Canadian Drug Policy Coalition

Submission to the UN Committee on the

Elimination of Discrimination against Women:

Review of Canada at 89th Session (October 7-25, 2024)

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HIV Legal Network

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INTRODUCTION

The HIV Legal Network (Legal Network) and the Canadian Drug Policy Coalition (CDPC) make this submission to the Committee on the Elimination of Discrimination against Women (CEDAW Committee) in advance of its review of the periodic report of Canada, held during its 89th Session (October 7-25, 2024).

The Legal Network is a health justice organization that works to promote 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.

CDPC is a national, non-partisan organization working to advance drug policy grounded in evidence, public health and human rights in Canada.

In this submission, we wish to highlight priority concerns regarding inadequate implementation of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) for women and gender minorities who use drugs. We are particularly concerned with insufficient protections against gender-based violence (GBV), as well as other violations of the human rights to health, safety, and protection from discrimination (notably Articles 2, 3, and 12 of CEDAW) for women and gender minorities who experience multiple, intersecting forms of oppression.

background

The Canadian government has acknowledged the need to implement enhanced health and safety initiatives for women, girls and gender-diverse people, who historically and contemporaneously experience elevated rates of ill health and unmet safety needs. To this end, Canada has made some advancements in how it conceptualizes and addresses health and safety for people who are marginalized at the intersections of their socioeconomic background, race, ethnicity, cultural background, and/or ability. However, women and gender minorities who use illegal drugs, and who are involved in the illegal drug trade, continue to experience extreme discrimination — compounded for women and gender minorities who experience intersecting oppressions due to their race, ethnicity, cultural background, socioeconomic status, and ability.

Women and gender minorities who use illegal drugs have been systematically dehumanized by well over a century of criminal-legal responses to drug use and the cultural attitudes that flow from these responses — so much so that they are routinely excluded from basic conceptions of personhood. For example, the belief that women and gender minorities who use drugs lack rationality and self-control manifests in discriminatory housing, shelter, employment, and child apprehension policies. It is still taken for granted that caregivers who use drugs are automatically a risk to themselves and their children. Because drug-related stigma is naturalized in nearly every domain of social activity, it has been rendered invisible.

Our primary purpose with this submission is to illuminate how the human rights of women and gender minorities who use drugs remain obscured, deprioritized, or overlooked by the Canadian government even as its understanding of gender-based health and safety is evolving.

Working Definitions of Health and Safety

"Health" is characterized by more than the mere absence of physical illness, disease, or disablement. It is a multi-faceted state of mental, emotional, physical, and communal well-being. Health outcomes are also shaped by socio-cultural, political, and economic factors through complex causal pathways. Therefore, we adopt a broad and holistic definition of health that encompasses multiple outcome measures, and will describe how specific policies, programs, practices, laws, and regulations at every level of Canadian government preclude women and gender minorities who use drugs from access to the very conditions required to pursue health. We do so to incorporate considerations of how legislative and regulatory environments promote or undermine health for individuals and communities.

Similarly, we view "safety" as more than the absence of mental, emotional, and bodily harm or the threat of harm. A robust and comprehensive definition of safety denotes objective and perceived security in every domain of social activity. To be "safe" is to trust that one can meet their material needs for food, shelter, and other requirements for sustaining life; can readily access a range of interpersonal supports to improve their objective and perceived security; can seek meaningful recourse when they experience mental, emotional, and bodily harm or the threat of harm; and can enjoy the benefits of full civic, economic, and political participation. One's experience of safety is therefore heavily contingent on the legislative and regulatory environments, and the presence of policies, programs, practices, laws, and regulations designed to promote objective and perceived security. With this submission, we discuss how women and gender minorities are routinely excluded from accessing the conditions required to pursue health and safety.

women WHO USE DRUGS AND GENDER-BASED VIOLENCE

Violence against women (VAW) is among the "most pervasive health risks to women and gender-diverse people" in Canada, and since 2019, the country has seen increasing rates of femicides — borne disproportionately by certain populations, including women who use drugs and Indigenous women. This is in the context of an unprecedented overdose crisis in Canada that has claimed almost 45,000 lives since 2016, with Indigenous women particularly affected.

Despite increasing recognition of the need to provide shelter and supports to women who use drugs, several provinces continue to mandate zero-tolerance among their shelters or link drug use to dangerous behaviour. As a result, women are often barred from admission if they are noticeably intoxicated or are forced to leave for having or using drugs. A 2021 national survey found that, among 500 women and gender diverse people, those who used drugs were barred from shelters at a rate that was three times higher than those who did not.

