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对加拿大的访问

人人有权享有能达到的最高标准身心健康特别报告员的报告* **

概要

人人有权享有能达到的最高标准身心健康问题特别报告员代纽斯·普拉斯于2018年11月5日至16日访问了加拿大。

加拿大有一个强大的公共卫生系统，它牢牢植根于公平和公正原则，牢牢植根于医疗保健的获得应当以需求而不是支付能力为基础的理念。虽然公共卫生系统包括许多与健康权相匹配的要素，但仍需要一种基于人权的方针，以便国家全面履行其保护、尊重和实现健康权的义务。加拿大作为世界范围内的重要榜样，坚定参与国际合作，因而也负有一项责任，这就是确保向其他国家提供的国际支持与人权是一致的。

主管部门应加强努力，继续设法处理仍然存在的挑战，涉及公共健康保险未涵盖的服务、各省和地区之间的差异、包括土著人民在内的弱势人士难以获得医疗保健，以及身体健康与精神健康之间尚未达到同等水平。

* 本报告概要以所有正式语文分发。报告正文附于概要之后，仅以提交语文分发。

** 本报告逾期提交，以尽可能纳入最新信息。

Annex

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

Contents

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 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 realized in the country.

2. The Special Rapporteur travelled to Ottawa, Winnipeg, Vancouver and Montreal. He met with the Ministers for Health and Indigenous Services of the Government of Canada and with a number of federal and provincial government representatives, such as the Chief Public Health Officer of Canada and provincial chief medical or health officers, as well as with officials in charge of health services at Correctional Service Canada, including the Correctional Commissioner. He also met with independent bodies, such as the Canadian human rights and mental health commissions, the Correctional Investigator, a provincial youth human rights commission and officials from a provincial ombudsman office.

3. The Special Rapporteur visited many health-care facilities, from community-based centres and clinics to large hospitals, and paid a visit to a 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 Fredericton, Halifax, Regina and Toronto.

4. The Special Rapporteur attested to the country's complex policy and technical machinery for delivering health services and the different 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

A. Background

5. Canada is politically structured as a constitutional monarchy, a parliamentary system, a federal system and a representative democracy. It has a federal Government for the entire country and provincial/territorial governments for its 10 provinces (Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island, Quebec and Saskatchewan) and 3 territories (Northwest Territories, Nunavut and Yukon). The federal system bestows legislative and executive powers on those two levels, which are sovereign in their respective domains. Canada is officially a bilingual country.

6. Canada is the second largest country in the world but one of the least densely populated. Sixty-nine per cent of its 37.3 million people[1] live in cities of more than 50,000 inhabitants.[2] By contrast, there are many remote and isolated communities that can sometimes only be reached by plane or ship. This remoteness has a negative impact on 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. Overall well-being is high: in 2017, the human development index value for Canada was 0.926,[3] 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

[1] See www.worldometers.info/world-population/canada-population.
[2] See www.oecd.org/cfe/CANADA-Regions-and-Cities-2018.pdf.
[3] See http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/CAN.pdf.

schooling (by 3.0 years). Canada ranks higher when the index is associated with indicators on the quality of health, but falls to 0.852 when inequality is factored in.

8. While income inequality in Canada is within the average for countries of the Organization for Economic Cooperation 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, Prince Edward Island and Yukon are located at the bottom of several of those indicators.[4] The relative poverty rate in Canada is above the OECD average.[5]

9. Canada made progress in achieving the Millennium Development Goals that relate to the right to health and has committed to promote the 2030 Agenda for Sustainable Development. It achieved progress in two of the three right-to-health and related Millennium Development Goals, namely Goal 4 (Reduce child mortality) and 6 (Combat HIV/AIDS, malaria and other diseases) but not in Goal 5 (Improve maternal health). Whereas the adolescent birth rate per 1,000 women was halved from 25 in 1990 to 12.6 in 2011, the maternal mortality ratio per 100,000 live births was 7 in 2015, the same as it was in 1990.[6]

10. In terms of Goal 3 of the Sustainable Development Goals (Ensure healthy lives and promote well-being for all at all ages), official assessments[7] highlight the pending tasks as: (a) addressing indigenous peoples' poor health outcomes; and (b) tackling health inequalities linked to socioeconomic indicators, including income, education levels, employment and occupation status.

B. Normative and institutional framework

11. Canada is party to seven international human rights treaties, including the International Covenant on Economic, Social and Cultural Rights, which enshrines the right to health. However, it has not yet ratified a few additional but significant instruments, including the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights. If ratified, the Optional Protocol 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.

