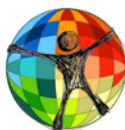


‘War on Drugs’—or on Pregnant Women who Use Drugs? Situating Russia and Canada in Global Drug Policy



International Human Rights Internships Program - Working Paper Series



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Abstract

Two of the largest countries in the world, known for their vastness and frigid temperatures, Canada and Russia have much in common on the surface. They also both are federations and offer universal health care coverage, but upon a closer look, one such divergence between the two countries is the delivery of health care services and implementation of social policies. To illustrate these similarities, yet divergences, this paper will zone in on a particular issue: barriers that pregnant women who use drugs face when drug dependence treatment and other harm reduction programming in Russia and Canada against the backdrop of global drug policy fora.

The timing of the United Nations General Assembly Special Session (UNGASS) on the World Drug Problem in April 2016 coincided with the release of the concluding observations by the Committee on the Convention on the Elimination of the Discrimination against Women (CEDAW) for both the Russian Federation (November 2015) and Canada (November 2016)—both of which called for a greater incorporation of harm reduction programming and greater federal leadership, and were concerned about the lack of treatment and services for pregnant women who use drugs. The coinciding of UNGASS and the release of the CEDAW Concluding Observations on the Russian Federation and Canada make for a timely discussion and comparison between two geographically vast federations that could not be more dissimilar in their politics and policies, yet face similar challenges in administration and governance. Undertaking such a comparison makes apparent that a discussion of how the respective countries are responding to international calls to shift and reform drug policy warranted a closer look, as there were likely more lessons to be learned, similarities to be drawn and parallels to be constructed than one might anticipate at a first glance. Looking at Russia and Canadian drug policy comparatively, against the backdrop of global drug policy discussions, elucidates the possibility, and necessity, of shifting domestic drug policy away from a prohibitionist approach, while also allowing for a frank discussion of roadblocks to reaching a global consensus.

To be able to fully compare these contexts, a detailed overview of the current landscape of drug policies Russia and Canada will be provided. The recent shift in Canadian drug policy illustrates the potential for domestic governments to employ harm reduction programming, even if there is hesitancy to do so at the global level. On the other hand, Russia embodies this hesitancy, leading the charge to continue pushing forward prohibitionist drug policies domestically and internationally. This paradox between Russia and Canada was exhibited at UNGASS 2016. After critically engaging with CEDAW's Concluding Observations for both countries, this paper will conclude that perhaps there is a moment of opportunity for Canada to take the lead to make global drug policy more gendered, so as to counter Russia's prohibitionist policies and attitudes.

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“Who ever heard of a female drug lord? As the terms ‘kingpin’ and ‘drug lord’ denote, men are almost always at the head of major drug operations, and yet the rate of imprisonment of women for drug crimes has far outpaced that of men. Families and children suffer—but why?”¹

“[b]eing a woman was a strike against them, being a pregnant woman was a second strike, and being a drug using pregnant woman was the third and final blow in their social standing.”²

“No example more fully demonstrates the slavery of drug addiction than the pregnant addict. To learn that the craving for drugs can override even essential maternal concern for the well-being of an unborn child is a frightening and tragic phenomenon.”³

Introduction

Although men are more likely than women to be targeted by drug law enforcement, women are often more frequently cast as “invisible participants” and victims of war on drugs.⁴ Some have even gone so far as to say the ‘war on drugs’ has become a ‘war on women’, as the bodies of women who use drugs have become increasingly regulated and punished through legal sanctions, social service provision and medical policies.⁵ While women represent one out of three drug users, only one out of five drug users in treatment is a woman⁶—a statistic that lends merely a superficial portrayal of the issue. Many other vulnerabilities intersect with drug use, further exacerbating the marginalization of women in society-at-large, as well as in the context

¹ American Civil Liberties Union (ACLU), “Breaking the Chains and Brennan Centre for Justice. Caught in the Net: The Impact of Drug Policies on Women and Families” (New York: 2005) at 3, online: <<https://www.aclu.org/caught-net-impact-drug-policies-women-and-families>> [ACLU].

² Paloma Sales & Sheigla Murphy, “Surviving Violence: Pregnancy and Drug Use” (2000) 30:4 J Drug Issues 695 at 695 [Sales].

³ The opening statement made by Senator Brockman Adams (D-WA) as cited in Nancy D Campbell, *Using Women: Gender, Drug Policy, and Social Justice* (New York: Routledge, 2000) at 169 [Using Women].

⁴ Drug Policy Alliance, “Fact Sheet: Women, Prison and the Drug War” (February 2016), online: <http://www.drugpolicy.org/sites/default/files/DPA_Fact%20Sheet_Women%20Prison%20and%20Drug%20War%20%28Feb.%202016%29.pdf> [DPA]; see also UN Women, “Bringing women’s needs into policy response on drug use” (23 June 2016), online: <<http://www.unwomen.org/en/news/stories/2016/6/bringing-womens-needs-into-policy-response-on-drug-use>> [UN Women].

⁵ Bernida Reagan, “The War on Drugs: A War against Women” (2013) 6:2 Berkeley J. Gender L. 203 [Reagan].

⁶ United Nations Office on Drugs and Crime (UNODC), “The World Drug Report” (2015), online: <https://www.unodc.org/documents/wdr2015/World_Drug_Report_2015.pdf> [World Drug Report], as cited in UN Women, *supra* note 5; see also Susan Boyd, “Mothers and Illicit Drugs: Transcending the Myths” (Toronto: University of Toronto Press, 1999) at 169 [Transcending Myths].

of drug policy discussions. To begin to scratch the surface of this issue, women who use drugs bear a greater risk of acquiring HIV and/or other sexually transmitted infections, are more likely to be exploited or experience violence, endure stigmatization and discrediting when entering the judicial system, and must overcome significant barriers when accessing treatment and services.⁷ Moreover, most of the research on drug treatment has focused on men, with findings often generalized to include women.⁸ Even upon a careful consideration of these trends and intersections, most drug strategies and policies continue to be male-centric.

A panel on drug use and women at the United Nations General Assembly Special Session (UNGASS) in April 2016 on the World Drug Problem underscored the need to bring women to the forefront of global drug policy discussions.⁹ Many barriers impeding women who use drugs' accessibility to treatment and services were tabled. During this panel on gender in drug policy, Italian Justice Minister Andrew Orlando, in the capacity as co-host of the panel, stated that "[a]t every stage of the development, implementation, monitoring and evaluation of drug programmes and policies, women must be involved to prevent and counter discrimination against female drug users and their children".¹⁰ But even with these discussions, many called UNGASS a "missed opportunity", as "rather than inspiring a call for more humane and just drug policy, it double[d] down on the status quo".¹¹ The same critic called for Canada to lead the charge on drug policy reform given the "reaction to Health Minister Jane Philpott's barnstormer of a speech in the UN General Assembly" instead of the UN's Commission on Narcotics (CND), whose responsibility is to safeguard the three narcotics conventions. It is worth noting that China, Egypt, Indonesia and Russia are among the 53 members of the CND, and all four countries are staunchly opposed to rebalancing global drug policy.¹² Moreover, United Nations Office on Drug and Crime (UNODC), who was tasked with leading the

⁷ *World Drug Report*, *supra* note 7 as cited in *UN Women*, *supra* note 5.

⁸ *Transcending Myths*, *supra* note 7 at 134.

⁹ *UN Women*, *supra* note 5.

¹⁰ *Ibid.*

¹¹ Robert Muggah, "The United Nations fumbles on global drug policy" *The Globe and Mail* (22 April 2016), online: < <http://www.theglobeandmail.com/opinion/the-united-nations-fumbles-on-global-drug-policy/article29719615/> > [Muggah].

