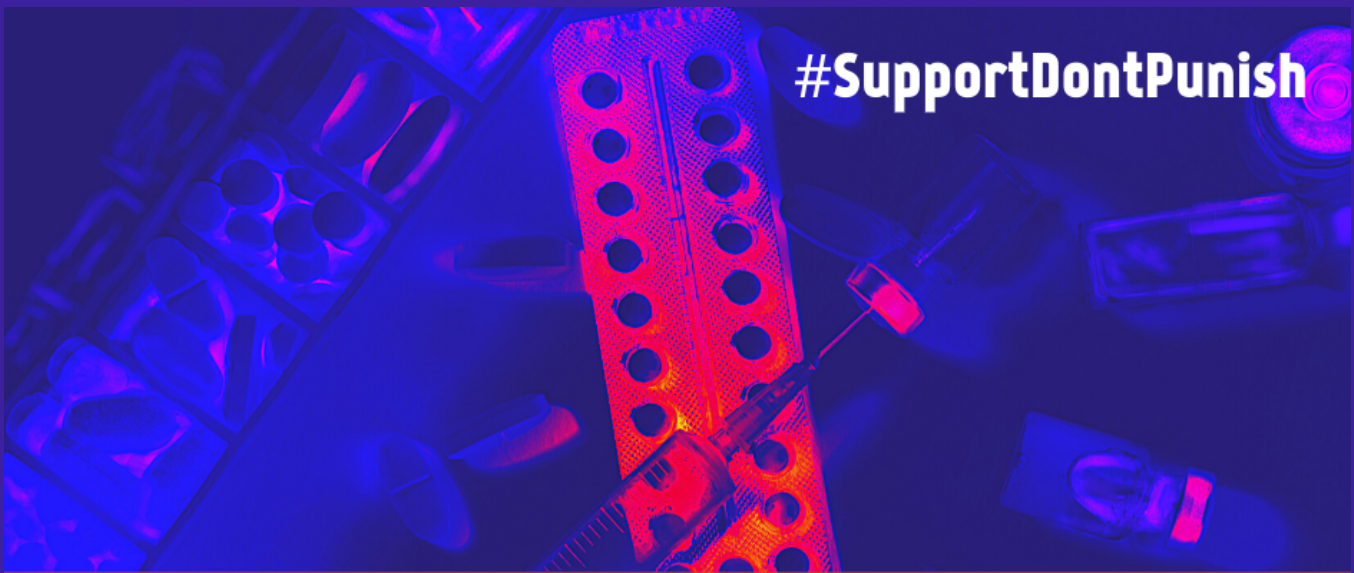


DRUG POLICY AND THE FUNDAMENTAL HUMAN RIGHTS OF WOMEN WHO USE DRUGS



States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services.

Article 12, CEDAW

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I. INTRODUCTION

Across the world, women who use drugs endure intersecting forms of discrimination related to gender, drug use, HIV status, mental health conditions, and other factors. They are denied basic rights to equality and non-discrimination, life, the highest attainable standard of physical and mental health, family, information, privacy, and freedom from cruel, inhuman, and degrading treatment. While these fundamental rights are espoused in different international treaties, scant attention has been paid to the millions of women who use drugs worldwide, who suffer from criminalization, stigmatization, and marginalization by political, legal, and medical actors, as well as by society as a whole. This situation is particularly egregious in the Russian Federation, whose drug policy is highly punitive, as will be discussed in this report.

Through an in-depth analysis of the relevant human rights standards and interpretations of those standards, this report aims to assist advocates and stakeholders in the human rights system in addressing the multiple human rights violations of women who use drugs. Specifically, it examines the intersectional discrimination suffered by women who use drugs; the need for a public health, rather than a punitive, approach to drug policy; the link between drug dependence and mental health conditions; and the importance of a gender sensitive response to drug dependence that accounts for reproductive health, pregnancy, and relations with children.

Routine mistreatment and neglect of women who use drugs violates virtually every major human rights treaty, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), [1] the International Covenant on Economic, Social, and Cultural Rights (ICESCR), [2] the International Convention on Civil and Political Rights (ICCPR), [3] the Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (CAT), [4] the Convention on the Rights of the Child (CRC), [5] the Convention on the Elimination of All Forms of Racial Discrimination (CERD), and the Convention on the Rights of Persons with Disabilities (CRPD). [6] As the following sections will show, protection of basic rights is not only consistent with international law, but also with good medical practice and scientific evidence.

II. CEDAW Requires Recognition of Intersectional Discrimination Against Women Who Use Drugs and Women Living with HIV

This section provides a human rights analysis of discrimination against women who use drugs and women living with HIV and the importance of taking an intersectional approach to address such discrimination. Women who use drugs and women living with HIV are doubly or triply marginalized based on both their gender and their health status. The analysis in this section examines global experiences with a particular focus on the Russian Federation's drug policy.

A. Equality and non-discrimination are core human rights

The rights to equality and non-discrimination are at the core of international human rights law, as solidified by ICESCR, the ICCPR, and CEDAW. Article 2 of ICESCR, “guarantee[s] that the rights enunciated in the present Covenant will be exercised without discrimination.” [7] Article 26 of the ICCPR establishes that, “all persons are equal before the law” and that the law shall prohibit, “any discrimination and guarantee to all persons equal and effective protection against discrimination on any grounds.” [8] The principle of non-discrimination is described by CESCR as a “core obligation,” meaning, it must be realized immediately, not over time. [9] Article 3 of the ICCPR emphasizes gender equality and notes that “discrimination” is interpreted to mean any “distinction, exclusion or preference which is based on any ground such as color, sex, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.” [10] Article 1 of CEDAW defines discrimination as any exclusionary or restrictive treatment made on the basis of sex, “which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms.” [11] CEDAW, Article 2(f), requires that states undertake, “all appropriate measures, including legislation, to modify or abolish existing laws, regulations and practices which constitute discrimination against women.” [12] In interpreting these provisions, the CEDAW Committee has stressed the need to account for intersecting forms of discrimination that compound violations. [13] Women's drug use and HIV status cannot diminish their fundamental human rights to equality and non-discrimination.

B. People who use drugs and people living with HIV are stigmatized and marginalized

"The stigma created or reinforced through punitive enforcement or treatment regimes also may increase health risks. Targeted abuse and violence towards people who inject drugs by authorities may increase users' risk of physical and mental illness." - Anand Grover, Special Rapporteur on the Right to Health

People who use drugs and live with HIV are among the most marginalized and vulnerable groups in the world. Drug use is one of the most stigmatized behaviors worldwide, [14] and people who use drugs are often made into “scapegoats” and face discrimination by law enforcement, the judicial system, and society as a whole. People who use drugs face “an elevated risk of many forms of violence.” [15] For example, a report from Pakistan shows that most people who injected drugs in 2018 reported suffering physical violence in the past 12 months. [16] Further, a national campaign in the Philippines to crack down on the drug trade resulted in thousands of extra-judicial killings, [17] and violated the right to life. [18]

In the Russian Federation especially, people who use drugs are subject to punitive restrictions and violations of their human rights. Authorities in the Russian Federation promote only abstinence-based treatment, and provide no alternatives, despite scientific evidence regarding the positive results of alternatives. The Human Rights Committee (HRC) criticized the legal ban on opioid substitution therapy (OST) and expressed “concern over the misuse of withdrawal symptoms by the police in order to obtain forced confessions” from people who use drugs. [19]

The United Nations (U.N.) Special Rapporteurs on torture and other cruel, inhuman and degrading treatment or punishment (Special Rapporteur on Torture) and on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur on the Right to Health) likewise expressed this concern. They followed up with the Russian Federation regarding “a well-documented case of a drug-dependent person who was beaten by police and refused drug-dependence treatment and HIV medications while being in police custody, all with the purpose of extracting a confession from him. Without denying the case, the Russian government affirmed that they found no human rights violations against the complainant.” [20]

People who use drugs may face compounded discrimination based on their HIV status. As the Joint U.N. Programme on HIV/AIDS (UNAIDS) explains, “HIV-related stigma is multi-layered, building on and reinforcing negative connotations through the association of HIV with already-marginalized behaviors, such as sex work, drug use, and homosexual and transgender sexual practice.” [21] Thus, people living with HIV are less likely to receive care and support. [22] In 19 countries with available data, 25% of people living with HIV report experiencing some form of discrimination in healthcare settings. [23]

For instance, one woman from Estonia reported the following discriminatory encounter with her doctor:

- “This is a very sensitive topic. But these three pregnancies you had before...they told you that you have to make an abortion?
- No, those were just miscarriages.
(...)
- What did the doctor say to you when it happened?
- He said that HIV ate it.
- HIV?
- Yes, HIV ate my baby.
(...)
- In hospital during labour the doctor that helped me to deliver forced me to put on a mask. It was already hard to breath, and with this mask.... They told me to stop panting and put on the mask so I won't spit my HIV on them.” [24]

Furthermore, people living with HIV also experience discrimination in workplace settings. In Ukraine, 15% of people who had lost a job or source of income in a 12-month period in 2018 attributed it to their HIV positive status; in Belize, this percentage is up to 80%. [25] This directly contradicts the right to non-discrimination. ICCPR Article 2(1) provides that people must not be discriminated against based on “other status,” which has been specifically interpreted by the HRC to encompass HIV status. [26]

While people who live with HIV and use drugs experience stigma throughout the world, [27] the problem is particularly pronounced in the Russian Federation, where vulnerabilities are further aggravated by State-promoted intolerance to drug use. [28]

For instance, BBC Russia recounts an instance, where a woman suffering from tuberculosis, tuberculous spondylitis, a neck fracture and HIV, was denied basic healthcare by the Russian state. Tanya, [29] a resident of Yekaterinburg, could not get out of bed at all for several months from the beginning of 2018. [30] When she was finally sent to the hospital that summer, she endured lengthy testing, and her operation was delayed several times. [31] In addition, Tanya also reported that doctors would frequently go on vacations, as she was transferred from one doctor to the next. [32]

When she was finally examined, the doctors found traces of drugs in her system. She was refused the operation and was immediately discharged from the hospital. In an interview, Tanya said the following:

- “They did a test and said that they just wouldn't do [the surgery]- that they don't want to do it.
- Do not want to at all?
- The only way to be able to have surgery is to get a certificate from a narcologist. [33] And how can I find a narcologist if I am registered [in the drug registry]? Well, how will I bring them the information they want? I don't know ... This is the situation.
- That is, in their opinion, you must first solve the problems with drugs, and then come to the operation?
- Yes, they said I should 'be cured' first. Do they think that it takes only a day, or two, or three?” [34]

The dire situation faced by people who use drugs in the Russian Federation is further exemplified in the case, *Keller v. The Russian Federation*. [35] The applicant’s son— who used drugs and lived with HIV—had been caught riding a stolen bicycle. [36] The victim was subject to such severe abuse due to his HIV status and his status as a person who uses drugs, that he leapt to his death to escape police custody, and his body was found covered in bruises consistent with physical abuse by police. [37]

C. Women who use drugs and women living with HIV face additional stigma and marginalization

As a result of gender stereotypes, women who use drugs and women living with HIV are subject to additional stigma and discrimination, compared to men with the same drug-use and HIV status. According to the U.N. Office of the High Commissioner for Human Rights (OHCHR), a gender stereotype is a “generalized view or preconception about attributes, characteristics and roles that ‘ought to be’ possessed by or performed by women and men.” [38] Women who use drugs and women living with HIV conflict with gender stereotyping of women’s ‘purity’ and their ‘role’ as mothers, which leads to heightened marginalization, as well as violence and criminalization.