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 under the International Covenant on Civil and Political Rights, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of Persons with Disabilities. The right to health is directly protected under the latter two, and some provisions are protected under the International Covenant through the right to life.[8]

13. In April 1999, Canada issued a standing invitation to the special procedure mandate holders of the then Commission on Human Rights and has received visits from many of them. It has further ratified the World Health Organization Framework Convention on Tobacco Control and the main United Nations conventions related to drug control.

[4] See www.oecd.org/cfe/CANADA-Regions-and-Cities-2018.pdf.

[5] See https://read.oecd-ilibrary.org/economics/oecd-economic-surveys-canada-2018_eco_surveys-can-2018-en#page86.

[6] See http://mdgs.un.org/unsd/mdg/data.aspx.

[7] See Global Affairs Canada, *Canada's Implementation of the 2030 Agenda for Sustainable Development: Voluntary National Review* (Ottawa, 2018), available at https://sustainabledevelopment.un.org/content/documents/20312Canada_ENGLISH_18122_Canadas_Voluntary_National_ReviewENv7.pdf.

[8] See Human Rights Committee general comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life.

14. In May 2018, the State underwent its third universal periodic review. Canada accepted, among others, the recommendation that it ensure the justiciability of economic, social and cultural rights.[9] The Special Rapporteur welcomes that particular acceptance as, in terms of the right to health, it will enhance the commendable public health approach that has been 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 essential elements of the right to health concerning 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.[10]

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 forward the principles of non-discrimination and equality, so that no distinction, exclusion, restriction, preference or other differential treatment is made in the exercise of the right to health on grounds such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[11]

17. The human rights-based approach will moreover bring the notion of the indivisibility, interdependence and interrelation of all rights. It will shed light on the centrality of the right to health to, and its dependency upon, the realization of other rights, including those already recognized by the public health approach, i.e. food, housing, work and education, but also rights that support human dignity and the rights to life, freedom from torture, privacy, access to information and 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 and in complying with its obligations under international human rights law. The justiciability of the right to health, defined as those matters that are appropriately resolved by the courts,[12] will not be fully realized in Canada with such an approach.

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

[9] See A/HRC/39/11 and A/HRC/39/11/Add.1.

[10] See Committee on Economic, Social and Cultural Rights general comment No. 14 (2000) on the right to the highest attainable standard of health.

[11] See Committee on Economic, Social and Cultural Rights general comment No. 20 (2009) on non-discrimination in economic, social and cultural rights.

[12] See Committee on Economic, Social and Cultural Rights general comment No. 9 (1998) on the domestic application of the Covenant.

Canadian Charter of Rights and Freedoms. The Constitution also prescribes which powers – legislative, executive and judicial – may be exercised by which State organs 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 Charter, many of its provisions may be protected through other rights specified therein, 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. Until now, people in Canada have relied on sections 7 and 15 of the Charter to challenge barriers that prevent access to health care 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 such judicial challenges is the inaccurate assumption that the international human rights obligations of Canada have allegedly no binding legal effect. He stresses that international human rights law presents obligations that States are bound to respect when they become parties to the treaties.

23. In a 2018 decision made under the complaint procedure of the International Covenant on Civil and Political Rights, the Human Rights Committee stressed that, while the Covenant did not protect the right to health as such, the right to life, could not be properly understood in a restrictive manner and its protection required positive measures by the State.[13] The Committee recalled that the right to life extended to reasonably foreseeable threats and life-threatening situations that could result in loss of life. States were therefore obliged to adopt health-related positive measures even if such threats and situations did not result in loss of life. At the minimum, States must provide access to existing health-care services that were reasonably available and accessible when lack of access to health care would expose a person to a reasonably foreseeable risk that could result in loss of life.

24. Finally, the Committee concluded that the denial of health-care coverage to an undocumented migrant under the Interim Federal Health Program for immigrants violated the migrant's right to life (article 6 of the International Covenant on Civil and Political Rights). It also determined that excluding the subject of the complaint from health-care coverage under the Program on the basis of the subject's immigration status had been a violation of the right to equality before the law and equal protection of the law without any discrimination (ibid., art. 26). It compelled Canada to provide the subject with an effective remedy, full reparation and adequate compensation and reminded it of its obligation to take all steps necessary to prevent similar violations in the future, including by reviewing its national legislation to ensure that irregular migrants enjoyed access to essential health care to prevent a reasonably foreseeable risk that could result in loss of life.

25. The Special Rapporteur agrees with those conclusions and further notes that, considering that access to essential health care is protected under the International Covenant on Civil and Political Rights in its articles 6 (on the right to life) and 26 (on the right to equality and non-discrimination), the same should apply in terms of section 7 of the Charter (on the 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 (on the 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 the international obligations of Canada.