¹² Muggah, *supra* note 12.

UNGASS negotiations, leaned towards a criminal justice approach, which arguably short changed the weight of the work and input of other UN agencies.¹³ In other words, although gender was tabled, it was by no means a breakthrough moment for advocates of gendering global drug policy—leaving them feeling that yet again women’s experiences and issues in drug policy were shuffled to the side.

The timing of this special session coincided with the release of the concluding observations by the Committee on the Convention on the Elimination of the Discrimination against Women (CEDAW) for both the Russian Federation (November 2015) and Canada (November 2016)—both of which called for a greater incorporation of harm reduction programming and greater federal leadership, and were concerned about the lack of treatment and services for pregnant women who use drugs. The coinciding of UNGASS and the release of the CEDAW Concluding Observations on the Russian Federation and Canada make for a timely discussion and comparison between two geographically vast federations that could not be more dissimilar in their politics and policies, yet face similar challenges in administration and governance. Undertaking such a comparison makes apparent that a discussion of *how* the respective countries are responding to international calls to shift and reform drug policy warranted a closer look, as there were likely more lessons to be learned, similarities to be drawn and parallels to be constructed than one might anticipate at a first glance. Looking at Russia and Canadian drug policy comparatively, against the backdrop of global drug policy discussions, elucidates the possibility, and necessity, of shifting domestic drug policy away from a prohibitionist approach, while also allowing for a frank discussion of roadblocks to reaching a global consensus.

The arguments of this paper are three-pronged. Firstly, this paper argues in broad strokes that the currently global drug policy leadership is stifling the voices of actors that could round out the debate on drug policy reform. The CND and UNODC should make room for the voices of other UN agencies and human rights organizations so they can untether themselves from the outdated narcotic drug conventions and ‘war on drug’ policies—something that did not occur to the greatest extent possible at UNGASS 2016. Secondly, this paper argues that some, exhausted and frustrated by global drug policy fora, are shifting gears at home and employing

¹³ *Ibid.*

harm-reductionist programs, as will be exemplified by the recent Canadian experience. Thirdly, attention will be brought to the ‘road blocking’ maneuver by the Russian Federation, which is rendering it difficult for a global consensus to be reached on the importance of a human-rights based and public-health oriented drug policy. In each one of these arguments, it is apparent that women, most notably pregnant women who use drugs, continue to be pushed to the periphery of health service and treatment provision, the justice system and more broadly, drug policy-making—a hurdle that cannot be overcome unless the stigmatization and discrimination against pregnant women who use drugs is addressed. Focusing on pregnant women who use drugs also makes more explicit the need for a more holistic approach to drug policy—an approach that factors in the vast intersections that contribute to the experiences of pregnant women who use drugs, such as hesitancy to seek pre-natal counselling, enter drug-dependence treatment or opt for other harm-reduction programs.

To contextualization this comparative discussion between Canadian and Russian drug policy landscapes, a brief overview of harm-reduction will be provided, followed by a discussion of how gendered constructs of pregnant women who use drugs impacts drug policy. This will set the stage to delve into the discussions at UNGASS 2016, and the parallel recommendations made by CEDAW to Russia and Canada alike, before concluding with a discussion on whether pregnancy is a gateway entry point for women into global drug policy fora.

Embracing a Harm Reductionist Approach

There is a growing international consensus that the drug control framework must be people-centred, public health and human rights-based to tackle the global drug crisis¹⁴—with harm-reduction programming essential to such a strategy. And it is no wonder—there are more than 12 million people who inject drugs worldwide, and joint UNODC, WHO, World Bank and UNAIDS estimates indicate that 13 percent of the people who inject drugs (or 1.7 million people) are living with HIV.¹⁵ People who inject drugs are also 28 times more likely to acquire

¹⁴ UNAIDS, “A Public Health and Rights Approach to Drugs” (2015) at 6, online: <http://www.unaids.org/sites/default/files/media_asset/JC2803_drugs_en.pdf> [*Public Health and Rights*].

¹⁵ *World Drug Report*, *supra* note 7.

HIV than the general population.¹⁶ In reference to Russia and Canada, the countries of focus in which this paper, women constitute a sizable minority of people who use drugs, at 33 and 30 percent respectively.¹⁷ Speaking to HIV prevalence in both countries, Russia reached its millionth HIV case in January 2016, with over 57 percent acquiring HIV through drug use.¹⁸ Over in Canada, federally incarcerated females were more likely to have HIV than incarcerated males, with numbers being 50 percent higher for women who identify as Aboriginal.¹⁹ Given irrefutable evidence that HIV infections drastically decrease when drug use is not treated as a crime, but rather as a health condition, the need to reform global drug policy becomes strikingly apparent,²⁰ as it is not just a matter of controlling drug-use, but also of stifling epidemics.

The wave of advocacy geared towards embracing a harm-reduction approach lends a serious counterbalance to the supremacy of the disease model of addiction.²¹ Advocates for harm-reduction agree that drug-use ranges from positive experience to ones that are problematic, rendering abstinence both unnecessary and unrealistic for many people who use drugs.²² This being said, harm reduction does not reject abstinence, but rather includes it alongside a list of other options available to people who use drugs.²³ According to *Harm Reduction International*, a harm-reductionist approach consists of “policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop”, with the defining features being “the focus on the

¹⁶ UNAIDS, “Global AIDS response progress reporting, 2014: Construction of Core Indicators for monitoring the 2011 United Nations Political Declaration on HIV and AIDS” (Geneva: 2014), online: <http://www.unaids.org/sites/default/files/media_asset/GARPR_2014_guidelines_en_0.pdf> [UNAIDS 2014].

¹⁷ *World Drug Report*, *supra* note 7 at 13.

¹⁸ Matt Broomfield, “Russian HIV cases reach record high of more than a million” *Independent* (23 January 2016), online: <<http://www.independent.co.uk/news/world/europe/russian-hiv-cases-reach-record-high-of-over-a-million-a6828816.html>> [Broomfield].

¹⁹ Dianne Zekaria et al., “*Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey*” (Correctional Service of Canada: 2010), online: <<http://www.csc-scc.gc.ca/research/005008-0211-eng.shtml>> [Zekaria].

²⁰ *Public Health and Human Rights*, *supra* note 15 at 1.

²¹ *Transcending Myths*, *supra* note 7 at 135.

²² *Ibid.*

²³ *Ibid.*

prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs”.²⁴ Not only does this approach make sound sense in terms of being of greater benefit to the health and well-being of the general population, it is a fraction of the cost associated with putting people who use drugs behind bars.²⁵

Per advocates of harm reduction, pregnancy is viewed as a moment of opportunity to improve their health and well-being of both the woman who uses drugs and the fetus. Harm-reduction efforts geared towards pregnancy recognize that drug use is one factor among many that shapes a healthy pregnancy, and reducing or stopping substance use at any time during pregnancy can have positive effects on both the woman and fetus. However, what is more often the case is that pregnant women who use drugs are highly vulnerable, often receiving little to no accurate information about how drug use affects pregnancy and how to prevent mother-to-child HIV transmission.²⁶ In some countries, such as Russia, pregnant women who use drugs are rejected by health care providers, sometimes even threatened with criminal penalties or loss of child custody, or coerced into having an abortion or abandoning their newborn to the state.²⁷ Additionally, the lack of provision of opioid substitution therapy jeopardizes the pregnancies of opiate-dependent drug users, which is also the case in Russia, where OST is illegal.²⁸ Canada is no better, currently offered fragmented OST at best.

