Action Canada
for Sexual Health & Rights

Submission to the UN Human Rights Committee
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Review of Canada

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

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Introduction

1. This report is submitted by Action Canada for Sexual Health and Rights (Action Canada) in advance of Canada's review during the 145th Session of the UN Human Rights Committee, taking place in March 2026. This report provides information on the List of Issues Prior to Reporting, with a focus on Canada's compliance with Article 6 of the CCPR, the right to life, focusing on access to health, particularly for migrants in Canada.

2. This submission includes insights from Action Canada's Access Line and Access Fund, two national programs that support people seeking information, referrals, and financial assistance related to sexual and reproductive health care, including abortion. Together, these programs offer a valuable window into the real-world challenges people encounter when trying to access health information and services across Canada. The experiences reflected in this work inform broader analysis in this submission, including concerns about whether Canada is meeting its obligations regarding the right to health and, by extension, the right to life.

3. Canada's last review under the International Covenant on Civil and Political Rights (ICCPR) was in 2015. Since then, the domestic, and the global context has shifted significantly. The world is currently facing a human rights crisis, with many governments, including Canada, reducing resources for crucial elements that enable the fulfillment of all human rights.

4. Action Canada regularly participates in Canada's reviews before treaty bodies, as well as the Universal Periodic Review (UPR), raising many of the concerns outlined in this report. To date, however, no concrete or adequate changes have been implemented to address these issues. Through this submission, Action Canada aims to inform the Human Rights Committee of the developments since Canada's last review and to ensure that Canada fulfills its responsibility to uphold the rights enshrined in the ICCPR.

Article 6- Right to life

Right to health

5. Article 6 of the International Covenant on Civil and Political Rights (ICCPR) recognizes that every human being has the inherent right to life and requires States to protect this right by law. As affirmed by the Human Rights Committee in General Comment No. 36 (2019), this obligation extends beyond preventing arbitrary deprivation of life and includes the duty to address general conditions in society that may give rise to direct threats to life, such as homelessness, poverty, and inadequate access to health care[1]. The failure to ensure timely and equitable access to essential health services can therefore constitute a violation of the right to life.

6. The interdependence and indivisibility of the right to life and the right to health is well established in international human rights law, including under the International Covenant on Economic, Social and Cultural

[1] *International Covenant on Civil and Political Rights*. (2019). Retrieved from https://docs.un.org/en/CCPR/C/GC/36

Rights (ICESCR). As articulated in General Comment No. 22, these rights are mutually reinforcing and cannot be realized independently of one another[2]. Where barriers to health care result in preventable illness, deterioration of health, or premature death, States may be in breach of their obligations under both Covenants.

7. These obligations apply to all individuals within a State's jurisdiction, without discrimination of any kind, including on the basis of nationality or immigration status. International human rights law requires Canada to respect, protect, and fulfil the rights to life and health for refugees, migrants, and people with precarious or irregular status on an equal basis, and to refrain from policies or practices that have discriminatory effects on access to life-saving health care.

8. Despite having ratified the ICCPR and ICESCR, Canada has failed to fully integrate a human rights–based approach to health care. In 2018, the former Special Rapporteur on the right to health, Dainius Puras, observed that although Canada has committed internationally to protecting the right to health, it has not embedded human rights principles into its health-care system, limiting its ability to comply with its obligations to respect, protect, and fulfil this right[3].

9. Recent developments demonstrate deficiencies across the core elements of the right to health, as defined by international standards: **availability, accessibility, acceptability, and quality**. The availability of primary health-care services in Canada has deteriorated, with an estimated 5.9 million adults lacking access to a family doctor, nurse practitioner, or primary care team[4]. Shortages in health-care providers and services disproportionately affect marginalized populations, including refugees, migrants, and low-income communities.

10. Accessibility remains a significant concern. Health services that are geographically distant, financially unaffordable, or conditioned on legal or administrative status are effectively inaccessible to many. Cost-sharing measures, gaps in public coverage, and restrictions affecting people with precarious immigration status create barriers that undermine equal access to essential and preventative care, placing lives at risk.

11. The acceptability and quality of health care are also compromised when individuals experience discrimination, stigma, or racism within health-care settings, or when services are not culturally appropriate or responsive to the needs of diverse communities. The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), General Comment No.37 states that 'the realization of the right to equality and non-discrimination is an absolute prerequisite for the effective enjoyment of the right to the highest attainable standard of physical and mental health'[5]. Such barriers deter individuals from seeking care and further exacerbate health inequities, with direct implications for both the right to health and the right to life.