C. National health-care system

26. Canadian health-care systems are firmly rooted in values of equity and fairness and the overall notion that access to health care should be based on need and not on the ability

[13] See communication No. 2348/2014, *Toussaint v. Canada* (CCPR/C/123/D/2348/2014), para. 11.3.

to pay. Those values are embedded in single-payer public health-care systems partially funded by the Federal Government and implemented in each province and territory.[14]

27. The legal grounds for that arrangement are found in the Constitution Act, 1867, section 92.7 of which 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 (sections 91.3 and 91.4, respectively). These constitutional provisions have generally been interpreted as granting provinces and territories the jurisdiction to manage overall health care 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 health-care plan. Instead, there are 13 provincial/territorial health-care plans and some targeted federal plans for specific groups.[15] To support their own plans, provinces and territories receive federal funding through the Canada Health Act and the Canada Health Transfer.

29. The federal 1984 Canada Health Act establishes publicly funded health-care insurance to cover medically necessary services provided by hospitals and physicians in the provinces and territories. Section 3 of the Act states that the primary objective of Canadian health-care 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.

30. The Act defines the criteria and conditions for insured health services and extended health-care services that provinces and territories must comply with in order to receive the full federal transfer under the Canada Health Transfer. There are five criteria: (a) public administration; (b) comprehensiveness; (c) universality; (d) portability; and (e) accessibility. The Act also establishes two conditions – information and recognition – and one provision that prohibits extra billing and user charges.

31. Provincial and territorial governments manage, organize and deliver health-care services, although the Federal Government provides health-care 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 or territories fail to meet the criteria, or if they allow extra billing by medical practitioners or user charges for insured health services, they face a penalty in the form of a reduction or withholding of the Canada Health Transfer.

32. Health-care 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 health-care 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 health-care personnel such as dentists and physiotherapists operate as self-employed professionals and are not generally paid by provinces or territories.

[14] Under the 2004 and 2017 accords with the Government of Canada, the authorities in Quebecare fully responsible for the planning, organization and management of Québec’s health system.

[15] 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 programmes for veterans and an optional public service health-care plan for federal public service employees that supplements provincial/territorial plans.

33. The levels of government involved in the Canadian health-care system suggest complexities for the State to be accountable under the right-to-health framework. This was highlighted by the Committee on Economic, Social and Cultural Rights 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".[16]

34. The Special Rapporteur recalls that, even with different health-care 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: (a) include human rights criteria in the existing criteria for health federal transfers under the Canada Health Transfer; and (b) consider adopting a rights-based national health-care 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 Canada Health Transfer, so that those 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 health-care delivery

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

(a) Gaps in health goods and services that are not covered by provinces or territories, mainly linked to current requirements in the national legal framework;

(b) Discrepancies in gaining access to quality health care by provinces and territories owing to the federal division of health-care responsibilities;

(c) Gaps faced by groups in vulnerable situations owing to the barriers they continue to encounter while gaining access to health-care services, including indigenous peoples;

(d) Lack of parity between mental and physical health.

37. Regarding the first gap, the Canada Health Act does not require provincial or territorial governments to include services that are provided outside of hospitals by health-care personnel other than doctors, such as physiotherapy, psychotherapy and occupational therapy. In Quebec, for example, access to the latter requires first seeing a physician. The Special Rapporteur further received information about challenges regarding waiting lists, online registrations to consult primary-care doctors for the first time and changing clinics in Quebec.

38. Provincial/territorial governments are also not required to cover prescription medication, older persons' care, mental health and "addiction services",[17] dental and vision care or rehabilitation services, among others. Those 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 they are paid for through out-of-pocket payments.

39. The current coverage of medicines differs significantly by province and territory, considering the Canada Health Act does not establish requirements for the public funding of out-of-hospital pharmaceuticals, nor a homogenous pharmacare system. Each province

[16] See E/C.12/1/Add.31, para. 19.

[17] "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 behaviour" (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 has adopted a common position to the world drug problem whereby it chooses not to use the terms "substance" and "addiction" (https://digitallibrary.un.org/record/3792232?ln=en).

and territory has its own approach: some have specific programmes with different degrees of pharmaceutical coverage for groups in vulnerable situations, such as those who receive social assistance, older and young persons, or by specific disease, such as cancer, palliative care or infectious diseases.[18] For example, British Columbia and Manitoba do not have plans specifically for older persons. Others have established income-based plans that provide pharmaceutical coverage for the entire population only against catastrophic costs and only when a household's pharmaceutical spending 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 to 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 has a negative impact on prices, which are negotiated separately in each province and territory. The high costs of medicines are further compounded by 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 the Advisory Council on the Implementation of National Pharmacare and its interim report of March 2019. He hopes that the process triggered by the Council will allow for the establishment of a national pharmacare plan or guidelines that are compliant with the country's right-to-health obligations, including non-discrimination, accountability, availability, accessibility, acceptability and quality.