Moreover, abortion counselling and availability for pregnant women who use drugs is especially problematic in both Russia and Canada, given the introduction of a late-term abortion ban in Russia, and the sparse and fragmented abortion service provision in several Canadian provinces and territories. Combined, these policies hamper not only the ability of

²⁴ Harm Reduction International, “What is Harm Reduction? A Position Statement from Harm Reduction International”, online: <<https://www.hri.global/what-is-harm-reduction>> [HRI].

²⁵ *Public Health and Human Rights*, *supra* note 15 at 1.

²⁶ Sophie Pinkham and Kasia Malinowska-Sempruch, “Women, Harm Reduction, and HIV” (New York: International Harm Reduction Development Program of the Open Society Institute, 2007) at 3, online: <https://www.opensocietyfoundations.org/sites/default/files/women_20070920.pdf> [Pinkham].

²⁷ *Ibid.*, as cited in The Global Coalition on Women and AIDS, “Women who use drugs, harm reduction and HIV” (Geneva) at 8, online: <<http://idhdp.com/media/1114/brief-women-drugs-hiv-harm-final.pdf>> [Global Coalition].

²⁸ *Ibid.*

pregnant women who use drugs to access treatment and services to mitigate their drug dependence, but also make choices about their reproductive lives. It is for this very reason that Carol Smart, a feminist sociologist, concludes that women's bodies are used as a 'point of entry for social values and norms', as pregnancy is often the first time women encounter the power of the state and the ideology of mothering as both a biological and social event.²⁹ Comparing Canada and Russia's diverging approaches to drug policy allows us to push the scopes and bounds of this theory, particularly when placed against the backdrop of global drug policy fora.

Gendered Constructs of Pregnant Women in Drug Policy

The ideologies that underpin drug prohibition, cast stereotypes and fuel propaganda claim that drugs are bad, people who use them are criminal and that women who use drugs are immoral and pose a risk to the fetus and children. Even though there is a clear lack of intent to harm the fetus the woman is carrying, "drug-using pregnant women have been constructed as de facto criminal perpetrators. When women become noticeably unable or unwilling to carry out their assigned social roles and responsibilities as parents, they have often been demonized as 'bad mothers,' and criminalized."³⁰ In turn, there is a sentiment that judges should lean towards prison, punishment and legal and social marginalization as appropriate responses.³¹ All the above adversely impacts women's interactions with the criminal justice system and health care providers, particularly the interactions of pregnant women who use drugs.

Research has demonstrated that "being a woman was a strike against them, being a pregnant woman was a second strike, and being a drug using pregnant woman was the third and final blow in their social standing".³² There is also sufficient research illustrating that not all women who use drugs, or are suspected of using drugs, are viewed equally. Being poor, or being

²⁹ Susan C. Boyd, "From Witches to Crack Moms: Women, Drug Law and Policy" (Durham: Carolina Academic Press, 2015) at 80 [*Crack Moms*].

³⁰ *Using Women*, *supra* note 4 at 101.

³¹ SFU Centre for the Study of Gender, Social Inequities and Mental Health and the Canadian Drug Policy Coalition, "Challenging Drug Prohibition & The Regulation of Reproduction and Mothering (Forum Report 2015)" (Victoria: 2015) at 8, online: < http://drugpolicy.ca/wp-content/uploads/2015/02/PUBLIC_FORUM_REPORT_Jan30.pdf > [*Regulation of Reproduction*].

³² *Sales*, *supra* note 3 at 695.

racialized or indigenous, can also act as additional strikes against women who use drugs.³³ In other words, women who use drugs “are vulnerable to interlocking, and often competing, spheres of regulation”.³⁴ And nowhere are these competing and interlocking spheres of regulation more present than during pregnancy.

The impact on the health of both the mother and child, especially brain development in the newborn, should there be exposure to drugs during pregnancy and the post-natal phase, quickly raises eyebrows. It can also objectively ignite a heartfelt concern. Yet, society continues to turn a blind eye towards this issue, and consequently, pregnant women who use drugs often cannot access the care they need, even though CEDAW calls for their prioritization in programming, treatment and service delivery.³⁵ This neglect is often rooted in “erroneous ideas about neonatal ‘addiction’” that “gain a foothold in the popular mind, even to the point of calling into question decades of research and WHO endorsement of the effectiveness of opiate substitution therapy in pregnancy”.³⁶ In fewer words, misconceptions about addiction and pregnancy restrict options available to pregnant women—whether that means keeping or aborting the fetus—and nowhere else are these misconceptions more present than in Russia.

In other words, “services designed for women need to address the profound stigma and demonization faced by women who use drugs, since they are often quickly branded by society as immoral and unfit mothers”.³⁷ While pregnancy can be a motivating factor to seek drug treatment, if drug use and policies are ridden with such gendered constructs, impediments to seeking out care quickly transpire. The rights of women, particularly pregnant women, should be a central concern in global drug policy reform discussions and debates—but this means first overcoming the stigmatization and discrimination associated with using drugs during pregnancy,

³³ *Regulation of Reproduction*, *supra* note 33 at 4.

³⁴ *Ibid.*

³⁵ Canadian Centre on Substance Abuse, “Licit and Illicit Drug Use during Pregnancy: Maternal, Neonatal and Early Childhood Consequences” (2013), online: < <http://www.ccsa.ca/Resource%20Library/CCSA-Drug-Use-during-Pregnancy-Report-2013-en.pdf> > at 4 [CCSA].

³⁶ Kasia Malinowska-Sempruch & Olga Rychkova, “The Impact of Drug Policy on Women” (Open Society Foundation: 2012), online: < <https://www.opensocietyfoundations.org/sites/default/files/impact-drug-policy-women-20160928.pdf> > [Open Society].

³⁷ *Ibid.*

more broadly speaking. Perhaps then women's bodies would no longer be used as "the newest terrain for advancing the war on drugs" if society were to abandon drug prohibitionist attitudes, policies and frameworks.³⁸

UNGASS: Setting the Stage for a Shift in Global Drug Policy

To borrow the words of Diederik Lohman, Acting Director of Health and Human Rights at Human Rights Watch, the "so-called War on Drug has been lost. So, what now?"³⁹ He is not the only advocate to have heralded the war on drugs as lost, nor is he the only one questioning the best step forward. Even a 2008 report released by the International Narcotics Control Board (INCB) recognized that "the international drug control system was 'not perfect'".⁴⁰ Building upon the acceptance of this failed drug strategy, advocates, governments and organizations are working to veer away from the prohibitionist stance that once dominated drug policy fora, with the stage set for UNGASS 2016 to do just that.

There was hope amongst the global community that UNGASS would provide an opportunity to revolutionize the drug control system that has been enshrined in international law since 1961, when the Single Convention on Narcotic Drugs was adopted. The global drug policy landscape has greatly changed over the past half of a century since the adoption of this Convention. For instance, no longer is addiction referred to as "a serious evil for the individual" and a "social and economic danger to mankind", as was stated in the 1961 Convention.⁴¹ The Global Commission on Drug Policy echoes this statement in calling the global war on drugs a failure, noting the devastating wreck it has left in its path and calling for urgent reforms.⁴²

³⁸ *Regulation of Reproduction*, *supra* note 33 at 8.

³⁹ Diederik Lohman, "The War on Drugs – A Cure Worse Than the Disease" *Human Rights Watch: Rethinking the War on Drugs* (22 March 2016), online: <<https://www.hrw.org/blog-feed/rethinking-war-drugs>> [*Lohman*].

