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Visit to Chile

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng*

Summary

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, visited Chile from 21 November to 4 December 2024.

The Special Rapporteur was encouraged by progress made in terms of access to health since the return to democracy in 1990 and by the Government's goal of providing universal healthcare to all. She noted good practices, including public primary care centres and intercultural health initiatives.

In the light of the bifurcated private and public health system, she remains concerned about unequal access, especially how it affects marginalized groups, including Indigenous Peoples and persons deprived of their liberty, and the lengthy waiting times in the public health system.

The Special Rapporteur recommends that the Government bolster its public health system, including through adequate budgetary and human resources, including additional doctors and health and care workers. The challenges related to mental health are immense, and she recommends that Chile increase the number of specialists in the country, particularly for children, and ensure access in all regions.

Regarding sexual and reproductive rights, the Special Rapporteur noted legal and practical barriers to accessing abortion and recommends that Chile adopt legislation ensuring access to safe and legal abortion in the country.

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

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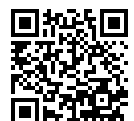

Annex

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, on her visit to Chile

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, visited Chile from 21 November to 4 December 2024 at the invitation of the Government.

2. She visited Santiago, Osorno, Temuco, Makewe, Quintero-Puchuncaví and Valparaíso. She met with the Minister for Women and Gender Equality; the Minister of Justice and Human Rights; members of the National Congress; officials of the ministries of health, social development and family, education, and foreign affairs; representatives of the Office of the Minister and Secretary-General of the Office of the President and of the National Migration Service; and regional and local officials.

3. The Special Rapporteur met with representatives of international organizations and national human rights mechanisms, including the National Institute of Human Rights, the Committee for the Prevention of Torture and the Office of the Children's Ombudsman. She also met with prison administrators, members of the Prison Service (Gendarmería de Chile) and women deprived of their liberty, as well as with directors of hospitals and primary care centres, doctors, nurses, midwives and other health and care workers.

4. She met with members of the Mapuche Indigenous communities, including traditional Indigenous healers (*machis*). She also met with a broad range of civil society representatives and with women, migrants, older persons, persons with disabilities, women of African descent, Chilean-Palestinians, LGBTIQA+ persons, victims and survivors of the dictatorship and of the repression during the 2019 protests, and persons whose rights have been affected by the degradation of the environment.

5. The Special Rapporteur wishes to reiterate her gratitude to the Government of Chile for inviting her to assess, in a spirit of cooperation, the realization of the right to health in the country. She thanks the authorities for their critical support in the preparation and undertaking of the visit, their openness to engage in constructive discussions and their willingness to make necessary changes. She reiterates her appreciation to the Resident Coordinator and the Regional Office for South America of the Office of the United Nations High Commissioner for Human Rights for the exceptional support they provided before, during and after the visit. She thanks the Mapuche people for their welcome. She expresses her gratitude to all who took the time to meet with her and share their personal stories and cosmovision, which helped her to better understand the historical context, current realities and challenges related to the availability, accessibility, acceptability and quality of healthcare services in Chile, as well as the underlying determinants of health.

6. The Special Rapporteur assessed access to health in Chile through the framework of the availability, acceptability, accessibility and quality of healthcare. As with all her work, the Special Rapporteur used an anti-colonial and anti-racist framework to analyse the challenges. She employed an inclusive approach, focusing on the underlying socioeconomic, political, legal and commercial determinants of health, marginalized and criminalized groups, and populations that are often discriminated against and made invisible.

II. Legal and institutional framework

7. The right to health is an inclusive right that extends not only to timely and appropriate healthcare but also to the underlying determinants of health, including access to potable water, sanitation, food, housing, a healthy environment and workplace, education and public health-related information, including on sexual and reproductive health. The participation of

the population in health-related decision-making at the community, national and international levels is an important aspect of the enjoyment of the right to health.

8. Chile is a State Party to all of the core international human rights treaties, notably those guaranteeing the right to health, including the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities. While it ratified the keystone International Covenant on Economic, Social and Cultural Rights in 1972, it has signed, but not ratified, the Optional Protocol thereto, meaning that it has not accepted its communications and inquiry procedures.

9. Chile ratified the American Convention on Human Rights in 1990 and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights in 2022.

10. Under article 5 of the Constitution of Chile, international legal obligations are incorporated into national law.

11. States' obligations to ensure the full realization of the right to health include providing sufficient recognition of the right to health in their national political and legal systems, preferably by way of legislative implementation, and adopting a national health policy with a detailed plan for realizing the right to health.

12. The right to health in and of itself is not enshrined in the Constitution of Chile. Article 19 (9) of the Constitution provides that everyone has the right to choose the health system, be it public or private, of which they wish to avail themselves.[1] The article therefore does not specifically guarantee the right to health but rather the right to choose one's health system. Furthermore, the Special Rapporteur was told, and herself observed, that this was not a genuine choice, as the private health system was only available to those who could afford it, leaving the majority of the population in the public system by default. She underscores that, for people in Chile to be able to enjoy the highest attainable standard of physical and mental health, the Constitution must be brought into line with the international human rights obligations of Chile and must guarantee the full breadth of the right to health.

13. The entity primarily responsible for managing the overall healthcare system of Chile is the Ministry of Health. The Special Rapporteur's visit occurred during commemorations of the 100th anniversary of the establishment of the Ministry of Health in its current form. The Ministry is involved in the implementation of health-related laws, policymaking and the delivery of healthcare services across the country. The principal national legislation governing health in Chile is the Health Code (Act No. 725/1968) and its implementing regulations, as well as other laws relating to specific elements of health. Matters relating to public health and well-being fall within the purview of the Ministry of Health. However, basic healthcare services for persons deprived of their liberty are provided by the Prison Service (Gendarmería), which is part of the Ministry of Justice and Human Rights. Other laws related to health fall within the purview of other ministries; for example, health education is the responsibility of the Ministry of Education. The Special Rapporteur observed a need for increased coordination among ministries on issues related to health, especially, but not limited to, access to healthcare in prisons.

14. Chile has formalized its obligations relating to non-discrimination in the delivery of healthcare in national law through Act No. 20.584 of 2012, by which it confirms the right of all to have access to healthcare in a non-discriminatory manner. However, the Special Rapporteur observed a worrying lack of progress on various bills related to the right to health, particularly women's health, such as a comprehensive bill on women's reproductive health, known as Adriana's Law (Bulletin No. 12148-11), and a bill on establishing liability for defective contraceptives (Bulletin No. 14094-11). Similarly, there has been retrogression in positive initiatives, such as the "Grow with Pride" (Crece con Orgullo) programme on the health of transgender adolescents.

[1] "*Cada persona tendrá el derecho a elegir el sistema de salud al que desee acogerse, sea éste estatal o privado*."