42. The second gap is illustrated by access to abortion, which is elaborated in paragraphs 93 and 94 below. The rest of the challenges are developed in specific sections.

2. Civil society partnerships

43. Civil society organizations contribute to closing the 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 health-care system. This, together with new rights-based criteria for federal transfers under the Canada Health Transfer, will allow federal and provincial/territorial governments not only to strengthen the health-related expertise developed by the civil society, but also to use and mainstream it. In that 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: (a) allow for multi-year funding of, for example, 7 years; (b) support projects in different regions within provinces and territories; and (c) include mechanisms of accountability and transparency. Notably, long multi-year funding would provide stabilization to civil society projects, allowing them to build programmes, build trust with constituencies and stakeholders and to evaluate activities properly.

[18] See www.ncbi.nlm.nih.gov/pmc/articles/PMC5915235/.

III. Right to mental health

A. 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 young people.

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 health care, although there have been good efforts in that direction. The Canadian Collaborative Mental Health Initiative, a national project originally supported with federal funds, has endeavoured to integrate mental health into primary care through prevention, early detection, treatment, rehabilitation and recovery. In some provinces, the health ministries have also worked with primary care and mental health planners to develop and fund integrated projects, including the Centres de santé et de services sociaux in Quebec,[19] Family Health Teams in Ontario, Primary Care Networks in Alberta and the Practice Support Program in British Columbia.[20]

48. In 2007, the Federal Government created the Mental Health Commission of Canada, as recommended in the 2006 report entitled "Out of the Shadows At Last",[21] 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 for the period 2007–2017 and a consultative framework to advance the strategy, which was extended 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 the aspirations to align relevant policies with the Convention on the Rights of Persons with Disabilities to fight stigma, address discrimination and eliminate the structural barriers that persons with mental health conditions face. 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 those advance directives will help Canada to eventually lift the reservation on substitute decision-making it made when ratifying the Convention and to adopt a supported decision-making paradigm. In addition, the Special Rapporteur recommends that Canada align the language in the strategy to the human rights language reflected in applicable instruments, including the Convention and relevant resolutions of the Human Rights Council.[22]

50. For the past 50 years, Canadian provinces and 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

[19] 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.

[20] See Mental Health Commission of Canada, *Changing Directions Changing Lives: The Mental Health Strategy for Canada* (Alberta, 2012), available at www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf.

[21] Available at www.mentalhealthcommission.ca/sites/default/files/out_of_the_shadows_at_last_-_full_0_0.pdf.

[22] See for example Human Rights Council resolutions 32/18 and 36/13. See also the reports of the Special Rapporteur contained in documents A/HRC/35/21 and A/73/216, and the reports of the United Nations High Commissioner for Human Rights contained in documents A/HRC/34/32 and A/HRC/39/36.

provinces and territories has been implemented in various degrees and with different timings and rates of bed closures, investment in community-based services and decreased days in psychiatric institutions. Regrettably, Alberta, British Columbia, Manitoba, Nova Scotia, Prince Edward Island, Quebec[23] and the territories continue to place persons with disabilities in institutions. Moreover, while some provinces have made good progress in terms of law and policies, mental health care 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 health care. Persons with autism in particular continue to be excluded from the design of services aimed at supporting them. Their health care 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 and territories that are not necessarily covered by public insurance and are often delivered in partnership with different stakeholders. The Special Rapporteur observed some of them in British Columbia, Manitoba and Quebec.

53. He learned first-hand about the least-restraint policy at Actionmarguerite, a care facility in Winnipeg that offers palliative services under Manitoba's 2000 Protection for Persons in Care Act and Winnipeg's regional policy on restraints in personal care homes. There, the use of restraints, both physical and chemical (medication), is restricted to the bare minimum through interdisciplinary assessments, consent and the understanding that any restraint may affect the person's physical safety and psychological well-being. While that practice is in line with the Special Rapporteur's recommendation[24] to radically reduce medical coercion, he hopes that the 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. In addition, he recommends that the regional policy be re-examined to shift provisions on substitute decision makers to a paradigm of supported decision-making.[25]

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 used by its eating disorders programme. 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 learned about 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 the government of British Columbia 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 about restraint through sedatives by Ontario school workers. Residential homes for autistic persons in Toronto continued to use physical restraints and expose vulnerable young persons to sexual and other physical and psychological abuse by staff. The government of

[23] In Québec, individuals are held in custody in institutions in accordance with the legal provisions of the Province.

