protections, and security of the person?Recommended Questions to be included in the List of Issues Recognizing ongoing violations of sex workers' right to health and safety, What steps has the Government of Canada taken to respect, protect and fulfill sex workers' rights by removing all criminal sanctions against sex work?What steps will the Government of Canada take to ensure that laws, policies, and programs, including those targeting human trafficking, do not infringe on sex workers' fundamental rights to health, labour protections, and security of the person?Migrant sex workers are at particularly at risk of experiencing human rights violations, detainment, and deportation. Reports suggest migrant women sex workers are being targeted, creating environments of fear which further limit sex workers' ability to access health services, report incidences of violence, or seek broader support services. Canada's sex work-related laws do not explicitly address migrant sex workers but their stated objective is to "ensure consistency between prostitution offences and the existing human trafficking offences." The laws rests on the incorrect conflation of consensual sex work with coercion or trafficking, which prohibits the former. Human trafficking frameworks are therefore being applied to the context of sex work, which limits meaningful dialogue about the rights of sex workers and creates the assumption that all sex workers are victims. The new laws therefore uphold misconceptions about sex work and sex workers: that all sex workers are women or that they are inherently victims. It positions all sex workers, and by extension women, as vulnerable or in need of state protection. This approach denies sex workers, and women more generally, their agency as rational decision-makers who each navigate more or less constrained choices. It is also important to consider that Canada has existing laws that directly target exploitation, violence and non-consensual sexual activities, including those that prohibit physical assault, sexual assault, threatening, harassment, murder, extortion, human trafficking, and child exploitation.

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What steps will the Government of Canada take to ensure that laws, policies, and programs, including those targeting human trafficking, do not infringe on sex workers' fundamental rights to health, labour protections, and security of the person?

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What steps will the Government of Canada take to ensure that laws, policies, and programs, including those targeting human trafficking, do not infringe on sex workers' fundamental rights to health, labour protections, and security of the person?

BACKGROUND: Comprehensive sexuality education

Sexuality education is recognized as a basic human right of all children and youth in both the Annual Report of the Special Rapporteur on the right to education to the UN General Assembly in 2010, General Comment No. 4 of the Committee on the Rights of the Child, and UN Committee on Economic, Social and Cultural Rights General Comment No. 22. States' obligation to provide sexuality education, is a requisite for the realization of the rights to education, to health and non-discrimination, among others. In words of this Committee, States must "ensure that all educational institutions incorporate unbiased, scientifically accurate, evidence-based, age-appropriate and comprehensive sexuality education into their required curricula." When effectively implemented, comprehensive sexuality education contributes to the reduction of the transmission of sexually transmitted infections, gender-based violence, stigma, and discrimination, unwanted pregnancies, and the development of healthy sexual and non-sexual relationships, among other outcomes.

At the international level, Canada consistently works to advance progressive standards on comprehensive sexuality education, recognizing its linkages to violence against women, the right to health, and the right to education, amongst others. At the national level, Canada has, in recent years, received numerous recommendations from human rights accountability mechanisms calling for immediate action to realize young peoples' right to comprehensive sexuality education. In 2016, the CEDAW Committee called for Canada to harmonize sex education curricula among provinces and territories and allow the Federal Government to hold them accountable for implementing such guidelines or standards. In 2018, Canada received and accepted a recommendation as part of its UN Universal Periodic Review to take action to ensure equal access to comprehensive sexuality education across provinces and territories. The Government of Canada has failed to take meaningful steps to address discrepancies in access to comprehensive sexuality education across jurisdictions.

Comprehensive sexuality education in Canada

Documented discrepancies in the quality and delivery of comprehensive sexuality education curriculums in Canada represent violations of article 10 as interpreted within this cited work of the Committee. Specifically, the Government of Canada has failed to hold provinces and territories accountable for the delivery of comprehensive, quality, evidence-based sexuality education, in line with national guidelines for sexual health education and international human rights obligations. In 2019, the Canadian guidelines for sexual health education by Sex Information and Education Council of Canada (SIECCAN), endorsed by the Public Health Agency of Canada, were re-released. They are meant to guide educators and policy makers when it comes to comprehensive sexuality education in Canada. Since the launch of the Guidelines, the Government of Canada has not taken any steps to disseminate or raise awareness to the existence of the guidelines, nor has it engaged provinces and territories towards strengthening the quality or implementation of comprehensive sexuality education across jurisdictions in line with human rights obligations.

The Federal Government has repeatedly shirked responsibility for its human rights obligations concerning comprehensive sexuality education, stating the division of power between federal and provincial jurisdictions as reason for not taking a leadership role. Evidence clearly demonstrates that in the absence of standardized access to comprehensive sexuality education, young people are susceptible to experiencing poor sexual health outcomes, heightened levels of gender-based violence, and homophobic and transphobic bullying, among other negative consequences. Given the public health, violence, stigma, and discrimination impacts associated with the delivery of poor sexual health education, combined with its human rights obligations, there is sufficient scope for the Federal Government to play a leadership role eliminating discrepancies in access to comprehensive sexuality education across jurisdictions.

