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**Human Rights Council**

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Agenda item 3

**Promotion and protection of all human rights, civil,**

**political, economic, social and cultural rights,**

**including the right to development**

Visit to Canada

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health[[1]](#footnote-2)\*, \*\*

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| *Summary* |
| The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Mr. Dainius Pūras visited Canada from 5 to 16 November 2018.  Canada counts with a strong public health system firmly rooted in the principles of equity and fairness and the notion that access to healthcare should be based on need and not on the ability to pay. While the public health system includes many elements compatible with the right to health, a human rights-based approach is still needed for the State to comprehensively comply with its obligations to protect, respect, and fulfil the right to health. The important role model that Canada plays worldwide and its solid position in international cooperation, also carries with it a responsibility to ensure that the international support provided to other countries is in line with human rights.  Authorities should enhance their efforts to continue addressing remaining challenges in terms of services that are not covered by the public health insurance; disparities across Provinces/Territories; poor access to healthcare by persons in vulnerable situation, including Indigenous peoples, and the lack of parity between physical and mental health. |
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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Canada

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I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Mr. Dainius Pūras, visited Canada from 5 to 16 November 2018 at the invitation of the Government. The purpose was to ascertain, in a spirit of dialogue and cooperation, how the right to health is realised in the country.

2. The Special Rapporteur travelled to Ottawa, Winnipeg, Vancouver, and Montreal. He met with the Government of Canada’s Ministers of Health and Indigenous Services Canada and with a number of Federal and Provincial Governments’ representatives, such as the Chief Public Health Officer of Canada and Provincial Chief Medical or Health Officers, as well as officials in charge of health services at Correctional Service Canada, including the Correctional Commissioner. He met with independent bodies such as the Canadian Human Rights and Mental Health Commissions, the Correctional Investigator, a Provincial Youth Human Rights Commission, as well as officials from a Provincial Ombudsman Office.

3. The Special Rapporteur visited many healthcare facilities, from community-based centres and clinics to large hospitals, and paid a visit to one high-school in Montreal. He is grateful to the great number of committed civil society representatives, academics, professionals and psychiatrists with whom he met, not only in person in each city to which he travelled, but also remotely, including stakeholders from Toronto, Halifax, Regina and Fredericton.

4. The Special Rapporteur verified the complex machinery of policy and technical schemes involved in Canada’s delivery of health services and the different levels of responsibilities and jurisdictions of the Federal, Provincial/Territorial and Municipal authorities. He is grateful to the Government of Canada for its full and high level of cooperation in close coordination with Provincial and local authorities.

II. Right to health in Canada

1. Background

5. Canada is politically structured as a constitutional monarchy, a parliamentary system, a federal system and a representative democracy. It has two levels of Government: the Federal for the whole country and Provincial/Territorial governments for ten Provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador) and three Territories (Yukon, Northwest Territories and Nunavut). The federal system bestows legislative and executive powers on these two levels, which are each sovereign in their respective domains. Canada is officially a bilingual country.

6. Canada is the second largest country in the word but one of the least densely populated. Seventy-one percent of Canada’s 36 million people[[2]](#footnote-3) live in cities of more than 50,000 inhabitants.[[3]](#footnote-4) In contrast, there are many remote and isolated communities which sometimes may be reached only by plane or shipping vessels. This remoteness negatively impacts peoples’ accessibility of rights, including the right to physical and mental health.

7. Canada is a developed and advanced country, part of the Group of Seven most industrialized and largest economies worldwide.[[4]](#footnote-5) Overall well-being is high. In 2017, Canada’s human development index (HDI) value was 0.926,[[5]](#footnote-6) above the average for countries in the very-high human development group (0.894). Between 1990 and 2017, the country experienced notable increases in life expectancy at birth (by 5.2 years) and mean years of schooling (by 3.0 years). Canada ranks first when the HDI is associated with indicators on the quality of health, but falls to 0.852 when inequality is factored in.

8. While Canada’s income inequality is within the average for countries of the Organization for Economic Co-operation and Development (OECD), significant disparities remain notably among Indigenous peoples and recent immigrants. Disparities also persist among regions with large differences in terms of safety, health and housing. Nunavut, Yukon and Prince Edward Island are located at the bottom of several of these indicators.[[6]](#footnote-7) While overall poverty rates have remained practically unchanged, the relative poverty rate in Canada is above the OECD average.[[7]](#footnote-8)

9. Canada made progress in Millennium Development Goals (MDG) that are relevant to the right to health and has committed to advance the 2030 Agenda for Sustainable Development. It achieved progress in two of the three right-to-health related MDG, namely MDG 4 (Reduce child mortality) and MDG 6 (Combat HIV/AIDS, malaria and other diseases), but did not showed the same trend in MDG 5 (Improved maternal health). Whereas the adolescent birth rate per 1,000 women was cut by half (from 25 in 1990 to 12.6 in 2011), the maternal mortality ratio per 100,000 live births was 7 in 2015, the same value of 1990.[[8]](#footnote-9)

10. In terms of SDG 3 (Ensure healthy lives and promote well-being for all at all ages), official assessments[[9]](#footnote-10) highlight as pending tasks: i) addressing Indigenous peoples’ poor health outcomes and ii) tackling health inequalities linked to socioeconomic indicators including income, education levels, employment, and occupation status.

B. Normative and institutional framework

11. Canada is a party to seven international human rights treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), which enshrines the right to health. However, it has not yet ratified a few additional but significant instruments, including the ICESCR Optional Protocol (ICESCR-OP). If ratified, the ICESCR-OP would allow individuals to submit complaints on alleged violations of, inter alia, the right to health for consideration by the Committee on Economic, Social and Cultural Rights (CESCR).

12. Canada has, however, accepted the same complaint procedure for other international treaties. Individuals in-country may submit complaints of alleged violations of rights protected by the International Covenant on Civil and Political Rights (ICCPR), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of Persons with Disabilities (CRPD). The right to health is directly protected in the last two and some provisions are protected by the ICCPR through the right to life.[[10]](#footnote-11)

13. In April 1999, Canada issued a standing invitation to the special procedures mandate holders of the then Commission on Human Rights and has been visited by many of them. Canada has further ratified the WHO Framework Convention on Tobacco Control and the main United Nations Conventions related to drug control.

14. In May 2018, the State underwent its third cycle evaluation under the Universal Periodic Review (UPR). Canada accepted, among others, recommendation No. 149 to “Ensure the justiciability of economic, social and cultural rights.”[[11]](#footnote-12) The Special Rapporteur welcomes this particular acceptance as, right-to-health wise, it will enhance the commendable public health approach implemented in-country for years and will ensure the understanding of health beyond its public service notion as a human right.

15. The public health approach indeed advances standards that are compatible with the right-to-health’s essential elements of accessibility, availability, acceptability and quality as well as access to health related information, education and information, including on sexual and reproductive health rights. The current public health approach in Canada also includes a solid equity approach aimed at reducing health disparities. It focuses on the needs of persons in the most vulnerable situations by paying special attention to their social determinants of health such as education, income, and housing as well as accessible and affordable food. This is welcomed and in line with further aspects of the right to health which considers food, nutrition, education and housing as underlying determinants of health and their linkages with poverty.[[12]](#footnote-13)

16. In Canada, a human rights-based approach to health will further improve accountability and enhance the protection of the right to physical and mental health through, inter alia, improved avenues for seeking effective remedies when the enjoyment of the right is not ensured; this includes issues such as the denial of medical treatment and others. This approach will further complement the equity approach by bringing the principles of non-discrimination and equality forward, so that no distinction, exclusion, restriction or preference, or other differential treatment is made in the exercise of the right to health based on grounds such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[[13]](#footnote-14)

17. The human rights-based approach will moreover bring the notion of the indivisibility, interdependence and interrelation of all rights. It will shed light into the right-to-health’s centrality to, and dependency upon, the realisation of other rights, including those already recognized by the public health approach, i.e. food, housing, work and education, but also rights that supports human dignity and the rights to life, freedom from torture, privacy, access to information, participation, and the freedoms of association, assembly and movement.