Unsurprisingly, most shelters do not meet the needs of women who use drugs. In a survey of 203 low-barrier women's shelters, 79% of shelters reported that it was a "major challenge" to serve women who use drugs. Consequently, women are dying in shelters.

Similarly, there remains inadequate access to supervised consumption services (SCS) in Canada — particularly gender-sensitive and culturally appropriate SCS. SCS provide a safe, hygienic environment where people can use drugs with sterile equipment under the supervision of trained staff or volunteers to prevent HIV and hepatitis C (HCV) transmission and overdose deaths and have been one key measure to address Canada's ongoing unregulated drug crisis. SCS can also provide a refuge from various forms of violence that women may experience on the street and have been found to disrupt certain social structures such as gender power dynamics, enabling women to assert agency over their drug use practices.

In particular, gender-specific SCS can connect women who use drugs to resources including women's shelters and programming for domestic and sexual violence prevention.

There are two SCS sites in Canada offering gender-specific services for women, and such services should be made more widely available. Women who rely on intimate partners for assisted injection are at greater risk of intimate partner violence. Young women who inject drugs in Vancouver's Downtown Eastside are 54 times more likely to die prematurely, often by violence, compared to people in Canada who do not inject drugs, and at least 4 times more likely to die prematurely than young men who inject drugs from the same region.

A major barrier to accessing both shelter and SCS for women who use drugs is the criminalization of people who use drugs, which fuels stigma towards drug use and prevents women from seeking or obtaining protection. Blanket bans on substance use in shelters are justified on discriminatory and unfounded beliefs that people who use drugs are inherently dangerous to shelter staff, other shelter participants, and children, or on the perceived need to minimize criminal liability for permitting prohibited drugs on site. Criminalization also hinders the scale-up of SCS while deterring people from vital health services and forcing people who use drugs to acquire drugs from an unregulated market.

Following her 2018 visit to Canada, the Special Rapporteur on VAW called on Canada to establish an adequate number of, and sustainably fund, shelters and services for women fleeing violence, considering the needs of women belonging to vulnerable groups. At the time, there were 553 VAW shelters, which the Special Rapporteur concluded was insufficient. The Special Rapporteur also called on Canada to ensure that women are not criminalized when they seek protection. As of 2020-2021, there are only 557 shelters, with hundreds of people turned away from shelters each day, and about three in ten returning to the home in which their abuser lives.

Failing to provide shelter and SCS to women who use drugs represents a clear violation of the Convention. During its 2016 review of Canada, the CEDAW Committee expressed its concern with “the significant legislative and administrative barriers women face to access supervised consumption services” and recommended that Canada “reduce the gap in health service delivery related to women’s drug use, by scaling-up and ensuring access to culturally appropriate harm reduction services.” Moreover, the CEDAW Committee has previously concluded that States Parties had breached their Convention obligations because they did not have sufficiently accessible VAW shelters, including for women who use drugs.

CANADA MUST:

Increase funding to all shelters for women fleeing violence;

Ensure that women are not barred from shelters on the basis of drug use;

Reduce the gaps in health service delivery related to drug use by funding, scaling-up, and ensuring access to gender-sensitive and culturally appropriate harm reduction services, including supervised consumption services, and services in shelters;

Decriminalize the possession of all drugs for personal use and the sharing or selling of drugs for subsistence, to support personal drug use costs, or to provide a safer supply and ensuring the meaningful involvement of people who use drugs.

programmes to combat HIV and other sexually transmitted infections

Women and gender minorities who use drugs experience poorer health outcomes compared to other women and to men who use drugs. One clear indicator of poorer health outcomes and the need for expanded gender-specific programming is the disproportionately high rates of HIV transmission among women who inject drugs.

In 2022, there were 1,833 new HIV diagnoses in Canada, a 24.9% annual increase compared to 2021. Among women, 36.1% of new HIV diagnoses were linked to injection drug use. Comparatively, among men, 13.1% of new HIV diagnoses were linked to injection drug use and 4.9% were linked to male-to-male sexual contact combined with injection drug use. Women who inject drugs are also starkly overrepresented among women who are newly diagnosed with HIV at the regional level in Canada. For example, in 2021, the province of Manitoba was the only Canadian province that did not meet any of the previous UNAIDS 90-90-90 treatment targets. From 2018 to 2021, 44.8% of new HIV diagnoses in Manitoba were among women; a higher proportion than the national rate of 30%. 71.8% of women newly diagnosed with HIV in Manitoba reported injection drug use. Across the country, new clusters of HIV diagnoses are being driven by women who inject drugs who also have a high overlapping burden of homelessness and mental health conditions.