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[2] Economic and Social Council. 2016. *General comments No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights*. Retrieved from https://docs.un.org/en/E/C.12/GC/22

[3] OHCHR. 2019. *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.* Retrieved from https://www.ohchr.org/en/documents/country-reports/ahrc4134add2-visit-canada-report-special-rapporteur-right-everyone

[4] Canadian Medical Association. (2025). Retrieved from *National Survey: 5.9 million in Canada still without regular doctor.*

[5] ICERD. 2025. *General recommendation No. 37 (2024) on equality and freedom from racial discrimination in the enjoyment of the right to health*. Retrieved from https://docs.un.org/en/CERD/C/GC/37

Systemic weakening of the health care system

12. Canada's public health system is under sustained pressure due to austerity measures, privatization, chronic underfunding[6], and workforce shortages[7]. Health care workers face inadequate compensation, increasing administrative burdens, and unsafe workloads, contributing to burnout and attrition[8]. These systemic challenges have led to longer wait times, reduced service availability, and widening inequities in access to care, particularly for marginalized populations.[9]

13. Despite these structural issues, government responses have targeted migration as a primary driver of health system strain[10]. This narrative is both inaccurate and harmful. Migrants, especially those with precarious or irregular status, are often excluded from public health coverage altogether and are therefore not significant users of the system. Migrants are not responsible for the health system's systemic failures and these harmful narratives not only obscure the root causes of underfunding and mismanagement but also deep insecurity and stigma, with direct consequences for migrants' willingness and ability to seek care.

14. Healthcare governance in Canada is shared between federal, provincial and territorial governments. Canada's thirteen provinces and territories have separate healthcare insurance plans, and each holds jurisdiction over its administration and the delivery of healthcare services. While Canada has received repeated recommendations from UN treaty bodies to ensure equitable access to health care, including for migrants, jurisdictional fragmentation continues to be used as a justification for inaction. In 2026, we are seeing provinces such asQuebec[11] and Alberta[12], where stakeholders are asking to declare a state of emergency for health care due to the crisis that the system is facing. However, they are not the only provinces facing this reality, the entire country has a health care crisis that needs to be addressed now[13].

15. Canada has received recommendations related to improving access to health from the Committee on the Elimination of Discrimination Against Women (CEDAW)[14] and from different countries through the Universal Periodic Review (UPR)[15]. Notably, Canada has failed to implement recommendations arising from *Toussaint v*

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[6] Canadian Labour Congress. (2025). *Canada's unions sound alarm on public health care crisis. Retrieved from* https://canadianlabour.ca/canadas-unions-sound-alarm-on-public-health-care-crisis/

[7] Institute for Canadian Citizenship (2025*). Canada's Healthcare Crisis: The Growing Gap Between Need and Supply*. Retrieved from https://forcitizenship.ca/article/canadas-healthcare-crisis-the-growing-gap-between-need-and-supply/

[8] Canadian Institute for Health Information. (2025). *Health workforce: overtime and staffing challenges in hospitals*. Retrieved from https://www.cihi.ca/en/health-workforce-overtime-and-staffing-challenges-in-hospitals

[9] Mofokeng, Tlaleng. 2025. *Health and care workers as defenders of the right to health*. Retrieved from https://docs.un.org/en/A/HRC/59/48

[10] Conservative Party of Canada. *Conservatives call on liberals to consider healthcare capacity in immigration*. Retrieved from https://www.conservative.ca/conservatives-call-on-liberals-to-consider-healthcare-capacity-in-immigration/

[11] Derfel, Aaron. 2026. ***Analysis: Health care was François Legault's Achilles heel*.** Retrieved from https://montrealgazette.com/news/local-news/analysis-health-care-was-francois-legaults-achilles-heel

[12] CUPE Alberta. 2026. *Declare a health care State of Emergency*. Retrieved from https://stateofemergency.ca/

[13] Canadian Health Coalition. 2023. *Health care in Canada lagging behind*. Retrieved from https://www.healthcoalition.ca/primary-care-in-canada-lagging-behind/?gad_source=1&gad_campaignid=22789169275&gbraid=0AAAAA_o-TVCGnluu_6Bs9RKutmPjo-CRi&gclid=Cj0KCQiAyvHLBhDlARIsAHxl6xroSvlU-SvFsQJJomRQD91aR4n1hKmzraM9K63vAl6EdaaKdULEy7YaAqGBEALw_wcB