18. In sum, a human rights-based approach will support Canada in implementing the normative framework by which it has abided itself and to comply with its obligations under international human rights law. The justiciability of the right to health, defined as those matters which are appropriately resolved by the courts,[[14]](#footnote-15) will not be fully realised in Canada without a human rights-based approach to health.

19. Likewise, advancing the realization of the right to health and related rights in the country is key in ensuring good health and well-being of all people therein living. It is also key to Canada’s important role as a model for many countries and its position in the international cooperation. Canada should ensure that its international support to other countries is in line, not only with evidence-based data, but with a human rights-based approach.

National legal framework

20. The Constitution of Canada contains a series of Acts and instruments, including two main documents (the *Constitution Act, 1867* and the *Constitution Act, 1982*) and a set of unwritten principles and conventions. Constitutional amendments enacted in *the Constitution Act, 1982* included protections of individual rights and freedoms in the *Canadian Charter of Rights and Freedoms*. The Constitution also prescribes which powers –legislative, executive and judicial– may be exercised by which organs of the State and how legislative powers are distributed between the Parliament of Canada and the provincial legislatures. The unwritten rules (constitutional principles and conventions) govern the relationship among the State’s entities and condition the exercise of legal powers.

21. While the right to health is not explicitly mentioned in the Canadian Charter of Rights and Freedoms, many of its provisions may be protected through other rights therein specified, in particular the right to life and security of the person (section 7), and the right to equal protection and equal benefit of the law without discrimination (section 15).

22. Up to present, people in Canada have relied on sections 7 and 15 of the Charter of Rights and Freedoms to challenge barriers for accessing healthcare based on need and barriers to addressing poverty, homelessness, and other significant determinants of health. The Special Rapporteur received information indicating that a common opposing argument to these judicial challenges is the inaccurate assumption that Canada’s international human rights obligations have allegedly no binding legal effect. He stresses that international human rights law lays down obligations which States are bound to respect when they become parties to the treaties.

23. In a decision of a national case brought for consideration by the United Nations Human Rights Committee under the complaint procedure of the ICCPR,[[15]](#footnote-16) the Committee stressed that, while the ICCPR does not protect the right to health as such, the right to life, cannot be properly understood in a restrictive manner and its protection requires positive measures by the State. The Committee reminded that the right to life extends to reasonably foreseeable threats and life-threatening situations that can result in loss of life. States are therefore obliged to adopt health-related positive measures even if such threats and situations do not result in loss of life; at the minimum, States must provide access to existing healthcare services that are reasonably available and accessible when lack of access to the healthcare would expose a person to a reasonably foreseeable risk that can result in loss of life.

24. Finally, the Committee concluded that the denial of healthcare coverage to an undocumented migrant under the Interim Federal Health Program for immigrants violated the migrant’s right to life (ICCPR article 6). It also determined that excluding her from the healthcare coverage under the Program, on the basis of her immigration status, was a violation of her rights to equality before the law and equal protection of the law without any discrimination (ICCPR article 26). It compelled Canada to provide the migrant with an effective remedy, full reparation and adequate compensation and asked it to take all steps necessary to prevent similar violations in the future. This through, inter alia, reviewing its national legislation to ensure that irregular migrants have access to essential healthcare to prevent a reasonably foreseeable risk that can result in loss of life.

25. The Special Rapporteur agrees with these conclusions and further notes that, considering that access to essential healthcare is protected by ICCPR articles 6 (right to life) and 26 (right to equality and non-discrimination), the same should apply in terms of the *Canadian Charter of Rights and Freedoms’* section 7 (right to life, security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice) and section 15 (right to equality before and under the law and to the equal protection and equal benefit of the law without discrimination). The argument that the Charter imposes no positive obligations to protect the health-related elements of the rights to life, security of the person and equality contravenes Canada’s international obligations.

C. National healthcare system

26. Canadian healthcare systems are firmly rooted in values of equity and fairness and the overall notion that access to healthcare should be based on need and not on the ability to pay. These values are embedded in single-payer public healthcare systems partially funded by the Federal Government and implemented in each Province and Territory.[[16]](#footnote-17)

27. Legal grounds for this arrangement are found in the Constitution Act, 1867. Its section 92.7 bestows jurisdiction to Canadian Provinces over hospitals, asylums, charities and psychiatric institutions. Federal jurisdiction, on the other hand, includes quarantine and the establishment and maintenance of Marine Hospitals (section 91.11) and power over raising money by taxation and borrowing money on the public credit (section 91.3 and 91.4, respectively). These Constitutional provisions have generally been interpreted as granting Provinces/Territories the jurisdiction to manage overall healthcare with funds from the Federal Government.

28. As a result, Canada does not have one single entity that is responsible for health delivery, nor one single national healthcare plan. Instead, there are thirteen provincial/territorial healthcare plans and some targeted federal plans for specific groups.[[17]](#footnote-18) To support their own plans, Provinces and Territories receive federal funding through the *Canada Health Act* and the Canada Health Transfer (CHT).

29. The 1984 Canada Health Act is federal legislation that establishes a publicly funded healthcare insurance to cover medically necessary services provided by hospitals and physicians in the Provinces/Territories. According to the Act, “the primary objective of Canadian healthcare policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (Section 3).

30. The Act defines criteria and conditions for insured health services and extended healthcare services that Provinces/Territories must comply with in order to receive the full federal transfer under the CHT. There are five criteria: i) public administration, ii) comprehensiveness, iii) universality, iv) portability, v) accessibility. The Act also establishes two conditions (information and recognition) and one provision that prohibits extra-billing and user charges.

31. Provincial/Territorial governments manage, organize and deliver healthcare services, although the Federal Government provides healthcare services for certain groups, including refugees, veterans, members of the armed forces, federal prison inmates, and some services for Indigenous First Nations and Inuit. The Federal Government is further responsible for enforcing the Canada Health Act. Accordingly, if any of the Provinces/Territories fail to meet the criteria, or if they allow extra billing by medical practitioners or users’ charges for insured health services, they will face a penalty in the form of a reduction or withholding of the CHT.

32. Healthcare services are delivered by a broad range of providers, some of which are owned or employed by the government, and others are privately-owned or self-employed. Hospitals are either public or private non-profit institutions. Other healthcare services (such as home care and long-term care) are delivered by a mix of private for-profit, private non-profit and public organizations. Physicians are predominantly “self-employed free agents”, generally paid by the respective government, on a fee-for-service basis, which is negotiated with medical associations (although the use of alternate payment systems such as capitation is increasing). Other healthcare personnel such as dentists and physiotherapists operate as self-employed professionals and are not generally paid by Provinces/Territories.

