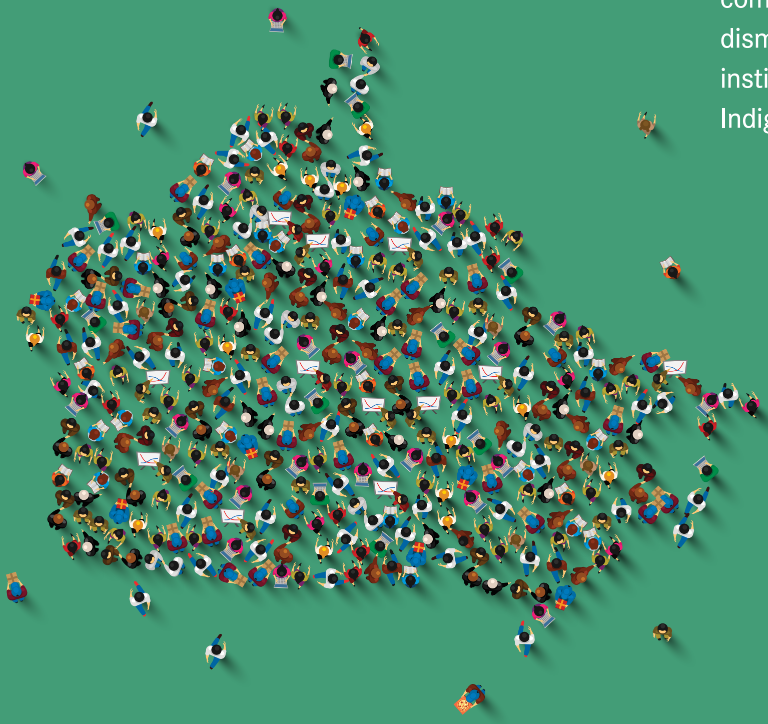
HIV LEGAL NETWORK
RÉSEAU JURIDIQUE VIH

THE Right TO Care

HEPATITIS C AMONG PRIORITY POPULATIONS IN CANADA

About the HIV Legal Network

The HIV Legal Network promotes the human rights of people living with HIV or AIDS and other populations disproportionately affected by HIV, punitive laws and policies, and criminalization, in Canada and internationally. We do this through research and analysis, litigation and other advocacy, public education, and community mobilization.



The HIV Legal Network works on the land now called Canada, located on treaty lands, stolen lands, and unceded territories of Indigenous groups and communities who have respected and cared for this land since time immemorial. We work to address the ongoing injustices and resulting health inequities faced by Indigenous Peoples. They contribute to the disproportionate impact of the HIV and hepatitis C epidemic on Indigenous communities. We are committed to learning to work in solidarity and to dismantling and decolonizing practices and institutions to respect Indigenous Peoples and Indigenous ways of knowing and being.

ACKNOWLEDGEMENT

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Graphic Design: Ryan White (Registered Graphic Designer, Mixtape Branding)
Translation: Josée Dussault and Jean Dussault

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Context: The Enduring Nature of HCV

The elimination of hepatitis C (HCV) as a public health threat is within Canada's reach.[1] Over the past decade, medical advancements have transformed HCV prevention, testing, and treatment. For instance, in 2014, direct-acting antivirals (DAA) were developed, which for the first time provided highly effective curative HCV treatment.[2] Treatment now consists of daily pills for eight to12 weeks, with minimal side effects, curing 95% of chronic HCV cases.

Even so, HCV remains pervasive. In 2019, an estimated 204,000 people in Canada were living with HCV, among which 9,470 were new infections.[3] That same year, 2,692 people died of HCV-related causes — a 7% increase from 2015.[4] HCV thus remains the most burdensome transmissible illness in Canada, responsible for more years lost than any other such illness.[5]

Multiple barriers contribute to HCV's endurance.[6] For instance, harm reduction services, such as needle and syringe distribution programs, are inconsistently available through the country, despite evidence that 85% of HCV infections occur through the sharing of drug injection equipment. Additionally, one-time testing for chronic HCV is not universal. Testing for chronic HCV often only occurs after a person tests positive for acute HCV and shows risk factors for chronic HCV, even though HCV symptoms usually only appear years into a chronic infection, when significant liver damage has already occurred. Moreover, due to a lack of point-of-care (PoC) testing, which provides same-day diagnosis and enables same-day treatment starts, people with HCV must wait days or weeks for their results and make multiple trips to their healthcare providers to begin treatment.

UNDERSTANDING HEPATITIS C

HCV is a liver infection spread through blood-to-blood contact. Most infections occur through non-sterile drug injection equipment, unsafe healthcare, unscreened blood transfusions, and sexual practices that lead to exposure to blood. While one in four people will clear an **acute HCV** infection on their own, others will develop **chronic HCV** and require treatment. Without treatment, chronic HCV causes liver damage, which can lead to liver failure and/or cancer. An estimated 20-30% of people living with HIV become infected with HCV. For those living with HIV, the risks of liver disease progression and death are increased.

Sources: World Health Organizations, *Hepatitis C: Key Facts,* 18 July 2023, available at www.who.int/news-room/fact-sheets/detail/hepatitis-c#:~:text=The%20hepatitis%20C%20virus%20is,lead%20to%20exposure%20to%20blood; CATIE, *The epidemiology of hepatitis C in Canada,* 2023, available at www.catie.ca/sites/default/files/2023-09/fs-epi-hcv-en-09-2023.pdf; and M. Hull et al., "CIRH Canadian HIV Trials Network Coinfection and Concurrent Diseases Core Research Group: 2016 Updated Canadian HIV/Hepatitis C Adult Guidelines for Management and Treatment," *Can J Infect Dis Med Microbiol* (2016).