1. Women who use drugs are more vulnerable to discrimination, violence, and criminalization

While all people who use drugs face social stigma, women who use drugs are particularly vilified as unfit mothers and “fallen” members of society. [39] An example of this stigma is the image of the “crack mother” as sexually promiscuous and irresponsible. [40] Popular media outlets have also sensationalized the “crack-baby” epidemic to paint women who use drugs as monsters. [41] Recognizing this additional layer of discrimination faced by women who use drugs, the CEDAW Committee identified women who use drugs as a disadvantaged group, that faces intersecting forms of discrimination. [42]

While gender stereotyping impacts women who use drugs around the world, the situation is particularly egregious in the Russian Federation. One example of codified gender stereotypes in Russian society, which contributes to the compounding effects of multiple discrimination of women who use drugs, is a law that prohibits women from taking certain jobs. [43] This prohibition was at issue in *Medvedeva v. The Russian Federation*, where a woman was denied a job under Article 253 of the Russian Federation Labor Code, which forbids women from taking jobs involving heavy machinery, alleging concern for female health.

The applicant sought an injunction to compel the company to make working conditions for her safer, but she was unsuccessful. The CEDAW Committee determined that, “such legislation reflects persistent stereotypes concerning the roles and responsibilities of women and men in the family and in society, which have the effect of perpetuating traditional roles for women as mothers and wives and undermining women’s social status and their educational and career prospects.” [44]

Such discrimination based on gender stereotypes is specifically prohibited by Article 5 of CEDAW, which calls upon states “...to modify the social and cultural patterns of men and women, with a view to achieving the elimination of prejudice and customary and all other practices which are based on the idea of the inferiority or the superiority or either sexes or on stereotyped roles for men and women.” [45] In *R.K.B. v. Turkey*, a case where an employer dismissed a woman for allegedly having an affair with a co-worker without penalizing the male co-worker involved, the CEDAW Committee affirmed the prohibition of discriminatory gender stereotypes. The Committee held that Turkey violated Article 5(a) of CEDAW because the state used “gender-biased and discriminatory... evidence” when it addressed the “moral integrity” of the female employee. [46] The Committee concluded the case by stressing that the “full implementation of the Convention requires States parties not only to take steps to eliminate direct and indirect discrimination and improve the de facto position of women, but also to modify and transform gender stereotypes and eliminate wrongful gender stereotyping, a root cause and consequence of discrimination against women.” [47]

In addition to being vulnerable to discrimination based on gender stereotypes, women who use drugs are further particularly vulnerable to violence. This abuse is perpetrated by intimate partners as well as by law enforcement officers. [48] In a survey in Kyrgyzstan, 81% of women in harm reduction programs reported surviving sexual, physical, or other injurious violence at the hands of their partner, their family, or the police. [49] Similarly, in Georgia, 80% of women in harm reduction programs reported experiencing violence in the year prior to the survey. [50] A study in Indonesia found that 50% of women who use drugs reported physical and sexual violence from their male partners, and 60% of women in the same study reported verbal abuse by the police. [51] The common thread across these statistics is the perception that drug use is incompatible with the expected gender role of a woman as a wife and a mother and is thus deserving of violent reprisal and male control. [52] When violence is perpetrated by police, who are supposed to protect victims of violence, women are less likely to seek legal protection or even medical help. [53]

Additionally, integrated services that address both drug dependence and violence are scarce. Services designed to treat drug dependence do not address violence, and many domestic violence shelters explicitly ban women who use drugs. [54] This is particularly problematic because violence and drug use are often intertwined; many women identify trauma, relationship problems, and family problems as causes of their initiation or continuation of substance use. [55]

Women who use drugs further bear the brunt of highly punitive and male-centered drug policies. While men make up the majority of people who sell and use drugs, more women are incarcerated for drug use than men, and often suffer disproportionate incarceration rates compared to their male counterparts. [56] The U.N. Special Rapporteur on violence against women, its causes and consequences (Special Rapporteur on Violence against Women), reported that drug laws and policies “are a leading cause of rising rates of 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 given longer prison sentences than men who commit major trafficking offenses.” [57] As the CEDAW Committee noted in its Concluding Observations of Brazil, women are often low-level members of the drug organization, working as drug mules at the request of their partners. [58] Moreover, women may be subjected to harsher penalties than their male counterparts because they do not have access to “insider information” that allows men to plea-bargain or make deals with the prosecutors in exchange for lighter sentences. [59] Women further suffer from intersecting discrimination based on race and socioeconomic class. Reviewing the United Kingdom’s report, the CEDAW Committee expressed concern at the number of women “imprisoned for drug offenses or because of the criminalization of minor infringements, which seem to be indicative of women’s poverty.” [60]

This is likewise the case in the Russian Federation where punitive drug policies have a disparate impact on women. Compared to their male counterparts, “women who use drugs face more serious charges, leading to much tougher sentences.” [61]

“[W]omen convicted of drug-related offenses account for about 40% of all incarcerated women in the Russian Federation, whereas the proportion of men imprisoned for drug-related offenses stands at some 20% of the male prison population. In 2013, more than 14% of all the Russians serving prison sentences for drug offenses were women, while the proportion of women in the overall prison population in the Russian Federation is less than 7%.” [62] Moreover, “the proportion of women sentenced for crimes in complicity and for running a drug den are double the respective proportion of men charged with drug offenses.” [63]

Incarceration then leads to further marginalization and violations. Women facing drug dependence rarely have suitable treatment in prisons, as the CEDAW Committee has recognized in its reviews of Georgia and Kazakhstan. [64] Moreover, women who use drugs are highly vulnerable to violence and sexual abuse in detention facilities. [65] These women are further stigmatized when they return to society, as their status as ex-convicts limits their opportunities for employment and social engagement. [66] Additionally, criminal networks often prey on criminalized women, exploiting their lack of economic opportunity to involve them in the drug trade and engaging in abuse with impunity. [67] As the CEDAW Committee has explained, “criminal provisions that impact women disproportionately” contribute to gender based violence and hence must be repealed. [68] There is thus a need to reform current punitive drug policy, which disparately impacts women who use drugs.

2. Women who use drugs and live with HIV face additional layers of discrimination based on HIV stigma

Women who use drugs and who also live with HIV face magnified stigmatization, as noted by the CEDAW Committee. UNAIDS 2014 compilation data showed that the HIV prevalence among women who inject drugs was 13% compared to 9% among men from the same countries. [69] Aside from the risk of intravenous infection from injecting drugs, there is also the risk associated with sex work. [70] In these situations, women are not able to demand condom usage and are often met with sexual violence. [71] Further, the stigma associated with HIV prevents many women from seeking and utilizing health services. [72] Although drug-related and sex-related HIV risk is often a pressing concern for women who use drugs, it is largely unaddressed in drug treatment programs. [73] The CEDAW Committee recognized women living with HIV as a disadvantaged group facing rampant discrimination, [74] and dedicated a General Recommendation to “Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS).” [75]

Gender stereotypes similarly play a central role in discrimination against women who are living with HIV. In many societies, the ideal man is sexually controlling, and the ideal woman is submissive and sexually passive. [76] Given the sexualized nature of HIV and the intersection between HIV and drug use, gender stereotypes are intrinsically detrimental to women living with HIV.

Women are valued for their stereotypical role as mothers and caretakers, but the body of a woman living with HIV is labeled as “marked by deviance, and is therefore considered ‘threatening’ in a society that expects women to strictly adhere to gendered social norms and moral standards.” [77]

Moreover, there are links between HIV status and violence. Violence is both a cause of HIV vulnerability and a consequence of infection: more than 35% of HIV positive women experienced physical and/or sexual violence in their lives and women who have experienced violence are 1.5 times more likely to acquire HIV than women who have not experienced violence. [78] Women who are subject to domestic violence have little control over their sexual lives and their ability to protect themselves from infection, and women who disclose their HIV status to partners are at greater risk for violence. [79] Marriage does not protect women from the transmission of HIV, especially where women have little sexual autonomy and are economically dependent on their unfaithful husbands. [80] Studies found that women living with HIV were up to two times more likely to experience immediate violence than women that do not live with HIV. [81] Rates of non-disclosure are especially high among women seeking prenatal care, as pregnant women are particularly vulnerable and likely to be financially dependent on someone else. [82]

Operating in secrecy, women who are aware of their status may not disclose their status even in a healthcare setting for fear that their partner may find out. [83] Women who use drugs and are living with HIV thus face additional layers of stigma and discrimination, which need to be taken into account when analyzing violations.

D. International human rights law requires an intersectional approach to drug policy that addresses layers of discrimination

The layers of discrimination experienced by women who use drugs and women living with HIV interplay with gender stereotypes and necessitate an intersectional approach. An intersectional analysis first emerged within Black feminism to call attention to multiple forms of discrimination experienced by Black women. [84] Intersectionality recognizes identity as inseparable from a person's life experiences and the accumulation of vulnerabilities from several levels of societal marginalization. [85] Discrimination against women who use drugs and women who live with HIV cannot be understood separately; rather, it is a combination of several interconnected marginalizing variables which increase vulnerability. So, to ensure the rights to non-discrimination and equality, drug policy must take an intersectional approach.

The CEDAW Committee has further highlighted intersectionality as a "basic concept" underlying the state obligation to ensure equality. [86] It has recognized that "discrimination of women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste and sexual orientation and gender identity." [87]

Moreover, these "intersecting factors...effect some women to degrees or in ways that differ from those affecting men or other women." [88] The Committee has thus called upon states to "legally recognize such intersecting forms of discrimination and their compounded negative impact on the women concerned and prohibit them." [89]

In particular, the CEDAW Committee has recognized the importance of addressing multiple forms of discrimination in the context of health. In General Recommendation 24 on women and health, the CEDAW Committee noted that "special attention should be given to the health needs of women belonging to vulnerable and disadvantaged groups." [90] In the case of *Alyne Pimentel v. Brazil*, the CEDAW Committee provided an analysis of compounding marginalization contributing to "grossly negligent healthcare" experienced by a woman of African descent, a disadvantaged population in Brazil. [91] Additionally, in its review of Kyrgyzstan, the CEDAW Committee specifically recognized women who use drugs and women who live with HIV as disadvantaged groups. [92] The Committee stressed that for these women "who face intersecting forms of discrimination," special measures need to be taken to protect them from "violence, abuse and exploitation." [93]

Failure to take intersectionality into account can lead to further marginalization. Rashida Manjoo, the Special Rapporteur on Violence against Women, makes this point with regards to the need for an integrated approach to address violence and drug dependence:

The lack of an intersectional approach can lead to the reinforcing of one form of discrimination in attempts to alleviate another. At the practical level, the norm is to use a silo approach of service delivery which addresses a narrowly defined set of issues and operates alongside other institutions which deliver services to another narrowly defined issue. For example, domestic violence shelters in many countries do not have the capacity, or the trained staff, to assist women who have problems such as both substance misuse and violence in their lives. [94]

The Committee on the Elimination of Racial Discrimination (CERD) likewise took an intersectional approach in *LG v. Korea*, where it recognized harmful gender stereotypes and discrimination based on HIV status. [95] In this case, a foreign, female English teacher in Korea was forced to take an HIV test due to her status as a foreign woman. This same test was not required for native Korean teachers. Petitioner argued that “this policy had been adopted not because of health concerns, but because of general negative beliefs about the moral character of foreign teachers.” [96]

She further argued that the HIV/AIDS stigma and discrimination were inter-related and often associated with “immoral behavior.” [97] The Committee held that the mandatory HIV/AIDS testing policy was exclusively based on negative stereotypes about foreigners, and not for a legitimate public health concern. [98] While the petitioner did not live with HIV, the Committee further held that discriminating against people who live with HIV is “against international human rights norms” and the fact that the petitioner was female and from a different ethnicity compounded to exacerbate discrimination. [99] Understanding the effects social stigma and gender stereotypes have in a given context, “is essential to developing an appropriate public health response and is particularly relevant for populations who are disadvantaged, stigmatized, and vulnerable to ill health and human rights abuses.” [100]

III. CEDAW Requires a Rights-Based Rather Than Punitive Approach to Drug Dependence, Which Addresses HIV and Mental Health Conditions

"By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of [...] the scientific evidence pointing to the ineffectiveness of punitive measures." - Juan E. Méndez, Special Rapporteur on Torture

This section provides an analysis of how a punitive approach to drug policy violates the right to health because it negatively impacts women who use drugs, women who live with HIV, and women who live with mental health conditions. The right to health provides a framework for an effective approach to drug dependence that calls for evidence-based treatment rather than criminalization and incarceration. Punitive drug policy in countries such as the Russian Federation deters people who use drugs from obtaining medically appropriate treatment and results in a worsening global drug problem, the spread of HIV, and strains on mental health. Realization of the right to health requires a shift from a punitive to a public health approach to drug use that takes account of mental health and provides harm reduction and social support.