⁴⁰ Dr. David R. Bewley-Taylor, *International Drug Control: Consensus Fractured* (New York: Cambridge University Press, 2012) at 276 [*Bewley*].

⁴¹ Single Convention on Narcotic Drugs (1961), online: <https://www.unodc.org/pdf/convention_1961_en.pdf> [*Single Convention*].

⁴² Global Commission on Drug Policy, "War on Drugs: Report of the Global Commission on Drug Policy" (June 2011), online: <https://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Commission_Report_English.pdf> [*GCDP*].

However, of particular importance to mention for the purpose of this paper, the strategies that took root in the 1961 Convention particularly failed women and families, as it institutionalized laws and practices that disempowered women and violated principles and values that underpin women's equality.⁴³

Fast forward to present day, the three UN Conventions on Narcotic Drugs—1961, 1971, and 1988—do not mention discrimination based on sex or otherwise recognize issues faced by women who use drugs. However, UN bodies do recognize the special burden that is placed on women with regards to drug use, drug-related health services, and involvement in activities deemed criminal in drug laws.⁴⁴ A 2005 resolution by the UN Commission on Narcotic Drugs (formally) recognized the “adverse impact of drug use on women’s health, including the effects of fetal exposure” and urged member states to implement “broad-based prevention and treatment programs for young girls and women” and to “consider giving priority to the provision of treatment for pregnant women who use illicit drugs”.⁴⁵ On the other hand, the UNODC notes that women, including pregnant women, “encounter significant systemic, structural, social, cultural and personal barriers: to obtaining good-quality drug treatment, including “lack of childcare [in treatment programs] and punitive attitudes towards parenting and pregnant women, which makes them fear losing custody of their children and prevents them from seeking treatment early enough”.⁴⁶ Treatment for drug dependence also finds roots in international law more broadly, touching upon three of the principal conditions to fully realize the right to health. It is important to control epidemics, provides a health service to the ill, and by treating parents and pregnant women, can also improve the health and development of young children.⁴⁷

⁴³ For more information, see UNGASS Women 2016, online: <<http://www.ungasswomen2016.com/english/>> [UNGASS Women].

⁴⁴ *Open Society*, *supra* note 38.

⁴⁵ See the 2005 Resolution from the UN Commission on Narcotic Drugs.

⁴⁶ *Open Society*, *supra* note 38.

⁴⁷ Connie I. Carter & Donald MacPherson, “Getting to Tomorrow: A Report on Canadian Drug Policy” (Canadian Drug Policy Coalition: 2013) at 47, online: <http://drugpolicy.ca/report/CDPC2013_en.pdf> [Getting to Tomorrow].

The Women's Declaration was key in the push by UN member states to act on the disproportionate harm caused by prohibitionist drug policies on women around the world at UNGASS 2016. With over 20 civil society signatories, the document touted recommendations from the International Network of Women Who Use Drugs on how to align drug policy reform with the new Sustainable Development Goals, specifically those pertaining to gender.⁴⁸ Countries have spent more than \$100 billion USD on drug control and the 'war on drugs', which has led to mass incarceration, public health crises and unprecedented crime and black-market-fueled violence—and women are no exception to the devastating consequences that spiralled from the aftermath of these policies. To unpack how countries have responded to this aftermath, particularly the adverse impact these policies have had on women, we will now explore the Canadian and Russian experiences with drug policy, using the CEDAW Concluding Observations as a touchpoint.

Changing Tides: The Canadian Drug Policy Landscape

Released in November 2016, CEDAW's Concluding Observations on Canada spoke to a wide-range of issues pertaining to gender. At the onset, the observations were quick to "stress the crucial role of the legislative power in ensuring the full implementation of the Convention".⁴⁹ They flagged the concern that the provisions of the Convention were not adequately known to Parliamentarians, judges and citizens alike, calling upon the federal government to lead the implementation of the Convention and promote the justiciability of such rights.⁵⁰ Speaking specifically on Canada's drug policy, the observations welcomed Canada's commitment to shift its drug policy from a criminal to public health and harm reduction approach, but remains "concerned about the excessive use of incarceration as a drug-control measure against women

⁴⁸ Claudia Stoicescu, "Countries should put women at the forefront of the UN drug policy debate" *The Conversation* (18 April 2016), online: <<http://theconversation.com/countries-should-put-women-at-the-forefront-of-the-un-drug-policy-debate-57930>> [Stoicescu].

⁴⁹ Committee on the Elimination of Discrimination against Women, "Concluding observations on the combined eighth and ninth periodic reports of Canada" CEDAW/C/CAN/CO/8-9 (18 November 2016) [*Canadian Concluding Observations*].

⁵⁰ *Canadian Concluding Observations*, *supra* note 51.

and the ensuring female over-population in prison”.⁵¹ The Committee was particularly concerned about the inaccessibility of supervised consumption sites for women due to legislative and administrative barriers, particularly in light of the opioid overdose crisis plaguing the country.⁵² It called upon Canada to make harm-reduction a core pillar of their federal drug strategy and “reduce the gap in health service delivery related to women’s drug use”.⁵³ Given that 13 percent of new HIV infections diagnosed in Canada were attributed to the use of used needles and syringes in 2014—with nearly 25 percent of new infections among women—closing this gap in health care service delivery related to women’s use of drugs becomes apparent. Tag on the estimation that half of all new infections attributed to unsafe drug injection occurred amongst Indigenous people, the needs to close this gap could not be more accentuated.⁵⁴

The Committee further called upon Canada to repeal the *Respect for Communities Act*,⁵⁵ and establish a more transparent process to apply for an exemption to operate a supervised consumption site, as well as repeal mandatory minimum sentences for minor, non-violent drug-related offences.⁵⁶ Echoing the ripple effect of criminalization of drug use on public health as mentioned above, the Committee expressed concerned about the high rates of HIV/AIDS among female prisoners, calling for the expansion of services available to women in detection who are living with or vulnerable to HIV, including harm reduction programming.⁵⁷

Canada has witnessed a steady decrease in crime over the past decades, but this is not the same trend for drug offences, which have been steadily increasing. Drug offences increased 39.5 percent between 1998 and 2011, with over 109 455 drug offences being reported to police in 2012 alone.⁵⁸ Over the past thirty years, the number of women charged with a criminal offence

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ Canadian HIV/AIDS Legal Network, “Advocacy in Action: Charting the Future of Canada’s Drug Policy” (19 November 2016), online: <<https://www.youtube.com/watch?v=bVYu8cqpFWI>> [*Charting Future*].

⁵⁵ *Respect for Communities Act*, S.C. 2015, c. 22 [*Respect for Communities*].

⁵⁶ *Canadian Concluding Observations*, *supra* note 51.

⁵⁷ *Ibid.*

⁵⁸ *Regulation of Reproduction*, *supra* note 33 at 7.

has also soared, as well as the number of women in prison.⁵⁹ Of those in women in federal prison, 27 percent (compared to 16 percent of men) were there for drug offences⁶⁰—a statistic that does not likely feel the harsh shift in Canada’s drug laws in 2012, when federal mandatory minimum penalties for some drug offences were imposed.⁶¹ Again, this shift did not bode well for women, with 86 percent of Canadian women in one study saying that the country’s narcotic laws have had a negative effect on their lives.⁶² Specifically, 19 percent of mothers interviewed in the same study had lost custody of their children due to arrest and incarceration, and of those women, only one mother regained custody of her child post-arrest.⁶³

Although there was great concern for any array of gender issues in the Concluding Observations, there was very little reference to pregnant or parenting women. From the angle of the transmission of HIV, this might be due in part to the fact that “Canada has virtually eliminated the incidence of mothers passing HIV to their infants at birth, primarily because of high rates of pre-natal testing and ready access to drug treatment that subdues the infection.”⁶⁴ From less nuanced perspective, the availability of treatment and services for pregnant women caught the attention of other actors. In 1996, the issue of whether a pregnant woman who uses drugs is obligated to undergo treatment went before the courts, with the discussion of whether a woman owed a duty of care to her fetus going before the Supreme Court of Canada. Ultimately, seven out of the nine judges concluded that a pregnant woman who has substance abuse problems cannot be forced into a treatment program.⁶⁵ In a report by Health Canada on how health care providers can reduce barriers to treatment access for diverse groups of women

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ *Ibid* at 8.