A FOCUS ON PRIORITY POPULATIONS

The HCV burden is disproportionately borne by certain groups, recognized as “priority populations.”[7] They include people who inject drugs; people in the prison system; Indigenous people; gay, bisexual, and other men who have sex with men (GBMSM); and migrants from countries with high prevalence of HCV. In 2019, of the estimated 387,000 people who had ever had HCV in Canada (or 1.0% of the Canadian population):

- **61,600** were people who inject drugs (or 46.1% of people who inject drugs);
- **175,000** were people with a history of injecting drugs (or 44.9% of people with a history of injecting drugs);
- **4,050** were people in prison (or 10.7% of people in prison);
- **134,000** were Indigenous people (or 7.4% of Indigenous people);
- **23,400** were GBMSM (or 3.7% of GBMSM); and
- **178,000** were immigrants (or 1.5% of immigrants).[8]

These priority populations face amplified barriers to HCV care due to discrimination, stigma, and criminalization.[9] The elimination of HCV will not occur until these barriers to healthcare for priority populations have been lifted.

A HUMAN RIGHTS APPROACH

A human rights approach is essential to eliminating HCV as a public health threat,[10] and capturing the social, cultural, economic, and other barriers to the enjoyment of rights, including the right to health. This approach also provides a mechanism to hold governments accountable to their human rights promises.[11]

> **HIV, viral hepatitis, and sexually transmitted infections share modes of transmission and common interventions. They are also shaped in similar ways by social and structural determinants of health, such that communities facing poorer socioeconomic conditions, or discrimination, including discrimination experienced by key populations, experience greater vulnerability to infection and worse health outcomes. Putting people at the centre of rights-based health system responses — by organizing services around people's needs rather than around diseases, and by promoting integrated patient-centred approaches and linkages with primary healthcare services — is the key to ending these epidemics.**

Source: World Health Organization, *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030,* July 2022, available at www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/strategies/global-health-sector-strategies#:~:text=The%20strategies%20aim%20to%20end,convergence%20while%20maintaining%20disease%20specificities.

The Right to Health: The right to health is not explicitly protected in Canadian law. Instead, protections for the right to health derive from the right to life, liberty, and security of the person under the *Canadian Charter of Rights and Freedoms* (the *Charter*), the emphasis on equity and fairness in healthcare in the *Canada Health Act,* and the right to the highest attainable standards of health reflected in Canada's international human rights obligations.[12]

In Canada, at a minimum, the right to health encompasses the right to access healthcare,[13] including harm reduction services, although how this right is interpreted by governments and courts is a matter of debate.[14] International human rights norms dictate that healthcare must be available in sufficient quantity, accessible without discrimination, responsive to the needs of different populations, and of good quality.[15] Moreover, governments must refrain from interfering — "from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers, and [irregular] immigrants, to preventative, curative, and palliative health services."[16]

Barriers: Multiple barriers limit the priority populations' enjoyment of the right to health.

The division of authority over healthcare creates significant inconsistencies in healthcare provision by jurisdictions. While the federal government is directly responsible for the healthcare of people in federal prisons, people claiming asylum, and Indigenous Peoples on reserve, and guides the provinces and territories through the *Canada Health Act* to each establish public healthcare systems, each province and territory has significant discretion in determining who is eligible and what services are included in each of their public healthcare systems. Consequently, there is no single, coordinated healthcare system — and no single, coordinated approach to HCV. Indeed, in 2023, Action Hepatitis Canada (AHC) found wide variation between the federal, provincial, and territorial responses to HCV.[17] AHC found that seven provinces were on track to meet HCV elimination goals, but that two of those not on track were the most populated provinces in the country.

As noted by the Special Rapporteur on the right to the highest attainable standard of health (the Special Rapporteur), following their visit to Canada in 2019:

> **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."[18]**

Moreover, comprehensive health-related data is not consistently collected across Canada. For instance, there is limited high-quality data on the number of people living with HCV.[19] There is also limited health equity data, such as the number of people who inject or the number of needles and syringes that are distributed,[20] as well as intersectional cascade of care data related to people who belong to two or more of the priority populations. There is thus no clear picture of the barriers faced by the priority populations.

Additionally, HCV remains highly stigmatized across the country because it is transmissible and linked to drug use[21] and other stigmatized priority populations, as discussed further below.

Enabling Guidelines and Policies: Canada has adopted multiple strategies to eradicate HCV, including among priority populations:

- In 2016, Canada signed on to the *Global Viral Hepatitis Strategy (Strategy 2016),* endorsed by 194 member states of the World Health Organization (WHO), which tasked Member States with developing national action plans to meet specific HCV-elimination targets. *Strategy 2016* emphasized the need to eliminate barriers, such as stigma and discrimination, to care.[22]
- In 2018 and 2019, the Public Health Agency of Canada (PHAC) developed HCV-elimination strategies within *A Pan-Canadian Framework for Action: Reducing the Health Impact of Sexually Transmitted and Blood-Borne Infections (STBBIs) in Canada by 2030*[23] and *Accelerating our Response: Government of Canada Five-Year Action Plan on Sexually Transmitted and Blood-Borne Infections.*[24] Each province and territory in Canada adopted both strategies, which replicate the WHO targets and emphasize the need to eliminate barriers for priority populations.
- Finally, in 2022 Canada signed on to the WHO's *Global Viral Hepatitis Strategy (2022-2030) (Strategy 2022),* updating and renewing commitments from *Strategy 2016*. Again, *Strategy 2022* stresses the need to address barriers to health services faced by the priority populations.[25] In 2024, PHAC released the *Government of Canada's Sexually Transmitted and Blood-Borne Infections (STBBI) Action Plan 2024-2030,* affirming its commitment to the WHO's 2030 STBBI targets.[26]

Meeting the Rights of Priority Populations

Each of the priority populations faces a distinct set of barriers to the enjoyment of the right to health. Realizing the right to health across Canada will therefore require strategies responsive to their unique set of needs. Those strategies must recognize that many people identify as belonging to more than one of the priority populations.