A. Punitive approaches to drug dependence violate the right to health, creating barriers to treatment and exacerbating other health problems such as mental health conditions and HIV

ICESCR provides the authoritative standard for the right to health in its Article 12 (1) and (2): "1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present covenant to achieve the full realization of this right shall include those necessary for:...(c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness." [101] CEDAW Article 12 (1) obligates States Parties to ensure the right to health applies equally to women as to men. Specifically, States must "take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to healthcare services." [102] The CRPD also recognizes the right to health, as well as the principle of non-discrimination in its applicability to people with disabilities, including people with mental health conditions or substance abuse disorders. [103]

1. Punitive approaches to women who use drugs, such as drug registries and incarceration, impede treatment and violate several basic rights, including the right to health

Punitive drug policy through drug registries and incarceration directly impacts the right to health, as well as other basic rights. These policies deter people who use drugs from seeking treatment in the first place or leave them further stigmatized and isolated by a system that brands them as a “drug user” or criminal. They further obstruct the right to effective, evidence-based medical treatment: (1) drug registries make people who use drugs a target for harassment by police and abuse or neglect by healthcare providers; and (2) prison walls are a literal barrier to medical professionals who are independent from the punitive system. Drug registries and incarceration create discriminatory barriers to access to proper healthcare for populations who need treatment the most, especially for health issues that often accompany substance abuse, such as mental health conditions and HIV.

The maintenance of drug registries, or government records of “chronic drug users,” is an aspect of punitive drug policy that impedes treatment and care in countries such as the Russian Federation. Dating back to the Soviet-era, drug registries have been used to restrict the rights of people who use drugs, including their ability to obtain a driver’s license, work in certain jobs, and maintain custody of children, [104] implicating the human rights to movement, [105] employment, [106] and family. [107]

Moreover, people on drug registries are often targets of police harassment, [108] as well as ill-treatment by healthcare providers, as the Special Rapporteur on Torture has noted. [109] Once on the registry, people are required by the Russian government to obtain treatment the government deems appropriate, including inpatient treatment. [110] Coerced inpatient treatment violates the right to liberty and security of person because inpatient treatment is a form of confinement or detention without court proceedings. [111] The U.N. Office on Drugs and Crime (UNODC) recommends that coerced treatment involving detention should only be used as a last resort, for a limited number of days, only where the person is at imminent risk of harming themselves or others. [112] Moreover, coerced treatment based on government mandate and not the opinion of medical professionals is arbitrary and violates the right to health. People who use drugs must further remain on the registry for at least five years (if a person on that list continues to use drugs, the time period is extended), [113] and while on the registry, are subject to rights restrictions, even if they have stopped using drugs. [114] Drug registries with these various punitive measures serve as a deterrent to treatment because seeking care entails risking placement on a registry by a healthcare worker.

Incarceration and the threat of incarceration further impede access to treatment and erode the right to health. As an initial matter, incarceration increases the stigmas of drug use and drives people who use drugs underground, preventing access to health services. The threat of incarceration causes people who use drugs, not to stop using drugs, but to use drugs in a hasty manner and to store and dispose of injecting equipment without safety precautions. [115] Police in some cases have destroyed injecting equipment, which does not deter drug use, but rather leaves people who use drugs at a higher risk of contracting HIV because they are likely to inject by either sharing injecting equipment or re-using old equipment. [116] People who use drugs are targets of abuse by police because this vulnerable population is not only extorted by corrupt police officers, but they are also used to fill arrest quotas. [117] In some instances, needle exchange sites have to be shut down because the fear of police raids at the sites is so great that people who use drugs stop coming. [118] The threat of police abuse and arrest instills such fear in people who use drugs, that they may feel safer sharing or re-using injecting equipment than going to the site. [119] During the raids, police are known to arrest not only people who use drugs, but also humanitarians merely working at the sites. [120]

Moreover, treatment and care for people who use drugs in prisons is inadequate. [121] Prisons in the Russian Federation are an infamous example of how overcrowded, unsanitary conditions, and lack of access to proper medical care in prisons contribute to the spread of Tuberculosis and HIV. [122]

People who inject drugs are especially vulnerable to these health problems because they are likely to continue injecting drugs in prisons, where harm reduction services are not available at all in the Russian Federation. [123] Accessibility, as one of the four essential elements of the right to health, encompasses the right to non-discrimination and requires specifically that marginalized people, such as those with criminal records, have access to treatment and care. [124] As discussed in Part II of this report, realization of the right to equality and non-discrimination requires addressing social stigmas; this obligation applies to social stigmas associated with not only drug use, but also criminal convictions.

The Russian Federation's punitive approach to drug policy has resulted in a high rate of incarceration for drug-related offenses. Evidence of the severity of the Russian Federation's particularly punitive approach is that the acquittal rate in drug cases is less than 5%, and 70% of the accused are sentenced without trial. [125]

2. Punitive drug policies not only create barriers to appropriate treatment for drug dependence, but they also exacerbate other health problems such as mental health conditions and HIV

Punitive drug policies result in further stigmatization of people who use drugs by leaving them incarcerated or with criminal records upon release from prison. This leads to isolation and lack of social support, which exacerbates mental health problems. Incarceration of people who use drugs not only contributes to isolation, but also acts as an additional barrier to medical treatment for conditions that often accompany drug use, such as HIV.

Punitive drug policies aggravate mental health conditions experienced by people who use drugs. Mental health conditions may develop before, during, or after a person develops drug dependence. [126] There is a cyclical relationship between drug dependence and mental health conditions, where people who use drugs are more prone to mental health conditions, and people with mental health conditions are more likely to experience drug dependence. [127] In fact, persons with mental health conditions may be twice as likely to have a substance use problem than the general population, and at least 20% of all people who have a mental illness have a substance use problem. [128] Any treatment of co-presenting conditions and disorders must take both into account in order to be successful. [129] As Anand Grover, Special Rapporteur on the Right to Health, noted, “The stigma created or reinforced through punitive enforcement or treatment regimes also may increase health risks.

Targeted abuse and violence towards people who inject drugs by authorities may increase users’ risk of physical and mental illness.” [130]

Incarceration is a direct barrier to mental health treatment that co-presents with substance abuse disorders because mental health treatment is scarce in prisons. [131] In one study of 24 European countries, experts held that almost two-thirds of the countries had considerable gaps in mental healthcare in prisons and mental healthcare available to the general population, a violation of the rights to equality and non-discrimination. [132] In many European countries, mental healthcare in prisons is overseen by the Ministry of Justice rather than the Ministry of Health, which is contrary to World Health Organization (WHO) recommendations. [133] Moreover, decisions about what health services are available to detained people are often made by administrators of punitive institutions, not by public health officials. [134]

Incarceration further exacerbates mental health conditions because it contributes to isolation from support networks and educational or professional commitments. [135]

The Special Rapporteur on the Right to Health explained, “Being deprived of liberty itself is an emotionally fraught experience, carrying with it potential exposure to inhumane and crowded conditions, violence and abuse, separation from family and community, the loss of autonomy and control over daily living and an environment of fear and humiliation, and the absence of constructive, stimulating activities.” [136]

Incarceration is particularly problematic for women who use drugs and have mental health conditions. In Europe, it is estimated that up to 80% of women in prison have a diagnosable mental health problem, often coupled with drug use. [137] Death rates on discharge from prison are substantially higher for women than for men. [138] Also, though women make up only about 4% of Europe’s prison population, 50% of all self-harm incidents in prison are carried out by women; many of the self-harm incidents are reported amongst women who are withdrawing from drugs. [139] This is a result of male-centered healthcare in prisons that does not take into account women’s needs including mental healthcare: [140]

Once women are inside, the gendered and challenging environment of detention and confinement compounds their immediate and long-term health risks, reproduces past violence and trauma, and undermines the full and effective realization of the right to health for themselves and their dependent children and families left on the outside. [141]

Moreover, incarceration as a blanket response to people who use drugs violates the right to health by perpetuating risky drug use and blocking access to HIV treatment for populations most vulnerable to HIV. Persons who are incarcerated are entitled to, not only treatment for drug dependence, but also “prevention and treatment of other conditions commonly found in people who use drugs such as HIV, hepatitis, tuberculosis, mental disorders, and drug overdose.” [142]

The transmission of HIV through intravenous drug use among prison populations is rampant. According to information published by the UNODC, “[a]pproximately one in three people held in prison have used drugs at least once while incarcerated, with approximately one in eight reporting use in the past month.” [143] Within the prison population, instances of HIV is high: “The global median prevalence of HIV among people living in prisons is estimated at 3.0 per cent, which is five times higher than the global median prevalence of HIV of 0.6 per cent among the general population aged 15-49.” [144] In many countries, there is a higher rate of HIV among females in prison than males in prison, and women are more likely than men to contract HIV in general. [145] Discriminate access to healthcare for incarcerated persons who are denied clean needles and HIV treatment is perpetuated by both health and prison officials who deny access “as a form of informal punishment.” [146] People who use drugs are often denied access to healthcare facilities that are independently regulated outside of the prison system. [147] This directly violates states’ obligation to ensure the right to non-discrimination and the principle of accessibility in the right to health because people who are incarcerated must have equal access to the same quality of healthcare as the general population. [148]

The spread of HIV among prison populations contributes to the HIV epidemic outside of prison among the general population as well. As the Special Rapporteur on the Right to Health has noted, “Once in prison, high rates of injecting drug use, combined with a lack of access to [opioid substitution therapy] and sterile injecting equipment create enormous risk for inmates. That risk is then passed on to members of the public upon prisoners’ release.” [149]

B. A rights-based approach to drug dependence must provide harm reduction and take account of mental health conditions

States must move to a rights-based approach to drug dependence that entails harm reduction and psychosocial support for mental health conditions.