⁶² *Transcending Myths*, *supra* note 7 at 168.

⁶³ *Ibid.*

⁶⁴ Sheryl Ubelacker, “HIV transmission from mother to child nearly eliminated in Canada” *CBC Health* (22 July 2015), online: CBC News <<http://www.cbc.ca/news/health/hiv-transmission-from-mother-to-child-nearly-eliminated-in-canada-1.3164274>> [Ubelacker].

⁶⁵ Canada FASD Research Network’s Action Team on Prevention from A Women’s Health Determinants Perspective, “Substance Abuse during Pregnancy: An Overview of Key Canadian Policy and Practice Areas” at 3, online: <<http://bccewh.bc.ca/wp-content/uploads/2014/09/Canadian.Policy-on.Subst-Use-+-Preg.Sept-2-2014web.pdf>> [FASD].

who use drugs, the lack of programs that accept pregnant women and/or their children was flagged.⁶⁶ Although the report recognized that outpatient counseling and other supports were available for pregnant and parenting women, the report called for residential arrangements that accommodate such a situation, and create greater access to treatment programming.⁶⁷

Reverting to the broader discussion of domestic drug policy, Canada has witnessed a flurry of debate on the subject since the Trudeau Liberal government was elected in on a platform promising the decriminalisation of cannabis by spring 2017. This policy sprung from, among other things, years of critiques that Canadian drug policy was ignoring the harms and societal costs of drug prohibition, and in turn, supporting the demonization of people who use criminalized drugs.⁶⁸ It was this political sentiment that spurred the federal Conservative government in 2007 to adopt the National Anti-Drug Strategy—a \$527.8 million effort to tackle illegal drug use in Canada.⁶⁹ “This strategy was accompanied by other ‘tough-on-crime’ efforts that expand a punitive approach while doing little to address the root causes of crime.”⁷⁰ One year later, the leadership for this anti-drug strategy moved from its location within Health Canada to the Department of Justice, physically illustrating the lenience towards a more punitive approach, rather than one more grounded in public health.⁷¹

Given the global movement to embrace a harm-reductionist approach, the national opioid overdose crisis in Canada, and the shift in federal leadership, the tables are turning. At UNGASS to specifically discuss the world’s drug problem, federal Minister of Health, Jane Philpott acknowledged that Canada must do better for their citizens, saying that she was “proud to stand up for drug policy that was informed by solid scientific evidence and uses a lens of public health

⁶⁶ Janet C. Currie, “Best Practices: Treatment and Rehabilitation for Women with Substance Abuse Problems” (Health Canada: 2001), online: <<http://www.cwhn.ca/en/node/21475>> [Currie].

⁶⁷ *Ibid.*

⁶⁸ *Regulation of Reproduction*, *supra* note 33 at 7.

⁶⁹ Susan C. Boyd, Connie I. Carter & Donald MacPherson, *More Harm than Good: Drug Policy in Canada*, (Halifax: Fernwood Publishing, 2016) at 36 [*More Harm Than Good*].

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

to maximize education and minimize harm.⁷² She concluded her speech in saying that Canada's "approach to drugs must be comprehensive, collaborative, and compassionate", and "work will law enforcement partners to encourage appropriate and proportionate criminal justice measures", as "it is impossible to arrest our way out of this problem".⁷³ This rang a very different tune than the previous government's 'tough on drugs' messaging, where former Prime Minister Stephen Harper was quoted saying "if you sell or produce drugs, you will pay with prison time".⁷⁴

The federal government recently announced it would be replacing NAD, the former government's drug strategy, with a "more balanced approach" called the Canadian Drugs and Substances Strategy, of which harm reduction would be central.⁷⁵ An announcement was also made that his new strategy will be housed with the ministry of health, rather than the ministry of justice—reverting back to its original home before the introduction of NAD.⁷⁶ In the same breath, the federal government also announced that the 26 criteria in *Respect for Communities Act* that were previously required to get a supervised injection site approved will now be repealed, to be replaced with five benchmarks which are more reasonable to achieve.⁷⁷

Despite the shift sparked by the current liberal government, harm-reduction programming in Canada continues to be spotty at best, particularly for pregnant women who use drugs. "Most harm reduction programs are not funded to provide these services and in some jurisdictions,

⁷² "Jane Philpott on drug policy: 'We must do better for our citizens'" *Maclean's* (20 April 2016), online: <<http://www.macleans.ca/politics/ottawa/jane-philpott-on-drug-policy-we-must-do-better-for-our-citizens/>> [Philpott].

⁷³ *Ibid.*

⁷⁴ *Charting Future*, *supra* note 56. Canadian HIV/AIDS Legal Network, "Advocacy in Action: Charting the Future of Canada's Drug Policy" (19 November 2016), online: <<https://www.youtube.com/watch?v=bVYu8cqpFWI>> [Charting Future].

⁷⁵ Peter Zimonjic & Matthew Kupfer, "Liberals to make safe injection sites easier to open and fentanyl harder to smuggle into Canada" *CBC Politics* (12 December 2016) online: CBC News <<http://www.cbc.ca/news/politics/safe-injection-sites-goodale-philpott-1.3892687>> [Zimonjic].

⁷⁶ *Ibid.*

⁷⁷ The five benchmarks are: (1) Demonstration of the need for such a site to exist; (2) Demonstration of appropriate consultation of the community; (3) Presentation of evidence on whether the site will impact crime in the community; (4) Ensuring regulatory systems are in place; and (5) Site proponents will need to prove appropriate resources are in place. *See Respect for Communities Act*, *supra* note 57, cited in Zimonjic, *supra* note 77.

services simply do not exist for pregnant and mothering women who use drugs.”⁷⁸ But the services that do exist have shown very positive results, such as *Sheway*, a Pregnant Outreach Program (P.O.P.) located in the Downtown Eastside of Vancouver, and *The Jean Tweed Centre* in Toronto, which provides counselors at various sites to offer support services to women and children and connect mothers with local resources.⁷⁹ *Fir Square* also offers a harm reduction approach for women unable to practice abstinence during pregnancy at the maternity unit at the British Columbia Women’s Hospital.⁸⁰ *Healthy Empowered, Resilient Pregnancy Program* (H.E.R.) also operates out of Edmonton, in conjunction with Streetworks. Two other programs are also in development: *Herway Home* in Victoria, and the *Mothering Project* in Winnipeg.⁸¹

Canada has strong lineup of front line service workers and organizations, but their efforts are often hampered by “fear, lack of leadership and poorly informed policies based on outdated ideas and beliefs about drugs and the people who use them”.⁸² Canada is however slowly but surely joining the chorus of international actors who are seeking out creative and brave policy changes to address drug policies that are causing more harm than good, with their most recent announcements illustrating such an effort.⁸³ Yet, considering this shift happened relatively quickly over during the government’s first year in power, it remains unclear if they can lead diplomatic efforts to rid the prohibitionist attitudes currently poisoning global drug policy reform, while also keeping pace with managing their drug policy crisis at home. It might be best to remain cautiously optimistic about Canada’s ability to balance domestic duties with global diplomatic leadership pertaining to drug policy.