33. The levels of government involved in Canada’s healthcare system suggest complexities for the State to be accountable under the right-to-health framework. This was highlighted by the CESCR in 1998 when it regretted that “by according virtually unfettered discretion to Provincial governments in relation to social rights, the Government of Canada has created a situation in which Covenant standards can be undermined and effective accountability has been radically reduced.”[[18]](#footnote-19)

34. The Special Rapporteur recalls that even with different healthcare schemes at the Provincial/Territorial levels, the obligation to protect, respect and fulfil the right to health remains with Canada as a whole. He offers two recommendations to help Canada comply with its international obligations: i) to include human rights criteria in the existing ones for health federal transfers under the CHT, and ii) to consider adopting a rights-based national healthcare framework/strategy for the whole country.

35. The right-to-health framework provides concrete standards, such as non-discrimination, acceptability, quality, informed consent or participation that can be added to existing criteria on federal financial transfers under the CHT, so that these funds may be withheld or reduced by the Government of Canada when human rights are not protected, respected and/or fulfilled by the Provincial/Territorial governments.

1. Identified remaining gaps in healthcare delivery

36. The Special Rapporteur commends the strong focus on public health, universality, equality and fairness of the Canadian healthcare system. He however identifies four types of remaining challenges:

1. Gaps in health goods and services that are not covered by Provinces/Territories mainly linked to current requirements in the national legal framework;
2. Discrepancies to accessing quality healthcare by Province/Territory owing to the federal division of healthcare responsibilities;
3. Gaps faced by groups in vulnerable situations owing to the barriers they continue to encounter while accessing healthcare services, including Indigenous peoples, and
4. Lack of parity between mental and physical health.

37. Regarding the first gap, the Canada Health Act does not require Provincial/Territorial governments to include services that are provided outside hospitals by healthcare personnel other than doctors, such as physiotherapy, psychotherapy and occupational therapy. In Québec for example, access to the later requires first seeing a physician; the Special Rapporteur further received information about challenges with waiting lists, online registrations to consult primary-care doctors for the first time, and changing clinics in Québec.

38. Provincial/Territorial governments are neither required to cover prescription medication, older persons’ care, mental health and “addiction services,”[[19]](#footnote-20) dental and vision care, or rehabilitation services, amongst others. These types of services are, in some cases, covered by private health insurance plans that employers or unions offer for their respective constituencies, and in other cases these are paid through out-of-pocket payments.

39. The current coverage of medicines differs significantly by Province/Territory considering the Canada Health Act does not establish requirements for public funding of out-of-hospital pharmaceuticals, nor a homogenous pharmacare system. Each Province/Territory has its own approach; some have specific programmes with different degrees of medicines’ coverage for groups in vulnerable situation, such as those on social assistance, older persons and youth, or by specific disease such as cancer, palliative care or infectious diseases.[[20]](#footnote-21) For example, some Provinces (British Columbia and Manitoba) do not have plans specifically for older persons. Others have established some level of medicines’ coverage for the entire population which are income-based plans and which cover only against catastrophic costs and can be accessed solely when the pharmaceutical spending of a given household rises to a substantial share of its annual income.

40. Overall prices of medicines are high throughout the country. Recent efforts through the pan-Canadian Pharmaceutical Alliance (pCPA) to achieve lower prices for some medicines are positive, but remain insufficient to benefit either uninsured persons who continue to purchase medicines out-of-pocket, or those who are privately insured. Furthermore, the segmented Provincial/Territorial approach to pharmacare negatively impacts on prices, which are negotiated separately in each Province/Territory. The high costs of medicines are further compounded with overprescribing practices by medical professionals.

41. The right-to-health framework compels States to provide access to essential medicines and to ensure non-discriminatory access to health facilities, goods and services, including medicines. The Special Rapporteur commends the Federal Government’s establishment in 2018 of an Advisory Council on the Implementation of National Pharmacare and its interim report of March 2019. He hopes that the process triggered by the Advisory Council will allow for the establishment of a national pharmacare plan or guidelines that are compliant with the Canada’s right-to-health obligations, including non-discrimination, accountability, availability, accessibility, acceptability and quality.

42. Regarding the second gap, an example illustrating it refers to access to abortion which is elaborated further down. The rest of the challenges are developed in specific sections.

2. Civil society partnerships

43. Civil society organizations importantly contribute to closing remaining gaps; they are sometimes funded by the Federal and/or Provincial/Territorial governments and, in most cases, have developed innovative approaches often including a human rights approach, even if not explicitly.

44. The Special Rapporteur recommends that the Federal Government continue to support these good projects, while investing and building human rights capacity within the publicly financed and administered healthcare system. This, together with new rights-based criteria for federal transfers under the CHT, will allow Federal and Provincial/Territorial governments not only to strengthen the health-related expertise developed by the civil society, but also to use it and mainstream it. In this process, the level of governance and cooperation between Federal and Provincial/Territorial authorities should be enhanced to prevent miscommunications between various levels of governments.

45. The funding from Federal and Provincial/Territorial governments to civil society projects should be further revisited, so as to i) allow for multiyear funding of, for example 7 years, ii) support projects in different regions within Provinces/Territories, and iii) include mechanisms of accountability and transparency. Notably, long multi-year funding will provide stabilization to civil society projects allowing them to build programmes, build trust with constituencies and stakeholders, and to properly evaluate activities.

III. Right to mental health

A. The national approach

46. The Special Rapporteur commends the sustainable development of a broad range of mental health services, from mental health promotion and prevention of mental health conditions, to treatment and rehabilitation services, especially for children, adolescents and youth.

47. Overall, health responses to “problematic substance use” in Canada are managed as a subset of mental health responses, as both are associated with distress and/or different degrees of impairment, with symptoms that vary from mild to severe. However, mental health is not formally integrated into primary healthcare, although there have been good efforts in this direction. The Canadian Collaborative Mental Health Initiative, a national project originally supported with federal funds, has endeavoured to integrate mental health in primary care through prevention, early detection, treatment, rehabilitation and recovery. Some Provinces’ Health Ministries have also worked together with primary care and mental health planners to develop and fund integrated projects, including the Centres de Santé et de Services Sociaux in Québec[[21]](#footnote-22), Family Health Teams in Ontario, Primary Care Networks in Alberta, and the Practice Support Program in British Columbia.[[22]](#footnote-23)

48. In 2007, the Federal Government created the Mental Health Commission of Canada, as recommended by the 2006 “Out of the Shadows At Last” report, with the objective of providing a national framework for mental health. The Commission is constituted as a non-profit organization and funded with federal resources to support the Federal and Provincial/Territorial governments. It developed the national mental health strategy for Canada (2007-2017) and a consultative framework to advance the strategy which extended it to 2022.

49. The Special Rapporteur welcomes the national framework and its objectives to uphold the rights of persons with disabilities and of Indigenous peoples. He appreciates aspirations to align relevant policies with the CRPD, to fight stigma, address discrimination and eliminate structural barriers faced by persons with mental health conditions. He notes the use of advance directives to allow persons with psychosocial, intellectual or cognitive disabilities to express preferences on services, treatments and support ahead of times when they may find it more challenging to make decisions. He hopes these advance directives will help Canada to eventually lift the reservation on substitute decision-making it made when ratifying the CRPD and to adopt a supported decision-making paradigm. Additionally, the Special Rapporteur recommends aligning the language of the strategy to the human rights language reflected in applicable instruments, including the CRPD and relevant Human Rights Council resolutions.[[23]](#footnote-24)

50. For the past 50 years, Canadian Provinces/Territories have implemented a process of deinstitutionalization to move persons out of psychiatric hospitals and into the community, while expanding community-based services. Deinstitutionalization in the Provinces/Territories has been implemented in various degrees and with different timings and rates of bed closures, investment on community-based services and decreased days in psychiatric institutions. Regrettably, Alberta, British Columbia, Manitoba, Nova Scotia, Prince Edward Island, Québec,[[24]](#footnote-25) and the Territories continue to place persons with disabilities in institutions. Moreover, while some Provinces have made good progress in law and policies, the practice in mental healthcare seems to be still dominated by a biomedical model, the overuse of psychotropic medications and an overall conception that mental health conditions result from chemical brain imbalances or other neurobiological and genetically determined mechanisms.