1. Harm reduction contributes to the realization of the right to health for people who use drugs and helps to combat the HIV epidemic

Instead of a punitive approach to drug use that impedes treatment and exacerbates health conditions, a rights-based approach would provide harm reduction services. Harm reduction refers to multiple programs which aim to reduce harms associated with using drugs, such as overdose and HIV, by meeting people where they are, without necessarily discouraging drug use. [150] According to Harm Reduction International, “there is no universally accepted definition of harm reduction,” but “harm reduction encompasses a range of health and social services and practices that aim to minimise negative health and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights – it focuses on positive change and working with people without judgment, coercion, discrimination, or requiring that they stop using drugs as a precondition of support.” [151]

Put another way by a report from Open Society Foundations, “While harm reduction approaches often serve as a bridge to drug dependence treatment or cessation of drug use, these outcomes are not preconditions or the only goals.” [152]

There are a variety of harm reduction services that have been implemented around the world with positive results. One harm reduction program, which has been proven to reduce the spread of blood-borne infections such as HIV in a cost-effective manner with zero negative consequences, is needle or syringe exchanges, where people who use drugs intravenously can obtain sterile needles. [153] Other examples of harm reduction programs include drug-consumption rooms, education programs, and opioid substitution therapy (OST). [154]

Drug consumption rooms are medically supervised injection sites that provide sterile, private rooms and hygienic equipment for injection, to reduce the risk of fatal overdoses and the spread of blood-borne illnesses as well as vascular injury associated with hasty injection. [155] Education and outreach programs inform people who use drugs about their rights and their access to resources such as counseling, support groups, and sterile injecting equipment. [156] OST involves prescription and medically-supervised use of medications, such as methadone, a safer alternative to heroin. [157] Increasing awareness surrounding harm reduction services encourages women who use drugs to seek treatment. As one woman from Ukraine stated, “I knew about substitution treatment long before I went on it. A woman from the Red Cross came by trying to convince me to go. I claimed that I wasn’t a user, that I didn’t need substitution treatment, because I simply didn’t believe that it could work... then I ran into a friend who had already tried it. I thought, hey, if it helps her, why wouldn’t it help me? Aren’t I like her? I should go.” [158]

The implementation of harm reduction services has been widely endorsed. Extensive research has demonstrated that harm reduction measures reduce the use and injection of illegal drugs, as well as prevent other drug and sex-related risk behavior that increases the risk of HIV infection. [159] Moreover, as Human Rights Watch and Harm Reduction International have noted, there is “strong and consistent evidence that harm reduction interventions which include access to sterile injecting equipment, opioid substitution therapies, and community-based outreach, are the most effective and cost effective means of reducing HIV-related risk behaviours and therefore preventing transmission of HIV, hepatitis C and other blood borne viruses among people who inject drugs.” [160]

According to the WHO, evidence indicates that increasing availability of sterile injecting equipment “reduces HIV infection substantially,” and research further suggests that needle syringe programs can promote “recruitment into drug treatment and possibly also into primary healthcare.” [161]

The elements of “availability” and “quality” are components of the right to health, requiring the availability of harm reduction and legalization of evidence-based treatment options such as OST. Availability requires that medical treatment is available to all people on an equal basis, regardless of drug use or incarceration, in-line with the rights to non-discrimination and equality. [162] The CEDAW Committee has recognized the need for harm reduction services especially for women in detention. In its Concluding Observations to Georgia, it urged the provision of “gender-sensitive and evidence-based drug treatment services to reduce harmful effects for women who use drugs, including harm reduction programmes for women in detention.” [163] Additionally, according to the Special Rapporteur on the Right to Health, if OST were provided globally, an estimated 100,000 new cases of HIV could be prevented. [164]

Furthermore, deprivation of certain harm reduction services may amount to torture. The Special Rapporteur on Torture has indicated that total prohibition of OST can be considered torture if the pain of withdrawal amounts to torture (or if OST is withheld to induce criminal confessions from those suffering from opioid withdrawal): [165] “By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures.” [166] The Special Rapporteur on Torture has also called upon states to ensure OST and all harm reduction measures to be provided to people who are incarcerated. [167]

The near total absence of available harm reduction services in the Russian Federation has been particularly concerning to human rights bodies such as CESCR and the CEDAW Committee, especially considering the Russian Federation’s growing HIV crisis. [168] The Russian Federation is home to one of the largest populations of people who inject drugs in the world and a worsening HIV crisis, yet federal laws prohibit OST. CESCR has highlighted as problematic the lack of harm reduction programs in the Russian Federation, especially the lack of needle exchanges and the total prohibition of OST, which is contrary to recommendations by the WHO and UNAIDS. [169]

CESCR has noted the high level of drug use in the Russian Federation and recognized the punitive approach to address this issue deters people who use drugs from seeking medical treatment, which then contributes to higher rates of incarceration of people who use drugs, and thus the spread of HIV:

The Committee is concerned about the high level of drug use in the State party and that the State party essentially applies a punitive approach to address drug problems. The Committee is particularly concerned that drug users tend to refrain from seeking medical treatment under the policy of criminalization, which contributes to increased incarceration of drug users. The Committee is also concerned about the lack of harm reduction programmes, such as the distribution of syringes, and about the prohibition of opioid substitution therapy. Furthermore, the Committee is concerned at the spread of HIV, and the prevalence of hepatitis C and tuberculosis in the State party, especially among drug users (art. 12). [170]

Additionally, the CEDAW Committee has called upon the Russian Federation, “to develop programmes of substitution therapy, in line with recommendations of the World Health Organization for women drug users [and to] intensify the implementation of strategies to combat HIV/AIDS, in particular preventative strategies, including by increasing efforts to prevent sexual and mother-to-child transmission . . . to reduce the high rate of HIV/AIDS among women and improve the availability of and access to HIV/AIDS services.” [171]

CESCR’s recommendations to the Russian Federation have called upon the State to implement harm reduction services. CESCR specifically called on the State to consider decriminalizing drug use, provide education programs about the health consequences of drug use, and address the discrimination against people who are dependent on drugs in their access to healthcare services. [172] CESCR further recommended that the Russian Federation provide psychological services for people who use drugs, legalize OST, and ensure the availability of harm reduction programs in prisons. [173]

2. Community-based treatment for drug dependence promotes mental health and the realization of the right to health for people who use drugs

Community-based treatment entails short-term, peer-led interventions that do not involve involuntary or coerced detention for people who use drugs and/or have mental health conditions. Community-based treatment allows people who use drugs and live with mental health conditions to remain in their communities and thus keep ties with social support, family relationships, and professional obligations, which are essential for long-term recovery and treatment. As explained by the Special Rapporteur on the Right to Health, this respects a person’s fundamental dignity, enabling self-determination and reintegration into society. [174]

Community-based treatment is more conducive to rehabilitation of drug dependence and mental health conditions than a punitive approach to drug use that punishes people who use drugs and offers no meaningful solution to the underlying issues.

Punitive approaches to drug policy separate people with mental health conditions from their families and support systems, contribute to further stigmatization of mental health conditions, and discourage people from seeking mental health treatment and substance abuse treatment. The right to health requires treatment that enables reintegration into the community. [175] Community-based treatment and intervention includes non-coerced treatment options such as peer-led crisis houses, respite houses, recovery colleges, and community development models for social inclusion. [176] Rights-based treatment supports short-term psychosocial interventions and treatment alternatives [177] that empower people using mental health services to exercise choice over their treatment plans. [178]

Unfortunately, despite evidence that short-term psychosocial interventions are effective, they are “viewed as luxuries and not necessities” in many states. [179] This is due to the dominant biomedical approach and the resulting investment exclusively in medication, hospitals, and other interventions that fall under that approach but may not be appropriate for each person experiencing mental health issues. The Special Rapporteur on the Right to Health goes as far as to say that “Psychosocial interventions, not medication, should be the first-line treatment options for the majority of people who experience mental health issues.” [180]

The right to health necessitates implementation of human rights-based drug policy that incorporates recommendations by the WHO, UNAIDS, and human rights bodies. Drug dependence intersects with various issues and identities, impacting women in particular ways, especially those with mental health conditions, and placing them at greater risk of contracting HIV. In order to effectively treat this health condition, States must provide harm reduction services and ensure they are accessible to all people equally regardless of their HIV status or criminal records. Effective treatment of drug dependence includes community-based rather than punitive treatment for mental health conditions, as well as accessible healthcare options.

IV. CEDAW Requires a Gender Sensitive Approach to Drug Dependence, Which Takes Account of Women's Reproductive Health and Relationship With Children

This section analyzes how non-discriminatory drug policy requires a gender sensitive approach that considers women’s reproductive health and relationship with children. Globally, women who use drugs face a host of gender-specific human rights violations: they lack access to and information about contraception; are subject to coerced and forced abortion and sterilization, as well as criminalization of their pregnancies; must contend with barriers to treatment when they have children; and risk losing custody of their children.

CEDAW supports a gender-sensitive drug policy approach. The CEDAW Committee’s Concluding Observations on Georgia expressed concern about the “lack of gender-sensitive, accessible and evidence-based drug treatment programmes for women,” and recommended conducting nationwide research on women who use drugs and, “providing gender-sensitive and evidence-based drug treatment services to reduce harmful effects for women who use drugs, including harm reduction programmes for women in detention.” [181]

Similarly, in their Concluding Observations on Macedonia, the CEDAW Committee noted, “the lack of information on health and rehabilitation services available to women and girl drug users.” [182]

The right to health under ICESCR specifically requires a gender-sensitive approach to drug policy. CESCR’s General Comment 14 recognizes the importance of a gender-sensitive approach as a core element of the right to health and a critical component of the accessibility and acceptability of care. [183] CESCR explained that central to acceptability under the right to health are policies that are “sensitive to gender.” [184] In fact, “the failure to adopt a gender-sensitive approach to health” constitutes a violation of the obligation to fulfill the right to health. [185] CESCR explained that a gender-based approach to health “recognizes that biological and sociocultural factors play a significant role in influencing the health of men and women.” [186] CESCR recommended that states “integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men.” [187]

A gender sensitive approach to drug policy is not only required by international human rights law but is also good medical practice. Research indicates the need to take gender into account to prevent substance abuse among girls and women because “there are factors of vulnerability and resilience that are specific to girls and women and there are indications that drug prevention in strategies do not necessarily benefit girls equally.” [188] The National Institute of Drug Abuse’s research-based guide explains that “effective treatment attends to multiple needs of the individual, not just his or her drug abuse,” and recommends that “treatment be appropriate to the individual’s age, gender, ethnicity, and culture.” [189]

A. To comply with international human rights law, drug policy must protect the reproductive health of women who use drugs

Drug policies that do not account for women's reproductive health and pregnancies violate fundamental human rights. Unfortunately, all too often, both globally and in the Russian Federation, laws and policies inhibit access to contraception and reproductive health education, result in forced abortion or sterilization, stigmatize pregnancies, and impede access to critical health services.

Women's reproductive rights are well-established under international human rights law. Both CEDAW and CESCR provide that reproductive health is a basic human right. CEDAW sets the stage for protecting women's right to reproductive health in its preamble, stating, "the role of women in procreation should not be a basis for discrimination." [190] In General Recommendation 24, the CEDAW Committee "affirm[ed] that access to healthcare, including reproductive health, is a basic right," [191] and recommended that states "ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health." [192] CESCR's General Comment 22 specifically focuses "on the right to sexual and reproductive health," establishing that "reproductive health is an integral part of the right to health." The General Comment noted that "health facilities, goods, information and services related to sexual and reproductive healthcare should be accessible to individuals and groups without discrimination and free from barriers." [193]

The General Comment also acknowledged the reproductive rights particular to women: "Due to women's reproductive capacities, the realization of the right of women to sexual and reproductive health is essential to the realization of the full range of their human rights," and moreover, that "[g]ender equality requires that the health needs of women, different from those of men, be taken into account and appropriate services provided for women in accordance with their life cycles." [194]

Thus, violations of women's reproductive rights implicate not only the right to health, [195] but rights to information, [196] education, [197] non-discrimination and equality, [198] privacy, [199] and freedom from torture and cruel, inhuman, and degrading treatment. [200] Women's reproductive rights are of central importance to their basic human dignity, enabling women to exercise control and autonomy over their own bodies and dismantling the widespread and engrained assumption that women exist to care for others. [201]

The CEDAW Committee has noted several concerns regarding women’s right to reproductive health in the Russian Federation. In its Eighth Concluding Observations on the Russian Federation, this Committee remarked that it was “concerned at the absence of age-appropriate sexual and reproductive health and rights education with a gender perspective in the curricula of basic and secondary schools,” and recommended that the Russian Federation “introduce comprehensive, gender-sensitive, and age-appropriate sexual and reproductive health and rights education, incorporating a gender perspective for girls and boys, in the curricula at the basic and secondary levels of the education system.” [202] The CEDAW Committee also noted that it was concerned about “the limited access of women and girls to healthcare in rural and remote areas, the lack of trained personnel and obstetric health service for women and women’s limited access to adequate and reproductive health services.” [203]