Although many advocates, governments and organizations were singing in an almost unified chorus that global drug policy should veer away from its prohibitionist past and embrace a public-health approach moving forward, Russia has been a part of a small but vocal minority adamant not to even engage with language that hints at such a direction. Some have even

⁷⁸ *Getting to Tomorrow*, *supra* note 49.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Getting to Tomorrow*, *supra* note 49.

⁸² *Ibid.*

⁸³ *Ibid.*

referred to this move as the “Russian roadblock”.⁸⁴ However, this was not the first-time Russia has attempted to pull such a maneuver. In 2011, a speaker of Russia’s lower house, Boris Gryzlov, showed continue support for a ‘total war on drugs’ to counter the soaring abuse rate of Afghan heroin soaring through central Asia and onwards to Europe.⁸⁵ Proposed legislation—which was under parliamentary review at the time of this statement—would have forced drug addicts into treatment or jail, with dealers being handed heftier custodial sentences.⁸⁶ Gryzlov stated that “the barons of narco-business must be put on par with serial killers with the appropriate punishment in the form of a life sentence”.⁸⁷ There was even talk of drug dealers being sent to forced labour camps under these laws drafted by the Kremlin-controlled parliament.⁸⁸ It is this political sentiment that continues to inform not only the country’s drug policies, but also its stance on reproductive rights and provision of drug dependence treatment, specifically opioid substitution therapy—all policies in which adversely impact pregnant women who use drugs. Considering Russia is home to one of the world’s largest populations of people who inject drugs (estimated at over 1.8 million),⁸⁹ and there are estimates that 11 percent of pregnant women have used illicit substances,⁹⁰ it does not take long to do the math and realize that the policies are not impacting a small portion of Russia’s population.

Before CEDAW released its concluding observations on Russia, the Public Mechanism for Monitoring Drug Policy Reform in the Russian Federation submitted a report to CEDAW flagging great concern for the systematic discrimination of women who use drugs in Russia.

⁸⁴ Transform: Getting Drugs Under Control, “Drug policy reform hits a Russian roadblock at the UN”, *Transform* (4 April 2016), online: <<http://www.tdpf.org.uk/blog/drug-policy-reform-hits-russian-roadblock-un>> [*Russian Roadblock*].

⁸⁵ Tom Parfitt, “Russia defies growing consensus with declaration of ‘total war’ on drugs” *The Guardian* (8 June 2011), online: <https://www.theguardian.com/world/2011/jun/08/russia-total-war-on-drugs> [Parfitt].

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*

⁸⁹ Sarah K. Calabrese et al., “Internalized HIV and Drug Stigmas: Interacting Forces Threatening Health Status and Health Service Utilization Among People with HIV Who Inject Drugs in St. Petersburg, Russia” (2016) 20:1 AIDS Behav 85 at 85 [*Calabrese*].

⁹⁰ Committee on the Elimination of Discrimination against Women, “Concluding observations on the eighth periodic report of the Russian Federation”, CEDAW/C/RUS/CO/8 (20 Nov 2015) [*Russian Concluding Observations*].

This issue had yet to be covered in periodic reports by the Russian Federation or addressed by CEDAW. This concern was fueled by compelling evidence of roughly 425,000 drug-dependent women who were subjected to discrimination and violence, including their criminalization and oppression through official Russian state policy.⁹¹ The vulnerability of women who use drugs to physical and/or structural violence, as well as gender discrimination, particularly in the Russian criminal justice system, was previously flagged two years prior by the Special Rapporteur on Violence Against Women.⁹² The following year, CEDAW noted that this vulnerability to discrimination also manifested itself when accessing health care in Russia, particularly reproductive health services.⁹³ In other words, the CEDAW Concluding Observations were not the first time that the criminalization of drug use in Russia was heralded as depriving women of several of their basic rights, such as the right to health, the right to be free from violence, the right to be free from torture, inhuman or degrading, and the right to access justice.⁹⁴

According to evidence provided in the report, this comes to no surprise as there are no medical protocols to guide the prenatal care of women with drug dependence in Russia, and most of the medications prescribed in Russia for the treatment of drug addiction are contraindicated during pregnancy.⁹⁵ Further, Russian gynecologists are not trained to care for women with drug dependence in certain aspects, while drug addiction is considered an indication for abortion.⁹⁶ The state-promoted intolerance towards patients with addictions causes medical professionals to pressure drug using women who wish to carry the pregnancy to

⁹¹ Public Mechanism for Monitoring Drug Policy Reform in the Russian Federation, *REPORT to the Committee on the Elimination of Discrimination against Women (CEDAW) on the implementation by the Russian Federation of the Convention on the Elimination of Discrimination against Women (Convention) as it relates to women who use drugs and drug dependent women*, 62nd Sess (26 October – 20 November 2015) [Public Mechanism].

⁹² United Nations Economic and Social Council, “Integration of The Human Rights of Women and a Gender Perspective: Violence Against Women: Report of the Special Rapporteur on violence against women, its causes and consequences: Mission to the Russian Federation” (2013) [Special Rapporteur RF].

⁹³ *Public Mechanism*, *supra* note 93.

⁹⁴ *Ibid.*

⁹⁵ Order of the Russian Federation Ministry of Health of 28 April 1998, No 140 endorsing the Standards (Model Protocols) for diagnosis and treatment of patients with addictions [Model Protocols 1].

⁹⁶ Order of the Russian Federation Ministry of Health and Social Development of 3 December 2007, No. 736 endorsing the List of medical indications for termination of pregnancy [Medical Indications].

term into having an abortion by convincing them that their babies would be born with abnormalities.⁹⁷

CEDAW, in their Concluding Observations on the Russian Federation, expressed concern about the patriarchal attitudes and stereotypes of women in Russia, particularly the degree to which women are primarily cast as mothers and caregivers, discriminated against, subordinated within family and society, restricted in their educational and professional choices and participation in political life.⁹⁸ The Committee went so far as to say that Russia “has not taken sustained measures to modify or eliminate discriminatory stereotypes and negative traditional attitudes”, pointing to the media who has persistently conveyed these negative stereotypes and degrading images of women.⁹⁹ To provide examples of these media depictions, in a graphic series of public service announcements produced by the Krasnoyarsk regional government, a young woman is sitting with a series of jars in front of her, with each jar containing a fetus, with which the woman attributes to different drugs she has used in the past.¹⁰⁰ In another ‘educational’ campaign issued by a drug treatment center in Tomsk, a brochure listed stillbirth, deformities and defects among the list of dire consequences pregnant women could purportedly face if they continue to use drugs—even going so far as to say that rates of infant deaths among pregnant women who use drugs is four times that of women who don’t use drugs, citing a 70 percent fatality rate for infants born to women who use heroin in particular.¹⁰¹ Needless to say, these campaigns do not make for accessible treatment, informed choices or approachable services, depriving Russian pregnant women who use drugs of the rights in the Convention—and it weaves throughout all other facets of a pregnant women who use drugs’ ability to uphold her rights.

⁹⁷ Andrey Rylkov Foundation for Health and Social Justice, «...Маленькая девочка со взглядом волчицы» (14 April 2012), <online: <http://rylkov-fond.org/blog/lichnye-svidetelstva/yulia-story/>> [originally in Russian] [*Yulia Story*].