(1) PEOPLE WHO USE DRUGS

People who inject drugs experience the highest rates of HCV infection in Canada. One in four people who inject drugs are living with chronic HCV. About 85% of new HCV cases are among people who inject drugs.[27] Even so, people who inject drugs are underserved by healthcare systems throughout the country. Tellingly, up to 70% of people who inject drugs in Canada are unaware of their HCV status.[28]

The Right to Health: The right to health exists irrespective of drug use. The denial of healthcare based on drug use is a form of discrimination.

In 2011, the Supreme Court of Canada confirmed that government action that restricted access to a harm reduction program for people who use drugs constituted a breach of the *Charter* right to life, liberty, and security of the person. Specifically, the Court found that the Government of Canada could not reasonably justify denying access to a supervised consumption site to people who use drugs, as the restriction deprived people who use drugs of "lifesaving and health protecting services," such as sterile injection equipment and supervision during drug use.

The same principle exists in international human rights law. The enjoyment of the right to health of people who use drugs is applicable "irrespective of the fact of their drug use."[29] State interference with the right to health on the basis of drug use is discriminatory, regardless of whether a person is recognized as having a drug dependence, or a state's drug policies penalize such drug use.[30] Indeed, the Special Rapporteur on the right to health has affirmed that states remain bound to their obligations to respect, protect, and fulfill human rights, *including when they are developing or implementing drug policies.*[31] The *International Guidelines on Human Rights and Drug Policy,* based on national, regional, and international human rights law, also confirm that states must take concrete steps to ensure that healthcare is provided to people who use drugs on a non-discriminatory basis, and repeal policies that inhibit access to healthcare.[32]

Barriers: The right to health is regularly denied to people because of their drug use. People who use drugs are often excluded from Canada's healthcare systems.

Specifically, Canada's drug policies prioritize punishment over health. Despite narrow exemptions to select harm reduction services, activities associated with drug use are broadly criminalized.[33] Criminalization perpetuates stigma and discrimination, including within the healthcare setting, as people who use drugs are depicted as dangerous and reckless.[34] Consequently, people are sometimes refused treatment because of their drug use, based on a belief that they are unlikely to adhere to treatment, despite no evidence to support such a belief.[35] Moreover, people are deterred from harm reduction and other healthcare due to stigmatizing or punitive experiences, including the threat of criminalization.[36]

In fact, studies have found that antipathy to healthcare services, combined with stigma related to HCV and drug use, are common barriers to HCV testing.[37]

> **Research has also shown that the frequent contact that police have with people who use drugs contributes to their "health risk environment through pathways, such as syringe and naloxone confiscation, and physical and verbal harassment," which can lead to syringe sharing, rushed injection, and isolation while using drugs.[38] As a result, people who use drugs face increased risk of HCV transmission.**

Additionally, harm reduction programming is inconsistently available across the country — even though it has consistently been found to be cost-effective relative to the long-term healthcare costs of HCV.[39] A 2017 study found that only two provinces had meaningful harm reduction policies, with many other provinces' policies requiring abstinence from drug use to access healthcare.[40] The study concluded that few provincial policies offered "robust characterization of harm reduction or go beyond rhetorical or generic support for the approach."[41] Large gaps remain today, with many crucial services (such as supervised consumption sites, which offer access to drug checking and sterile drug-use equipment), mostly available in cities in British Columbia, Alberta, Ontario, and Quebec.[42]

Enabling Policies: Despite ongoing barriers, the Government of Canada has enacted legislative amendments and produced policies that facilitate access to healthcare for people who use drugs:

- In 2017, the federal government amended the *Controlled Drugs and Substances Act* (CDSA), to replace onerous legislative requirements with simpler, streamlined requirements to receive a federal exemption to run a supervised consumption site, and thus allowed for their scale up.[43]
- In 2022, acknowledging that "problematic substance use should be addressed primarily as a health and social issue" and that criminalizing personal drug possession "can increase the stigma associated with drug use," the federal government amended the CDSA authorizing police and prosecutors to refrain from charging people for personal drug possession.[44]
- In 2023, Health Canada published a renewed *Canadian Drugs and Substances Strategy* affirming its commitment to promote "substance use services and supports that support the full continuum of care, including treatment, harm reduction, and recovery options."[45]

PROMISING PRACTICES

KeepSix, a supervised consumption site in Toronto, has incorporated an HCV program in its services, with point-of-care[46] testing as well as on-site nurses and physicians who assess, prescribe, and dispense medication on site. A study of the program found that, between 2018 to 2021, 43.5% of participants tested positive for HCV and 67.2% of those individuals were linked to care and treatment. The authors found that, “despite the challenges faced by the population, progression through the continuum of care was good for those diagnosed at baseline or throughout the study.” The authors concluded that offering HCV testing and treatment at supervised consumption services is both possible and effective.

Mainline Needle Exchange, a program of the Mi’kmaw Native Friendship Centre in Nova Scotia, aims to reduce transmission of HCV, among other STBBIs, increase awareness of health and social issues faced by people who use drugs, and empower people who use drugs through education and support. Through their Brown Bag Program, Mainline joined forces with more than 100 pharmacies to increase access to harm reduction materials. In each brown bag provided at partner pharmacies, Mainline offers ten sterile syringes, as well as other safe injection materials. In 2023, Action Hepatitis Canada reported that, in Nova Scotia, drug injection equipment has been distributed to people who use drugs at high rates, even exceeding recommended HCV elimination targets.

Sources: B. Lettner et al., “Rapid hepatitis C virus point-of-care RNA testing and treatment at an integrated supervised consumption service in Toronto, Canada: a prospective, observational cohort study,” *The Lancet Regional Health* 22(100490) (2023). Mainline Needle Exchange, *Brown Bag Program,* available at https://mainlineneedleexchange.ca/brownbag. Action Hepatitis Canada, *2023 Report: Progress Toward Viral Hepatitis Elimination in Canada,* May 2023, available at www.actionhepatitiscanada.ca/progressreport.html.