1. Women who use drugs lack access to and information about contraception in violation of international human rights law

Women’s right to have access to and information about contraception is established under international human rights law. CEDAW expands upon this right in Article 10, articulating that women’s right to education encompasses “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.” [204] CEDAW also grants women equal rights in deciding “freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.” [205] Because contraception is fundamental to family planning, states that fail to provide it for women who use drugs violate their right to “access to healthcare services, including those related to family planning” under Article 12. [206]

Moreover, states that fail to provide information about and access to contraception for women who use drugs violate Article 16(e), as contraception is central to women deciding “freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise their rights.” [207] Special Rapporteur on the Right to Health, Anand Grover, stated that the realization of women’s right to health “requires the removal of barriers which interfere with individual decision-making on health-related issues and with access to health services, education and information, in particular on health conditions that only affect women and girls.” [208]

Women who use drugs lack access to comprehensive reproductive health services, including contraception. While access to family planning has generally increased globally from 74% in 2000 to 76% in 2019, [209] there remain significant gaps when it comes to women who use drugs. For instance, a study in Kenya found that only 29% of women who injected drugs were using contraceptives; the women not using contraceptives cited perceived infertility due to drug use, side effects, costs, difficulty finding transportation, and lack of information. [210] A study in the United States found that only half of women diagnosed with opioid and substance abuse disorders used contraception, and even fewer used very effective contraception methods as a result of economic barriers, inaccessible transportation, and lack of information. [211] Moreover, women who use drugs are falsely perceived as careless when it comes to contraception. Research from Australia indicates that in reality, women who use drugs aspire to control their fertility, have contraceptive preferences, and have tried a number of contraceptive methods. [212] However, unmet needs, including a lack of education regarding reproductive health and limited access to contraception, lead to lower rates of contraceptive use. [213]

The Russian Federation in particular lacks both reproductive health education and accessible, effective contraception for women who use drugs. In a St. Petersburg study, researchers found that 67% of the Russian Federation women who injected drugs or had sexual partners who injected drugs reported their last sexual intercourse as being unprotected. [214]

This percentage, however alarming, is unsurprising, given that the Russian Federation's state health system lacks reproductive health programs, preventing women who use drugs from seeking counseling and care regarding family planning. [215] Moreover, without initiatives for free condoms, abortion is one of the only options for birth control for many Russian Federation women who use drugs, and as a result, the Russian Federation has the highest number of abortions performed annually. [216] In its Concluding Observations on the Russian Federation, the CEDAW Committee highlighted its concerns regarding "limited access to modern contraceptives for women and girls, in particular in rural and remote areas, and the lack of accurate, evidence-based information on the types and effects of contraceptives available to the public." [217]

The global, as well as Russian Federation-specific, lack of access to and education concerning contraception for women who use drugs violates Article 12 and Article 16 of CEDAW. [218] To comply with human rights, drug policy must provide for women's access to and information about contraception.

2. Women who use drugs are subject to forced and coerced abortion and sterilization in violation of international human rights law

In some countries, women who use drugs are forced or coerced to have an abortion or undergo sterilization because society deems them “unfit” to be mothers. Forced and coerced abortion and sterilization of women who use drugs violate several fundamental rights to non-discrimination and equality, [219] health, [220] family, [221] information, [222] privacy, [223] and freedom from torture and cruel, inhuman, and degrading treatment. [224] CEDAW General Recommendation 35 on gender-based violence against women specially acknowledges, “Violations of women’s sexual and reproductive health and rights, such as forced sterilization, forced abortion...are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.” [225] The Human Rights Committee in General Comment 28 likewise recognized that forced abortion or sterilization can rise to a violation of torture or cruel, inhuman, or degrading treatment, requesting that states provide the Committee information on measures to prevent these coercive practices. [226] The Special Rapporteur on Torture, Juan Mendez, also confirmed that “forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture.” [227] Mendez further recognized that forced and coerced abortion can cause “tremendous and lasting physical and emotional suffering.” [228]

Globally, women who use drugs face pressures to abort their pregnancies due to stigma and criminalization of drug use. As a professor of law and sociology explained, “the prosecution of drug-addicted mothers can be seen as encouraging abortion because pregnant drug-addicts may feel pressure to abort the fetus rather than risk being charged with a crime.” [229] Coerced abortions are especially common in relationships with intimate partner violence where male partners seek to assert reproductive control over their female partners. [230] In the Russian Federation specifically, women who use drugs are often encouraged to abort. [231] The stigma of mothers who use drugs is directly related to lack of awareness from healthcare professionals that women who use drugs can give birth to healthy babies if provided adequate support and care, [232] and the Russian Federation gynecologists believe that drug use is an “indication of abortion.” This creates a significant barrier to reproductive healthcare and violates women’s right to make free choices about family planning. [234] Misinformation is often extreme, with doctors recommending women who use drugs “to abort immediately or you will give birth to a freak.” [235] These recommendations are reflected in the staggering statistic that worldwide, the Russian Federation has the highest number of abortions performed annually. [236]

Coerced sterilization of women who use drugs is also a global problem. According to the International Federation of Gynecology and Obstetrics (FIGO) guidelines, marginalized women “have experienced a long history of forced and coerced sterilization,” and “fears remain that...HIV-positive, low-income and drug-using women...and other vulnerable women around the world, are still being sterilized without their own freely-given, adequately informed consent.” [237] A United States/United Kingdom-based organization, “Project Prevention” (formerly Children Requiring a Caring Community, or CRACK), implements coerced sterilization by offering women who use drugs payment to get sterilized. [238] These monetary incentives are highly coercive to an already vulnerable population, violating women’s right to make free choices concerning their reproductive health. [239] Furthermore, sterilization campaigns for women who use drugs only worsen stigma and discrimination. Forced sterilization may also take place through court order. In a recent case in Brazil, a judge ordered a woman to undergo compulsory sterilization because of her low socioeconomic status, drug dependence, and five other children. [240] The impacts of forced sterilization can be devastating, resulting in feelings of grief and loss of self-esteem. [241] In some cultures, it might even result in abandonment by partners or loss of economic support. [242] Furthermore, women who have undergone non-consensual sterilization are likely to distrust the healthcare system and be deterred from seeking future medical care. [243]

Women who use drugs, who are also living with HIV, face additional vulnerability to forced and coerced sterilization. Some of the women most impacted by forced and coerced sterilization are those who live with HIV. [244] The Special Rapporteur on Torture noted that people living with HIV “are reportedly...denied access to medical services unless they consent to sterilization.” [245] Forced and coerced sterilization of women living with HIV has been documented in Chile, Kenya, Namibia, and South Africa. In some extreme circumstances, women even face the threat of no longer receiving life-sustaining antiretroviral medication if they do not sign a consent to sterilization form. [246]

Both human rights and medical bodies recognize that forced and coerced sterilization violates women’s fundamental human rights. In General Recommendation 24, the CEDAW Committee explained, “Acceptable [health] services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality, and is sensitive to her needs and perspectives. State parties should not permit forms of coercion, such as non-consensual sterilization...that violate women’s rights to informed consent and dignity.” [247] The Special Rapporteur on Torture stated “Forced sterilization is an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.” [248]

A joint U.N. interagency statement reaffirmed “sterilization as a method of contraception and family planning should be available, accessible, acceptable, of good quality, and free from discrimination, coercion, and violence, and that laws, regulations, policies and practice should ensure that the provision of procedures resulting in sterilization is based on the full, free and informed decision-making of the person concerned.” [249] According to the FIGO guidelines, only women themselves can consent to sterilization and forced or coerced sterilization cannot be justified on the premises of medical emergency. [250] The World Medical Association’s (WMA) International Code of Ethics provides that physicians are expected to “respect a competent patient’s right to accept or refuse treatment,” “not allow [clinical] judgment to be influenced by...unfair discrimination,” and “respect the rights and preferences of patients.” [251] Specifically, the WMA condemns forced sterilization, calling for consent to be obtained when the patient is not under significant stressors and for national medical associations “to advocate against forced and coerced sterilisation in their own countries and globally.” [252]

3. Pregnant women who use drugs face criminalization, stigmatization, and restricted access to health services in violation of international human rights law

Pregnant women who use drugs are subject to stigma and discrimination that impedes access to drug treatment. This violates both women’s fundamental equality [253] and right to health [254] and may constitute cruel, inhuman, and degrading treatment. [255] Because women are generally the ones in society who can become pregnant, laws that criminalize the pregnancies of women who use drugs are by nature discriminatory against women. [256] The CEDAW Committee has upheld that discriminating against pregnant women is inherently sex discrimination in *Alyne v. Brazil*, when it found that Brazil, in denying an Afro-Brazilian woman necessary maternal health services ultimately leading to her death, had discriminated against her for her sex. [257]

Globally, women who use drugs and have children are vilified, perpetuating the systematic discrimination against them.

The sensationalized perception of “crack-babies” not only dehumanizes pregnant women who use drugs but is also scientifically unsound. While there are correlations between pregnant women’s use of drugs and certain pregnancy outcomes, there is no proven causal relationship. [258] Yet, laws in the United States and Norway go so far as to essentially criminalize mothers or pregnant women who use drugs. In the United States, 38 states have adopted “Fetal Assault Laws,” which include fetuses under the legal definition of a victim of assault, and prosecutors have used these laws to target pregnant women who use drugs. [259] In Alabama, a chemical endangerment law, intended to protect children from exposure to environments with controlled substances, has also been used to prosecute pregnant women who use drugs. [260]

In Norway, social workers have the right to incarcerate women who are dependent on drugs, and pregnant women remain under control of ward staff until they give birth or terminate the pregnancy. [261] Closed wards include locked doors, windows nailed shut, and a restroom without a lock. [262] This high level of coercion and stigmatization can have devastating psychological impacts on women who have likely already experienced serious detriments to their sense of freedom and control. [263]

Criminalization of women who use drugs' pregnancies has an invisibilizing effect, driving women underground such that they cannot access support services. In the United States, women reported that the threat of criminal punishment for drug use during pregnancy discouraged them from seeking out healthcare, prenatal care, and drug treatment. [264] Furthermore, information from the National Commission on Correctional Health Care, a non-profit dedicated to improving the standard of care in correctional facilities, provides that once incarcerated, pregnant women in the United States often do not receive adequate prenatal care, counseling, or opioid substitution therapy, resulting in an unhealthy environment for both mother and child. [265]

When pregnant women who use drugs are able to access healthcare services, they are especially susceptible to obstetric violence. Obstetric violence is defined as the physical, sexual, or verbal bullying, coercion, humiliation, and/or assault that childbearing women face at the hands of healthcare providers. [266]

Pregnant women who use drugs are particularly vulnerable to healthcare discrimination and mistreatment in various forms, including lack of integrated drug treatment services with reproductive health, the practice of drug testing and releasing medical records without informed consent, and the shaming of pregnant women who use drugs as unfit to be mothers. [267]

Women who use drugs in the Russian Federation face very limited access to healthcare during both pregnancy and childbirth. [268] The Russian Federation drug treatment clinics usually refuse to treat pregnant women, and most prenatal clinics do not have addiction specialists on staff. [269] Moreover, the total ban on OST in the Russian Federation particularly impacts pregnant women because OST is the best opioid treatment during pregnancy; it produces fewer complications during pregnancy and can improve obstetric, perinatal, and neonatal outcomes. [270]

B. To comply with international human rights law, drug policy must protect the rights of women who use drugs with children

Women who use drugs have the right to not have their children arbitrarily removed, and international human rights standards support policies that keep mothers and children together. [271] For instance, Article 10 of ICESCR stipulates, “The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children.” [272] Further, ICCPR, Article 23 states that “the family is the natural and fundamental group unit of society is entitled to protection by society and the state.” [273] The CRC also articulates in Article 9(1) that “a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine . . . that such separation is necessary for the best interests of the child.” [274]

Women who use drugs’ right to family is violated through lack of integrated drug treatment and childcare services, as well as through laws in which drug dependence is immediate grounds for losing child custody. [275] Moreover, widespread cultural attitudes towards mothers who use drugs make it especially difficult for them to come to terms with drug dependence, let alone seek professional drug treatment and care. [276] Accordingly, to comply with international human rights standards, drug policy must take into account women’s relationship with children.