⁹⁸ *Russian Concluding Observations*, *supra* note 92 at para 19.

⁹⁹ *Ibid.*

¹⁰⁰ Becky Tolson, “Setting the Record Straight on Motherhood and Drug Use” *Open Society Foundations Voices* (16 December 2010), online: <<https://www.opensocietyfoundations.org/voices/setting-record-straight-motherhood-and-drug-use>> [*Tolson*].

¹⁰¹ *Tolson*, *supra* note 102.

By way of three changes in Russian law, the report to CEDAW recommended changes to articles 2, 5 and 12 of the Convention: (1) develop and implement evidence-based standards of low-threshold drug treatment and harm reduction services, including OST, for women who use drugs, including pregnant women and women with children; (2) amend article 61 of the Family Code of the Russian Federation and Eliminate addiction as a ground for the termination of parental rights, and stop discouraging women from accessible drug treatment and from rehabilitation services for women with children; and (3) address social stigma faced by women who use drugs through awareness campaigns and special training for criminal justice actors to increase accountability for law enforcement agencies and officers that commit violence against women who use drugs or do not respond to their appeals.¹⁰²

However, these recommendations become difficult to implement on two fronts: firstly, the paucity of monitoring and data on pregnant drug-using women in Russia, and secondly, the lack of legal and administrative mechanisms available to women to exercise these rights. The Russian government currently does not collect data on the prevalence of pregnancy among women who use drugs, with only peripheral evidence pointing to the severity of the issue. Considering this paucity of information to speak to the scope of the issue, CEDAW called for a separate division on gender equality to be established within the Office of the Ombudsman, which would collect gender-disaggregated statistics.¹⁰³ Gaining a general sense of the overall situation of pregnant women who use drugs in Russia, as well as women more broadly, becomes difficult to tackle without numbers speaking to the scope of the issue.¹⁰⁴

Two policies further complicate the already precarious situation for pregnant women who use drugs in Russia: the illegalization of opioid substitution therapy and the introduction of a policy banning late-term abortion and. To first delve into the prohibition of OST by the Russian state, we shall turn to a current case before the European Court of Human Rights, which will also illustrate the current frustrations navigating the Russian judicial system as a means to uphold human rights. Mikhail Golichenko, a Russian lawyer with the Canadian HIV/AIDS Legal

¹⁰² *Russian Concluding Observations*, *supra* note 92.

¹⁰³ *Ibid* at para 12.

¹⁰⁴ *Russian Concluding Observations*, *supra* note 92 at para 47.

Network, is representing three people who use drugs on a claim against the legal prohibition of OST in Russia at the European Court of Human Rights, after an attempt to use Russia's domestic legal system was unsuccessful.¹⁰⁵ The three claimants said that over the years of battling their addictions, they have exhausted all domestic treatments, and have since contracted HIV. Their claim is that being denied OST violates international human rights law, namely the prohibition of inhuman or degrading treatment (article 3) and discrimination (article 14).¹⁰⁶ If they are successful, it will be the first legally-binding decision from the European Court of Human Rights that will recognize that people who use drugs are vulnerable people who are entitled to protection under international human rights law.¹⁰⁷

Speaking secondly to the ban on late term abortion, it is often the case that women who use drugs do not find out they are pregnant until several months after conception. Prolonged exposure to illicit substances can compromise reproductive function and disrupt a woman's menstrual cycle, which can include the complete cessation of menstrual periods. As such, women who use drugs often deem themselves as infertile, only to learn about their pregnancy late in the term. Even a growing abdomen is not often perceived as a sign of pregnancy for Russian women who use drugs, as women often explain it by other health complications, such as liver problems or being overweight.¹⁰⁸

When a woman does find out she is pregnant, then there comes the decision of whether she wants to keep the child, which quickly becomes a much more complicated question in the Russian Federation. The right of a woman who uses drugs to terminate an unwanted pregnancy clashes with the recent policy of the Russian government to reduce the maximum gestational period for lawful termination to the first trimester. Rape is now the only 'social condition' whereby a late abortion would be allowed in Russia, with administrative fines imposed for

¹⁰⁵ *Larsson, supra* note 103.

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ Nonprofit Partnership EVA (2014), online: < <http://evanetwork.ru/en/the-history-of-np-eva/> > [EVA].

doctors violating this policy on late-term abortion services.¹⁰⁹ Although his legislation is only applicable for government-funded abortions, it still significantly hampers the reproductive choice of women who use drugs in Russia, as they often live in poverty and do not have the resources to pay for an abortion at a private clinic—which is often the case for pregnant women who use drugs. Although Russia heralds this policy as one that protects maternity in the country, it violates women’s rights on many fronts, particularly Article 4 of CEDAW, which states that “measures aimed at protecting maternity shall not be considered discriminatory”.¹¹⁰

It is not only the responsibility of the Russian government to make sure these rights are enforced, but also educate their citizens about these rights, so women have a greater opportunity to claim them. Currently, the Russian government does not educate women who use drugs about their reproductive health or family planning options, nor does it designate resources to NGOs providing such a service, which also conflicts with Article 10 and 12 of CEDAW, and Article 24.2 of the Convention on the Rights of the Child. In other words, it does not suffice to merely change laws—public health programming is crucial to ensure the accessibility, implementation and protection of these rights. With not a single harm reduction program in place for women who use drugs in the country, even though in about 59% of all newly registered HIV cases in 201 and unsafe injecting of narcotic drugs was reported as a cause of HIV transmission, it becomes strikingly clear that there is a moment of opportunity for the Russian government to act—and it is not just judicially, internationally or legislatively. It is through adopting a public health approach that is non-discriminatory, women-centered and harm-reductionist.¹¹¹

¹⁰⁹ Matthew Cullinan Hoffman, “Russia defends late-term ‘social abortions’ as country moves to curtail high abortion rate” *SITE* (28 February 2012), online: < <https://www.lifesitenews.com/news/russia-defunds-late-term-social-abortions-as-country-moves-to-curtail-high> > [Hoffman].

¹¹⁰ *Convention on the Elimination of Discrimination against Women* (3 September 1981) [CEDAW].

¹¹¹ The official statistics on AIDS epidemic is available on the website of the Federal AIDS Center, although they are incomplete.

Russia and Canada: Side by Side or Divergent on Drug Policy?

When placed side by side, it became clear that both Russia and Canada struggled to inform their citizens of the rights that were available to women through CEDAW. In both Concluding Observations, it became apparent that this was of notable concern for women who lived in remote and rural corners of either country. It is for this reason that the importance of the legislative power to ensure the Convention was fully implemented was underscored in both instances. And this did not just stand for the legislature, but also the judiciary. CEDAW expressed concern that the courts in Russia and Canada alike were not employing the Convention to its fullest potential, perhaps unaware of the rights that were of avail to them. For example, the fact that not a simple complaint of gender-based discrimination was filed with Russia's Office of the Ombudsman speaks to the lack of an effective complaint mechanism for women to claim their rights in Russia.¹¹²

Due to the enduring footprint of Harper's 'tough on drugs' policies, there remains also a striking commonality from a criminal law standpoint between Russia and Canada, and both countries should bear in mind the recommendations made jointly by UNODC, INPUD, UN Women and the WHO. These agencies recognize many women arrested and incarcerated for drug offenses have not committed a violent crime or are first-time offenders, and harsh punishments in these cases are disproportionate and unjust, both to them and to their families. Less punitive laws for minor and non-violent drug infractions are the best single means of reducing incarceration of women and thus incarceration-related abuse.¹¹³ In other words, there is a call for proportionality in sentencing women arrested and incarcerated for a drug offence—a call that might be more likely to be better received by Canada than Russia, given the new leadership that is seemingly more receptive to less stringent criminal laws for certain drug-offences.