(2) PEOPLE IN THE PRISON SYSTEM

HCV is significantly more common in prison than in the community as a whole. In Canada, approximately 25% of people in federal and provincial prisons have had HCV – a rate 40 times higher than the general population.[47] The ongoing impacts of colonization has also meant that Indigenous people are both overrepresented in the prison system, and disproportionately affected by HCV. It is estimated that 28% of Indigenous men and 45% of Indigenous women in prison are living with HCV.[48] The criminalization of people who use drugs has also increased the risk of HCV transmission within prisons, as an estimated 76% of people who inject drugs in Canada have a history of incarceration, and an estimated 50% of people who are in prison report a history of drug use.[49]

The Right to Health: People who enter the prison system do not forego their right to health and have a right to healthcare that is equivalent to that which is available in the community.

The *Charter* offers protections for the health and wellbeing of people in prison, which Canadian courts have interpreted with reference to the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the Nelson Mandela Rules).[50] Rule 24 of the *Nelson Mandela Rules* confirms that people in prison have "the same standards of healthcare that are available in the community." To meet these obligations, the WHO has recommended that health ministries, as opposed to ministries of justice, be responsible for healthcare in prisons.[51]

> **In 2023, the WHO and the United Nations Office on Drugs and Crime (UNODC) also published a recommended package of interventions for HIV, viral hepatitis, and STI prevention, diagnosis, treatment, and care for people in prisons.[52]**

Within Canada's federal correctional institutions, responsibility for healthcare falls on the Correctional Service of Canada (CSC). Pursuant to the *Corrections and Conditional Release Act,* CSC must provide "essential health care" and "reasonable access to non-essential health care" to every person incarcerated in a federal institution.[53] That healthcare must "conform to professionally accepted standards."[54] Within provincial and territorial jurisdictions, the *Canada Health Act* is applicable, which broadly recognizes that "continued access to quality health care without [...] barriers [is] critical."[55]

Barriers: People in prison are regularly denied access to healthcare that is available in the community.[56]

Notably, the division of authority over healthcare has created an unequal system. For instance, people who are incarcerated in federal institutions are excluded from the *Canada Health Act,* which "creates separate, operationally unequal, and substandard medical care for [...] incarcerated persons" in federal institutions, as compared to other residents in Canada who receive healthcare from their provincial governments.[57] Similarly, in many provinces and territories (e.g. Manitoba, New Brunswick, Ontario, Prince Edward Island, Saskatchewan, and Yukon), ministries of public safety or justice are responsible for the provision of healthcare in prisons, while ministries of health are responsible for providing healthcare to those in the community.[58]

Consequently, there is great disparity in healthcare from one jurisdiction to the next. For instance, at the federal level, CSC provides universal, opt-out STBBI testing and treatment, including for HCV.[59] Conversely, at the provincial level, less than 50% of prisons offer universal HCV testing, and only about 50% of prisons permit the initiation of HCV treatment.[60] A 2021 study found that only two provinces, British Columbia and Prince Edward Island, offer to initiate DAAs in all of their prisons.[61] Unsurprisingly, in jurisdictions in which healthcare is the responsibility of the ministry of health, DAAs are more likely to be initiated.[62]

Even in jurisdictions with comprehensive healthcare policies, barriers in practice exist. The lack of confidentiality in prisons, and stigma around certain health conditions (including HCV), have repeatedly been cited as barriers to accessing healthcare.[63] Additionally, limited links between healthcare in the community and in prisons means that people experience interruptions to their healthcare, when they enter or leave prison. For instance, opioid agonist therapy (OAT) and DAA interruption is regularly reported.[64] For provincial institutions, the short periods of incarceration compound these challenges, given delays in diagnosing conditions like HCV and beginning treatment.[65]

> **In both federal and provincial prisons, there is also inadequate access to harm reduction programming, even though drug use (particularly by injection) and tattooing commonly occur in prisons.[66]**

In the federal system, CSC allows people to initiate or continue OAT in prison and discourages involuntary termination, but reports persist of people being forced off the program.[67] Additionally, recent studies have found that people initiating OAT within federal prison face months-long waitlists, during which people report contracting STBBIs, including HCV, from shared drug injection equipment.[68] Other reported barriers include unreliable access to doctors in prison, inconsistent OAT practices between prisons, limited access to preferred OAT types, and gaps in care in transitioning from prison to community.[69]

CSC also has a Prison Needle Exchange Program (PNEP), which offers participants access to sterile injection equipment. However, at the time of writing the PNEP only exists in 10 of 43 federal prisons, and participation remains low, due in part to the need to obtain approval from security staff to enroll, and numerous other breaches of confidentiality.[70] CSC also provides overdose prevention services (OPS), with a designated space, drug checking, and sterile equipment to consume drugs under the supervision of healthcare staff. At the time of writing, OPS exist in only three institutions, where they have limited hours, and confidentiality and punishment for drug use remain barriers to broader service uptake.[71]

At the provincial level, the discrepancies are even greater. There are no PNEP or OPS. Moreover, while most provinces now provide OAT in their institutions, many barriers continue to prevent broader uptake. For instance, most provinces and territories — including Manitoba, Nova Scotia, Ontario, Prince Edward Island, Quebec, Saskatchewan, and Yukon — do not, in practice, initiate OAT for people who were not on OAT in the community.[72] A 2018 survey of physicians in Ontario prisons described several more barriers, including insufficient nursing support, lack of resources to deliver OAT, and limited links to community healthcare providers.[73] A 2021 study of OAT in Ontario prisons confirmed that many physicians working in that setting are not prescribing OAT, and only a minority are initiating OAT in prison.[74]

Enabling Policies: Throughout the country, several jurisdictions have developed and implemented policies that are removing barriers to the right to health for people in prison:

- As of 2013, British Columbia's *Health Care Services Manual* provides for voluntary STBBI testing upon entry and during incarceration.[75] Pre- and post-test counselling is provided to those who request HCV testing. The manual also confirms that an educational program on hepatitis is provided to correctional staff and people who are incarcerated, with information on HCV prevention.[76]
- In 2020, Saskatchewan developed *Health Care Standards* that explain that people in prison must have access to healthcare services in the community, and that healthcare is delivered in partnership with the community. The *Health Care Standards* also clarify that care for "infectious or communicable diseases" will be carried out in accordance with Saskatchwan's public health legislation, thus bringing care into conformity with the province's public healthcare system.[77]

PROMISING PRACTICES

In British Columbia, Correctional Health Services and the BC Centre for Disease Control worked together to develop a program for universal STBBI testing, and linkage to care, with input from people who have experienced prison and who have had HCV. The program was rolled out to the province's prisons throughout 2022, increasing access to HCV care.

In federal institutions, universal, opt-out HCV testing is conducted upon admission, with participation rates of 80% to 90%. For those who test positive for chronic HCV, DAA prescriptions are available, regardless of disease stage.

Sources: Action Hepatitis Canada, *2023 Report: Progress Toward Viral Hepatitis Elimination in Canada,* May 2023, available at www.actionhepatitiscanada.ca/progressreport.html; Ontario Hepatitis C Planning Group, Advisory Committee and Working Groups, *The Ontario Hepatitis C Elimination Roadmap,* 2023, available at https://on.endhepc.ca/about.

(3) INDIGENOUS PEOPLE

Historic and present-day colonialism, and the resulting stigma and discrimination, have significantly affected the health of Indigenous people in Canada, including First Nations, Inuit, and Métis communities.[78] This is reflected in the disproportionate impact of HCV on Indigenous people in Canada, as well as their overrepresentation among people who use drugs and people in prison.[79] Evidence suggests that not only are Indigenous people five times more likely to have HCV than the general population,[80] but they are less likely to access treatment.[81]

Right to Health: Canada has committed itself to protect and respect the right to health of Indigenous people, and to work with Indigenous people to improve health outcomes.

In 2021, Canada enacted the *United Nations Declaration on the Rights of Indigenous Peoples Act (Indigenous Rights Act),* incorporating into Canadian law the promises of the international declaration of the same name.[82] Under the *Indigenous Rights Act,* the Government of Canada must protect the right of Indigenous people to improve their economic and social conditions, including health, without discrimination;[83] to be actively involved in developing and determining health programs that affect them;[84] to have their traditional medicines and maintain their health practices;[85] and to enjoy the highest attainable standard of health.[86]

The *Indigenous Rights Act* also draws on the Truth and Reconciliation Commission's *Calls to Action,* which themselves affirm the right to health.[87] For instance, Call to Action 19 requires the government to work towards closing the health gaps between Indigenous and non-Indigenous communities.[88] Similarly, the National Inquiry into Missing and Murdered Indigenous Women and Girls, Call for Justice 3.1 directs the government "to ensure the rights to health and wellness of Indigenous Peoples, and specifically of Indigenous women, girls, and 2SLGPTQQIA people, are recognized and protected on an equitable basis."[89]

Barriers: The ongoing impacts of colonialism have created broad barriers to Indigenous people's enjoyment of the right to health.

First, as noted by the Special Rapporteur on the right to health, the division of authority over healthcare in Canada has created "severe barriers for Indigenous peoples' access to healthcare."[90] While the federal Non-Insured Health Benefits (NIHB) program provides some First Nations and Inuit people with health benefits, including medical transportation to access medically required health services not available on reserve or in their community, as well as medications that are not otherwise covered through social programs, private insurance plans, and provincial or territorial health insurance,[91] many are excluded from the NIHB, including Métis people. Those excluded must rely on provincial health systems to access treatment, which are often not responsive to linguistic, cultural, or geographic needs.

Geography poses another important barrier. For instance, Inuit communities are geographically isolated in the north of the country,[92] where there are fewer health services and health professionals, meaning that travel is often necessary for people to access healthcare, including testing and treatment.[93] Consequently, Inuit people must be away from their communities for extended periods of time and incur significant costs, including travel and accommodation costs, to access healthcare. Similarly, many First Nations people living in remote areas have limited access to healthcare. In 2016, in Ontario (which has the highest number of remote First Nations communities in Canada), one in four First Nations communities were only accessible year-round by plane, or by ice road in the winter.[94] For many First Nations living on reserve, lack of available healthcare staff, long wait lists, and prohibitive travel costs pose significant barriers to accessing healthcare.[95,96]

> **Even where healthcare is available, inadequate access to linguistically or culturally appropriate services pose barriers to access.[97]**

There are few Indigenous-led healthcare options or culturally safe and responsive options, and Indigenous people often face widespread racism and discrimination when seeking healthcare,[98] including experiences of coerced sterilization and neglect in emergency departments.[99] Indeed, between 2017 and 2020, 20.3% of First Nations living off reserve, 17.9% of Métis and 56.5% of Inuit surveyed across Canada reported being without a regular healthcare provider — a significantly higher proportion compared to the non-Indigenous population.[100]

Enabling Policy: Several provinces have implemented legislation to improve access to healthcare for Indigenous people, by recognizing Indigenous people's authority over their own health:[101]

- Under Ontario's *Connecting Care Act,* Ontario Health must engage with Indigenous communities to establish an Indigenous Health Planning Entity. The entity is meant to ensure that healthcare planning is done "in a manner that recognizes the role of Indigenous peoples in the planning and delivery of health services in their communities."[102] Similarly, under Ontario's *Ministry of Health and Long-Term Care Act,* the Ministry must establish an Indigenous Health Council to advise on issues related to health and service delivery for Indigenous people.[103]
- Under Yukon's *Health Act,* the government must collaborate with Indigenous people to inform planning, implementation, and evaluation of healthcare in the territory. Under Yukon's *Hospital Act,* a First Nations Health Committee must oversee First Nations Health services provided at hospitals, and a First Nations Employment Equity and Training Policy and policy implementation plan must be developed, which must focus on improving the quality of healthcare for First Nations and on their representation in its delivery.