1. Drug policy that impedes access to treatment for mothers who use drugs violates international human rights law

Generally, women with children face difficulties when accessing drug treatment due to the lack integrated treatment and childcare services. This lack of integrated care for mothers who use drugs obligates them to secure outside childcare, which places a financial strain on an already vulnerable population, presenting an insurmountable barrier for many. [277] Moreover, drug treatment facilities may be far from home or have inflexible admission requirements. [278] These barriers disproportionately impact women of low socioeconomic status. ICESCR, Article 10 calls for “the widest possible protection and assistance” to the family, which would include drug treatment that mothers are reasonably able to access. [279] This requires accessible, integrated drug treatment and childcare services.

2. Drug policy that automatically deprives women of custody and relations with children based on drug use violates international human rights law

In Eastern European and Central Asian, seeking treatment is particularly difficult for mothers who use drugs because being in treatment for a drug problem results in being placed on drug registries, which may be automatic grounds for losing custody of their children. [280] In Estonia, law enforcement, healthcare workers, and child protective services all work together to take away children from women who use drugs. [281] Such policies conflict with international human rights standards. CESCR has recognized this and in its recent Concluding Observations on Estonia, and expressed concern about “the absence of gender-specific interventions targeting women drug users, particularly those who are pregnant or have children.” [282]

In the Russian Federation specifically, laws make it difficult for women who use drugs and have children to seek treatment. The Russian Federation Family Code stipulates that chronic drug dependence is grounds for losing custody of children. [283] Article 69 of the Russian Federation Family Code states that a parent “may be deprived of parenthood, if they...suffer from chronic alcoholism or drug addiction.” [284] In fact, pregnant women registered as drug users may have their children taken from them in the maternity ward after they give birth. [285] The Russian Federation Family Code also notes that child adoption can be canceled if the adopters suffer from drug dependence. [286]

These laws not only prevent women who use drugs from seeking treatment, but also can have devastating impacts on families and are contrary to the best interests of children. Separating children from their mothers can have detrimental psychological, physical, and emotional impacts. [287] According to CRC General Comment 14, “the concept of the child’s best interests is complex and its content must be determined on a case-by-case basis... [i]t should be adjusted and defined on an individual basis, according to the specific situation of the child or children concerned, taking into consideration their personal context, situation and needs.” [288] Therefore, policies in which drug dependence alone is immediate grounds for losing child custody are inconsistent with CRC guidelines. [289] Thus, the provisions of the Russian Federation Family Code violate the human right to family and states’ obligation to keep families together.

V. RECOMMENDATIONS

INTERSECTIONALITY

- States should explicitly address intersecting forms of discrimination in law and policy.
- States should adopt measures to accelerate the elimination of stereotypical attitudes and behaviors that discriminate against women who use drugs and/or are HIV positive. For example, this can include funding for media campaigns that highlight the plight of women who use drugs. [290]
- States should develop guidance and training for law enforcement, social workers, and healthcare providers, in consultation with women who use drugs, covering women’s health and human rights and intersections between drug dependence, HIV, and gender-based violence. [291]
- States should allocate resources for the prevention and treatment of health conditions disproportionately impacting women who use drugs, including HIV/AIDS and Hepatitis C.

DECRIMINALIZATION AND HARM REDUCTION MEASURES

- States should decriminalize the use and possession of drugs for personal use and adopt policies and programs that address the needs of people who use drugs. [292]
- States should abolish the practice of using drug registries, government records of “chronic drug users,” which serve as a barrier to treatment and care.
- States should ensure drug control complies with human rights. [293] This includes access to controlled essential medicines for the treatment of health conditions. [294] States should use human rights indicators and guidelines to ensure that drug control does not undermine human rights. [295]
- States should provide interventions focused on addressing the harms associated with the use of psychoactive drugs. These harm reduction measures include needle syringe programs, OST, overdose prevention, linkages to medical services, including drug treatment if desired and HIV testing and treatment, and provision of psychosocial support, including legal services.[296]
- States should implement harm reduction measures in prison, including opioid substitution therapy, providing sterile injecting equipment via needle and syringe exchange programs, and use of naloxone to treat overdoses.

GENDER-SENSITIVE DRUG POLICY

- States should develop specific guidelines and training for healthcare professionals and administrators on drug treatment during pregnancy, highlighting the obligation to treat all patients with respect and without discrimination and to ensure the right to privacy. [297]
- States should develop gender-sensitive and integrated health services for women who use drugs that take into account women's reproductive health. States should provide the full range of reproductive health services, including reproductive health education programs and accessible and affordable contraception for women who use drugs.
- States should develop integrated health services to provide pregnant women with quality access to OST, HIV treatment, and reproductive care, and provide rehabilitation services that enable women to remain with their children. [298]
- States should eliminate coerced and forced sterilization or abortion of women who use drugs. This includes creating and implementing policies and protocols for medical professionals, as well as putting in place review mechanisms to investigate violations and provide redress. [299]
- States should encourage patient autonomy among women with substance use disorders by informing them about the risks and benefits, for themselves and for their fetuses or infants, of available treatment options, when making decisions about healthcare. [300]
- States should ensure gender-based violence services and shelters tailored to the needs of women with drug dependence. [301]

PROTECT THE FAMILY UNIT

- States should protect families against arbitrary removal of children and review definitions of child abuse to ensure they are based on evidence rather than the assumption that prenatal drug exposure alone is indicative of abuse. [302]
- States should develop policies and programs that support keeping mothers with children, recognizing the value of the relationship between a mother and her child and its importance for a child's development. [303]

VI. ENDNOTES

[1] Convention on the Elimination of All Forms of Discrimination Against Women (“CEDAW”), adopted Dec. 18, 1979, 1249 U.N.T.S. 13.

[2] International Covenant on Economic, Social, and Cultural Rights (“ICESCR”), adopted Dec. 16, 1966, 993 U.N.T.S. 3.

[3] International Covenant on Civil and Political Rights (“ICCPR”) art. (9), adopted Dec. 16, 1966, 999 U.N.T.S. 171.

[4] Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“CAT”), adopted Dec. 10, 1984, 1465 U.N.T.S. 85, 113.

[5] Convention on the Rights of the Child (“CRC”), 1577 U.N.T.S. 3, Nov. 20, 1989.

[6] International Convention on the Elimination of All Forms of Racial Discrimination (“ICERD”), adopted Dec. 18, 1979, 1249 U.N.T.S. 13; Convention on the Rights of Persons with Disabilities (“CRPD”), adopted Jan. 24, 2007, 2515 U.N.T.S. 3. Under the Russian Federation Constitution, these treaties are enshrined as the supreme law of the land, and the government must guarantee rights and freedoms “according to the universally recognized principles and norms of international law.” See Articles 15 and 17 of the Constitution of The Russian Federation; see also Article 55, which states that the rights and freedoms of The Russian Federation citizens extend beyond the enumerated rights of the Constitution, which “shall not be interpreted as a rejection or derogation of other universally recognized human rights and freedoms.”

[7] ICESCR, *supra* note 2, Art. 2.

[8] ICCPR, *supra* note 3, Art. 26.

[9] Committee on Cultural, Economic, and Social Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), at para. 43.

[10] Human Rights Committee, General Comment No. 18: Non-discrimination, para. 1, U.N. Doc. HRI/GEN/1/Rev.1 (1994) at 26.

[11] CEDAW, *supra* note 1, Art. 1.

[12] *Id.* at Art. 2(f).

[13] Comm. on the Elimination of Discrimination against Women, General Recommendation No. 28, on article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women, U.N. Doc. CEDAW/C/GC/28/Rev. 7 § 12 at 284 (May 12, 2004), at para. 18.

[14] Norbert Gilmore, Drug Use and Human Rights: Privacy, Vulnerability, Disability, and Human Rights Infringements, 12 *J Contemp. Health. L. & Pol’y* 355, 358 (1996).

[15] UNAIDS, Health, Rights and Drugs: Harm Reduction, Decriminalization and Zero Discrimination for People Who Use Drugs, at 13, (March 13, 2019), citing National AIDS Control Program, Integrated biological & behavioral surveillance in Pakistan, 2016-17 (April 2017).

[16] *Id.*

[17] *Id.*

[18] Universal Declaration of Human Rights (“UDHR”) art. #3, G.A. Res. 217 (III) A, U.N. Doc. A/810 (Dec. 10, 1948); ICCPR, *supra* note 3 Art. (9).

[19] Human Rights Committee, Concluding observations on the seventh periodic report of the Russian Federation, CCPR/C/SR.3157, (March 31, 2015), at paras. 16, 17.

[20] OHCHR, AL Health (2002-7) G/SO214 (53-24) RUS 11/2013 (Dec. 10, 2013), [https://spdb.ohchr.org/hrdb/24th/Public_AL_The Russian Federation_10.12.13_%2811.2013%29_Pro.pdf](https://spdb.ohchr.org/hrdb/24th/Public_AL_The_Russian_Federation_10.12.13_%2811.2013%29_Pro.pdf).

[21] UNAIDS, HIV-Related Stigma, Discrimination and Human Rights Violations: Case studies of successful programmes, Best Practice Collection, at 7, http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf.

[22] *Id.* at 5.

[23] UNAIDS, Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination, (Dec. 2018), at 3, www.unaids.org/sites/default/files/media_asset/global-partnership-hiv-stigma-discrimination_en.pdf

[24] Arune Kontautaitė, Daria Matyushina-Ocheret, Maria Plotko, Mikhail Golichenko, Mart Kalvet & Lena Antonova, Study of human rights violations faced by women who use drugs in Estonia, *Harm Reduction Journal*.

[25] Global Network of People Living with HIV, HIV and stigma and discrimination in the world of work: Findings from the People Living with HIV Stigma Index (July 2018), at 14, https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_635293.pdf.

[26] CESCR Committee General Comment No. 14 (2000) on Article 12 of ICESCR, E/C.12/2000/4, (hereinafter “CESCR General Comment No. 14”), paras. 18-19 and CRC Committee General Comment No. 3 (2003) on ‘HIV/AIDS and the rights of the child,’ CRC/GC/2003/3, (hereinafter “CRC Committee General Comment No. 3”), para. 9. The Human Rights Committee has also interpreted the term “other status” to include health status; see CHR Resolution on the protection of human rights in the context of HIV/AIDS, above fn. 6, preambular para. 16, https://www.ohchr.org/Documents/Issues/HIV/HIV_AIDS_IDP.pdf.

[27] Sarah E. Burke, A Tale of Two Cities: Stigma and Health Outcomes Among People with HIV who Inject Drugs in St. Petersburg, the Russian Federation and Kohtla-Järve, Estonia, *Soc. Sci. Med.* 130, (Apr. 2015), at 154-61, <https://doi.org/10.1016/j.socscimed.2015.02.018>.

[28] Mikhail Golichenko, Submission to the Committee on the Rights of Persons with Disabilities: Review of the Initial Periodic Report of the Russian Federation, at 5, <https://www.ecoi.net/en/document/1426813.html>.

[29] Tanya is a pseudonym used for privacy protection.

[30] *Id.*

[31] *Id.*

[32] *Id.*

[33] Narcologists are specialists in narcology and they focus on “[t]he treatment and study of alcohol and drug abuse (especially as a medical specialty in the Soviet Union or countries which were part of it)” <https://www.lexico.com/en/definition/narcologist>; <https://www.lexico.com/en/definition/narcology>.