In Canada, evidence demonstrates an overall lack of knowledge on sexual and reproductive health among youth populations. The number of new HIV diagnoses among youth has increased by 10% from 2013 to 2017. In 2016, almost one quarter of positive HIV tests were attributed to young people between the ages of 15 and 29. Some groups are more vulnerable to HIV infection; almost two-thirds (61%) of new youth HIV diagnoses were attributed to gay, bisexual, and other men having sex with men. Other sub-groups may also be more vulnerable to HIV infection, particularly Indigenous youth and young people coming from countries where HIV is endemic. Moreover, STI rates have been steadily on the rise since the 1990s. In 2016, the highest rates of reportable STIs reported were in the 15-19, 20-24, and 25-29-year age groups. Overall, cases in the 15-29-year age groups consisted of 76% of the total reported cases of chlamydia in 2016, as observed in 2015, although they represented only 19% of the total population. Young women are particularly vulnerable. Female cases were younger than male cases: among female cases, 81% were 15-29 years old, while 68% of male cases were in these age groups. Female rates were higher than male rates in all age groups except those aged 40 and over. This trend is ongoing; the rate of chlamydia has increased by 13% from 2011 to 2016, the rate of gonorrhea, 87%, and the rate of syphilis, 76%.

In 2018, the Government of Ontario announced the repeal of the 2015 sexual health education curriculum and replacement with the 1998 curriculum. The 2015 curriculum had only recently been updated to reflect sexual orientation and gender identity and the concept of consent, among other issues. Action Canada submitted an urgent appeal to the UN's Special Procedures to draw attention to the human rights violations occurring as a result of the repeal. In December 2018, Canada received an official communication endorsed by seven UN human rights experts demanding Canada take immediate steps to ensure compliance with human rights obligations; including:

(1) providing information on the actions taken by the Federal Government of Canada to ensure that the State, including in Provincial jurisdictions, comply with its international human rights obligations, notably in terms of Economic, Social and Cultural Rights, including the rights to non-discrimination, health, and education, and

(2) explaining measures taken to ensure that all individuals and groups have access to comprehensive, non-discriminatory, evidence-based, scientifically accurate, and age appropriate information on all aspects of sexual and reproductive health, including gender equality, sexual and gender-based violence, and the issue of consent.

In response to the Communication, the Government of Canada, in collaboration with the Government of Ontario, submitted a response which fails to take adequate responsibility for human rights obligations (particularly regarding non-retrogression), puts forward inaccurate information regarding the curriculum in question, falsely claims there is no definition of “age appropriate,” refutes any violation of the freedom of expression of teachers by denying the creation of the “snitch” line, presents misleading information regarding the curriculum consultations, and incorrectly attributes rights entitlements to parents.

In Alberta, some school boards allow religious groups to deliver sexuality education, which can contain inaccurate and misleading information regarding sexual and reproductive health, diverse family formations and scientific evidence. In 2014, an Edmonton student launched a human rights complaint with the Alberta Human Rights Commission, providing evidence that religious groups were delivering misleading information to students on issues related to contraception and sexually transmitted infections, within an abstinence-based approach. Research shows the correlation between the implementation of abstinence-based approaches and rises in sexually transmitted infections, unwanted pregnancies, and other negative health outcomes, as it limits young people’s access to comprehensive, evidence-based, and scientific information related to sexual and reproductive health.

Despite the Federal Government having a role to play both in fulfilling young people’s sexual and reproductive rights (in part through the implementation of comprehensive sexuality education) and in gathering and analyzing data on trends in relation to the sexual and reproductive health of all people in Canada, there are no standards through which sexual health education curricula can be monitored and evaluated. Regular national studies are required in order to determine the effectiveness of sexuality education and, ultimately, to determine if curriculums are contributing to positive health outcomes and reductions in stigma and discrimination, among other outcomes.

Recommended Questions to be included in the List of Issues Recognizing the division of powers outlined in the Constitution of Canada as it relates to legislation respecting education, What steps has the Government of Canada taken to harmonize sex education curricula among provinces and territories and allow the Federal Government to hold them accountable for implementing such guidelines or standards?What steps has the Government of Canada taken to conduct regular monitoring on a robust set of sexual health indicators disaggregated by relevant factors?What actions has the Government of Canada taken to establish a robust accountability framework or mechanism to engage all levels of government to ensure compliance with international human rights law?Recommended Questions to be included in the List of Issues Recognizing the division of powers outlined in the Constitution of Canada as it relates to legislation respecting education, What steps has the Government of Canada taken to harmonize sex education curricula among provinces and territories and allow the Federal Government to hold them accountable for implementing such guidelines or standards?What steps has the Government of Canada taken to conduct regular monitoring on a robust set of sexual health indicators disaggregated by relevant factors?What actions has the Government of Canada taken to establish a robust accountability framework or mechanism to engage all levels of government to ensure compliance with international human rights law?Further, Canada has no progress to effectively implement human rights recommendations or to ensure the implementation of human rights law across governmental jurisdictions. Process by which the Government consults civil society and Indigenous organizations before and after treaty body reviews are either nonexistence or perfunctory. The Federal Government must establish a robust human rights accountability framework to ensure compliance with international human rights law. Such a framework or mechanism would engage all levels of government, maintain adequate resources for the implementation of human rights recommendations and Concluding Observations, incorporate regular monitoring and evaluation functions, and regularly engage civil society organizations and Indigenous peoples’ organizations towards greater implementation of and compliance with human rights law.

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