III. Availability, accessibility, acceptability and quality of the healthcare system

15. The right to health contains interrelated and essential elements, namely the availability, accessibility, acceptability and quality of healthcare. It also contains freedoms such as the right to control one's health, including the right to freedom from non-consensual medical treatment, and entitlements such as the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable standard of health. In its general comment No. 14 (2000), the Committee on Economic, Social and Cultural Rights defines the obligations that States Parties to the International Covenant on Economic, Social and Cultural Rights must fulfil in order to implement the right to health at the national level, including certain minimum core obligations that are of immediate effect.

16. The right to health also encompasses the underlying determinants of health, including access to potable water, adequate and safe food and nutrition, housing and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. These underlying determinants of health are also interconnected with other rights, including the rights to work, education, housing, information, freedom, security of person, a healthy environment, equality and non-discrimination, and bodily autonomy.

17. The Special Rapporteur is concerned that human rights, including the right to health, do not seem to be well regarded or understood in the country. She was repeatedly told that human rights were seen as something belonging politically to the left and related to discussions about the dictatorship.

A. Health system: universal health coverage

18. Chile has made strides in the provision of healthcare and towards the admirable goal of providing universal healthcare to all. There has been progress in the public sector, including with regard to access to health, since the return to democracy in 1990. However, for many, the goal of the availability, acceptability, accessibility and quality of healthcare has not yet been achieved. A principal reason for this is the bifurcated public and private health system in Chile.

19. The national public healthcare system is publicly funded through the National Health Fund and serves 82 per cent of the population in public hospitals and primary health centres, known as family health centres. There is a parallel private healthcare system comprised of private insurers and healthcare providers, including private clinics and hospitals. The private system serves about 18 per cent of the population, who are covered by private health insurers, known as private health insurance institutions. While significantly stronger than in many countries, the public system still has challenges, such as long waiting times, overcrowding and a lack of adequate access to specialized care in certain regions. Those who can afford it often go to the private system with its faster and more specialized care.

20. Long waiting times was a recurrent theme throughout the visit. The Special Rapporteur was told that over 2.5 million people are currently estimated to be waiting for diagnosis, tests and treatment in the public system. There is an urgent need for the public health system to be strengthened to ensure equal access to health for all people in Chile, regardless of geography or economic background.

21. The challenges in realizing the highest attainable standard of physical and mental health are acute for those in vulnerable situations, including Indigenous persons, migrants, refugees and those with intersecting risk factors, such as poverty, disability, age, xenophobia, health status, gender, gender identity and expression, and sexual orientation. Women requiring abortions, persons deprived of their liberty or living in residential institutions, and persons living outside the capital area, particularly in rural areas, also face acute challenges.

22. In the public system, the number of physicians per inhabitant is now below the level recommended by the Organisation for Economic Co-operation and Development (OECD). Furthermore, due to the geography and centralized nature of the country, there are regional

inequalities in access to healthcare. The Special Rapporteur heard that there were regional inequalities in access to specialized treatment outside the central zone, particularly with regard to specialists, such as psychiatrists, especially child psychiatrists.

23. The Special Rapporteur visited a primary care centre and four hospitals in four regions, including the largest public hospital offering emergency care in Santiago; the hospital, known as La Posta, is the main trauma referral hospital in Chile. Infrastructures visited ranged from brand new buildings at the family health centre in Quintero to La Posta's modern infrastructure and its original structures, dating back to the 1960s and still in use. The newly built family health centre in Quintero is a model for good practice; it demonstrated institutionalized, interministerial, multi-stakeholder, all-of-society coordination, as well as upscaling and a healthy work environment for the workers serving this community. Family health centres operate as critical primary care facilities across the country and should be strengthened to lessen regional inequalities.

B. Public health system funding

24. The lack of a sufficient budget for public health is a key issue contributing to the unequal access to healthcare; in recent years, public health spending in Chile has fallen below OECD-recommended levels. The Special Rapporteur received information regarding the lack of funding earmarked for healthcare directly and for civil society organizations and institutions that are key defenders of the right to health.

25. The Special Rapporteur is concerned that the bifurcated health system leads to inequality in access to health. On several occasions she was told that there was a perception that, in Chile, "health was a business, not a right". The obligation of Chile to protect the right to health includes ensuring equal access to healthcare and health-related services provided by third parties and ensuring that third parties do not limit people's access to health-related information and services. She learned, however, that powerful groups and industry players are operating with the aim of profit-making and that they tend to function without human rights safeguards, leading to poor management of the principles of medical ethics and health economics.

26. Access to health information and the participation of the population in health-related decisions at the local level are key elements of the right to health. Robust independent national human rights mechanisms and a strong civil society are key to ensuring equality in the enjoyment of the right to health. At the time of the visit, there was serious concern regarding the budget of the National Institute of Human Rights, the human rights institution of Chile, which has been accredited with category A status by the Global Alliance of National Human Rights Institutions. While it was awarded its budget during the visit, it is important that human rights mechanisms have assured multi-year funding to enable them to carry out their role as independent guardians of human rights, which includes ensuring equal access to healthcare.

27. The Special Rapporteur was disappointed to hear that members of civil society have concerns about their funding and feel uncomfortable speaking out publicly on human rights and health-related concerns. Individuals must be enabled and supported to defend the right to health.

C. Health and care workers

28. The Special Rapporteur reiterates that health and care workers are key to a human-centred healthcare system. Ensuring that their physical and mental health remain supported is key to the delivery of acceptable, accessible, affordable and quality care.

29. The Special Rapporteur was pleased to hear about efforts made to improve healthy working conditions, such as the ratification of the International Labour Organization (ILO) Violence and Harassment Convention, 2019 (No. 190) and its implementation through the adoption of Act No. 21.643, commonly known as the Karin Law, named after a healthcare worker who died by suicide after experiencing harassment in the workplace.

30. The Special Rapporteur spoke with healthcare workers in four regions of the country. During these discussions, she heard from healthcare workers and administrators who reported overwhelming workloads, unsustainable stress levels and exposure to disrespect and violence, including from patients frustrated with waiting times. She learned about mental health strains on health and care workers, including suicidality among workers and medical students.

31. The Special Rapporteur noted the commitment of healthcare workers to patients, despite working in demanding conditions. For example, at La Posta, the main trauma hospital in Santiago, she was impressed with the dedication of the doctors she spoke with who were responsible for the emergency care of 1.5 million people in the capital region. At that hospital, she was pleased to learn of the 50:50 staff gender split in hospital management. In an internal study done by the hospital, 55 per cent of healthcare workers reported being at high risk due to their physically demanding work and 65 per cent reported facing serious emotional demands owing to their jobs. Women make up 67 per cent of healthcare workers at the hospital. A good practice observed at La Posta was a childcare facility that is open 24 hours a day, seven days a week, for hospital employees.