[34] *Id.*

[35] *Keller v. The Russian Federation*, 26824/04 ECHR 985 (October 17, 2013).

[36] *Id.* at paras. 8-9.

[37] *Id.* at paras. 8-9.

[38] OHCHR, Gender Stereotyping, Your Human Rights, <https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/GenderStereotypes.aspx>.

[39] Kasia Malinowska-Sempruch and Olga Rychkova, The Impact of Drug Policy on Women, Open Society Foundations (Sept. 28, 2016), at 1, www.opensocietyfoundations.org/uploads/05b0d17a-4337-460a-8950-7804d0ad26fe/impact-drug-policy-women-20160928.pdf; see also U.N. Office of Drugs and Crime (UNDOC); Women and Drugs: Drug Use, Drug Supply and Their Consequences, *World Drug Report 2018*, p. 20, www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_5_WOMEN.pdf; Julia Kensy and others, Drug policy and women: addressing the negative consequences of harmful drug control,” Briefing Paper (London, International Drug Policy Consortium, 2012).

[40] Lisa Maher, Reconstructing the Female Criminal: Women and Crack Cocaine, 2 *S. Cal. Rev. L. & Women's Stud.* 131,134 (1992). “The history of recurrent moral panics that surround drug use suggests that moral entrepreneurship is contingent. Moral panics operate in, and are conditioned by, structural contexts. Contemporary developments in the wake of the ‘war on drugs’ in the United States, probably the best example of which is the ‘criminalization of pregnancy,’ serve to illustrate the structuring effects of gender, race, and class on crime discourse.” Crack babies, crack moms, and other frightful additions to our language can be seen as part of a broader moral lexicon concerned with the discipline and regulation of an increasingly unruly urban underclass, and in particular, with its female members who appear to blatantly violate dominant cultural norms in relation to womanhood, female sexuality, and motherhood.”

[41] Malinowska-Sempruch, Rychkova, *supra* note 39, at 10.

[42] CEDAW Concluding observations on the fourth periodic report of Kyrgyzstan (11 March 2015), at para. 33, <https://digitallibrary.un.org/record/791384?ln=en>. For further discussion about intersecting forms of discrimination, please see Part II, Section D.

[43] These limitations engrained in Article 253 of the Russian Federation Labor Code include patriarchal stereotypes about women's strength, prohibiting women from taking "manually intensive" jobs or jobs that involve "heavy lifting." See Russian Labor Code Article 253.

[44] *Medvedeva v. the Russian Federation*, Communication No. 60.2013, CEDAW Committee (Mar. 21, 2013), at para. 11.3, http://www.bayefsky.com/pdf/the-Russian-Federation-federation_t5_cedaw_60_2013.pdf.

[45] CEDAW, Art. 5.

[46] *R. K. B. v. Turkey*, Communication No. 28/2010, CEDAW Committee (Feb. 13, 2012) at para. 8.7, https://www2.ohchr.org/english/law/docs/CEDAW-C-51-D-28-2010_en.pdf.

[47] *Id.* at para. 8.8

[48] UNAIDS, *supra* note 15, at 13.

[49] *Malinowska-Sempruch, Rychkova*, *supra* note 39, at 16,

[50] Harm Reduction International, *Violence Against Women Who Use Drugs and Access to Domestic Violence Shelters*, (March 2013), at 2.

[51] IWRAP, *NGO Reporting Guidelines on CEDAW & Rights of Women Who Use Drugs*, at 4, <https://www.iwraw-ap.org/wp-content/uploads/2018/07/NGO-Reporting-Guidelines-on-CEDAW-Rights-of-Women-who-Use-Drugs.pdf>.

[52] *Id.*

[53] L. Gilbert et al., *Feasibility and preliminary effects of a screening, brief intervention and referral to treatment model to address gender-based violence among women who use drugs in Kyrgyzstan: Project WINGS (Women Initiating New Goals of Safety)*, *Drug and Alcohol Review* 132 (Jan. 2017), <https://onlinelibrary.wiley.com/doi/abs/10.1111/dar.12437>; see also *Kasia Malinowska-Sempruch and Olga Rychkova, The Impact of Drug Policy on Women* (Sept. 28, 2016), at 16, <https://www.opensocietyfoundations.org/sites/default/files/impact-drug-policy-women-20160928.pdf> [hereinafter *Malinowska-Sempruch & Rychkova*].

[54] International Harm Reduction Development (IHRD), *Addressing Violence Against Women Who Use Drugs: Access to Safety, Health, and Justice*, (Mar. 2014), at 1.

[55] Ellen Tuchman, "Women and addiction: the importance of gender issues in substance abuse research," *Journal of Addictive Diseases*, vol. 29, No. 2 (April 2010).

[56] *Malinowska-Sempruch, Rychkova*, *supra* note 39, at 1.

[57] Rashida Manjoo, U.N. Special Rapporteur on violence against women its causes and consequences, *Pathways to Conditions and Consequences of Incarceration Amongst Women*. U.N. Doc. A/68/340 (Aug. 21, 2013).

[58] CEDAW Committee, *Concluding observations on Brazil*, U.N. Doc. CEDAW/C/BRA/CO/7 (Feb. 23, 2012) at para. 32.

[59] *Malinowska-Sempruch, Rychkova*, *supra* note 39, at 16.

[60] CEDAW Committee, *State Party report on the United Kingdom*, U.N. Docs CEDAW/C/UK/3, Add.1 and 2, and CEDAW/C/UK/4, Add.1-4 (Jun. 10, 1999), at para. 312.

[61] OHCHR, *The Russian Federation Drug Policy as a Distorting Reflection of the UN Drug Conventions: Language, Overreliance on Punitive Restrictions, Indifference to Human Rights, and Obliteration of Science*, 28/28, UN Doc. A/HRC/28/L.22, (2015) at 10.

[62] *Id.* at 10, at note 63.

[63] “When facing criminal charges, women who use drugs are more likely than men to have their offenses categorized as serious crimes: in 2013, more than 43% of women convicted of drug-related offenses were sentenced for drug trafficking, 22% were convicted for particularly serious crimes, and 15% were convicted for crimes committed in complicity. To compare, in the same year, only some 25% of men charged with drug-related offenses were sentenced for drug trafficking, 13% for drug crimes considered particularly serious, and 7% for drug crimes committed in complicity. This analysis is based on sentencing statistics available from the Judicial Department of the Russian Federation Supreme Court (<http://www.cdep.ru/index.php?id=79>) and the Federal Penitentiary Service statistics (<http://fsin.su/statistics/>)” OHCHR, *The Russian Federation Drug Policy as a Distorting Reflection of the UN Drug Conventions: Stigmatizing Language, Overreliance on Punitive Restrictions, Indifference to Human Rights, and Obliteration of Science*, 28/28, UN Doc. A/HRC/28/L.22 (2015) at 10.

[64] CEDAW Concluding Observation on Georgia (2014), para. 31 (e); CEDAW Concluding Observations (2014) on Kazakhstan (calling for “gender sensitive” harm reduction programs for women in detention).

[65] Malinowska-Sempruch, Rychkova, *supra* note 39, at 9.

[66] *Id.* at 4.

[67] *Id.* at 17.

[68] CEDAW Committee, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, para. 31 (a), https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CEDAW_C_GC_35_8267_E.pdf.

[69] UNAIDS, *The Gap Report*, (2014), at 175, http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf.

[70] Malinowska-Sempruch, Rychkova, *supra* note 39, at 13.

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] CEDAW Committee, Concluding observations on Albania para. U.N. Docs CEDAW/C/ALB/CO/3 (Sept. 16, 2010), at 19. The CEDAW Committee particularly recognizes the importance of ensuring the implementation of legislation that “is conducive to the effective elimination of discrimination against women, especially women belonging to disadvantaged groups, such as ...women living with HIV/AIDS.”

[75] CEDAW Committee, General Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS), U.N. Docs CEDAW/A/45/38 (1990). https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=27.

[76] World Health Organization, *Violence Against Women and HIV/AIDS: Critical Intersections*, at 5, <https://www.who.int/hac/techguidance/pht/InfoBulletinIntimatePartnerViolenceFinal.pdf>.

[77] IWRAP, *NGO Reporting Guidelines on CEDAW & Rights of Women Who Use Drugs*, <https://www.iwraw-ap.org/wp-content/uploads/2018/07/NGO-Reporting-Guidelines-on-CEDAW-Rights-of-Women-who-Use-Drugs.pdf>.

[78] UNAIDS, *Fact Sheet – World Aids Day 2019* (Dec. 1, 2019), https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

[79] Tamar Ezer, *Lessons from Africa: combating the twin epidemics of domestic violence and HIV/AIDS*, 13 *HIV/AIDS Pol’y & L. Rev.* 57-58 (2008).

[80] *Id.*

[81] Campbell, Baty, Ghandour, Stockman, Francisco, Wagman, *The intersection of intimate partner violence against women and HIV/AIDS: a review* (Dec. 2008).

[82] Ezer, *supra* note 79, at 58.

[83] *Id.*

[84] Kimberle Crenshaw. *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, <https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1052&context=uclf>.

[85] *Id.*

[86] CEDAW, General Recommendation No. 28, on article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women on temporary special measures, U.N. Doc. CEDAW/C/GC/28/Rev. 7 § 12 at 284 (May 12, 2004), at para. 18.

[87] Committee on the Elimination of Discrimination against Women, General Recommendation No. 28, on article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women on temporary special measures, U.N. Doc. CEDAW/C/GC/28/Rev. 7 § 12 at 284 (May 12, 2004), at para. 18 (*italics added*); see also CEDAW, General Recommendation No. 25, on article 4 of the Convention on the Elimination of All Forms of Discrimination Against Women on temporary special measures, U.N. Doc. HRI/GEN/1/Rev. 7 § 12 at 284 (May 12, 2004), at para. 1 (“[C]ertain groups of women, in addition to suffering from discrimination directed against them as women, may also suffer from multiple forms of discrimination based on additional grounds such as race, ethnic or religious identity, disability, age, class, caste or other factors.”).

[88] CEDAW, General Recommendation No. 33, on women’s access to justice, U.N. Doc. CEDAW/C/GC/33, § 8 (July 23, 2015), at para. 8; see also CEDAW, General Recommendation No. 28, on article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women on temporary special measures, U.N. Doc. CEDAW/C/GC/28/Rev. 7 § 12 at 284 (May 12, 2004), at para. 18.

[89] CEDAW, *supra* note 86, at para. 18.

[90] CEDAW Gen Rec. 24 on Article 12, at para. 6. Please see section III for a discussion of the right to health.

[91] CEDAW, Communication No. 17/2008, *Alyne Pimentel v. Brazil*, U.N. Doc. CEDAW/C/49/D/17 (29 July, 2011), at para. 5.10, <https://www2.ohchr.org/english/law/docs/CEDAW-C-49-D-17-2008.pdf>.

[92] CEDAW Concluding observations on the fourth periodic report of Kyrgyzstan (11 March 2015), at para. 33.

[93] *Id.*

[94] UN Human Rights Council, Report of the Special Rapporteur on violence against women, its causes and consequences, 28 May 2014, A/HRC/26/38 at para. 42.

[95] *LG v. Korea*, Merits, United Nations Committee on the Elimination of Racial Discrimination, U.N. Doc. CERD/C/83/D/51/2012 at para. 3.2.

[96] *Id.* at para. 3.2.

[97] *Id.* at paras. 3.2-3.3.

[98] *Id.* at para. 7.3.

[99] *Id.* at para. 7.4.

[100] *Id.*

[101] ICESCR, *supra* note 2, Art. 12 (1), (2).