51. On the other hand, investments to include persons with psychosocial, intellectual and cognitive disabilities into the community have been insufficient; many still lack access to employment, education, housing and adequate healthcare. Autistic persons in particular continue to be excluded from the design of services aimed at supporting them. Their healthcare is still based on attempts to “fix” behaviours rather than understanding them; this approach filters into society and translates into abuses and exclusion.

B. Local mental health and “problematic substance use” services

52. There is a wide variety of mental health and “problematic substance use” services across Provinces/Territories which are not necessarily covered by public insurance and are often delivered in partnership with different stakeholders. The Special Rapporteur observed some of them in Manitoba, British Columbia and Québec.

53. He learned first-hand about the least restraint policy at Winnipeg-based Actionmarguerite’s home which offers palliative services under Manitoba’s 2000 Protection for Persons in Care Act and Winnipeg’s Regional Policy on Restraints in Personal Care Homes. Here, the use of restraints, either physical or chemical (medications), is restricted to the very minimum through interdisciplinary assessments, consent, and the understanding that any restraint may affect the person’s physical safety and psychological well-being. While this practice is in line with the Special Rapporteur’s recommendation[[25]](#footnote-26) to radically reduce medical coercion, he hopes that policy and practice will advance to a point where they will also be in line with his recommendation to eventually eliminate all medical coercion in mental health settings. He additionally recommends revisiting the Regional Policy to shift provisions on substitute decision-makers to a paradigm of supported decision-making.[[26]](#footnote-27)

54. The Special Rapporteur visited the Douglas Mental Health University Institute in Montreal and was particularly encouraged by the collaborative approach based on persuasion and support at the Eating Disorders Program. The programme applies a non-coercion approach in treatment delivery under any circumstance, including when dealing with the most severe cases. The Special Rapporteur also learnt about the Assertive Community Treatment in British Columbia, a recovery-oriented service for persons with mental health and “problematic substance use” issues delivered through a psychosocial rehabilitation perspective by multidisciplinary teams. He welcomes the focus of British Columbia’s government on integrating housing into mental health and “problematic substance use” services in partnership with various stakeholders.

55. The Special Rapporteur was briefed about cases of isolation and seclusion of autistic children in special education classrooms in Ontario, Saskatchewan and Alberta, and restraint through sedatives by Ontario school workers. Residential homes for autistic persons in Toronto continue to use physical restraints and expose vulnerable youth to sexual and other physical and psychological abuse by staff. The Ontario government should embrace the social approach adopted by other Provinces including measures such as inclusive design in classrooms, sensory-friendly spaces, improved workspaces for retainment, meaningful study of autistic persons’ needs, human rights regulation and enforcement, de-escalation alternatives and trauma-informed care, inclusion of autistic persons in social assistance and jobs legislation, as well as education for teachers, providers and policymakers that is informed by autistic people.

56. Regarding “problematic substance use”, the Special Rapporteur commends Canada, both Federal and Provincial authorities, for their leadership in investing in modern human rights approaches domestically and internationally, and for taking steps towards a comprehensive public health approach towards drug policy. He welcomes the Federal policy shift from preventing supervised consumption services (2006-2015) to supporting their scaling up. This shift involved 2017 amendments to the Controlled Drugs and Substances Act that simplified the process to obtain an exemption for the establishment of supervised consumption facilities through the Act’s Section 56.1 (Exemption for Medical Purposes at a Supervised Consumption Site Section). The national drug strategy was also updated to reintroduce the harm reduction pillar that was removed in 2006, so that together with the pillars of prevention, treatment and enforcement, proper supervised consumption sites may be supported, and access to naloxone and to other harm reduction services may be expanded.

57. Exempted facilities that offer supervised consumption services have increased from two in 2016 (both in Vancouver) to 39 in April 2019 in Alberta, British Columbia, Ontario and Québec. The Special Rapporteur visited two well organized sites providing a supervised consumption centre and an overdose prevention site in Vancouver and notes the need to continue replicating these types of services within British Columbia and across the country.

58. Canada faces an opioid overdose crisis. Official data[[27]](#footnote-28) reveals that between January 2016 and September 2018, more than 10,300 people died for opioid-related causes. The Special Rapporteur considers that this crisis is of such gravity that it may not be an exaggeration to compare it with the HIV/AIDS epidemics. He urges the authorities to keep up with the good efforts to support supervised consumption centres and to further consider a legal framework that does not require specific exemptions from the Controlled Drugs and Substances Act if centres meet specific conditions. He calls on Canada to redouble efforts to continue addressing the root causes of the opioid crisis and its social and underlying determinants, including poverty, discrimination, early childhood adversities, access to adequate housing and safe water, as well as access to healthy occupational and environmental conditions.

59. The Special Rapporteur visited Ndinawemaaganag Endaawaad Inc. (Ndinawe) in Winnipeg which provides safe and supportive services for youth at risk including those experiencing homelessness, sexual exploitation, family conflict, placement breakdown, and mental health crises, many of whom are Indigenous peoples. Through this commendable holistic model, young people aged 11-17 are outreached and provided with shelter and a wide-range of activities and services ranging from education, recreation, harm reduction, crisis intervention and stabilization, amongst others.

60. At a Foundry centre in Vancouver, the Special Rapporteur observed the good integrated model of care along a continuum of mental health and “substance use” services delivered by multiple partners. He appreciated the community-based Stepped Care Model that addresses youths’ mental conditions from mild to severe including early psychosis and “substance use” through active monitoring and information as well as services at three levels of intensity (low, short-term high, and high intensity/specialist) with tailored, minimized and “invisible” referrals.

C. Towards reaching parity between physical and mental health

61. The Special Rapporteur acknowledges efforts to include mental health into primary care, the national framework for mental healthcare and the many good models and practices in different Provinces. He also urges Federal and Provincial/Territorial authorities to further advance the realization of the right of everyone to mental health and the realization of all human rights of persons with autism, psychosocial, intellectual and cognitive disabilities. The overall main goal is to achieve parity between mental and physical health in the provision of health services.

62. During his visit to Vancouver General Hospital, the Special Rapporteur observed the high level of quality of specialized physical care for people who need intensive care or other physical care, jointly with a good management of admissions and referrals. These same high levels should be reached when issues relate to mental health and “problematic substance use.”

63. Innovative solutions are needed other than just investing in biomedical interventions if physical and mental health parity is to be achieved. This is why it is crucial to address imbalances in the provision and funding of healthcare. Policy decisions are needed to prioritize investments to those services that are human rights compliant and that do not feed the vicious cycle of discrimination, stigma, exclusion and overuse of the biomedical model.