[24] See the report of the Special Rapporteur contained in document A/HRC/35/21.

[25] See Committee on the Rights of Persons with Disabilities general comment No. 1 (2014) on equal recognition before the law and the report of the Special Rapporteur on the rights of persons with disabilities contained in document A/HRC/37/56.

Ontario 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 the federal and provincial authorities of Canada for their leadership in investing in modern human rights approaches at the domestic and international levels, and for taking steps towards a comprehensive public health approach towards drug policy. He welcomes the federal policy shift from preventing supervised consumption services to supporting their scaling-up. That shift involved amendments in 2017 to the Controlled Drugs and Substances Act that simplified the process of obtaining an exemption for the establishment of a supervised consumption facility. The national drug strategy was also updated to reintroduce the harm reduction pillar that had been removed in 2006 so that, together with the pillars of prevention, treatment and enforcement, proper supervised consumption sites might be supported and access to naloxone and to other harm reduction services might be expanded.

57. The number of exempted facilities that offer supervised consumption services has increased from 2 in 2016 (both in Vancouver) to 39 in April 2019 in Alberta, British Columbia, Ontario and Quebec. The Special Rapporteur visited two well-organized sites in Vancouver that provided a supervised consumption centre and an overdose prevention site and noted the need to continue to replicate those types of services within British Columbia and across the country.

58. Canada faces an opioid overdose crisis. Official data[26] reveals that, between January 2016 and September 2018, there were more than 10,300 opioid-related deaths. The Special Rapporteur considers that this crisis is of such gravity that it would not be an exaggeration to compare it with the HIV/AIDS epidemic. He urges the authorities to keep up their 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 upon Canada to redouble efforts to continue to address 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 young persons at risk, including those experiencing homelessness, sexual exploitation, family conflict, placement breakdown and mental health crises, many of whom are indigenous peoples. This commendable holistic model provides young people aged 11–17 with outreach, shelter and a wide-range of activities and services, including education, recreation, harm reduction, crisis intervention and stabilization.

60. At a Foundry centre in Vancouver, the Special Rapporteur observed the 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 young people's mental health 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.

[26] 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.

C. Towards reaching parity between physical and mental health

61. The Special Rapporteur acknowledges efforts to include mental health in primary care, the national framework for mental health care and the many good models and practices in different provinces. He 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 and 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 its high quality specialized physical care for people who need intensive care or other physical care, and its good management of admissions and referrals. That same high level should be reached when issues relate to mental health and "problematic substance use".

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

64. There are good opportunities for substantial progress. For example, the "Choosing Wisely" initiative seeks to engage health-care 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 develop rational health care by empowering users to choose health care that is truly necessary, supported by evidence, not duplicative and free from harm. Support from health-care authorities for initiatives such as Choosing Wisely could achieve more effectiveness and transparency in mental health and "problematic substance use" services, as well as in the health-care system at large.

65. Canada has a double responsibility towards reaching parity between physical and mental health. On the one hand, determinants of mental health, such as inequalities, discrimination and violence, need to be addressed at the domestic level with enhanced political will and increased investments, so that the risk factors for poor mental health outcomes can be effectively prevented. In that regard, overcoming early childhood adversities is of key importance, considering their detrimental impact and correlation with a higher prevalence for different patterns of poor physical and mental health, including suicide, numerous causes of death and other harm from "problematic substance use" and poorer outcomes in indigenous peoples' health. Integrating mental health into primary health care 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 at the global level and in modernizing mental health policies and services through international support. Its international cooperation should be directed towards the provision of rights-based mental health services and, in compliance with the Convention on the Rights of Persons with Disabilities, should move away from services based on over-medicalization and coercion. These should be conditions for receiving the support of Canada.

67. In 2016 and 2017, the Federal Government invested Can$ 42 million into 85 projects in 31 countries through the non-profit organization Grand Challenges Canada, which is primarily funded by Global Affairs Canada. To receive funding, projects must show they promote innovative approaches that can improve treatment and increase access to mental health care across priorities that include community-based care, non-specialist treatment, improving children's access to mental health care 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. Right to health of indigenous peoples

69. The Special Rapporteur held many meetings with grass-roots 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.[27] 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 those ruptures and abuses, including from the victims themselves.

