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**Submission to the United Nations High Commissioner for Human Rights**

**Punitive drug policy and its gendered health and human rights implications. May 2022**

**Submitting organisation:**

The Women and Harm Reduction International Network (WHRIN). WHRIN's work addresses a critical gap: the lack of harm reduction services for women worldwide. WHRIN works to build linkages among women and gender diverse people who use drugs, non-government organisations and international non-government organisations, service providers, national governments, international organisations, and development partners – in order to achieve the mission of expanding availability of gender-responsive harm reduction services.

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**Introduction**

We welcome the opportunity to provide this submission to the UN High Commissioner for Human Rights ahead of its report on human rights challenges in drug policy. Our collective experience confirms that punitive drug policy and harmful patriarchal norms combine to create the unique human rights violations commonly experienced by women who use drugs. WHRIN research together with ongoing data from our allies around the world, also highlights that, despite normative guidance at the international level, harm reduction services remain under-resourced and under-scale in most countries while gender responsive services are thin on the ground or absent[[1]](#endnote-1), reflecting a lack of commitment to gender equality and human rights.

**Findings**

Criminalisation, gender inequity, marginalisation and services access barriers combine to amplify risk of violence, HIV and viral hepatitis transmission, overdose and other harms experienced by women who use drugs..[[2]](#endnote-2),[[3]](#endnote-3),[[4]](#endnote-4),[[5]](#endnote-5),[[6]](#endnote-6),[[7]](#endnote-7) Women who use drugs experience rates of violence from individuals, community and the state between 5 and 24 times higher than that against women in the general population.[[8]](#endnote-8),[[9]](#endnote-9) This reality (and lack of tailored, responsive services) can have devastating consequences, leading to homelessness, socio-economic precarity, poor health outcomes, unintended pregnancies, incarceration and social isolation, impacting unfavourably on bodily autonomy and power dynamics.[[10]](#endnote-10),[[11]](#endnote-11)

Women are rarely involved in planning and delivering harm reduction services, and examples of harm reduction designed for women are scarce.[[12]](#endnote-12) The absence of services that meet the needs of women who use drugs is in of itself a significant barrier to health. Chief among these service gaps are perinatal services, childcare and parenting supports and gender-based violence services as well as service provision modalities that fail to overcome access issues including physical security and risks of loss of child custody. In turn, overdose, BBV transmission, violence and other risks are further inflated.[[13]](#endnote-13)

In many countries, child protection services conduct home inspections, often without a search warrant and often together with the police [[14]](#endnote-14)again serving to disenfranchise those who most need access to health and other supports. Women who use drugs experiencing violence often do not contact police in order to avoid arrest, deportation or intervention from child protection authorities.

In several jurisdictions, pregnant women who use drugs have been coerced to either terminate their pregnancies or relinquish their children to the state, and are denied information about, and access to, appropriate services.[[15]](#endnote-15),[[16]](#endnote-16) In the US, prosecutors have targeted pregnant women accused of drug use with attempts to create foetal rights that have led to the punishment of pregnant women and the introduction of further barriers to health care.[[17]](#endnote-17),[[18]](#endnote-18) These conditions are predicted to be exacerbated by the recent overturning of Roe by the US Supreme Court.[[19]](#endnote-19),[[20]](#endnote-20) In Estonia, parenting women who use drugs are forced to undergo urine tests using painful urinary catheters which pose risk of urethra and other organ infection and can be classed as torture or a form of cruel, inhuman, or degrading treatment.[[21]](#endnote-21)Such trends of discriminatory and invasive actions against parenting and pregnant women are an infringement of the right to health.[[22]](#endnote-22) In addition, sexual and reproductive health services tailored to the needs of women who use drugs are largely absent.[[23]](#endnote-23) This despite the fact that women who use drugs have particular sexual and reproductive health needs while also facing heightened risk of acquiring HIV and viral hepatitis, and other sexually transmitted infections.[[24]](#endnote-24)