64. There are good opportunities for this substantial progress. For example, the Choosing Wisely initiative provides relevant indications. It seeks to engage healthcare personnel in educating the general population against wasteful, unnecessary or costly use of medical tests, treatments and procedures, including specialized interventions. The goal is to empower users for them to choose healthcare that is truly necessary, supported by evidence, not duplicative and free from harm and to help developing rational healthcare. Support from healthcare authorities to initiatives such as choosing wisely could effectively contribute to more effectiveness and transparency in mental health and “problematic substance use” services, as well as in the healthcare system at large.

65. Canada has a double responsibility towards reaching parity between physical and mental health. On one hand, determinants of mental health, such as inequalities, discrimination and violence need to be addressed domestically with enhanced political will and increased investments, so that the risk factors for poor mental health outcomes can be effectively prevented. In this regard, overcoming early childhood adversities is of key importance, considering their detrimental impact and correlation with a higher prevalence of different patterns of poor physical and mental health, including suicides, numerous deaths and other harms from “problematic substance use”, and poorer outcomes in Indigenous peoples’ health, amongst others. Integrating mental health into primary healthcare is also important to reduce the stigma and discrimination still linked to mental health and “problematic substance use”, to enhance access to integrated and continuing care, and to improve social integration.

66. On the other hand, Canada could and should be a champion in critically assessing the current situation of mental health policies and services globally and in modernizing mental health policies and services through international support. Canada‘s international cooperation should be directed to the provision of rights-based mental health services and, in compliance with the CRPD, should move away from services based on over-medicalization and coercion. These should be obligatory conditions to apply for Canadian support.

67. Throughout 2016-2017, the federal Government invested CAD $42 million into 85 projects in 31 countries through the non-profit Grand Challenges Canada, which is primarily funded by Global Affairs Canada. To receive these funds, projects had to show they promoted innovative approaches that could improve treatment and increase access to mental healthcare across priorities that include community-based care, non-specialists treatments, improving the access of children mental healthcare and improving the supply of medication.

68. Canadian international assistance and cooperation must include the full range of human rights and prioritize persons and groups in the most vulnerable situations. In the field of mental health, Canada should direct its international support to projects that predominantly include community-based psychosocial and alternative interventions other than medication. This way individuals will be effectively safeguarded from discriminatory, arbitrary, excessive, inappropriate and/or ineffective clinical care, users will be empowered and their autonomy respected. The involvement of users should be ensured in the design, implementation, delivery and evaluation of mental health services and no international support should be given to support institutional care.

IV. The right to health of Indigenous peoples

69. The Special Rapporteur held many meetings with grass-root organizations and authorities of Indigenous peoples: First Nations, Inuit, and Métis, including the unique First Nations Health Authority in British Columbia which, in coordination with Provincial and Federal authorities, is now administering and delivering health services on reserves, including those in remote First Nations communities across the province.

70. In Canada, it is broadly recognized that colonial processes have had negative impacts on Indigenous peoples’ health and well-being. In 2015, the Truth and Reconciliation Commission described past assimilationist policies, particularly residential schools, as a cultural genocide.[[28]](#footnote-29) Through residential schools, Indigenous children were separated from their parents, not for educational purposes, but primarily to break their link to their culture and identity; child neglect was institutionalized and the lack of supervision paved the way to sexual and physical abuse. The Special Rapporteur was debriefed on these ruptures and abuses, including from victims themselves.

71. In June 2008, Prime Minister Harper, followed by all Provinces/Territories apologized to former students of residential schools. In 2015, the Liberal election platform pledged to change the relationship with Indigenous peoples through a new nation-to-nation relationship, the enactment of the 94 recommendations of the Truth and Reconciliation Commission and a federal inquiry into missing and murdered Indigenous women and girls, among others.

72. In 2016, Canada removed its objector status for the United Nations Declaration of the Rights of Indigenous Peoples and in February 2018, Prime Minister Trudeau committed to replacing the *Comprehensive Land Claims Policy* and the *Inherent Right Policy*. Among other things, changes to existing legislation and policies and the creation of new ones have been identified as needed to recognize and affirm Indigenous peoples’ rights and self-determination, ensure federal accountability and achieve socioeconomic equity and the overall well-being of Indigenous peoples.[[29]](#footnote-30)

73. The strong commitment of the Federal Government towards a meaningful reconciliation is commendable. Steps taken thus far are important and necessary, but continue to be just the first ones in a large list of needed efforts to effectively addressing the historic and structural determinants of health and the well-being of Indigenous peoples. Overall, a serious systemic problem of lack of trust persists which reflects the existence of remaining de-facto discriminatory attitudes in healthcare settings. Despite good efforts to improve Indigenous physical and mental health, the situation is still one of the most pressing issues in-country. Official data[[30]](#footnote-31) reveals that Indigenous peoples’ life expectancy is up to 15 years shorter; rates of infant mortality are two to three times higher; diabetes rates are almost four times higher for First Nations on reserve, and tuberculosis rates are 270 times higher for Inuit.

74. Indigenous peoples’ health situation is aggravated by high poverty rates, the geographic remoteness of many communities, overcrowded housing, high population growth rates and other issues including family violence. Indigenous peoples are overrepresented among those who use drugs and die from opioid overdose. Official data indicates that opioid-related deaths are up to three times higher for First Nations in British Columbia and Alberta.[[31]](#footnote-32) Indigenous peoples are also overrepresented among those who have mental health conditions, die by suicide and are incarcerated. Furthermore, they continue to experience various types of discrimination throughout many aspects of their daily life.

75. These phenomena indicates the existence of cross-cutting risk factors that affect the health of Indigenous peoples who live in remote communities but also in urban centres where they continue to face discrimination, higher rates of homelessness, “problematic substance use”, and poverty. There is a need to develop culturally appropriate measures; medicalized health and mental health services are insufficient and broader policies that effectively address the determinants of health should be prioritized. Moreover, jurisdictional disputes between federal and provincial healthcare providers pose severe barriers for Indigenous peoples’ access to healthcare.

76. To address delays and denials of healthcare services for First Nations children, the Federal Government supported a motion in the House of Commons on Jordan’s Principle in 2007. The Principle aims to avoid jurisdictional disputes in healthcare, social and education services for First Nations children and calls on the government of first contact to ensure they can access public services on an equal basis with other children. In May 2017, the Canadian Human Rights Tribunal found that Jordan’s Principle was not applied properly and in its full meaning and scope, resulting in unnecessary gaps, delays and denials of essential public services to First Nations children and youth. The Tribunal established key principles, including its application to all First Nations children, on or off reserve, and not limited to First Nations children with disabilities. It also ordered that Canada review previous requests for funding that were denied to ensure compliance with these key principles. The Special Rapporteur hopes that current efforts by the Federal Government to support children who need help right away and to make long-term changes for the future, will ensure the effective implementation of Jordan’s Principle.

Specific cases

77. The Special Rapporteur collected many testimonies about the situation in Red Sucker Lake, an Indigenous First Nations community northeast of Winnipeg. The community is accessible only by air or winter road and its nursing station provides solely sporadic basic health services. To access appropriate diagnosis and medical treatment for dialysis, chemotherapy, for heart disease or other major primary healthcare issues, community members often have to travel long distances. Sometimes, they have to relocate, either temporarily or permanently, to Winnipeg, notably in cases of dialysis.