PROMISING PRACTICES

The Sioux Lookout First Nation Health Authority (SLFNHA), directed by First Nations leadership, meets the needs of 33 remote First Nations communities in Northwest Ontario. SLFNHA operates a mobile primary healthcare service, which includes HCV prevention, testing, and treatment. As part of the program, SLFNHA distributes harm reduction equipment and overdose prevention training.

In Saskatchewan, Sturgeon Lake First Nation developed a wholistic community health model, bringing together traditional Cree wellness practices and guided by Community Elders and Knowledge holders. As noted by CATIE, "[the model] is the basis for over 40 culturally based, in-language programs at the health centre, including wraparound [HCV] care."

In British Columbia, the Cedar Project Hepatitis C Blanket Program helps Indigenous individuals navigate the provincial healthcare system, from HCV diagnosis to treatment, culminating in a blanket ceremony. The program works against discrimination in healthcare by providing wraparound services guided by principles of Indigenous wellness and including support from Elders.

Source: Sioux Lookout First Nations Health Authority, *What is SLFNHA?*, available at www.slfnha.com/about; CATIE, *Indigenous-centred Approaches to Harm Reduction and Hepatitis C Programs,* 2020, available at www.catie.ca/indigenous-centred-approaches-to-harm-reduction-and-hepatitis-c-programs.

(4) GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN

Gay, bisexual, and other men who have sex with men have historically not been a priority population. However, since 2000 the incidence and prevalence of HCV among GBMSM has increased dramatically. Some GBMSM engage in chemsex,[104] which increases risk of HCV (among other STIs), and sexual transmission of HCV is now well documented among the population, particularly among those living with HIV.[105] An estimated 5% of GBMSM in Canada have, or have ever had, HCV.[106]

The Right to Health: Canada has long recognized that the right to health exists, regardless of sexual orientation. The denial of healthcare on the basis of sexual orientation is discriminatory.

Since 1996, Canada has specifically prohibited discrimination based on sexual orientation, through an amendment to the *Canadian Human Rights Act.*[107] Today, that discrimination is also prohibited under the *Charter* and human rights legislation.[108]

International and regional human rights treaties also prohibit discrimination on the basis of sexual orientation, including with respect to access to healthcare. In 1992, for instance, the United Nations Human Rights Committee held that sexual orientation was a status protected from discrimination under the *International Convention on Civil and Political Rights.*[109] Since then, international and regional bodies have reiterated that sexual orientation is a protected ground.[110] Recently, in 2022, the United Nations Independent Expert on sexual orientation and gender identity (the Independent Expert) spoke to the ongoing "abuse at the hands of health system providers, and denial of essential healthcare and services," and their consequent "increased vulnerability to diseases such as HIV/AIDS due to exclusionary health prevention and education programs."[111] The Independent Expert thus called on governments "to lift discriminatory barriers preventing access to health by disadvantaged communities, and to put in place legal, policy and budgetary measures to progressively realize the right to health for all."[112] The Independent Expert further urged governments to put in place non-discrimination guarantees and strategies, including training and sensitization.[113]

Barriers: Despite Canada's commitment to promote and protect 2SLGBTQ+ rights, the community continues to face important barriers to accessing healthcare.

GBMSM face stigmatizing and discriminatory experiences, which contribute to poorer health outcomes, including outcomes related to drug use and sex that increase their risk of HCV exposure.[114] These risk factors are often overlooked by healthcare providers.[115] Moreover, homophobia, lack of visibility, and lack of cultural competency within healthcare systems further compromise the health of GBMSM.[116] For instance, healthcare providers have been known to refuse or delay healthcare for 2SLGBTQ+ individuals.[117] These barriers are compounded for Two-Spirit people who also experience colonialism, racism, and cultural insensitivity.[118]

> **Healthcare messaging for gay, bisexual, and other men who have sex with men has also historically been focused on HIV.[119]**

As a result, HIV prevention strategies that do not emphasize condoms or sterile injection equipment are unintentionally impeding HCV prevention efforts. HCV messaging also emphasizes transmission through injection drug use, and not sexual intercourse, which neglects the manner of transmission in which GBMSM are disproportionately affected.[120]

Enabling Policies: Federal and provincial governments have begun to study and recognize the barriers to healthcare among 2SLGBTQ+ individuals, leading the way for more effective strategies:

- In 2019, the House of Commons Standing Committee on Health published *The Health of LGBTQIA2 Communities in Canada,*[121] detailing the barriers to healthcare faced by 2SLGBTQ+ people in Canada, and strategies to reduce those barriers. The Standing Committee recommended that all levels of government work together to better train and educate healthcare professionals on the health needs of sexual minorities.[122] The Standing Committee also recommended that the federal government establish an advisory committee to support efforts to implement 2SLGBTQ+ community-specific measures in the *Canadian Drugs and Substances Strategy.*[123]
- In 2023, Manitoba published *Communicable Disease Management Protocol: Hepatitis C* in which it acknowledges that GBMSM face a disproportionate HCV burden and confirms that HCV may be transmitted through sexual intercourse.[124]

PROMISING PRACTICE

Action Canada for Sexual Health and Rights is a national organization that promotes rights related to sexuality and reproduction and provides education on STBBIs, including sexually transmitted HCV. The organization also has a directory of healthcare providers that are culturally competent and offer HCV testing and treatment.

Sources: Action Canada for Sexual Health & Rights, *Resources,* available at www.actioncanadashr.org/resources.