There are also significant regional disparities in health outcomes among women and gender minorities who use drugs in Canada. For instance, rates of virologic suppression among HIV-positive people are lower in rural areas compared to major urban centres. These disparities are linked to inequities in access to healthcare and harm reduction services,

including sterile drug use equipment and supervised consumption services (SCS), for people in remote, rural, and northern communities. Urban settings tend to have greater access to harm reduction services because geographic distance, lack of transportation, a shortage of trained healthcare providers, and lack of anonymity act as barriers for people living outside of them. There are also longer wait times in rural regions for referrals to care.

High rates of HIV, as well as poorer clinical outcomes after diagnosis, among women who use drugs can be traced to policy and legislative environments that penalize drug use. First, enforcement-based approaches to drug control are associated with increased risk behaviours. For instance, women who use drugs report frequent harassment and confiscation of drug equipment by police, which in turn fuels rushed and unsanitary injections and equipment sharing. Simultaneously, drug-related stigma is associated with decreased progression through the cascade of evidence-based HIV care. A culture of fear and mistrust of police, social service workers, and medical personnel amongst women who use drugs leads to low uptake of health and social services. Women report that experiences of sexism often intersect with other forms of discrimination to create significant barriers to accessing HIV treatment.

Rates of HIV and other infections are particularly pronounced among women who require assistance with drug injection. Women who inject drugs are more than twice as likely to require assistance with injection compared to men. Among women who require assistance, they are approximately twice as likely to contract HIV compared to women who do not require assistance. This is because those who provide assistance with injecting often use the same syringe between two individuals. Women who cannot self-administer injections commonly report consuming drugs via injection equipment that has already been used, some of which may be attributed to gendered power dynamics within heterosexual partnerships.

Sterile Drug Use Equipment Distribution, Supervised Consumption Services, and Decriminalization

Higher rates of new HIV diagnoses due to injection drug use among women point to a need for greater access to sterile drug use equipment, SCS, assisted injection services, and harm reduction programs for women and girls who use drugs.

With respect to sterile drug use equipment, the provinces and territories, which are responsible for healthcare service delivery, do not provide equal or consistent access. The Saskatchewan government has withdrawn its funding and support for sterile smoking equipment and introduced excessive limitations on distribution of sterile injection supplies. These policy changes create significant barriers to accessing sterile equipment. Yet, lack of access to sterile smoking equipment in Saskatchewan has led to increases in injection drug use, which pose greater risk of HIV transmission. Significantly restricted or eliminated access to sterile drug use equipment, results in a greater likelihood of transmission of bloodborne infections. Notably, Saskatchewan has the highest rate of new HIV diagnoses in Canada at 19 per 100,000 population, more than four times the national rate. Other provinces and territories also have inconsistent access to harm reduction equipment, leading to harms which are exacerbated for women who use drugs. The Ontario government has indicated its intention to prohibit sterile drug use equipment at provincially funded “health hubs.” In B.C., the Premier has ordered a review of a harm reduction program that dispenses free sterile equipment, eliciting grave concerns such programs may be cancelled or rolled back.

As discussed, SCS are low-barrier facilities where people can receive sterile drug use equipment, consume pre-obtained drugs, and receive lifesaving emergency response in case of drug poisoning or overdose. In most cases, SCS require approval via a formal exemption under the federal Controlled Drugs and Substances Act allowing people to consume criminalized substances in a site without threat of criminal prosecution, although healthcare is administered at the provincial/territorial level.

SCS that allow for assisted injection are particularly important for HIV and STI prevention among women. Although 29 of 39 federally approved SCS allow for peer-assisted injection, these sites do not authorize assisted injection by a healthcare provider. Assisted injection by peers and healthcare providers are a form of gender-sensitive harm reduction programming that could reduce the risk of HIV among women who inject drugs and should be expanded in SCS. Low-barrier distribution of sterile injection equipment, along with peer-based education on safer use practices, must be expanded to minimize the risk of infection transmission.