78. This healthcare is exclusively based on a biomedical model that leaves aside aspects that impact on community members’ well-being. On one hand, the ancient and holistic Indigenous approach to health and wellness, which includes the spiritual, mental, physical and emotional sphere, is disregarded; on the other hand, relocating Indigenous peoples to alien urban centres breaks the connection to their land, family, community and culture, further creating additional needs in terms of the determinants of health. These include housing, healthy and nutritious foods, transportation, education, social care and services for children with disabilities, among others. Community members are not only isolated in the city, but exposed to different levels of discrimination and jurisdictional barriers when accessing healthcare, including health’s determinants.

79. The right to health compels States to ensure equal access for all to the determinants of health and to abstain from prohibiting or impeding traditional preventive care, healing practices and medicines. Federal authorities, in consultation with the community, should improve medical services available locally, notably for dialysis treatment, and Federal, Provincial and city of Winnipeg authorities should coordinate efforts to provide broader support when a Red Sucker Lake’s community member is relocated for medical reasons. The later may consider income assistance, transportation, interpretation and social support, the establishment of community centres and cultural support in consultation with the community.

80. A different case refers to Inuit peoples from Nunavut who continue to experience disproportionate rates of tuberculosis. Current efforts to address the issue are welcomed, including Prime Minister Trudeau’s apology in March 2019 for mistreatment of Inuit peoples during the tuberculosis epidemic, and the release in December 2018, of the Inuit Tuberculosis Elimination Framework in Inuit Nunangat. The latter followed the joint commitment between the Indigenous authority, Inuit Tapiriit Kanatami, and the Minister of Indigenous Services to reduce tuberculosis rate in Inuit Nunangat by 50 percent by 2025 and to eliminate it by 2030. The framework is expected to be followed by action plans. The Special Rapporteur appreciates the participation of Indigenous peoples in the development of the framework and the incorporation of human rights elements including various determinants of health, communities’ empowerment as well as transparency and accountability.

81. The third case relates to the First Nations Grassy Narrows whose river, English-Wabigoon, continues to be contaminated. This not only prevents fishing, their traditional form of sustenance, economy and culture, but further causes neurological and developmental health impacts on individuals. Additionally, for decades, multi-national logging companies have cut the forests that is used for hunting, trapping, and gathering medicines, and their water treatment plant do not fulfil filtering conditions. Tap water has unceasingly surpassed guideline levels linked to potential serious health impacts, including cancer. Federal and Provincial governments should collaboratively invest efforts to compensate the community for the impact of mercury on their health and livelihoods; stop industrial logging on their territory; support the community’s plans to reviving their livelihood, and urgently upgrade the existing water treatment plant, while building a new plant that eventually replaces the old one.

82. The Special Rapporteur learnt about further resource development projects in Northeast British Columbia that are causing environmental damages and health-related harms on Indigenous communities. He reiterates the CESCR recommendation[[32]](#footnote-33) to regularly assess the environmental impact of extractive industry activities and of climate change on Indigenous communities with their full engagement. Furthermore, consultations with affected communities should always be carried out when resource development projects are implemented on Indigenous lands.

83. An additional remaining challenge refers to forced or coerced sterilization of Indigenous women. In 2017, a report of the Saskatoon Regional Health Authority documented 16 cases occurring between 2005 and 2010. Since then, at least 60 Indigenous women in Saskatchewan, Alberta, Manitoba, and Ontario[[33]](#footnote-34) have reported similar allegations. Overall, their “consent” to be sterilized was obtained during or immediately after giving birth, through coercive means, and often without information about alternative birth control methods.

84. The Special Rapporteur endorses recommendations by the United Nations Committee against Torture to Canada in December 2018 to ensure that all allegations of forced or coerced sterilization are impartially investigated, responsible persons are held accountable and adequate redress is provided to victims. Further, he urges Canada to adopt legislative and policy measures to prevent and criminalize 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 healthcare personnel of this requirement.[[34]](#footnote-35)

V. Additional remaining challenges

1. Other groups in vulnerable situation

85. The Interim Federal Health Program in Canada (IFHP) provides limited, temporary healthcare coverage to asylum seekers. The program was restricted in 2012 but reinstated in 2014 with some changes, pursuant to the Federal Court decision that ruled the cut as “cruel and unusual” and therefore unconstitutional; the Program was fully restored in 2016. The reinstatement brought confusion among individuals looking for healthcare coverage under the programme and among providers, including pharmacies, which continue to mistakenly believe that goods and services are either not covered by the Program or accessed through complex means only.

86. By law, no person in Canada can be denied emergency and life-saving medical services. While asylum seekers can mostly access healthcare in Canada, persons with no immigration status cannot. As a common rule, Provinces/Territories require identification documents to access healthcare. The Special Rapporteur visited the Doctors of the World Migrant Clinic in Montreal which offers a wide-range of healthcare services to migrants in precarious situations, with no public or private health insurance, nor the financial means to access healthcare. The Clinic has increasingly provided healthcare to children who were born in Québec, and are therefore Canadian citizens, but who have no public health coverage due to obstacles in obtaining a health insurance card.

87. Access to the IFHP should be ensured without discrimination based on immigration status.[[35]](#footnote-36) At the very minimum, Canada should ensure public healthcare to all migrants in cases of infectious diseases, including access to screening, diagnosis, treatment and follow-up. Moreover, all girls and women, regardless of their migration status, should have access to complete perinatal care, and to sexual and reproductive services, including voluntarily interruption of pregnancy, and all children, born in Canada and abroad, should have free-of-charge access to healthcare regardless of their parent’s immigration status.

88. The Special Rapporteur collected many testimonies of persons in situation of poverty in Québec who face barriers to access healthcare due to communication’s gaps and difficulties to interact with healthcare personnel, due to their different contexts and life experiences and healthcare personnel’s use of expert medical language. This translates into prejudice, social distance and miscommunication which discourages persons in situation of poverty from seeking healthcare or follow medical advice and pushes healthcare personnel to diagnose and indicate treatment rapidly, without full consideration of the barriers faced by persons in situation of poverty.

89. Healthcare of incarcerated women remains a challenge. Overall, healthcare is the most common complaint before the Office of the Correctional Investigator, the Ombudsman for federal offenders. Regarding women, the Special Rapporteur was informed that some prisons lack sex-specific healthcare, including hormonal contraception, abortion, prenatal care and breastfeeding support, clinical care and supplies while menstruating, among others. The experience of incarcerated pregnant women has not been documented and there is a lack of disaggregated data by race or gender about health-related experiences and outcomes of incarceration. Furthermore, with the exception of Québec,[[36]](#footnote-37) there are no provincial monitoring bodies similar to the Office of the Correctional Investigator, and some Provinces, including Nova Scotia, have no requirements for a public inquiry when a prisoner dies in provincial custody. All prisons should ensure healthcare for women and data collection to monitor the progression of incarcerated women’s health. Contact visits and residential mother-child options should be guaranteed for pregnant women and mothers, and alternatives to women incarceration should be developed, including adequate housing, income, health services and mental health support.

90. In Manitoba, the Special Rapporteur visited NorWest Centre a community-based organization providing a wide-range of health and social services for persons in vulnerable situation, including older persons, immigrants, persons in situation of poverty, Indigenous peoples, youth and victims of domestic violence. They implement a holistic approach and various programmes in different locations, including health services and referrals, support, advocacy and counselling in areas such as domestic violence, parenting, early learning childcare, housing, pregnancy and nutrition.