(5) MIGRANTS FROM COUNTRIES WITH HIGH HEPATITIS C PREVALENCE

In Canada, migrants face a disproportionate risk of HCV — most often acquiring HCV before coming to Canada through medical procedures.[125] About 2% of migrants in Canada are living with HCV, compared to 1% among the general population.[126] Migrants in Canada are more likely to experience delayed HCV testing and treatment, due to limited HCV screening programs for newcomers, lack of awareness in the healthcare sector that some migrants are at an increased risk of HCV, as well as barriers among migrants related to language and culture, lack of knowledge about the healthcare system, and experiences of discrimination.[127] Migrants are thus more likely to experience severe negative health outcomes related to HCV, including death, compared to Canadian-born individuals living with HCV.[128]

The Right to Health: In international human rights law, all people are entitled to the right to health, regardless of their immigration status.[129] In Canada, even though all people, including those who do not have Canadian citizenship, are protected by *Charter* guarantees to the rights to life, liberty, and security of the person, the right to be free from discrimination,[130] and the right to be free from "cruel and unusual treatment,"[131] the right to health is often restricted based on immigration status.

Specifically, access to healthcare is only guaranteed for migrants who qualify for the Interim Federal Health Program (IFHP), which provides "limited temporary coverage of health benefits" to some asylum seekers, who have not yet become eligible for provincial or territorial health insurance.[132]

IFHP coverage includes basic health services, vaccinations, and prescription drug coverage, including HCV treatment. Those who do not qualify for IFHP, who are in Canada on work, study, or visitor visas, must wait to become eligible for provincial and territorial health insurance, which in most cases takes 90 days of residency. Often visas will expire before people become eligible for that public healthcare.[133] Those who are in Canada without status are entirely restricted from federal or provincial and territorial healthcare plans.

In 2019, the Special Rapporteur on the right to health raised concerns around the treatment of migrants and noted a case before the UN Human Rights Committee, in which Canada was found to have violated the right to life, under Article 6 of the *International Covenant on Civil and Political Rights* of an individual in Canada without immigration status by denying them IFHP coverage.[134] The Special Rapporteur concluded that the IFHP should be provided without discrimination, noting that, "At the very minimum, Canada should ensure public healthcare to all migrants in cases of infectious diseases, including access to screening, diagnosis, treatment and follow-up."[135]

Barriers: Migrants face multiple, significant barriers accessing healthcare in Canada, even when they are covered by IFHP or by provincial or territorial health plans. The narrow accessibility of IFHP means that many migrants in Canada do not have healthcare coverage, or HCV treatment coverage, and must rely on insurance provided through educational institutions, employers, or private insurers. If they do not have access to those insurance plans, they must pay out of pocket. For newcomers, particularly those who are unemployed or in precarious or vulnerable employment, the cost of healthcare is prohibitively expensive.[136] People without status may be further barred by a fear of being exposed by healthcare providers to immigration authorities.[137]

Additionally, healthcare providers are not universally prepared to work with newcomers. Some healthcare service providers refuse to see people who are covered under IFHP; others refuse, or are unable, to work with migrants due to linguistic or cultural differences, which lead to poor communication and thus low quality of care.[138]

There is also a lack of accessible information about healthcare in Canada. Information is not adequately translated for migrants, given different linguistic and cultural contexts. A study from Quebec found that it took migrants an average of 10 years following their arrival in Canada to be diagnosed with HCV, and that migrants were more likely to be diagnosed with HCV at an older age, compared to Canadian-born individuals.[139] Routine screening programs for migrants before or after arrival, which may address some of these difficulties, do not exist.[140]

PROMISING PRACTICE

The Canadian Collaboration for Immigrant and Refugee Health (CCIRH) represents a community of newcomers and health practitioners and research in Canada. They provide an online tool to guide healthcare providers working with migrant populations, with information about region- and country-of-origin-specific screening and testing needs. CCIRH recommends screening for migrants originating from countries with an HCV prevalence above 3%.

Sources: Canadian Collaboration for Immigrant and Refugee Health, *Who Are We?,* available at https://ccirhken.ca/ccirh_main/sample-page/page1-2; Canadian Collaboration for Immigrant and Refugee Health, *1 e-clinical Checklist for New immigrants and Refugees,* available at https://ccirhken.ca/ccirh_main/sample-page/page3-2/1-e-clinical-checklist-for-new-immigrants-and-refugees.

Towards Care

HCV elimination will only be possible when priority populations are able to enjoy their right to health. The current barriers to the enjoyment of their rights exacerbate harm, violate international human rights law, and maintain HCV as the most burdensome transmissible illness. In addition to raising awareness and addressing stigma more broadly around HCV, the following recommendations are a first step in reducing HCV rates, by removing healthcare barriers and bringing Canada in line with human rights law:

PEOPLE WHO USE DRUGS:

- The federal government must decriminalize the simple possession of all drugs, as well as "necessity trafficking," wherein individuals incur criminal liability for selling and sharing drugs for subsistence purposes, to support the cost of their own personal drug use, or to provide a safer drug supply.
- All levels of government must fund and scale up key harm reduction interventions, including needle and syringe distribution programs, supervised consumption services, OAT, access to naloxone, condoms, and other safer sex supplies.
- All levels of government must develop and establish policies, with the input of people who use drugs, establishing low-barrier rapid HCV testing, diagnosis, and treatment, emphasizing overcoming discrimination on the basis of drug use or history of HCV.

PEOPLE IN PRISONS:

- All levels of government must ensure that healthcare in prison is the responsibility of provincial or territorial ministries of health, rather than ministries of public safety or justice.
- All levels of government must develop and implement policies establishing routine, universal, voluntary, rapid HCV testing, diagnosis, and treatment in all prisons, with mechanisms in place to ensure care following transfers between institutions and to community.
- All levels of government must implement or scale up key harm reduction interventions in prisons, including needle and syringe distribution programs, supervised consumption services, condoms, and other safer sex supplies, OAT, and sterile tattooing equipment.
- All levels of government must ensure trauma-informed, culturally sensitive, and appropriate care for Indigenous people in prison, as well as dedicated 2SLGBTQ+ services, with input from affected people in prison.