There are four decades of well-established evidence demonstrating the benefits of harm reduction services, including reduced rates of HIV transmission and other bloodborne infections. A recent resolution passed at the 67th UN

Commission on Narcotic Drugs directed member states to pursue harm reduction measures, while the UN Global AIDS Strategy 2021-2026 identified scaling up harm reduction and needle distribution programs and removing any associated legal, regulatory or financial barriers as a key priority area. Additionally, as noted above, the CEDAW Committee has previously expressed its concern with “the significant legislative and administrative barriers women face to access supervised consumption services” and recommended that Canada “reduce the gap in health service delivery related to women’s drug use, by scaling-up and ensuring access to culturally appropriate harm reduction services.” The Government of Canada’s own Sexually Transmitted and Blood-Borne Infections (STBBI) Action Plan 2024-2031 indicates that access to sterile drug use equipment is critical to STBBI prevention and has committed the federal government to investing in community-based harm reduction programs and supporting the establishment of SCS.

Despite this, political leaders in Canada have increasingly spread misinformation and harmful claims about harm reduction programs and services. For example, the current leader of the federal opposition has described SCS as “drug dens” and vowed to shut down these essential services if he forms government in 2025. Ontario's premier has described SCS as “the worst thing that could ever happen to a community”.

Decriminalization of drug use and possession would also help support safer drug use practices, access to harm reduction programs, HIV prevention, and reduction of overdose among women who use drugs. Canada’s STBBI Action Plan 2024-2031 commits the federal government to divert individuals away from the criminal justice system for drug possession charges through alternatives to prosecution, while a 2021 Federal Expert Task Force on Substance Use recommended decriminalizing simple drug possession.

Despite this, simple drug possession remains a crime in Canada, deterring women who use drugs (including those who are primary caregivers for children) from utilizing SCS and other health services. The criminalization of drugs, discriminatory surveillance of people who use or are perceived to be using drugs, and a deterministic conflation of parental drug use with child abuse and neglect have resulted in real or possible perceived loss of child custody or family reunification. SCS and other harm reduction services can function as a site of surveillance for mothers who use drugs, whereby access to these services can create a greater risk for child apprehension, particularly for mothers who are poor, racialized, and gender diverse. Further, the pain, grief and trauma of experiencing child apprehension can cause women to initiate or intensify drug use or engage in unsafe drug use practices such as injecting alone or rushing injections. All of these factors increase risk of overdose and other drug-related harms.

As one part of a wider strategy to address the unmet health and safety needs among women who use drugs, CANADA MUST:

Expand access consistently throughout the country to harm reduction programs including supervised consumption services and sterile drug use equipment distribution programs designed to account for the specific needs of women and gender minorities;

Implement nationwide drug decriminalization.

DISADVANTAGED GROUPS OF women

The ongoing impacts of colonialism and a legacy of racist criminal law and law enforcement practices has resulted in the mass incarceration of Indigenous, Black, and other racialized communities in Canada. In particular, Indigenous and Black women are disproportionately affected. Indigenous women account for about half of all women in federal prisons (where people serve sentences of 2+ years), while representing roughly 4% of Canada’s adult female population, and Black women account for (on average) 6% of all women in federal prisons, while representing approximately 3% of Canada’s female adult population. This overrepresentation is also mirrored in provincial and territorial prisons.

In recent decades, there has also been a substantial increase in the proportion of women who are federally incarcerated for a drug offence. Whereas only 16% of federally incarcerated women were serving sentences for drug offences in 1981, this increased to 28% in 2021-2022; in comparison, 14% of federally incarcerated men in 2021-2022 were serving sentences for drug offences. As the Correctional Investigator (Canada’s ombudsperson for federal prisons) has noted, federally sentenced women are twice as likely to be serving a sentence for drug-related

offences as their male counterparts, while Black women are more likely than white women to be in prison for that reason. Acknowledging this troubling reality, the CEDAW Committee has previously expressed its concern with the "excessive use of incarceration as a drug-control measure against women.

Significant numbers of prisoners also use drugs. In a national survey conducted by the federal correctional service (Correctional Service Canada), 34% of men and 25% of women reported using non-injection drugs during the past six months in prison, while 17% of men and 14% of women reported injecting drugs. Other studies have revealed high rates of syringe-sharing among people who use drugs in Canada's prisons, due to the lack of sterile injection equipment in prisons. An increasing number of people in prison are also dying from preventable overdoses.