32. The Special Rapporteur also heard from members of civil society regarding discrimination against patients by health and care workers. While healthcare workers advised that little human rights education was included in their formal education, the Special Rapporteur was encouraged to hear that a course on human rights in medicine is being developed at the University of Santiago de Chile medical school.

IV. Structural and State violence

33. The Special Rapporteur observed the striking, lasting impact of the dictatorship on the health of the people of Chile, particularly on their mental health. She heard first-hand accounts of intergenerational trauma stemming from the dictatorship. This trauma was apparent in meetings with those who had experienced the dictatorship directly, as well as their families. During hospital visits and meetings with members of the College of Physicians, she learned about the legacy of hospitals that had been used as torture centres, where people had been disappeared, and how doctors had been among the disappeared.

34. The Special Rapporteur learned about the Compensation and Comprehensive Healthcare Programme to provide reparations to victims and survivors of human rights violations during the dictatorship. There was a strong emphasis on memorialization in the country, including the context provided by the impactful Museum of Memory and Human Rights, in Santiago. In Osorno, she visited a hospital that had been used for the questioning and torture of persons during the dictatorship. There, a mural of remembrance reads “I am here, I never left, from pain and memory, I keep the dream alive”,[2] a statement that sums up the spirit of the Chilean people, as demonstrated during the visit.

35. There is now a new generation of Chileans suffering trauma from State violence owing to excessive use of force during protests amid civil unrest in 2019. While the Plan for the Support and Care of Victims of Ocular Trauma provides compensation to those with ocular trauma sustained during the protests, the reparations provided to date to these victims have been inadequate, and programmes for other victims are needed. There is no registry of victims, and the impact on victims who lost their vision during the protests has reportedly been severe. Discussions with young victims of ocular trauma illustrated that more needed to be done to provide them with comprehensive reparation, including critical psychosocial support. Young people have comprehensive needs that should be framed within a comprehensive multisectoral response addressing the holistic needs of survivors of violence and their families, including through referrals to specialized services, financial and legal support, accountability and redress. This is particularly urgent given the number of young people affected who have since died by suicide.

[2] “*Estoy aquí, nunca me fui, desde el dolor y la memoria, mantengo el sueño vivo*.”

36. While reparation programmes exist for victims and survivors of the dictatorship and of the 2019 unrest, the population remains significantly affected by the impact of historical and recent State violence.

V. Mental health

37. Mental health was one of the primary concerns raised throughout the visit. In addition to trauma caused by the dictatorship and the repression of the 2019 protests, the issue also arose regarding the mental health of Indigenous Peoples facing the militarization of their lands; children, adolescents and those who care for them; older persons; teachers; and health and care workers. The director of one hospital said that the demand for mental healthcare had increased by 500 per cent in the past five years, including due to the coronavirus disease (COVID-19) pandemic. Healthcare workers reported an acute lack of resources for mental health treatment. There is an urgent need for an increase in the availability and quality of psychosocial mental health practitioners, specialists and community-based psychiatrists for screening, early diagnosis, treatment and follow-up to care.

38. The mental health of children and adolescents was cited as being particularly grave and had worsened since the pandemic. The Office of the Children's Ombudsman said that 115,683 children had received mental healthcare in the country in 2024 and that there were concerns about suicide rates among adolescents. Parents shared information on their advocacy efforts regarding the bill on the mental health of students (Bulletin No. 16428-04); the Special Rapporteur urges Chile to adopt this bill without delay.

39. While there is a general lack of psychiatrists in the country, it is especially true of child psychiatrists. At the San José Osorno public hospital, the Special Rapporteur was pleased to visit a new mental health unit for children and adolescents, which was set to open in early 2025 and would allow children and adolescents in need of mental healthcare to stay in their region.

VI. Women's right to health and their sexual and reproductive health rights

40. Chile has taken progressive steps related to women's right to health. It is a State Party to the Convention on the Elimination of All Forms of Discrimination against Women and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women. Women's right to a life free from violence is an important element in the realization of the right to health. The Government has taken legislative steps, including to address gender-based violence, to improve women's rights, such as by passing Act No. 21.013 of 2017 defining ill-treatment; Act No. 21.675 of 2024, on the right of women to a life free of violence, which includes the concept of gynaecological-obstetric violence; and Act No. 21.030 of 2017 decriminalizing abortion in certain cases. It has also updated various national policies on sexual and reproductive health rights in recent years; access to some services was restricted during the pandemic but has since been restored. The Special Rapporteur was pleased to hear about the national breastfeeding policy, enabling workers to take one hour in their workday to feed their babies for the first two years of life, in line with World Health Organization (WHO) recommendations to support breastfeeding.

41. The Special Rapporteur was, however, concerned by the lack of progress on various bills related to women's right to health, including a bill establishing liability for defective contraceptives (Bulletin No. 14094-11); a bill on endometriosis (Bulletin No. 14750-11), which would guarantee adequate treatment for endometriosis; and a bill amending the Labour Code to grant leave from work for painful menstruation (Bulletin No. 15933-34), thus recognizing temporary incapacity for serious menstruation-related pathologies. All of these bills have been stalled in the National Congress since early 2024. In addition, there is the lack of progress on the aforementioned Adriana's Law, a comprehensive bill rooted in dignity in treatment that provides for a comprehensive framework on women's sexual and reproductive healthcare, guarantees women's right to make medical decisions about their own bodies, ensures the provision of information and deals with gynaecological-obstetric violence and

accountability. The lack of progress made by the Senate's Health Committee towards adopting this bill is particularly concerning, given its comprehensive scope in respect of women's health rights. In that connection, the Special Rapporteur expresses concern at the practice of using peoples' names for health-related laws, as it may lead to stigmatization, and recommends that this practice be reviewed.

42. The Special Rapporteur was deeply concerned to learn that there is no comprehensive sexual education curriculum in schools. Information related to the right to health, including sexual and reproductive health, is central to that right. She urges Chile to adopt a comprehensive national curriculum on sexual and reproductive health. She reiterates her availability to provide technical support on the matter and points the State to "A Compendium on comprehensive sexuality education", which she published with other special procedure mandate holders.[3]

43. Healthcare workers at family care centres reported increased violence and alcoholism in communities and expressed serious concerns about violence against women and girls, including domestic violence. At family care centres and hospitals alike, the Special Rapporteur learned about special protocols and areas for victims of gender-based violence, including rape, and about legal reporting obligations.

44. The Special Rapporteur emphasizes that sexual health requires a positive and respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. She stresses that services, facilities and goods for sexual and reproductive health must be comprehensive.