71. In June 2008, the then-Prime Minister, Stephen Harper, followed by all provinces and territories apologized to former students of residential schools. In 2015, in its election platform, the Liberal Party 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 on the Rights of Indigenous Peoples and, in February 2018, the Prime Minister, Justin 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 necessary 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.[28]

73. The strong commitment of the Federal Government towards a meaningful reconciliation is commendable. Steps taken thus far are important and necessary but remain the first in a long list of efforts necessary to address effectively the historic and structural determinants of health and the well-being of indigenous peoples. Overall, there remains a serious systemic lack of trust that reflects the existence of remaining de facto discriminatory attitudes in health-care settings. Despite efforts to improve indigenous physical and mental health, the situation is still one of the most pressing issues in-country. Official data[29] reveal that indigenous peoples' life expectancy is up to 15 years shorter; rates of infant mortality are 2 to 3 times higher; diabetes rates are almost four times higher for First Nations on reserves; and tuberculosis rates are 270 times higher for Inuit people.

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 indicate that opioid-related deaths are up to three times higher for First Nations peoples in

[27] See http://s3.documentcloud.org/documents/2091415/trc-executive-summary-2015-05-31.pdf.

[28] See www.afn.ca/wp-content/uploads/2018/08/Issues-Summary-ENG.pdf.

[29] See www.canada.ca/en/indigenous-services-canada/news/2018/01/improving_healthoutcomes.html.

British Columbia and Alberta.[30] 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 indicate 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 health-care providers pose severe barriers for indigenous peoples' access to health care.

76. To address delays and denials of health-care 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 health care, social and education services for First Nations children and calls upon the government of first contact to ensure they can gain access to public services on an equal basis with other children. In May 2017, the Canadian Human Rights Tribunal found that Jordan's Principle had not been 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 young people. The Tribunal established key principles, including its application to all First Nations children, on or off reserves, and not limited to First Nations children with disabilities. It also ordered that Canada review previous requests for funding that had been denied, to ensure compliance with the key principles. The Special Rapporteur hopes that current efforts by the Federal Government to support children who need help immediately 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 north-east of Winnipeg. The community is accessible only by air or winter road, and its nursing station provides only sporadic basic health services. To receive appropriate diagnosis and gain access to medical treatment for dialysis, chemotherapy, heart disease or other major primary health-care 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 health care is exclusively based on a biomedical model that leaves aside aspects that affect community members' well-being. On the 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 are also exposed to different levels of discrimination and jurisdictional barriers when gaining access to health care, including health determinants.

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

[30] Ibid.

80. Another case is that of Inuit people 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 the mistreatment of Inuit people 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 for Indigenous Services to halve the tuberculosis rate in Inuit Nunangat 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 health determinants, community empowerment as well as transparency and accountability.

81. The third case relates to the First Nation Grassy Narrows, whose river, English-Wabigoon, continues to be contaminated. This not only prevents fishing – their traditional form of sustenance, economy and culture – but also has neurological and developmental health impacts on individuals. In addition, for decades, multinational logging companies have cut down the forests that is used for hunting, trapping and gathering medicines, and their water treatment plants do not meet filtering standards. Tap water has constantly exceeded guideline levels linked to potential serious health impacts, including cancer. Federal and provincial governments should make joint efforts to compensate the community members for the impact of mercury on their health and livelihoods, put an end to industrial logging on their territory, support the community's plans to revive its livelihood and urgently upgrade the existing water treatment plant, while building a new plant to replace the old one.

82. The Special Rapporteur learned about further resource development projects in Northeast British Columbia that are causing environmental damage and health-related harm to indigenous communities. He reiterates the recommendation of the Committee on Economic, Social and Cultural Rights that Canada regularly assess the environmental impact of extractive industry activities and of climate change on indigenous communities with their full engagement.[31] Furthermore, the affected communities should always be consulted when resource development projects are implemented on indigenous lands.

83. An additional remaining challenge relates to the forced or coerced sterilization of indigenous women. In 2017, a report of the Saskatoon Regional Health Authority documented 16 such cases between 2005 and 2010. Since then, at least 60 indigenous women in Saskatchewan, Alberta, Manitoba and Ontario[32] have made similar allegations, including that their "consent" to be sterilized had been obtained during or immediately after giving birth, through coercive means and often without information about alternative birth-control methods.

84. The Special Rapporteur endorses the recommendations made in December 2018 by the Committee against Torture that Canada ensure that all allegations of forced or coerced sterilization are impartially investigated, that responsible persons are held accountable and that adequate redress is provided to victims. Furthermore, he urges Canada to 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 health-care personnel of that requirement.[33]

[31] See E/C.12/CAN/CO/6, para. 54.

[32] See Inter-American Commission on Human Rights press release dated 18 January 2019, available at https://mailchi.mp/dist/iachr-expresses-its-deep-concern-over-the-claims-of-forced-sterilizations-against-indigenous-women-in-canada?e=a4c01651de.

[33] See CAT/C/CAN/CO/7, paras. 51 and 54.