[14] CEDAW. 2024. *Concluding observations on the tenth periodic report of Canad*a. Retrieved from https://www.ohchr.org/en/documents/concluding-observations/cedawccanco10-concluding-observations-tenth-periodic-report

[15] Universal Periodic Review. *UPR of Canada 4th cycle, 44th session: Thematic list of recommendations*. Retrieved from https://www.ohchr.org/sites/default/files/documents/hrbodies/upr/sessions/session44/ca/UPR44_Canada_Thematic_List_of_Recommendations.doc

Canada, in which the Human Rights Committee found Canada violated the rights to life and non-discrimination by denying healthcare access to a migrant[16]. Canada responded to this, informing the Human Rights Committee that 'while it had taken steps to disseminate the Committee's views it would not be taking any further measures to give effect to the Committee's view [...] Canada will not be following up further on the Committee's recommendations'[17] in contravention of its ICCPR obligations.

Impact on Sexual and Reproductive Health and Rights

16. The weakening of Canada's health care system also impacts sexual and reproductive health and rights (SRHR). Access to SRH services is highly sensitive to system capacity, funding levels, and insurance coverage, making these services especially vulnerable during period of crisis.

17. The UN Human Rights Committee along with other treaty bodies and Special Procedures, have outlined governments' obligation to ensure access to safe abortion services, as part of the right to health and the right to life. General Comment 36 affirms that "States parties must provide safe, legal and effective access to abortion […] States parties should also effectively protect the lives of women and girls against the mental and physical health risks associated with unsafe abortions. In particular, they should ensure access for women and men, and especially girls and boys, to quality and evidence-based information and education on sexual and reproductive health and to a wide range of affordable contraceptive methods and prevent the stigmatization of women and girls who seek abortion. States parties should ensure the availability of, and effective access to, quality prenatal and post-abortion health care for women and girls, in all circumstances and on a confidential basis."[18]

18. Abortion is a common and essential healthcare procedure. In Canada, although abortion is a decriminalized healthcare service, and widely supported by the Canadian public, barriers to access persist, as many people lack access to the public health system entirely, and others face prohibitive barriers to abortion care.

19. About half of all confirmed pregnancies in Canada are unintended[19] and around one third of people who can become pregnant will have an abortion in their lifetime.[20] Abortion access is a crucial component of a broader sexual and reproductive rights framework, which encompasses "the right to a pleasurable, satisfying and safe sex life free from discrimination, coercion and violence; and the freedom to decide whether, when and how often to reproduce, as well as the right to have the information and means to make this decision."[21]

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[16] International Covenant of Civil and Political Rights. (2018). *"Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication No. 2348/2014*".Retrieved from https://www.socialrights.ca/2018/D2348.pdf

[17] Government of Canada. 2014. *Canada's reply to the Committee's request for further information on follow-up to the Committee's view*. Retrieved from https://www.socialrights.ca/2024/Canada%20Response%20to%20Follow-up.pdf

[18] International Covenant of Civil and Political Rights. (2019). Retrieved from https://docs.un.org/en/CCPR/C/GC/36

[19] Public Health Agency of Canada (PHAC). 2017. *"Chapter 2: Preconception Care" in Family-centred maternity and newborn care: National guidelines.* Retrieved from https://www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-2.html

[20] Norman, W. 2012. *Induced abortion in Canada 1974-2005: Trends over the first generation with legal access*. *Contraception*, 85, 185–191.

[21] Tlaleng Mofokeng, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2021. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health - Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic.* A/76/172, para 18. Retrieved from: https://www.ohchr.org/en/documents/thematic-reports/a76172-report-special-rapporteur-right-everyone-enjoyment-highest

20. Canada's failure to implement universal pharmacare further undermine SRHR. As the only country with a universal health care system that does not provide prescription drug coverage, Canada leaves many people unable to access essential medications, including contraceptives.

21. The introduction of Bill C-64, *An Act Respecting Pharmacare,* in 2024 raised expectations that this longstanding gap would be addressed. However, following 2025 federal election, progress stalled. The current government has deprioritized pharmacare and allocated no additional funding toward its implementation. As of 2026, only four provinces and territories, British Columbia, Manitoba, Prince Edward Island and Yukon, have signed agreements, leaving nine jurisdictions without coverage. As a result, access to contraception remains uneven and limited, particularly for those already marginalized. Universal access to contraception is essential for bodily autonomy to make informed choices about their health and lives[22].