A. Abortion

45. Every day of the visit, people who spoke with the Special Rapporteur expressed concerns regarding women's access to reproductive healthcare, particularly their lack of access to safe abortions. Bodily autonomy is a central part of the right to health. It includes the right to control and make decisions regarding one's health and body and sexual and reproductive freedoms. States have an obligation to refrain from imposing discriminatory policies and practices relating to women's health status and needs.

46. Until 2017, abortion was a crime in all cases in Chile. On 23 September 2017, Act No. 21.030 came into force, decriminalizing abortion on three grounds, namely when the woman's life is at risk, the fetus is not viable or pregnancy resulting from rape up to 12 weeks of gestation, extended to 14 weeks for girls under 14 years of age. This law, which amends article 119 of the Health Code, and its accompanying regulations, comprise the current abortion framework in the country.

47. In 2022 and 2023, there were two constitutional processes dealing with full decriminalization of abortion, but neither were passed. In June 2024, the President of Chile announced an upcoming bill on legal abortion that was to be presented in the second half of 2024. As of the end of the visit in December 2024, the bill had not yet been introduced, but the Special Rapporteur looks forward to following up on this legislative process.

48. While the Special Rapporteur commends the efforts made by the State, she remains concerned at the lack of access to safe, timely and legal abortion. She is concerned that abortion continues to be criminalized except in the above-mentioned narrow exceptions. Furthermore, Act No. 21.030 incorporates limitations on those exceptions, particularly through the institutionalization of conscientious objector status. She is extremely concerned that, notwithstanding the cases in which abortion is de jure allowed, practical barriers mean that even abortions permitted by law remain largely inaccessible in practice.

49. One barrier of particular concern is the overuse of conscientious objections. As in many countries, religious beliefs, which are individual rights, can be asserted by individuals. However, this should only be permitted if their objection does not mean denial of access

[3] Available at https://www.ohchr.org/en/documents/tools-and-resources/compendium-comprehensive-sexuality-education.

where there are no other providers willing to provide the care sought. Furthermore, in Chile, Act No. 21.030 provides for institutional conscientious objection, meaning that entire institutions may object on such grounds. Institutional objections also prevent healthcare workers from providing care if they work at an institution that has objected. The Special Rapporteur was informed of the absurd situation in which some doctors were deemed to be objectors, as their job was at an institutional objector, but those same doctors would then provide that care to privately insured individuals in other clinics, furthering inequalities in access.

50. The Special Rapporteur visited institutions where teams were reportedly conscientious objectors. While she learned that public institutions were not allowed to claim institutional conscientious objector status, it was explained that, in those cases, entire medical teams would claim individual conscientious objector status, thereby effectively rendering the institution a de facto conscientious objector. Civil society reported that more than 45 per cent of obstetricians authorized to provide abortions in the public system were registered as conscientious objectors in the case of pregnancies that are the result of rape and that, in at least five public hospitals, all the obstetricians were conscientious objectors, thereby either severely reducing or, in some cases, eliminating access to abortion for women in those areas. The Special Rapporteur also heard about how some doctors faced peer pressure by objecting colleagues to also object to providing abortions.

51. Another often-cited practical barrier concerns rural zones, including isolated areas, where access to abortion is virtually non-existent. In addition to the will of the woman, the first two grounds on which abortion is permitted require official diagnoses by medical teams, often from different specialisms. Individuals reported that, even if available, there were often delays in the process due to a lack of specialists to provide approval or the non-fulfilment of other requirements for the exception to be met. Civil society also reported that hospitals were adding extra diagnostic and time requirements that were not required by law, such as shortening the gestational age under which the third ground was permitted and creating time limits under the first ground, even though no time limit is established by law.

52. Another issue of particular concern is that of access to timely abortions for minors. Under the current system, girls under 14 whose pregnancies are the result of rape require the consent of their legal guardian. However, in cases where they do not have a legal guardian, the legal guardian refuses to consent or the perpetrator is a family member, they can seek authorization for the procedure from a judge. There are frequently delays in this process. Young girls who have been raped thus face additional obstacles, which revictimizes them and causes critical delays in their care, which may amount to denial of the procedure altogether.

53. The Special Rapporteur was concerned to hear that, although not required by law, healthcare providers sometimes report women who seek abortion services other than those allowed by law. This behaviour could have a chilling effect on those in need of medical attention, including post-abortion care for unsafe abortions to which they may have resorted; more generally, it could decrease patient-care provider trust, with broader impacts on women’s right to health. This is a form of abuse of power and it puts women and girls in a vicious cycle of conflict with the law.

54. The relevant law prohibits advertisement of the provision of abortion services, creating additional challenges to access and running contrary to the obligation of States to provide public health information in a non-discriminatory manner. The Special Rapporteur encourages the State to adopt the proposal made by the Ministry of Health, in May 2024, to amend the regulation on conscientious objection in order to strengthen the right to information in accessing healthcare and improve access to abortion services.

55. The Special Rapporteur urges the State to fully decriminalize abortion, eliminate institutional conscientious objector status, remove the need for and related barriers to girls under 14 having to obtain judicial approval for abortion in cases of rape, and eliminate all practical barriers to access, including by ensuring that use of individual conscientious objection does not impede access and that practitioners are available in all regions of the country. The lack of data collection and oversight in the implementation of Act No. 21.030 must also be urgently remedied.

56. States must provide safe, legal and effective access to abortion, should not introduce new barriers and should remove existing barriers to effective access by women and girls to safe and legal abortion. She urges the State to ratify amendments to Act No. 21.030 to ensure that at least one abortion care provider is available at every healthcare facility to fully implement this legislation. As the Government prepares the abortion bill announced by the President in 2024 (see para. 47 above), she reminds it of the need for public consultation and transparency in the drafting process. It is essential that this new legislation provide legal and workplace protections for abortion service providers. In line with recommendations made by other international human rights mechanisms, including the Committee on the Elimination of Discrimination against Women,[4] she urges Chile to immediately adopt the evidence-based WHO protocols and guidelines on medical and surgical abortions and to ensure that primary care centres and nurses and midwives are enabled to offer stigma-free services.

B. Contraception

57. The Special Rapporteur has previously engaged with Chile on the issue of defective contraceptives,[5] which can have serious consequences for women. While she learned about progress in litigation for earlier defective contraceptives, she was disappointed to hear that the issue had arisen again in 2024. Both the State and private companies must be held accountable for the impacts of defective contraception; this is particularly important in a State that does not guarantee access to safe, legal and timely abortions to all women who wish to have them. Civil society provided data indicating that more than 227 women have undergone forced maternity due to defective contraceptives that were largely provided through the public system and that this number represents only a small percentage of the total number affected. The women affected were disproportionately from lower-income backgrounds. It is particularly cruel that women in Chile could be put in a situation where they unknowingly took defective contraceptives and were then denied access to abortion in the case of an unplanned pregnancy. The Special Rapporteur notes the pending bill to establish civil liability for defective contraceptives (Bulletin No. 14094-11) and encourages the State to adopt it into law in order to provide compensation to the women affected.