B. Sexual and reproductive health rights

91. Canada has invested significant efforts in favour of sexual and reproductive health rights, however the Special Rapporteur received information about retrogressive measures such as Ontario’s Government elimination of the 2015 sexuality education curriculum in favour of reinstating a previous one which reportedly miss key contents in terms of consent, challenging homophobia, internet safety and information on a diversity of gender identities and sexual orientations.[[37]](#footnote-38)

92. Among good practices, the Special Rapporteur observed sexuality education in Lester B. Pearson High School in Montreal, whereby school professionals such as teachers have the opportunity to teach children obligatory content about sexuality with age-appropriate progression of topics, from basic concepts to more detail and deeper discussions. The programme covers the biology of sex as well as cultural, ethical, moral, emotional and interpersonal aspects of sexuality. It provides information to identify and prevent risky behaviour and teachers are guided to emphasize the positive role that sexuality plays in individuals’ lives.

93. A remaining challenge is access to abortion. While abortion was decriminalized in late 1988, the availability of, access to, and information about, safe abortion care is inconsistent across Provinces and Territories. Several Provinces maintain discriminatory policies, practices and regulations imposing different types of barriers to access abortion services.

94. For example, New Brunswick regulation 84-20 denies funding for the provision of abortion care in non-hospital settings, such as clinics. Moreover, while some Provinces, like Ontario and Québec, have a rather high number of hospitals and clinics that offer abortions, others do not, including the three Territories, Prince Edward Island and Nova Scotia. Regional barriers in policies and practices to access abortion are compounded with barriers of accessibility, availability and quality in remote and isolated Northern and rural communities, making it even more difficult for women in these areas to access the procedure.

95. Moreover, women continue to be refused sexual and reproductive health information and services for conscientious objection or religious grounds. Many have been further denied access to accurate information by administrative gatekeepers mainly in hospital settings and in some cases there seems to be an institutional-wide conscientious objection policy. Regrettably, national ethical guidelines by the Canadian Medical Association do not require physicians to provide timely referrals upon conscientious objection for abortion procedures, although they do provide for physicians’ ethical duty to inform about it. While some Provincial Colleges of Physicians and Surgeons[[38]](#footnote-39) include ethical requirements to provide referrals (Alberta, Ontario and Québec), the Special Rapporteur stresses that beyond professional ethical codes, the State has the duty to ensure that physicians’ conscientious objection does not impede women’s access to legal abortion services.[[39]](#footnote-40)

96. Additional challenges refer to criminalization of both sex work and of HIV non-disclosure and access to HIV medication. The 2014 Protection of Communities and Exploited Persons Act follows the so-called “Nordic Model” which focuses on reducing the demand for sexuality services by criminalizing the purchase of sexual services. It also prohibits advertising sexual services and profiting from others’ sexual services. It finally re-criminalizes third-party engagement in sex work. On the other hand, in Canada, individuals with HIV who do not disclose their HIV status to their partner before sexual activity that poses “a realistic possibility of HIV transmission” may be prosecuted under the Criminal Code, regardless of whether or not there was an intention to transmit HIV and whether or not there was actual transmission. The Special Rapporteur stresses that criminalization of both sex work and HIV non-disclosure creates stigma, discrimination and barriers to accessing healthcare, including medical tests, treatment and support, due to fear of prosecution. He recommends to decriminalize sex work, while developing appropriate occupational health and safety regulations and ensure a legal framework against abuse and exploitation. This can lead to sex workers’ improved health outcomes and reduce the incidence of violence.

97. Canada is one of the countries with the highest number of criminal prosecutions based on non-disclosure of HIV status. Persons with HIV are generally charged with grave crimes, often with serious sexual assault. Commonly, convicted persons receive a prison sentence and are registered in the sex offender registry. The Special Rapporteur highlights that criminal prosecution should only be initiated in very exceptional cases of intentional and actual transmission of HIV and that the recourse to the criminal law should be avoided in all other circumstances. He also recommends to develop specific training on HIV/AIDS for healthcare personnel to avoid discrimination. He acknowledges steps taken to address the over-criminalization of HIV non-disclosure, including Justice Canada’s report on the Criminal Justice System’s Response to HIV Non-Disclosure in December 2017, which recommends to limit the application of the criminal law to HIV non-disclosure cases as informed by the most recent medical science on sexual HIV transmission, and December 2018 announcement by the Attorney General of Canada of a prosecutorial Directive which promises to ensure an appropriate and evidence-based criminal justice system response to cases of HIV non-disclosure.

98. The Special Rapporteur visited the good model Vancouver-based Dr. Peter Center. It offers a HIV day health program with 24-hour nursing care residence. The Center provides healthcare to individuals with multiple medical conditions and who face social barriers, through a multidisciplinary approach including improved adherence to medical treatment and a personalized programme reflecting the user’s preference with: specialized nursing care for complex mental health conditions; short-term stabilization; transition from hospital back into the community; a methadone maintenance program, and harm reduction services. The Centre provides housing and various therapeutic services and manages conflict in the community with no coercion.

VI. Conclusions and recommendations

99. **Canada is a highly developed country that has achieved much in standard of living; it has good economic and social indicators, and a large number of Canadians enjoy a good standard of healthcare.**

100. **Canada counts with a strong public health system firmly rooted in the principles of equity and fairness and the overall notion that access to healthcare should be based on need and not on the ability to pay. The Canadian public health system also includes many elements compatible with the right-to-health framework, but a human rights-based approach is still needed to allow the State to comply with its international obligations.**

101. **The quality of healthcare services in-country is overall very good if a person can actually access them. Canada still faces structural challenges regarding services that are not covered by the public health insurance; disparities among Provinces/Territories; poor access to healthcare by persons in vulnerable situations including Indigenous peoples, and lack of parity between physical and mental health.**

102. **Investments with adequate financial and human resources in health are important and Canada is doing rather well in this regard. The crucial issue is the direction and prioritizing of resources and the use of rights-based criteria for federal health transfers. Cross-cutting to this is the issue of investing in the public health priorities of modern times, namely the so-called “new morbidities” in children and adults such as mental health, determinants of health, addressing drug use issues, adolescent and youth health related issues, including monitoring mechanisms to ensure the inclusion of an analytical right-to-health framework.**

**The Special Rapporteur recommends that the authorities in Canada:**

103. **Incorporate a human rights-based approach to health including through positive measures that improve access to justice and effective remedies.**

104. **Include rights-based criteria to existing ones in federal funding under the Canada Health Transfer and consider adopting a rights-based healthcare national framework/strategy.**

105. **Ensure the establishment of a national pharmacare plan or guidelines compliant with Canada’s obligations under the right-to-health framework.**

106. **Continue to support community- and rights-based projects by the civil society with longer time-frame’s funding, while building human rights capacity among health personnel.**

107. **Develop measures to achieve parity between mental and physical health while advancing the realization of the right of everyone to mental health and the realization of all human rights of persons with psychosocial, intellectual and cognitive disabilities and autistic persons.**

108. **Develop measures to overcome early childhood adversities and to integrate mental health into primary care to reduce the stigma and discrimination still linked to mental health, enhance access to integrated and continuing care, and improve social integration.**

109. **Ensure that Canada’s international cooperation worldwide supports the modernization of mental health policies by prioritizing rights-based and community-based mental health services and does not support services based on over-medicalization, institutionalization and other forms of coercion.**

110. **Support initiatives that contribute to more effectiveness and transparency in mental health services and the healthcare system at large.**

111. **Continue to address the root causes of the opioid crisis and related determinants, including poverty, discrimination, early childhood adversities, access to adequate housing and safe water, and access to healthy occupational and environmental conditions.**

112. **Federal authorities, in consultation with the community, improve medical services available in Red Sucker Lake and, in coordination with Provincial/Municipal authorities provide broader support during medical relocations to Winnipeg.**

113. **Ensure Indigenous peoples’ free and informed consent prior to the approval of any project that affects their lands, territories and other resources that may affect their health and livelihoods.**

114. **Ensure public healthcare, at the very minimum, to all migrants in cases of infectious diseases and free-of-charge healthcare access to all children born in Canada regardless of their parent’s immigration status.**

115. **Ensure that all girls and women in Canada, including migrants and Indigenous women, have access to sexual and reproductive health services and to abortion procedures across Provinces, regardless of conscientious objections.**

1. \* The summary of the report is being circulated in all official languages. The report itself, which is annexed to the summary, is being circulated in the language of submission only.