Unsurprisingly, research shows that the incarceration of people who inject drugs is a factor driving Canada's HIV and HCV epidemics. In prison, the risk of STBBI transmission increases, as people are barred from necessary health and harm reduction services, leading to higher rates of HIV and HCV in prison compared to the broader community. A 2016 study indicated that about 30% of women (compared to 15% of men) in provincial prisons are living with HCV, and 1–9% of women (compared to 1–2% of men) are living with HIV. Similarly, a larger proportion of women than men in federal prisons are living with HIV and HCV, with highest reported prevalence amongst federally incarcerated Indigenous women.

Despite this, Canada does not provide prisoners with access to key harm reduction measures, violating their rights to health, equality, and non-discrimination. As the UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) and the UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders recommend, incarcerated women must enjoy the same standards of healthcare that are available in the community, including access to gender-specific healthcare. This includes key interventions recommended by the UNODC, UNAIDS, and WHO such as sterile needle and syringe programs, safer sex supplies, programs to address tattooing, piercing and other forms of skin penetration, HIV treatment, care and support, and opioid agonist therapy (OAT). During its 2016 review of Canada, the CEDAW Committee expressed its concern with "high rates of HIV/AIDS among female inmates" and recommended that Canada "expand care, treatment, and support services to women in detention living with or vulnerable to HIV/AIDS, including by implementing prison-based needle and syringe programmes, opioid substitution therapy, condoms and other safer sex supplies."

With respect to OAT, WHO guidelines state that OAT should be available to people in prison and equivalent to community options. While access to OAT has improved in some Canadian jurisdictions, federal and provincial prisoners continue to experience significant barriers. Several provincial and territorial prisons still do not offer OAT or impose severe restrictions on access, resulting in acute withdrawal among prisoners and an increased risk of overdose. Among those jurisdictions that do initiate OAT, long waitlists and inappropriate medication terminations persist.

Access to sterile drug equipment in prison is also extraordinarily limited. To date, only 12 out of 43 federal prisons have a "Prison Needle Exchange Program" (PNEP) and no provincial or territorial prisons in Canada distribute sterile drug equipment. The program, which requires participants to keep their kits visible when not in use and to show the kits to correctional officers during daily visual inspections, is not in keeping with public health principles or professionally accepted standards for such programs. Most fundamentally, the PNEP violates prisoners' confidentiality without reasonable justification, and participation is contingent on the approval of both prison health staff and security staff. As the Correctional Investigator has observed, "Too much of what should be an exclusively health and harm reduction program has been shaped by security concerns," leading merely a handful of individuals to enrol in the program. The Correctional Investigator consequently recommended that program criteria be "significantly revamped to encourage participation … with a view to full national implementation."

With respect to overdose prevention, SCS currently operate in four federal prisons, where prisoners can access sterile equipment to consume drugs; no such services exist in provincial or territorial prisons. Naloxone, a medication used to reverse opioid overdoses, is available without prescription in the community, but is only accessible to prison staff. Incarcerated individuals do not have direct access to naloxone in any jurisdiction, requiring those who witness an overdose to alert staff, thus causing a delay in response. Only one province (Nova Scotia) permits individuals on safer supply (prescribed alternatives to toxic unregulated drugs) in the community to maintain their safer supply

prescriptions in prisons. As Canada's Correctional Investigator noted in 2023, "That there is a need for more access to a wider range of harm reduction measures behind bars now seems beyond doubt or dispute."

In meaningful consultation with prisoner groups, Indigenous organizations, and community health organizations, CANADA MUST:

Expand evidence-based alternatives to incarceration for people who use drugs, taking into account the need for gender-sensitive and culturally appropriate care for women and gender-diverse people;

Implement or remove barriers to key health and harm reduction measures in all prisons and other places of detention, including:

needle and syringe programs

opioid agonist therapy

condoms and other safer sex supplies

programs to address tattooing, piercing, and other forms of skin penetration

overdose prevention services

safer supply

and ensuring such programs are culturally appropriate and gender-specific;

Expand care, treatment, and support services in prison for women living with and vulnerable to HIV and HCV, including peer health programs, and ensure such support is gender-sensitive and culturally appropriate; and

Update all federal, provincial, and territorial prison drug strategies to reject stigmatizing "zero tolerance" approaches to drug use in favour of rights-based, evidence-informed harm reduction principles and practices.