C. Sterilization

58. While sterilization without consent is illegal in Chile, the Special Rapporteur heard about instances of forced sterilization. She was pleased to learn that, in May 2022, the Government had accepted responsibility in the case of *F.S. v. Chile* before the Inter-American Commission on Human Rights, which concerned an HIV-positive woman who had been forcibly sterilized in 2002. However, the Special Rapporteur was disappointed to learn that there are still isolated cases of forced sterilization, including of migrant women in the north of the country and Roma populations in public hospitals. Civil society explained that the trend in recent cases seemed to be linked to discrimination against certain ethnic groups, whereas cases in the early 2000s had largely involved discrimination against the HIV-positive population. Forced sterilization is not only discriminatory but also a serious violation of women’s right to health and bodily autonomy. It is crucial that Chile implement systemic changes to prevent any future forced sterilizations in the country.

VII. Access to health for persons deprived of their liberty

59. Healthcare in the Chilean prison system is complex, with some healthcare services depending on the Ministry of Justice and Human Rights, through the Health Department of the Prison Service (Gendarmería), and other services on the Ministry of Health. These structural elements are at the root of the unequal access to healthcare for persons deprived of their liberty in Chile; the fact that access to primary healthcare in prisons falls under the

[4] CEDAW/C/CHL/CO/8, paras. 37 and 38.

[5] See communication CHL 4/2021, available at https://spcommreports.ohchr.org/Tmsearch/TMDocuments.

purview of the Prison Service (Gendarmería), and not the Ministry of Health, creates administrative inefficiencies. This is further complicated by the fact that there are public and private prisons, as well as by the bifurcated health and insurance schemes in the country. The interplay between these structural elements creates inequality in access to healthcare for persons deprived of their liberty, including challenges in terms of quality, access and equity in access, which disproportionately affect women and Indigenous persons.

60. During a visit to the women's penitentiary in Temuco, the Special Rapporteur noted the dedication of prison administrators and was pleased to witness HIV testing in the nurses' station. At the same time, she was concerned to hear of other prisons where detainees have much less adequate access to healthcare.

61. Adequate resources for more specialized care in prisons, including for mental health and addiction treatment, is needed. The Special Rapporteur learned about overcrowding of prisons and its impact on the health of detainees, and concerns about ageing infrastructure. There were also reports of inadequate underlying determinants of health, as well as the use of prolonged solitary confinement and its impact on mental health.

62. The Special Rapporteur was informed of regular hunger strikes in prisons, particularly by Mapuche individuals. She was concerned to hear about harsh responses, poor management, including force-feeding, and reports of ill-treatment of and reprisals against these individuals, who have a right to bodily autonomy. Indigenous persons informed her about the overincarceration of the Mapuche people, including community leaders. She was extremely concerned to hear from former Mapuche prisoners, who reported witnessing the deterioration of other Indigenous detainees due to lack of access to medical care. Families of current Indigenous detainees provided further details, including a man who slept in a wheelchair for months after an injury in prison, and a woman and her children who slept in the street in order to bring medical devices to her husband, who had been transferred to a prison 200 km away from his home.

A. Women in prisons

63. Women deprived of their liberty often have intersecting vulnerabilities, including being from low-income backgrounds or having migrated to Chile. The Special Rapporteur was disappointed to hear that there was a disproportionately high number of women in pretrial detention. While 35 per cent of men deprived of their liberty are in pretrial custody, the rate for women is 47 per cent – and it is increasing.[6] Of those women who are in pretrial custody, many are there for lesser offences. Historically, many of these women were criminalized for seeking abortions; currently, more than half are imprisoned for drug offences. Many of them have been trafficked or are in other vulnerable situations.[7]

64. Given the disproportionate number of women in pretrial detention in the country, alternative sentencing should be explored, as should alternative approaches to drug policies. The Special Rapporteur was pleased to hear that a bill on alternative sentencing for women is being developed. She urges Chile to move this process forward and to take immediate measures to decrease the number of women incarcerated, particularly those in pretrial detention and pregnant women or mothers of small children.

65. The Special Rapporteur heard reports of inadequate access to sexual and reproductive healthcare in prisons. She heard of one case where a woman had a miscarriage in a prison bathroom; although she reported it immediately, she was only seen by a midwife one week later. The Ministry of Justice advised that it had established regional working groups to promote quality antenatal care in prisons.

66. The Special Rapporteur was shocked to hear about the 2016 case of a Mapuche woman who had been detained while pregnant and transferred 70 km to a hospital, where she underwent a caesarean section, all while shackled and with a guard present. The Special

[6] Data from the Ministry of Justice.

[7] Ibid.

Rapporteur urges the State to take all measures to prevent such obstetric violence from occurring in the future.

B. Mother and child units

67. In Chile, babies are allowed to remain in prison with their mothers until they reach 2 years of age, although this can be extended for several months. Mothers and babies stay in separate mother and child units for pregnant women and mothers of babies in prisons, away from the other inmates. The Special Rapporteur visited a mother and child unit in a women's prison in Temuco, where she witnessed particular care being provided to the women and babies. While these units support the essential mother–baby dyad, they also raise concerns that these children are essentially being incarcerated; care must be taken in the management of this system. One worrying example involved a child who was held in solitary confinement with her mother for more than 40 days.

68. Government programmes, such as the "Growing Together" (Creciendo Juntos), "Chile Grows More" (Chile Crece Más)[8] and Pathways (Abriendo Caminos) programmes, support these children, who are not subjects of the Prison Service (Gendarmería) and can travel outside the prisons for public day care and healthcare access. The Special Rapporteur was pleased to hear that a resolution on healthcare for these children was in progress; however, she also received information on delays in check-ups in some regions. While these efforts to maintain and support the mother-baby dyad are commendable, an important step in resolving this situation would be the use of alternative sentencing for these women, particularly those in pretrial detention or imprisoned for less serious offences.

VIII. Environmental health and business and human rights

69. During her visit, the Special Rapporteur heard about challenges to the right to health related to the environmental impact of industries and climate change. These have an impact on the right to a healthy environment and the right to health more broadly. Civil society reported a decade of water scarcity, the effects of the de facto privatization of water and diversion to development projects, and the lack of access to potable water in some rural areas and its impact on food production.

70. People expressed concerns about the impact of climate change on their lives and health. They recounted the devastation that more frequent and severe forest fires, including the record fires in the Valparaíso Region, in 2024, have had on the health of people and the environment.