V. Additional remaining challenges

A. Other groups in vulnerable situations

85. The Interim Federal Health Program in Canada provides limited, temporary health-care coverage to asylum seekers. The programme was restricted in 2012 but reinstated in 2014 with some changes, pursuant to a decision by the federal court that ruled the cut had been "cruel and unusual" and therefore unconstitutional; the programme was fully restored in 2016. The reinstatement brought confusion among individuals looking for health-care coverage under the programme and among providers, including pharmacies, which continued mistakenly to believe that goods and services were either not covered under the programme or could only be obtained through a complex process.

86. By law, no person in Canada can be denied emergency and life-saving medical services. While asylum seekers for the most part can gain access to health care in Canada, persons with no immigration status cannot. As a common rule, provinces and territories require that identification documents be shown in order to gain access to health care. In Montreal, the Special Rapporteur visited a migrant clinic of the organization Doctors of the World that offers a wide-range of health-care services to migrants in precarious situations who have neither public or private health insurance nor the financial means to gain access to health care. The clinic has increasingly provided health care to children who were born in Quebecand are therefore Canadian citizens but who have no public health coverage owing to obstacles in obtaining a health insurance card.

87. Access to the Interim Federal Health Program should be ensured without discrimination based on immigration status.[34] At the very minimum, Canada should ensure public health care 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 voluntary interruption of pregnancy, and all children born in Canada and abroad should have free access to health care regardless of their parent's immigration status.

88. In Quebec, the Special Rapporteur collected many testimonies of persons in situations of poverty who faced barriers in gaining access to health care owing to communication gaps and difficulties in interacting with health-care personnel because of their different contexts and life experiences and the tendency of health-care personnel to use expert medical language. This led to prejudice, social distance and miscommunication, which discourages persons in situations of poverty from seeking health care or following medical advice and pushes health-care personnel to diagnose and indicate treatment quickly without full consideration of the barriers that persons in situation of poverty face.

89. The health care of incarcerated women remains a challenge. Overall, health care 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 lacked sex-specific health care, including hormonal contraception, abortion, prenatal care and breastfeeding support, clinical care and supplies while menstruating. The experience of incarcerated pregnant women had not been documented and there was a lack of disaggregated data by race or gender about health-related experiences and outcomes of incarceration. Furthermore, with the exception of Quebec,[35] there were no provincial monitoring bodies similar to the Office of the Correctional Investigator, and some provinces, including Nova Scotia, had no requirements for a public inquiry when a prisoner died in provincial custody. All prisons should ensure health care for women and data collection to monitor the progression of incarcerated women's health.

[34] See E/C.12/CAN/CO/6, para. 50.

[35] The *Protecteur du citoyen* is the correctional Ombudsman for incarcerated persons in 1 of the 18 operating correctional facilities under the responsibility of the QuebecDepartment of Public Security. See https://protecteurducitoyen.qc.ca/en/about-us/role-and-mandates.

Contact visits and residential mother-child options should be guaranteed for pregnant women and mothers, and alternatives to incarceration for women 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 situations, including older persons, immigrants, persons in situations of poverty, indigenous peoples, young people and victims of domestic violence. The centre offers 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 made significant efforts regarding sexual and reproductive health rights. However, the Special Rapporteur received information about retrogressive measures, such as the elimination by the government of Ontario of the 2015 sexuality education curriculum in favour of reinstating a previous one that had reportedly missed key contents in terms of consent, challenging homophobia, Internet safety and information on a diversity of gender identities and sexual orientations.[36]

92. The Special Rapporteur observed several good practices, including sexuality education at the Lester B. Pearson High School in Montreal, where school professionals can teach children obligatory topics about sexuality at an age-appropriate progression, from basic concepts to more detail and deeper discussions. The programme covers the biology of sex as well as the cultural, ethical, moral, emotional and interpersonal aspects of sexuality. It provides information to help 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 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 gaining access to 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 Quebec, have a 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 gaining access to abortion are compounded by 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 gain access to 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 women about their objection. While some provincial colleges of physicians and surgeons[37] include ethical requirements to provide referrals (Alberta, Ontario and Quebec), the Special Rapporteur stresses that, beyond professional ethical codes, the State has the duty to ensure that

[36] For the allegations, see OL CAN 4/2018, available at https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=24216; for the Government's reply see https://spcommreports.ohchr.org/TMResultsBase/DownLoadFile?gId=34661.