Disproportionate impact on migrants

22. Migrant's experience of accessing health care in Canada vary, but many experience generalized precarity rooted in their migration status and poor labour protections[23]. These conditions are exacerbated by exclusion from public health coverage, economic marginalization, limited transportation, lack of access to information, and social isolation[24]. These barriers intersect and compound one another and are further aggravated by racism and xenophobia, in violation of Article 26 f the ICCPR. Such discrimination is "embedded in countries' immigration laws, policies, institutions and practices, which often subject migrants to dangerous conditions or impose obstacles to health services and resources."[25]

23. Costs associated with accessing care can inhibit access, especially for those who are "uninsured." Residents must register with the healthcare insurance plan in their province, but the criteria for residency and coverage requirements vary. Recent immigrants, undocumented migrants, and international students are frequently ineligible for these plans. Those without active health cards in their province of residence, which can include people experiencing homelessness or intimate partner violence, are eligible but may face difficulties registering or be turned away from services. For people experiencing homelessness, lack of a health card or other identification is often cited as the largest barrier to care.[26]

24. These systemic barriers within the broader healthcare system have particularly acute consequences for access to abortion care. Individuals who are excluded from the public health insurance coverage must pay for abortion services out of pocket, despite already being disproportionately financially strained. Procedure costs alone can

[22] Action Canada. 2024. *Canadian Contraception Policy Atlas*. Retrieved from https://www.actioncanadashr.org/canadian-contraception-policy-atlas-paper
[23] Action Canada and et al. 2023. *Universal Periodic Review of Canada*. Joint Stakeholder Report. Retrieved from https://www.sexualrightsinitiative.org/sites/default/files/resources/files/2023-12/UPR%2044%20Canada_%20JS%20Action%20Canada%20et%20al%20and%20the%20SRI%20%20%282%29.pdf
[24] Ibid
[25] Tlaleng Mofokeng, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2022. *Report by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health - Racism and the right to health.* A/77/197, para 28. Retrieved from: https://www.ohchr.org/en/documents/thematic-reports/a77197-report-special-rapporteur-right-everyone-enjoyment-highest
[26]Homeless Hub. n.d. *Public Health Care & Service Delivery.* Retrieved from: https://www.homelesshub.ca/about-homelessness/service-provision/public-health-care-service-delivery

range from CAD 500 to 3,200, often resulting in prohibitive financial hardship. Such costs undermine access to abortion care and stand in contravention of the right to health and the principles of universal health coverage.

25. In January 2026, following the federal budget presented in November 2025, the federal government announced that, beginning May 1, beneficiaries of the Interim Federal Health Program (IFHP) will be required to pay $4 CAD for each eligible prescription medication filled or refilled under the program. In addition, refugees and newcomers will be required to cover 30% of the cost of other supplementary health products and services[27]. These changes will have significant consequences for access to healthcare, particularly for some of the most marginalized people in Canada. They also run counter to the Committee's concerns regarding the 2012 cuts to the IFHP, which resulted in many irregular migrants losing access to essential health-care services (arts. 2, 7, 9, and 13).

26. Action Canada runs the Access Line, a national support service available by phone, text, and email to those seeking information and referrals related to sexual and reproductive health. We also manage an Access Fund, which helps people facing financial barriers to accessing abortion care. These services provide unique insights into the barriers people face when seeking healthcare information and services. In 2025, the Access Line supported 5297 people through calls, texts and emails, of which 70% were related to abortion care. Approximately 40% of the people calling the Access Line mentioned that they have faced major barriers to abortion, including travel costs, long wait times, precarious housing, immigration status, and intimate partner violence.

27. Demand for our services has accelerated in recent years, indicating that there are growing unmet information and service needs.[28] In 2025, the Access Line saw an overall 74% rise in contacts compared to 2022, making clear the rapid increase in people needing support to access the healthcare system. We have also seen a 110% increase in the number of people supported by our fund from 2022 to 2025 and a 161% increase in the financial support provided[29]. In 2025, approximately 45-50% of those receiving our financial and logistical assistance were migrants without documentation or with precarious status. During the COVID-19 pandemic, we found that most people who were ultimately unable to access abortion in Canada had precarious immigration status or were undocumented.[30]

28. In addition to financial and coverage-related barriers, migrants face practical and psychosocial obstacles that further delay access to abortion care. Precarious employment and limited labour protections often make it difficult to obtain permission to take time off work, while costs associated with transportation, childcare, and lost wages can be prohibitive. Fear of interacting with healthcare institutions, driven by concerns about immigration enforcement, discrimination, or prior experiences of racism and xenophobia, also discourages timely care-seeking.