71. The Special Rapporteur learned about the impact of development, including mining, on the health of local communities. She heard about, and experienced herself, worrying pollution levels and their impact on the right to health. She saw the destruction of the environment caused by extractive industries and the impact on the right to health. She visited the Quintero-Puchuncaví region, a notorious "sacrifice zone". According to the former Special Rapporteur on the human right to a clean, healthy and sustainable environment, a sacrifice zone is a place where residents suffer devastating physical and mental health consequences and human rights violations as a result of living in pollution hotspots and heavily contaminated areas.[9] The Quintero-Puchuncaví region has faced 60 years of impact from heavy metals and other pollutants, including those emitted by State-owned companies, such as copper smelters, as well as petrochemical facilities and coal-fired power plants.

72. In Quintero-Puchuncaví, the Special Rapporteur heard from people whose health has been directly affected by this industrialization. Health officials, civil society and residents reported suffering from increased rates of cardiovascular disorders and chronic respiratory, gastrointestinal and other ailments. Women reported higher rates of cervical and breast cancers and miscarriages. Health and care workers, parents and students shared testimonies of severe, wide-scale air contamination episodes in the region, in 2011 and 2018, when more

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[8] Formerly the "Chile Grows with You" (Chile Crece Contigo) programme.

[9] A/HRC/49/53, para. 27. See also A/HRC/WG.6/32/CHL/2, para. 16.

than a thousand people, including several hundred schoolchildren, had experienced health effects owing to airborne pollutants.[10] One affected student said that they had been forced to limit all their activities outside and that the local healthcare system had "collapsed". Many spoke of the resulting impact on their mental health. While coughing, others spoke of chronic lung issues, which have disproportionately affected children and older persons. One person, speaking through tears, said that they "were just working on living". The Special Rapporteur was profoundly disappointed by the systemic failures to prevent harm from or provide timely redress for the impact of these industries on health in the region. She urges the Government to take urgent action to prevent future damage, including by implementing WHO environmental standards and the Guiding Principles on Business and Human Rights.

73. As a Mapuche man in La Araucanía stated during the visit: "When we sacrifice the environment, we sacrifice ourselves." When the environment is sacrificed in the name of profiteering, human dignity suffers the most. The continued environmental impact of big business and lack of accountability results from ineffective regulation by States and impunity for corporations, such as mining and other polluting industries. The Special Rapporteur urges Chile to take resolute action going forward on the social determinants of health and on right-to-health protections and to hold big business accountable for its impact on a healthy environment. No natural area, nor its population, should be a sacrifice zone.

IX. Specific population groups

74. States have an obligation to provide access to health in a non-discriminatory way, both in law and in practice. Articles 2 (2) and 3 of the International Covenant on Economic, Social and Cultural Rights prohibit any discrimination in access to healthcare and the underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability, health status, sexual orientation, and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[11]

75. During the Special Rapporteur's visit, individuals – particularly women, Indigenous persons, migrants, older persons, persons with disabilities and persons deprived of their liberty – reported the discriminatory treatment and access they faced with regard to their right to health, including while seeking medical attention.

A. Children and adolescents

76. The Special Rapporteur was pleased to learn of the various social programmes in Chile for children, including "Chile Grows More" (Chile Crece Más) for children from 0 to 9 years old and its progress in decreasing child mortality rates. However, she is concerned at the reported levels of mental health challenges faced by children and adolescents, as well as the lack of child psychiatrists. The Special Rapporteur also learned of ongoing concerns regarding children in State custody and regrets the apparent lack of significant progress made since the inquiry procedure launched by the Committee on the Rights of the Child under article 13 of the Optional Protocol to the Convention on the Rights of the Child on a communications procedure, in 2018.[12] In the area of child nutritional health, the State has taken positive measures, such as the adoption of the Food Labelling Act (Act No. 20.060) and its "Choose a Healthy Life" programme. However nutritional maps demonstrate that there has been a 35 per cent increase in malnutrition due to excess weight in secondary school in recent years.[13]

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[10] See Supreme Court of Chile, *Francisco Chahuán v. Empresa Nacional de Petróleos, ENAP S.A.*, Case No. 5888-2019, Judgment, 28 May 2019.

[11] Committee on Economic, Social and Cultural Rights, general comment No.14 (2000), para. 18.

[12] See CRC/C/CHL/IR/1 and CRC/C/CHL/IR/1/Corr.1. See also CRC/C/CHL/CO/6-7, paras. 24 and 25.

[13] Information from the Office of the Children's Ombudsman, National School Support and Scholarships Board nutritional map (2009–2023 rates).

B. LGBTIQA+ persons

77. The Special Rapporteur was pleased to learn about the Government's "Grow with Pride" (Crece con Orgullo) programme, which supports transgender children and adolescents, including through psychosocial support. However, the day before her official visit began, news emerged that there was a parliamentary motion to reduce the budget for hormonal therapy for transgender adolescents. The Special Rapporteur understands that the budget has since been secured. As a medical doctor, she reiterates the serious negative impacts that any interruption of these therapies would have on the physical and mental health of these children and urges the State to ensure that there is a secure budget for these programmes. She was pleased to learn about joint efforts between the College of Physicians and the Ministry of Health to draw up guidelines on hormonal therapy for adolescents.

C. Persons with disabilities

78. One issue that arose during the visit was the lack of adequate provision of communication tools for persons with disabilities in public institutions. One deaf woman explained how the lack of sign language interpreters in hospitals created barriers to accessing healthcare, often at the expense of the privacy rights of persons with disabilities or leading to their children being exposed to information, such as news of bereavement or terminal diagnosis, being relayed to their parents. Act No. 21.331 prohibits sterilization without consent; and yet, the Special Rapporteur heard information about interference in decision-making, including by families of women with disabilities, including with regard to women with disabilities being sterilized without their consent.

D. Older persons

79. Older persons with whom the Special Rapporteur spoke shed light on access issues, such as being forced to decrease their insurance coverage and move from private to public systems upon retirement, contrary to their constitutional right to choose which health system they use.

E. Chileans of African descent, migrants and asylum-seekers

80. While power inequity and hostility between different ethnic and socioeconomic groups were not inventions of colonialism, coloniality has had a profound impact on the hierarchical social and political systems in postcolonial States. Experiences of racism have caused further stress and trauma and have disproportionately affected the health of people of African descent and migrants in the country. With increased migration to the country in recent years, Chile has also seen an increase in xenophobic and racist discourse.

81. In Chile, irregular migration has been decriminalized and transit camps have been closed. However, with the closing of these camps went the main access points to healthcare for migrants. The Special Rapporteur notes the progress that Chile has made towards equal access to healthcare for migrants, including through the provision of public health insurance to migrants through Supreme Decree No. 67 of 2016, as well as the Government's health policy for international migrants and its migrant healthcare access programme. However, although migrants legally have the right of access to healthcare, practical barriers exist, including language barriers, the economic expense of travelling to urban centres for care, verbal abuse, and the lack of awareness of current health circulars issued by administrators in some regions of the country, particularly regarding migrant populations.