[37] See www.arcc-cdac.ca/postionpapers/95-appendix-policies-conscientious-objection-healthcare.pdf.

physicians' conscientious objection does not impede women's access to legal abortion services.[38]

96. Additional challenges concern the criminalization of sex work and the non-disclosure of HIV status, and access to HIV medication. The 2014 Protection of Communities and Exploited Persons Act follows the so-called "Nordic model", which focuses on reducing demand by criminalizing the purchase of sexual services, prohibiting their advertising and profiting from others' sexual services. It criminalizes the profiting from sex work by third parties. However, in Canada, individuals living 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 gaining access to health care, including medical tests, treatment and support, due to fear of prosecution. He recommends that Canada decriminalize sex work, develop appropriate occupational health and safety regulations and establish a legal framework against abuse and exploitation. This can lead to sex workers' improved health outcomes and reduce the incidence of violence.

97. Canada has one of the highest number of criminal prosecutions based on non-disclosure of HIV status. Persons living with HIV are generally charged with serious crimes, including sexual assault. Typically, convicted persons receive a prison sentence and are registered in the sex offenders 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 criminal law should be avoided in all other circumstances. He also recommends that Canada develop specific training on HIV/AIDS for health-care personnel to avoid discrimination. He acknowledges the steps taken to address the over-criminalization of HIV non-disclosure, including the 2017 report that recommended that the application of the criminal law be limited to HIV non-disclosure cases as informed by the most recent medical science on sexual HIV transmission,[39] and the 2018 announcement by the Attorney General of Canada of a prosecutorial directive to ensure an appropriate and evidence-based criminal justice system response to cases of HIV non-disclosure.[40]

98. The Special Rapporteur witnessed a good model at the Vancouver-based Dr. Peter Centre, which offers an HIV day health programme with 24-hour nursing care residence. The centre provides health care 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. Services include specialized nursing care for complex mental health conditions; short-term stabilization; transition from hospital back into the community; a methadone maintenance programme, 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 a high standard of living; it has good economic and social indicators, and a large number of Canadians enjoy a good standard of health care.**

100. **Canada has a strong public health system that is firmly rooted in the principles of equity and fairness and the overall notion that access to health care should be based**

[38] See E/C.12/CAN/CO/6; Committee on Economic, Social and Cultural Rights general comment No. 22 (2016) on the right to sexual and reproductive health; and Committee on the Elimination of Discrimination against Women general recommendation No. 24 (1999) on women and health.

[39] Department of Justice Canada, *Criminal Justice System's Response to Non-Disclosure of HIV* (December 2017). Available at www.justice.gc.ca/eng/rp-pr/other-autre/hivnd-vihnd/hivnd-vihnd.pdf.

[40] See www.canada.ca/en/department-justice/news/2018/12/attorney-general-of-canada-to-issue-directive-regarding-prosecutions-of-hiv-non-disclosure-cases.html.

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 health-care services in-country is overall very good if a person can actually have access to them. Canada still faces structural challenges regarding services that are not covered by the public health insurance; disparities among provinces and territories; poor access to health care by persons in vulnerable situations, including indigenous peoples; and lack of parity between physical and mental health.**

102. **Canada has made major investments in health, including appropriate financial and human resources, and is doing well in that regard. It faces the crucial issue of directing and prioritizing resources and adopting rights-based criteria for federal health transfers. Cross-cutting to that is the issue of investing in the public health priorities of today, namely, the so-called "new morbidities" in children and adults, such as mental health, as well as the determinants of health, addressing drug use issues, and adolescents' and young people's health-related issues, including monitoring mechanisms to ensure the inclusion of an analytical right-to-health framework.**

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

(a) **Incorporate a human rights-based approach to health, including through positive measures that improve access to justice and effective remedies;**

(b) **Include rights-based criteria to existing ones in federal funding under the Canada Health Transfer and consider adopting a rights-based health-care national framework/strategy;**

(c) **Ensure the establishment of a national pharmacare plan or guidelines compliant with the obligations of Canada under the right-to-health framework;**

(d) **Continue to support community- and rights-based civil society projects with funding over a longer time frame, while building human rights capacity among health personnel;**

(e) **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;**

(f) **Develop measures to overcome early childhood adversities and to integrate mental health into primary care in order to reduce the stigma and discrimination still linked to mental health; enhance access to integrated and continuing care; and improve social integration;**

(g) **Ensure that the international cooperation of Canada worldwide supports the modernization of mental health policies by prioritizing rights-based and community-based mental health services and that it does not support services based on over-medicalization, institutionalization and other forms of coercion;**

(h) **Support initiatives that contribute to more effectiveness and transparency in mental health services and the health-care system at large;**

(i) **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;**

(j) **Ensure that 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;**

(k) **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;**

(l) **Provide public health care, at the very minimum, to all migrants in cases of infectious diseases and ensure that all children born in Canada have access to free health care regardless of their parent's immigration status;**

(m) **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.**