[27] Government of Canada, 2026. Changes to the Interim Federal Health Program. Retrieved from https://www.canada.ca/en/immigration-refugees-citizenship/news/notices/changes-ifhp.html

[28] The rise in calls likely does not imply an increase in people seeking abortion care but rather increased awareness of our services.

[29] In 2022 the Access Fund attended 217 clients and the numbers in 2025 increased to 455.

[30] Chabot, Frédérique. 2021. "Access to Abortion for Undocumented Persons During the COVID-19 Pandemic." *The Statelessness & Citizenship Review* 3 (1), 142-47. Retrieved from: https://statelessnessandcitizenshipreview.com/index.php/journal/article/view/305.

29. As a result, migrants may present later in pregnancy, when abortion procedures are more complex, time-sensitive, and less widely available. Many providers and facilities have limited capacity or are reluctant to offer later-gestation care, increasing the likelihood of denial, referral delays, or forced travel. These dynamics intensify migrants' experiences of isolation and abandonment within a healthcare system that fails to adequately support them, underscoring the need to increase the availability and capacity of hospital-based abortion services and trained providers.

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

31. More recently, the Canadian government presented Bill C-12 and Bill C-2, which undermined Canada's health act and introduce measures targeting migrants and raise serious concerns under Article 17 of the ICCPR, regarding the right to privacy[31]. These provisions have direct implications for access to health care, as many migrants and refugees fear seeking medical services due to potential consequences for their immigration status. Fear of violence, surveillance, discrimination, deportation, and incarceration continues to deter individuals from accessing information and care. Ongoing collaboration between law enforcement, border authorities, and other state institutions perpetuates harmful and racist practices, further undermining Canada's compliance with its ICCPR obligations, including Articles 6, 17 and 26.

32. **Recommendations**

- **All Jurisdictions: Recognizing that people in Canada experiencing intersectional forms of discrimination have the least access to abortion care, all jurisdictions in Canada must turn their efforts towards establishing low-barrier pathways to abortion care.**
- **All Jurisdictions:** Establish a clear legal mandate for National Mechanisms for Implementation, Reporting and Follow-Up (NMIRFs) to ensure effective coordination, legitimacy, sustainability, and institutional continuity. Such a mandate would institutionalize national-level human rights implementation and strengthen compliance with international human rights obligations.
- **Federal Government: Ensure that all people in Canada, regardless of immigration or citizenship status, have secure access to healthcare services, including abortion care, by removing barriers related to status and eliminating co-payments under the Interim Federal Health Program.**

[31] HIV Legal Network. 2025. BILLS C-2 AND C-12: THE 'UNDERMINING HEALTH IN CANADA' ACTS. Retrieved from https://www.hivlegalnetwork.ca/site/wp-content/uploads/2025/10/INFO-SHEET-Bill-C-2-C-12-FINAL-2.0.pdf

- **Federal Government: Provide accessible, multilingual information on sexual and reproductive health and rights (SRHR), including abortion care, to ensure that all people in Canada can make informed choices regardless of language proficiency.**
- **Federal Government: Provide resources for research on the reproductive health needs and experiences of people who face intensified systemic barriers. This is vital to inform effective resourcing, planning, and service delivery by healthcare and civil society organizations and ensuring equitable access.**
- **Federal Government: Increase resources to Health Canada's Sexual and Reproductive Health Fund to address barriers to access and provide essential core funding to civil society organizations.**
- **Federal Government: Strengthen compliance with the Canada Health Act by establishing benchmarks for the availability and accessibility of abortion care through the public health system and holding provinces to account.**
- **Federal Government: Increase Federal Health Transfers with ties to the expansion of reproductive and sexual health services, with emphasis on facilitating equal access to abortion, across the country.**
- **Federal Government: Guarantee the provision of healthcare to undocumented people and migrant workers through removing the co-pay of the Interim Federal Health Program and a no-exclusions regularization program granting full and permanent immigration status.**
- **Federal Government: Fully implement Pharmacare, a public drug plan that is universal, comprehensive, evidence-based, and sustainable.**
- **Provincial and Territorial Governments: Establish centralized pathways to abortion care, such as provincial helplines or comprehensive online resources, ensuring clear, up-to-date, and publicly accessible information about available services.**
- **Provincial and Territorial Governments: Increase the availability and capacity of hospital sites and trained providers to deliver later gestational abortion care, with particular attention to populations experiencing intersecting barriers, including those who are uninsured or have precarious immigration status.**