82. Migrants reported being hesitant to seek healthcare due to discriminatory treatment by healthcare workers, fear of having to divulge their migratory status, and the prioritization of Chileans in the system. Civil society working with migrants expressed concerns regarding the mental health of migrants, including high rates of suicide, and the impact of precarious work situations on their health. The Special Rapporteur was informed of disproportionate discrimination and obstetric violence against migrant women. She heard worrying reports of

cases of sterilization of Haitian women migrants without their consent due to a lack of understanding of the forms signed before procedures.

83. Chile must eliminate disparities in health status that might result from racism, racial discrimination, xenophobia and related intolerance and strengthen its human rights education for health and care workers.

F. Indigenous Peoples

84. During her visit, the Special Rapporteur visited traditional Mapuche and Huilliche territories, where she was welcomed by Indigenous Peoples to their communities. There, she witnessed and listened to accounts of the challenges they faced to the enjoyment of their right to health. She also witnessed several good practices in integrating traditional knowledge into public health.

85. Chile is a State Party to the ILO Indigenous and Tribal Peoples Convention, 1989 (No. 169), but has not recognized Indigenous Peoples under its Constitution. Such recognition would be a critical step towards ensuring non-discrimination in access to health for Indigenous Peoples in the country and securing the full enjoyment to their rights under article 24 of the United Nations Declaration on the Rights of Indigenous Peoples. It would also support their self-determination, which is critical to their overall health, both as individuals and as peoples, as is the full demilitarization of their lands.

86. Racism towards Indigenous Peoples is present in multiple localities and, in addition to being linked to poverty, leads to exceedingly high rates of police brutality, poor access to justice and redress, mass incarceration, exposure to toxic environmental pollutants and a lack of access to housing, education, employment, healthcare and culturally appropriate food.

87. Chile has made progress, through participatory processes, towards ensuring equal access to health for Indigenous Peoples, including through the adoption of Act No. 20.584 and implementation of the Health and Indigenous Peoples Programme. It has made notable efforts to introduce Indigenous health into its public system, including through the adoption, in 2023, of regulations on the right to culturally appropriate healthcare (Ministry of Health Decree No. 21), by which an obligation was established for public health institutions to provide culturally relevant care to Indigenous persons. The Special Rapporteur also noted efforts to raise awareness of these initiatives, including through obvious signage at hospitals.

88. While these initiatives are to be welcomed, the Special Rapporteur also heard concerns about how intercultural medicine was being introduced, as well as concerns about funding. Some Indigenous people reported that, even in hospitals identified as being intercultural, traditional knowledge and medicine were often not integrated and were more symbolic than substantive. One concern brought to her attention was that, with the introduction of new intercultural medicine programmes, funding was being diverted from some previously existing Indigenous-run health programmes, such as Indigenous health clinics that have been operating for many years in the Metropolitan Area, to fund the implementation of intercultural medicine in the broader public system.

89. In the Los Lagos Region, the Special Rapporteur visited the San José Osorno public hospital, where an intercultural birth model for the Huilliche Indigenous People has been developed and replicated in other parts of the country as a good practice. This midwife-led programme of the hospital's maternity ward goes beyond the level of intercultural integration used in many hospitals. In addition to a culturally appropriate space that extends to waiting rooms for families, Huilliche women are accompanied by traditional healers, or *machis*, who use traditional herbs, ceremonies and massages and catch the babies. This has also allowed *machis* to attend births again, years after births were taken out of communities – and even prohibited for a time – and moved to public hospitals to improve mother and baby mortality rates. Health and care workers reported that these rates have improved but also advised that births in the communities are now rare and that the infrastructure is not there to support them. The Special Rapporteur was also told that children feel more connected to their territory now that mothers can bury their placentas on their lands, a tradition permitted once again with the adoption of a regulation allowing mothers to take their placentas home. Increased recognition

and integration of traditional healers is an important element in providing truly intercultural healthcare; next steps could include the empowerment of Indigenous communities to reintegrate culturally appropriate prenatal, birth and postnatal infrastructure close to and, where possible, within Indigenous communities.

La Araucanía

90. Militarization in La Araucanía has had a serious impact on the health of the Indigenous Peoples, who have lived under a state of emergency since 2021. Mental health is a particular concern, with high suicide rates and severe impacts on Indigenous children, who live amid violence and fear, often witnessing house raids and arrests of family members. As in other Indigenous territories, many Mapuche people living in rural areas of La Araucanía face barriers to gaining access to healthcare due to a lack of transportation and health clinics.

91. During her visit to La Araucanía, the Special Rapporteur visited the Makewe Hospital and met with representatives of various Indigenous communities in the Makewe community *ruca*, or meeting place. There, she met with empowered Indigenous health and care workers, community leaders and *machis.* She commends them for their 20-year commitment to working towards having their own hospital – a public hospital that is administered by the community itself and where Indigenous knowledge and medicine are used. Health and care workers recounted improvements in patients' mental, physical and spiritual health through the use of traditional medicines and knowledge, which are central to their healing process, to which western medicine is often complementary.

92. Measures should be taken to train Indigenous healthcare workers to incorporate traditional medicine into health services. The participation of Indigenous communities should be increased as part of an inclusive and respectful approach to the provision of healthcare, and they should be empowered to provide and support primary healthcare and prenatal, birth and postnatal care close to and, where possible, within Indigenous communities.

93. More broadly, it is essential that Chile respect the rights of the Indigenous Peoples to self-determination, meaningful participation in law and policy design, decision-making and implementation and monitoring of any project, programme or policy affecting their rights, and return their territories in order to support their autonomy and dignity.

X. Conclusions and recommendations

94. **The Special Rapporteur reiterates that the right to health must be understood and expressed in law as an inclusive right interconnected with other rights, such as the rights to a healthy environment, equality and non-discrimination, and bodily autonomy.**

95. **Chile has a solid foundational public health system and has demonstrated considerable political will in its aim to provide universal health coverage to all. Important steps have been taken towards the enjoyment of the right to health since the end of the dictatorship. Investments must be made to bolster the public system, including through adequate budgeting.**

96. **For its people to be able to enjoy the highest attainable standard of physical and mental health, Chile must address key challenges, such as mental health, inequalities in access to health, including for those deprived of their liberty, and sexual and reproductive health rights, including the need for access to safe, timely and legal abortion for all women who need it.**

97. **The Special Rapporteur is committed to promoting the full realization of the right to health through continued cooperation and technical expertise and remains ready to provide the State with relevant support.**

98. **In this regard, the Special Rapporteur makes the following recommendations to the Government:**

(a) **Ensure that, in future constitutional reforms, the Constitution enshrines the right to health;**