To further this point, the UN Special Rapporteur on violence against women reported to the General Assembly in 2013 that drug laws and policies 'are a leading cause of rising rates of

¹¹² *Russian Concluding Observations*, *supra* note 92 at para 11.

¹¹³ *Open Society*, *supra* note 38.

incarceration of women around the world’ and expressed concern that in some countries ‘women who commit relatively low-level drug crimes’ are more likely to be handed long prison sentences than men who committed major trafficking offences”.¹¹⁴ In response, the UNODC has pushed for more gender disaggregated information to be included in its drug reporting to gain a better sense of the scope of this issue. Although there is little research speaking to the impact of these drug laws and policies, there has been research pointing to how women are at a disadvantage when a mandatory minimum sentence is imposed on them for a drug offence, particularly as they have little leverage when it comes to plea-bargaining. “Prosecution of women for drug-related offenses also rarely [factor in] the reasons why women may be involved with drugs in the first place, which may include pressure from a sexual partner, histories of domestic violence or other abuse, lack of mainstream livelihood opportunities, and lack of accessible treatment programs and related social support.”¹¹⁵ And ending up in prison often exacerbates these factors, including the risk of HIV transmission, specifically through high rates of injected drug use in prison.

Merging together the recommendation to ensure the judiciary and legislature are informed of the rights available to them through CEDAW, and the call to for more proportionate and just punishments for certain drug offences, CEDAW also calls for training of judges, prosecutors, police officers and other law enforcement. The training would zone in on “the impact of a strict application of criminal law provisions on violence against women and gender-sensitive procedures to deal with women who are victims of violence”.¹¹⁶ Training law officials to work with health professionals is also another potential option for both Russia and Canada, as was flagged by the Commission on the Status of Women. But why the importance of getting law enforcement involved? It is not just a matter of the extent to which women are using drugs, and the ripple effect on their health and well-being—but also the extent to which they are being incarcerated, punished and criminalized for doing so.

¹¹⁴ *Ibid.*

¹¹⁵ *Open Society*, *supra* note 38.

¹¹⁶ *Russian Federation Concluding Observations*, *supra* note 92.

Prohibitionist attitudes remain a huge barrier for facilitating such discussions in international drug policy-making fora, which is arguably most strikingly the case with Russia who remains in denial of the scientific evidence supporting harm reduction programming. Russia even refused to include ‘harm reduction’ in the *Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem*.¹¹⁷ Pushing for the language of ‘scientific’ evidence-based (rather than just evidence-based) to be in the document, Russia also objected to a reference made by UN Women to push for greater consideration of gender in drug policy at UNGASS.¹¹⁸ It is these sentiments and policies that road blocked efforts by the global community to shift the dialogue on drug policy reform.¹¹⁹ If the Canadian government had not changed hands in October 2015, Canada might have also chimed in part with Russia, as under the Harper Conservative government, moves were made to refocus drug policy within the criminal realm. However, given this political shift, federal Minister of Health Jane Philpott paved the way for a change in tune at UNGASS with a speech calling “to revisit our efforts in global drug policy”.¹²⁰

Yet, Canada was not always so open to reforming drug policy, and arguably leaned closer to the Russian stance until the federal government switched hands in October 2015. Tony Clement, former Minister of Health, was quoted at the 2008 International AIDS Conference in Mexico City saying “I don’t believe that someone sticking a needle in their veins is harm-reduction. I’m sorry. That is why *Insite*, to me, is an abomination”.¹²¹ While Russia continues down the path of drug control and denial of the evidence supporting a harm-reductionist approach, even amid the announcement in January 2016 of Russia’s one-millionth case of HIV

¹¹⁷ Samuel Oakford, “How Russia Became the New Global Leader in the War on Drugs” *VICE News* (18 April 2016), online: < <https://news.vice.com/article/how-russia-became-the-new-global-leader-in-the-war-on-drugs-ungass> > [Oakford]; see also United Nations General Assembly, *Our joint commitment to effectively addressing and countering the world drug problem*, GA Res S-30/1, UN GA, 13th Session, Supp No 8, UN Doc A/RES/S-30/1 (2016) [Joint Commitment].

¹¹⁸ *Ibid.*

¹¹⁹ Diane Riley, “Drugs and Drug Policy in Canada: A Brief Review and Commentary” (Canadian Foundation for Drug Policy and International Harm Reduction Association: November 1998), online: <<http://www.parl.gc.ca/Content/SEN/Committee/362/ille/rep/rep-nov98-e.htm>> [Riley].

¹²⁰ Philpott, *supra* note 73.

¹²¹ *Charting Future*, *supra* note 56.

and the soaring rates of injected drug use, Canada is attempting to turn a new leaf. There are political promises of decriminalizing cannabis by spring 2017, calls for harm-reduction to be front and centre to their new drug policy to be housed under the ministry of health, and a repealing of criteria in the *Respect for Communities Act* to facilitate the approval of safe injection sites across the country, which is particularly timely given the gravity of the national opioid overdose crisis. Yet, in lining up this Canadian shift against Russian adamant prohibitionist policies, the turbulent nature of global drug policy reform becomes apparent. As prohibitionist policies continue to poison efforts to reform global drug policy, it remains tricky, albeit not impossible, for harm reduction programming and other public-health oriented responses to drug use to find root in international mechanisms—such as the United Nations Office of Drug and Crime and the Commission on Narcotic Drugs—and not just soft law and recommendations put forward by international human rights bodies, such as the World Health Organization and UN Women. This scenario is deeply troubling for pregnant women who use drugs, as their rights fall at the intersection of so many realms.

Conclusion

Given the precarious circumstances of pregnant women who use drugs, amid a dynamic and stunted global drug policy, how can their voices be amplified? Particularly if there such a degree of resistance to even speak of harm reduction by various countries and international drug control bodies and agencies? Pregnancy, and the impact of drug use on newborns, is often the gateway for women to get a seat at the drug policy decision making table. Yet, drug policy should also strengthen women's autonomy in decisions that bear on their own lives—not just use maternal instinct as bait to engage in the conversation, as it does little to advance this goal that is more substantive in nature, as was demonstrated in this paper.¹²² International conventions to domestic strategies should prioritize pregnant women when accessing treatment and delivering services for drug dependence, paying careful heed to the unique and intersectional barriers that they often face.

¹²² *Using Women*, *supra* note 4 at 192.

So long as Russia continues to perpetuate and fuel prohibitionist attitudes in global drug policy, gendering global drug policy—by way of making harm reduction, human rights and public health core pillars—is likely to be a treacherous journey. Perhaps UNGASS 2020 will afford the opportunity for a greater global consensus on the gendering of global drug policy. To get there, it will require the continued critiques put forward by CEDAW to ensure women's rights are being respected in the realm of drug use, treatment and policy. Step by step, perhaps the global community can make strides towards a global drug policy that no longer pushes pregnant women who use drugs to the margin by way of prohibitionist policies. If Canada keeps moving forward at the pace they have set over the course of the Liberal government's first year in power, maybe they can lead this wave of change to make sure global drug policy is gendered, evidence-based and harm reductionist, as it is clear UNGASS 2016 was lacking strong, progressive leadership. Maybe then we can move away from the 'war on drugs' and prevent the 'war on pregnant women who use drugs' from escalating any further.

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