   \*\* The present report was submitted after the deadline so as to include the most up-to-date information possible. [↑](#footnote-ref-2)
2. 2016 Census estimates 35,151,728 people in Canada while the UN estimated 37,163,656 in February 2019 (<https://www.worldometers.info/world-population/canada-population/> and <https://esa.un.org/unpd/wpp/publications/files/wpp2017_keyfindings.pdf>). [↑](#footnote-ref-3)
3. See http://www.oecd.org/cfe/CANADA-Regions-and-Cities-2018.pdf. [↑](#footnote-ref-4)
4. Group of Seven includes Canada, France, Germany, Italy, Japan, the UK and the USA (https://www.imf.org/en/Publications/WEO/Issues/2018/09/24/world-economic-outlook-october-2018) [↑](#footnote-ref-5)
5. See http://hdr.undp.org/sites/all/themes/hdr\_theme/country-notes/CAN.pdf. [↑](#footnote-ref-6)
6. See http://www.oecd.org/cfe/CANADA-Regions-and-Cities-2018.pdf. [↑](#footnote-ref-7)
7. See https://read.oecd-ilibrary.org/economics/oecd-economic-surveys-canada-2018\_eco\_surveys-can-2018-en#page86. [↑](#footnote-ref-8)
8. See http://mdgs.un.org/unsd/mdg/data.aspx. [↑](#footnote-ref-9)
9. See https://sustainabledevelopment.un.org/content/documents/20312Canada\_ENGLISH\_18122\_Canadas\_Voluntary\_National\_ReviewENv7.pdf. [↑](#footnote-ref-10)
10. See Human Rights Committee General comment No.36 CCPR/C/GC/36. [↑](#footnote-ref-11)
11. See A/HRC/39/11/Add.1 and A/HRC/39/11. [↑](#footnote-ref-12)
12. See CESCR General Comment 14, E/C.12/2000/4. [↑](#footnote-ref-13)
13. See CESCR General Comment No.20, E/C.12/GC/20. [↑](#footnote-ref-14)
14. See CESCR General Comment No.9, E/C.12/1998/24. [↑](#footnote-ref-15)
15. See CCPR/C/123/D/2348/2014. [↑](#footnote-ref-16)
16. As per accords of 2004 and of 2017 with the Government of Canada, authorities in Québec are fully responsible for the planning, organization and management of Québec’s health system. [↑](#footnote-ref-17)
17. Including the Interim Federal Health Program for eligible refugees and other groups; the Non-Insured Health Benefits Program for registered First Nations and recognized Inuit; the Strengthening the Forces health promotion program for Canadian armed forces members; the Correctional Services Canada Healthcare Program for federal offenders; a variety of programs for veterans, and an optional Public Service Healthcare Plan (PSHCP) for federal public service employees that supplements provincial/territorial plans. [↑](#footnote-ref-18)
18. See E/C.12/1/Add.31, para 19. [↑](#footnote-ref-19)
19. “Addiction services” is used in Canada for services that address the “problematic use of substances”, defined as “the use of substances which affect the central nervous system and alter a person’s mood, thinking and/or behavior” (<https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/strengthening-canada-approach-substance-use-issue.html#a2>). The United Nations System adopted a common position to the world drug problem that declines the use of “substance” and “addiction” (https://digitallibrary.un.org/record/3792232?ln=en). [↑](#footnote-ref-20)
20. See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915235/. [↑](#footnote-ref-21)
21. Public institutions were merged into Integrated Health and Social Services Centers and Integrated University Health and Social Services Centers with the Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies (CQLR, chapter O-7.2), 1 April 2015. [↑](#footnote-ref-22)
22. See https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy\_Strategy\_ENG.pdf. [↑](#footnote-ref-23)
23. See A/HRC/RES/32/18, A/HRC/RES/36/13, A/HRC/35/21, A/73/216, A/HRC/34/32 and A/HRC/39/36. [↑](#footnote-ref-24)
24. In Québec, placement in institutions under custody in done in accordance with the Province’s legal provisions. [↑](#footnote-ref-25)
25. See A/HRC/35/21. [↑](#footnote-ref-26)
26. See CRPD/C/11/4 and A/HRC/37/56. [↑](#footnote-ref-27)
27. See https://infobase.phac-aspc.gc.ca/datalab/national-surveillance-opioid-mortality.html?utm\_source=HC%20BNews&utm\_medium=Email&utm\_campaign=launch\_opioid\_mortality\_report\_EN. [↑](#footnote-ref-28)
28. See http://s3.documentcloud.org/documents/2091415/trc-executive-summary-2015-05-31.pdf. [↑](#footnote-ref-29)
29. See https://www.afn.ca/wp-content/uploads/2018/08/Issues-Summary-ENG.pdf. [↑](#footnote-ref-30)
30. See <https://www.canada.ca/en/indigenous-services-canada/news/2018/01/improving_healthoutcomes.html>. [↑](#footnote-ref-31)
31. Ibid. [↑](#footnote-ref-32)
32. See E/C.12/CAN/CO/6. [↑](#footnote-ref-33)
33. See IACHR Press Release 18/01/2019 <https://mailchi.mp/dist/iachr-expresses-its-deep-concern-over-the-claims-of-forced-sterilizations-against-indigenous-women-in-canada?e=a4c01651de>. [↑](#footnote-ref-34)
34. See CAT/C/CAN/CO/7. [↑](#footnote-ref-35)
35. See E/C.12/CAN/CO/6. [↑](#footnote-ref-36)
36. The “Protecteur du citoyen” is the correctional Ombudsman for incarcerated persons in one of the 18 operating correctional facilities under the responsibility of the Québec Department of Public Security. https://protecteurducitoyen.qc.ca/fr/a-propos/role-et-mandats. [↑](#footnote-ref-37)
37. For allegations see OL CAN 4/2018 <https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=24216>, for the Government’s reply see https://spcommreports.ohchr.org/TMResultsBase/DownLoadFile?gId=34661. [↑](#footnote-ref-38)
38. See <http://www.arcc-cdac.ca/postionpapers/95-appendix-policies-conscientious-objection-healthcare.pdf>. [↑](#footnote-ref-39)
39. See E/C.12/CAN/CO/6; E/C.12/GC/22 and the CEDAW General Recommendation No. 24: https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1\_Global/INT\_CEDAW\_GEC\_4738\_E.pdf. [↑](#footnote-ref-40)