(b) **Take increased steps to guarantee access for all to the underlying determinants of health;**

(c) **Ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights;**

(d) **Take measures to harmonize the public and private health systems, with the eventual implementation of one broad public health system providing universal health coverage to all persons in Chile;**

(e) **Take all necessary measures to urgently decrease waiting times in the public system;**

(f) **Take measures to increase the number of physicians and other health and care workers, with a view to ensuring equal access throughout the country, and increase the number of physicians per inhabitants in accordance with OECD recommendations;**

(g) **Ensure that the National Institute of Human Rights has a consistent and ample multi-year budget and maintains its current broad mandate and strengthen financial support to other national human rights mechanisms and civil society organizations working on the right to health;**

(h) **Increase interministerial coordination on matters related to the right to health and bring access to healthcare services for persons deprived of their liberty under the responsibility of the Ministry of Health;**

(i) **Take immediate action to lower the high proportion of women in detention, including through the use of alternative sentencing, particularly for those in pretrial detention or imprisoned for less serious offences, pregnant women and mothers of small children, in line with the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders;**

(j) **Take measures to improve women's equal access to healthcare, including by finalizing and approving Adriana's Law (Bulletin No. 12148-11). Sexual and reproductive health rights are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;**

(k) **Ensure access to legal, safe and timely abortion without discrimination throughout the country, including by:**

(i) **Decriminalizing abortion in all cases;**

(ii) **Making amendments to the legal framework on conscientious objections, particularly to prohibit institutional conscientious objection, and ensuring that all institutions have at least one practitioner available to provide abortion care;**

(iii) **Eliminating practical barriers, including the lack of practitioners, particularly in rural regions, and eliminating additional requirements for access to abortion for girls under 14 who have been raped;**

(iv) **Improving oversight of implementation of the abortion framework to ensure that institutions are not raising additional barriers to access;**

(l) **Develop and promote comprehensive sexual and reproductive health education in public schools;**

(m) **Take immediate measures to guarantee access to quality modern contraceptives, ensuring that minimum quality controls are met, and take measures to provide compensation to women affected by defective contraceptives provided through the public system, including through the adoption of the bill on establishing liability for defective contraceptives (Bulletin No. 14094-11);**

(n) **Urgently adopt a comprehensive mental healthcare framework, including through meaningful consultation and adoption of the mental health bill (Bulletin No. 17003-11), to increase the availability, accessibility, acceptability and quality of healthcare to cover the different and emerging realities of the population, on the basis of a people-centred and human rights perspective, including by increasing the number**

of child psychiatrists. Responses must lead with empathy and include such initiatives as art and artistic expression. For persons with disabilities and persons with mental health conditions, deinstitutionalization is important and requires investments in the underlying determinants of health;

(o) **Take measures, in line with the international obligations of Chile under article 24 of the Convention on the Rights of the Child, on the right to the highest attainable standard of health and access to medical services, to adopt the bill on the mental health of students (Bulletin No. 16428-04) and to improve children's nutrition, including through regulations on advertising unhealthy products to young children, and restrict the availability of unhealthy foods and their advertising in schools; take urgent measures to ensure equal access to healthcare for all children in State institutions, including those in mother and child units in prisons; and ensure full implementation of all recommendations made by the Committee on the Rights of the Child under the inquiry procedure, in 2018, and related recommendations made by the Committee in its most recent periodic review of Chile;**[14]

(p) **Take measures to support the mental and physical health of health and care workers, including through investment in employee health and wellness programmes, expansion of childcare options for health and care workers, particularly for those doing shift work, ratification of the ILO Nursing Personnel Convention, 1977 (No. 149) and implementation of the Karin Law to ensure a safe and healthy work environment;**

(q) **Strengthen human rights education, including on the right to health and on gender, in the formal training of health and care workers, including through mainstreaming in medical schools;**

(r) **Take accountability for past State violence, provide reparations and bolster systems for the prevention of future violence; take measures to identify all victims of the repression of the October 2019 protests and provide them with comprehensive reparations, including mental health support; and ensure full implementation of the recommendations made by the Office of the United Nations High Commissioner for Human Rights in its 2019 mission report;**15

(s) **Provide comprehensive care to LGBTIQA+ persons and ensure adequate budgetary provision for hormonal therapies for adolescents in transition;**

(t) **Recognize Indigenous Peoples in the Constitution and demilitarize all Indigenous territories;**

(u) **Ensure that all intercultural regulations are implemented in a meaningful way, in consultation with the Indigenous Peoples; replicate the midwife-led intercultural programme carried out in maternity units in Osorno and, through this model, move towards bringing culturally appropriate prenatal, birth and postnatal care back to communities;**

(v) **Take steps to decrease xenophobia in the provision of healthcare, including through the provision of human rights education to health and care workers; and increase support for migrants to have equal access to healthcare, including by considering removal of the requirement for migrants to have identification cards to gain access to public health;**

(w) **Increase the number and availability of sign language interpreters in institutions providing healthcare;**

(x) **Ensure that no medical procedures, including sterilizations, are performed without informed consent and that no one, including persons with**

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[14] See CRC/C/CHL/IR/1 and CRC/C/CHL/IR/1/Corr.1; and CRC/C/CHL/CO/6-7.

[15] Available at https://www.ohchr.org/sites/default/files/Documents/Countries/CL/Report_Chile_2019_EN.pdf.

disabilities, faces undue pressure to consent, and ensure compliance with Act No. 21.331 prohibiting sterilization without consent;

(y) **Place at the forefront and listen to those who are in vulnerable situations owing to the climate crisis and minimize the disproportionate impact on them in relation to clinical care and the underlying determinants of health;**

(z) **Urgently enforce environmental safeguards regarding the extractive industries and implement regulations in line with WHO standards and the Guiding Principles on Business and Human Rights;**

(aa) **Implement the 2019 Supreme Court decision requiring steps to be taken to remedy the impact of contamination in Quintero-Puchucanví;**

(bb) **Adopt harm reduction approaches and the decriminalization of drug use, coupled with appropriate policies and evidence-based protocols, in the provision of accessible, acceptable, affordable and quality healthcare;**

(cc) **Consult relevant stakeholders, including the national human rights institution and civil society, in the adoption of laws, national plans, budgets and policies, including with the free, prior and informed consent of the Indigenous Peoples on matters affecting their rights and territories;**

(dd) **Collect disaggregated data from an intersectional perspective to serve in the adoption of targeted policies to not leave anyone behind;**

(ee) **Increase the visibility of public health information – and ensure that it is updated – in all regions;**

(ff) **Reinforce human rights education throughout the country, including in school curricula;**

(gg) **Ensure accountability, monitoring, review and redress; accountability is essential for the right to health to be more than an aspiration.**