INDIGENOUS PEOPLE:

- All levels of governments must fund and support Indigenous-led healthcare, and work with Indigenous communities to transfer healthcare authority to Indigenous people, prioritizing the involvement of Indigenous Elders, healers, and community members.
- All levels of government must ensure that all Indigenous people are included in publicly funded healthcare programs.
- All levels of government must develop and establish policies, with input from Indigenous people, establishing low-barrier, culturally safe, rapid HCV testing, diagnosis, and treatment, with an emphasis on addressing anti-Indigenous stigma and discrimination in healthcare.

GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN:

- All levels of government must develop and implement policies to raise awareness of HCV as an issue among GBMSM, with input from GBMSM and based on research regarding the health of 2SLGTBQ+ people, including in relation to chemsex and other drug use.
- All levels of government must develop and implement policies to improve the cultural competency of healthcare and other service providers to treat sexual minorities, and support and expand health and harm reduction services for 2SLGTBQ+ people.
- All levels of government must incorporate issues faced by sexual minorities in their drug strategies and incorporate HCV into their sexual health and HIV strategies and programming, clearly stating the risks of sexual transmission.

MIGRANTS FROM COUNTRIES WITH HIGH HEPATITIS C PREVALENCE:

- The federal government must establish universal, voluntary, opt-out STBBI screening, testing, and treatment programs for migrants, immediately following their arrival in Canada. Screening, testing, and treatment must be separate and independent from the immigration application process. The federal government must also eliminate provisions in immigration legislation that deny entry or stay in Canada based on medical conditions.
- The federal government must amend the eligibility provision of the IFHP so that all migrants in Canada can access publicly funded healthcare, regardless of their immigration status.
- All levels of government must develop and implement policies to improve the competency of healthcare professionals in treating migrants, including improving cultural and linguistic sensitivity and improving knowledge about HCV as a particular risk for migrants from certain countries.

> Until and unless these recommendations are fully implemented and the fundamental rights of priority populations are meaningfully protected, we will continue to see new and needless HCV cases. We can, and must, change the current trajectory.

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[103] *Hospital Act,* RSY 2002, schedule 2, s. 1.

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[106] Public Health Agency of Canada, "M-Track: Enhanced Surveillance of HIV, Sexually Transmitted and Blood Borne Infections, and Associated Risk Behaviours among Men Who Have Sex with Men in Canada, Phase 1 report," *Public Health Agency of Canada,* 2011, available at https://publications.gc.ca/site/eng/413927/publication.html.

[107] See, e.g., Government of Canada, *Rights of LGBTI persons,* 2023, available at www.canada.ca/en/canadian-heritage/services/rights-lgbti-persons.html.

[108] See, e.g., *Egan v Canada*, [1995] 2 SCR 513, in which the Supreme Court of Canada held that "sexual orientation" is a ground on which a claim of discrimination may be based; *Vriend v Alberta*, [1998] 1 SCR 493, in which the Supreme Court of Canada held that provincial human rights legislation that left out "sexual orientation" as a ground of discrimination violated s. 15(1) of the *Charter*.

[109] *Toonen v Australia* (1994), United Nations Human Rights Committee, CCPR/C/50/D/488/1992.

[110] See, e.g., *Young v Australia* (2003), United Nations Human Rights Committee, CCPR/C78/D/941/2000; *General Comment No 14: The Right to the Highest Attainable Standard of Health*, United Nations on Economic, Social and Cultural Rights, August 2000, E/C/12/2000/4; *Commission on Human Rights Resolution 2002/36: Extrajudicial, summary, or arbitrary executions*, United Nations Human Rights Committee, April 2002, E/CN.4/RES/2002/36.

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[114] D. Comeau et al., "Review of 2SLGBTQIA+ inequities in the Canadian health care system," *Front Public Health* 11 (2023).

[115] D. Comeau, *ibid*.

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[117] D. Comeau, *supra* note 114.

[118] H. Yu, *supra* note 116. See also, R Higgins et al., "Programs and interventions promoting healthy equity in LGBTQ2+ populations in Canada through action on social determinants of health," *HPCDP* 41(12) (2021).

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[121] House of Commons, *supra* note 116.

[122] House of Commons, *supra* note 116, recommendation 5.

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[124] Government of Manitoba, *Communicable Disease Management Protocol: Hepatitis C,* 2023, available at www.gov.mb.ca/health/publichealth/cdc/protocol/hepc.pdf.

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[128] C. Greenaway, *ibid*.

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[133] D. Jones, *supra* note 12.

[134] *Visit to Canada* 2019, *supra* note 10, at para. 24.

[135] *Visit to Canada* 2019, *supra* note 10, at para. 87.

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[137] *Fact Sheet No 31*, *supra* note 129.

[138] See, e.g., *Fact Sheet No 31*, *supra* note 129; Canadian Network on Hepatitis C, *supra* note 2; see also, M. Pandey et al., “Identifying Barriers to Healthcare Access for New Immigrants: A Qualitative Study in Regina, Saskatchewan, Canada,” *J Immigr Minor Health* 24(1) (2022): 188-198. C. Greenaway, *supra* note 127; see also, T. Turin et al., “Perceived barriers and primary care access experiences among immigrant Bangladeshi men in Canada,” *Family Medicine and Community Health* 8 (2020).

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[140] C. Greenaway, *supra* note 127.

HIV LEGAL NETWORK
RÉSEAU JURIDIQUE VIH

1240 Bay St. Suite 600, Toronto, ON M5R 2A7
Phone: +1 416-595-1666

hivlegalnetwork.ca