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- [113] Open Society Institute Public Health Program, *supra* note 108, at 10.
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- [120] *Id.*
- [121] *Id.*
- [122] *Id.*
- [123] *Id.*
- [124] CESCR Committee, *supra* note 26, at para. 12(b).
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- [130] UN General Assembly, Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, (Aug. 6, 2010), UN Doc A/65/255, at para. 24.
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[145] United Nations Office on Drugs and Crime, World Drug Report, Status and Trend Analysis of Elicit Drug (2015), at 1, 5; UNAIDS, Health, Rights and Drugs: Harm reduction, decriminalization and zero discrimination for people who use drugs (2019), Chapter 2: Harm Reduction: Linking human rights and public health. (explaining that women are more likely to contract HIV in part due to harmful gender norms that leave them with less control in injections, and when sharing needles for injection, they are often forced to use the needle after their male counterparts).

[146] Human Rights Council, *supra* note 131, at para. 28.

[147] *Id.*

[148] Stating that “States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees...to preventative, curative, and palliative health services...”

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[161] World Health Organization, Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users (2004) at 28.

[162] CESCR Committee, *supra* note 26, at para. 12(a)

[163] CEDAW Concluding observations on the combined fourth and fifth periodic reports of Georgia (2014) para. 31.

[164] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2010) at para. 52 (citing WHO, Briefing Note 2007: Access to Controlled Medications Programme (Geneva, 2007), p. 1).

[165] Juan E. Méndez, *supra* note 109, at para. 73.

[166] *Id.* at paras. 73, 74.

[167] *Id.* at para. 87.

[168] UNAIDS, *supra* note 15, Chapter 4: Role of Communities (stating that the prevalence of HIV in the Russian Federation has grown from an estimated 95,000 new infections in 2015 to 100,000 in 2017, and that in 2017 HIV prevalence among people who inject drugs in 6 cities was 75.2% and also noting that Eastern Europe and Central Asia region was home to 21% of the world's people who inject drugs (aged 15-64) in 2016, despite having only 4% of the global population within that age range).

[169] United Nations Economic and Social Council, Concluding observations on the sixth periodic report of the Russian Federation, 6 October 2017, UN Doc E/C.12/RUS/CO/6, at para. 50.; UNAIDS, Health, Rights and Drugs: Harm reduction, decriminalization and zero discrimination for people who use drugs (2019), Chapter 4: Role of Communities.

[170] CESCR, Concluding observations on the sixth periodic report of the Russian Federation, 6 October 2017, UN Doc E/C.12/RUS/CO/6, at para. 50.

[171] CEDAW, Concluding observations on the eighth periodic report of the Russian Federation, 20 November 2015, UN Doc CEDAW/C/RUS/CO/8, at para. 36, (d) (e).

[172] CESCR, *supra* note 170, at para. 51.

[173] *Id.*

[174] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2017), UN Doc A/HRC/35/21, at para. 32 (noting that the right to health ought to be understood as a guarantee to the right to treatment that involves reintegration into the community).

[175] *Id.*

[176] *Id.* at para. 83.

[177] *Id.* at para. 38.

[178] *Id.* at para. 43.

[179] *Id.* at para. 76.

[180] *Id.* at para. 80.

[181] CEDAW, *supra* note 64, at para. 30(d), para. 31(e), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fGEO%2fCO%2f4-5&Lang=en.

[182] CEDAW Concluding observations on the combined fourth and fifth periodic reports of the former Yugoslav Republic of Macedonia adopted by the Committee at its fifty-fourth session (1 March 2013), at para. 33, <https://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW.C.MKD.CO.4-5.pdf>.

[183] CESCR General comment 14 was discussed above, in section III A 1, with regard to the right to non-discrimination for marginalized populations such as those with criminal records. The present section analyzes the right to non-discrimination as it applies to women as a marginalized population.

[184] CESCR Committee, *supra* note 26, at para. 12.

[185] *Id.* at para. 52.

[186] *Id.* at para. 20.

[187] *Id.*

[188] United Nations Office on Drugs and Crime, (“UNODC”), Guidelines on drug prevention and treatment for girls and women, at 29.

[189] National Institute on Drug Abuse, (“NIH”), Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition), at para. 4.

[190] CEDAW, *supra* note 1, preamble.

[191] CEDAW General Recommendation No. 24: Article 12 on the Convention (Women and Health) Adopted at the Twentieth Session of the Committee on the Elimination of Discrimination against Women (1999), at para. 1.

[192] General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), at para. 1.

[193] *Id.* at para. 15.

[194] *Id.* at para. 25.

[195] CEDAW, *supra* note 1, Art. 12 (“State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care services, including those related to family planning...State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation”); ICESCR, *supra* note 2, Art. 12(1) (“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”).

[196] CEDAW, *supra* note 1, Art. 10(h) (“State Parties shall...ensure...access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning”); ICCPR, *supra* note 3, Art. 19(2), “Everyone shall have the right to...receive and impart information and ideas of all kinds...”).

[197] ICESCR, *supra* note 2, Art. 13(1) (The State Parties to the present Covenant recognize the right of everyone to education”); CEDAW, *supra* note 1, Art. 10 (“States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education...”).

[198] CEDAW, *supra* note 1, Art. 2 (“States Parties condemn discrimination against women in all its forms”); ICESCR, Art. 2(2) (“The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present covenant will be exercised without discrimination of any kind”); ICCPR, *supra* note 3, Arts. 3, 26, (“The State Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant,” “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law”).

[199] ICCPR, *supra* note 3, Art. 17 “No one shall be subjected to arbitrary or unlawful interference with his privacy...”

[200] UNCAT, *supra* note 4, Art 2(1) (“Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction”); ICCPR, *supra* note 3, Art. 7 (“No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”).

[201] Reva B. Siegel, Sex Equality Arguments for Reproductive Rights, *Emory Law Journal* (2007) at 819.

[202] CEDAW Concluding observations on the eighth periodic report of the Russian Federation, (Nov. 20, 2015) para. 31, para. 32(a).

[203] *Id.* at para. 3(a).

[204] CEDAW, *supra* note 1, Art. 10.

[205] *Id.* at Art. 16.

[206] *Id.* at Art. 12.

[207] *Id.* at Art. 16.

[208] Interim report on the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2011), at 2, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N11/443/58/PDF/N1144358.pdf?OpenElement>.

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[212] Anna Olsen, Cathy Banwell & Annie Madden, Contraception, punishment and women who use drugs, *BMC Women's Health* (2014), <https://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-14-5>.

[213] Mburu, Ndimbii, Ayon, Mlewa, Mbizvo, Kihara and Ragi, *supra* note 210, at 1.

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[215] Submission from civil society organizations from the Russian Federation for the 46th session of the Commission on the Elimination of Discrimination against Women, Discrimination against women from vulnerable groups, including women who use drugs and/or engage in sex work in the Russian Federation (2010) at 7.

[216] *Id.* at 8.

[217] CEDAW, *supra* note 202, at para. 35(c).

[218] CEDAW, *supra* note 1, Arts. 12, 16.

[219] CEDAW, *supra* note 1, Art. 2 (“States Parties condemn discrimination against women in all its forms”); ICESCR, *supra* note 2, Art. 2(2) (“The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present covenant will be exercised without discrimination of any kind”); ICCPR, *supra* note 3, Arts. 3, 26, (“The State Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant,” “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law”).

[220] CEDAW, *supra* note 1, Art. 12 (“State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care services, including those related to family planning...State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation”); ICESCR, *supra* note 2, Art. 12(1) (“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”).

[221] ICESCR, *supra* note 2, Art. 10(1) (“The widest possible protection and assistance should be accorded to the family...”); ICCPR, *supra* note 3, Art. 23(1) (“The family is the natural and fundamental group unit of society and is entitled to protection by society and the State”).

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[224] UNCAT, *supra* note 4, Art 2(1) (“Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction”); ICCPR, *supra* note 3, Art. 7 (“No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”); See also Eliminating forced, coercive and otherwise involuntary sterilization, An interagency statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, WHO (2014) at 1.

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[226] Human Rights Committee General Comment 28 (2000), at para. 11.

[227] Juan E. Mendez, *supra* note 109, at para. 48.

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[234] Submission from civil society organizations from the Russian Federation for the 46th session of the Commission on the Elimination of Discrimination against Women Discrimination against women from vulnerable groups, including women who use drugs and/or engage in sex work in the Russian Federation (2010) at 6; CEDAW Art. 10.

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[241] *Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture’s 2013 Thematic Report* 19 (2014) at 25.

[242] *Id.*

[243] *Id.*

[244] OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, WHO, *supra* note 239, at 3.

[245] Juan E. Mendez, *supra* note 109, at 17; see also *supra* note 241, at 29.

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[248] Juan E. Mendez, *supra* note 109, at para. 48.

[249] UNAIDS, UNDP, UNFPA, UNICEF, WHO, *supra* note 238, at 1.

[250] FIGO, *supra* note 237, at para. 10.

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[254] CEDAW, *supra* note 1, Art. 12 (“State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care services, including those related to family planning....State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation”); ICESCR, Art. 12(1) (“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”).

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[279] ICESCR, *supra* note 2, Art. 10.

[280] Open Society Foundations, The Impact of Drug Policy on Women (2015), at 10.

[281] Canadian HIV/AIDS Legal Network et al., The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Sessional Working Group with respect to Estonia, Para. 4, (2018).

[282] CESCR, Concluding observations on the third periodic report of Estonia, (March 27, 2019), at para. 44(d) <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1SKyxvprlxEitT1iPv5tsGoOiIeUbYK%2FAGvhE93KLAXM4z30cuUy4UFO6QpIsZDcil3ru4bJJOV1bQqfTumayrWAHmbmL8hJ8qa%2FeIa%2BbxB>.

[283] The Family Code of the Russian Federation (1995), Art. 69, <http://www.jafbase.fr/docEstEurope/RussianFamilyCode1995.pdf>.

[284] *Id.*

[285] Malinowska-Sempruch, Rychova, *supra* note 39, at 10.

[286] The Family Code of the Russian Federation, *supra* note 283, Art. 141.

[287] Human Rights Clinic at the University of Miami School of Law, The Canadian HIV/AIDS Legal Network, Eurasian Harm Reduction Association, Estonian Association of People Who Use Psychotropic Substances, Estonia’s Draconian Drug Policy Violates the Fundamental Human Rights of Women Who Use Drugs (June 21, 2019), at 24 <https://media.law.miami.edu/hrc/pdf/2019.06.21-Estonia-Submission.pdf>.

[288] Committee on the Rights of the Child, General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration, at para. 32.

[289] *Id.*

[290] *Id.*

[291] Wynn, *supra* note 267, at 11.

[292] In Portugal’s model, “decriminalization occurred alongside other efforts, including significant expansion of drug treatment programs, drug education and refocusing of police efforts on interruption of trafficking operations.” Human Rights Clinic at the University of Miami School of Law, *Alternative Models to Punitive Drug Policy* at 5 <https://miami.app.box.com/s/3r0xmufzbpzbz2f2jkz8lt8g3wdt7vk>.

[293] *Id.*

[294] *Id.*

[295] *Id.*

[296] *Id.*

[297] Wynn, *supra* note 267, at 11.

[298] Wynn, *supra* note 267, at 11; see CESCR Concluding Observations on Estonia, (March 27, 2019), at para 45.

[299] See OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, WHO, *supra* note 239, at 13-16.

[300] Wynn, *supra* note 267, at 11.

[301] Human Rights Clinic at the University of Miami School of Law, The Canadian HIV/AIDS Legal Network, Eurasian Harm Reduction Association, Estonian Association of People Who Use Psychotropic Substances, *supra* note 287, at 25.

[302] Wynn, *supra* note 267, at 11; see CESCR, *supra* note 282, at para. 44.

[303] Wynn, *supra* note 267, at 11; see CESCR, *supra* note 282, at para. 44.