Due to limited health service access, women who use drugs often experience significant delay in pre-natal care with attendant negative impacts. Additionally, vertical transmission rates for women who use drugs living with HIV are significantly higher than for other women living with HIV. Harm reduction services should integrate sexual and reproductive health to bridge this vital service gap together with options of assisted referrals for any specialist, clinical or surgical needs. To ensure that the resulting services are relevant to WUD, meaningful involvement of WUD is critical. For additional information, please see the [Frontline AIDS/WHRIN guide](https://frontlineaids.org/resources/advancing-the-sexual-and-reproductive-health-and-rights-of-women-who-use-drugs/) on advancing the sexual and reproductive health and rights of WUD.

With mandatory prison sentences for even low-level drug trafficking, the incarceration of women for drug offences has jumped by 53% since 2000 [[25]](#endnote-25), with more women in prisons on drug related sentences that for any other offence.Law is enforced differently with different women according to wealth, ethnicity, age and gender. For example, in North America, poor women of colour are far more likely to face punitive action than are white women, and in Canada, indigenous women are the fastest-growing prison demographic.[[26]](#endnote-26) The Bangkok Rules urge countries to seek alternatives to incarceration for non-violent offences. To date, however, punitive drug policy has undermined implementation of the Bangkok Rules by providing a platform for accelerated incarceration of women while inhibiting access to harm reduction and evidence-based treatment.[[27]](#endnote-27) Pre-trial detention and mandatory minimum prison sentences contribute to this dynamic,[[28]](#endnote-28) with some women held in pre-trial detention for years – sometimes for longer than their potential sentences.[[29]](#endnote-29) Only ten countries in the world have harm reduction services that are available in at least one prison setting,[[30]](#endnote-30) and where such rare services do exist they tend to be in prisons for men.[[31]](#endnote-31) In addition to imprisonment with inadequate services, drug prohibition also subjects women to high levels of violence and harassment at the hands of law enforcement[[32]](#endnote-32) as well as arbitrary detention, compulsory drug ‘treatment’ and/or registration (associated with a host of human rights violations and other damaging restrictions[[33]](#endnote-33)), discontinuity of essential medical treatments, denial of legal aid and lack of due process.[[34]](#endnote-34)

**Recommendations**

In light of the above, we urge the UN High Commissioner for Human Rights to provide the following recommendations to Member States and to stakeholders:

* Drug use must be decriminalised. Punitive responses to drug use can be actively and systematically dismantled in order to eliminate stigma, discrimination, violence and other human rights violations.
* Women-sensitive harm reduction services must be urgently expanded. To improve access, harm reduction services must become more responsive to the needs of women in all their diversity. Government and donor attention is required to support the adoption of gender-responsive approaches in design and implementation of harm reduction programmes and in the overall HIV/AIDS response.
* Women who use drugs must be recognised as experts in their own lives, meaningfully engaged in the design, implementation, monitoring, and evaluation of programmes and research affecting them;
* Political commitment for resource allocation, data collection and responsive services must be grounded in intersectional understandings and meaningful involvement from women who use drugs.
* Political leadership can co-ordinate between law enforcement, health and gender equity platforms, relevant technical working groups and human rights organisations to create spaces for women and gender diverse people who use drugs to meaningfully take part in building protocols and programmes.
* All service provision must not be contingent on drug use status, social status, occupation, sexual orientation, gender identity, motherhood or reproductive or marital status, immigration status or criminal record
* Relevant stakeholders should ensure meaningful involvement of women who use drugs at all levels of policy and programmatic responses for ethical, optimal and cost-effective outcomes.
* Donors and all relevant stakeholders should support the development of partnerships between communities of women who use drugs, the women’s movement and the health sector to build a shared vision to address the harmful convergence of punitive drug policy and gender inequality.
* Urgently and completely remove any legislation that makes drug use a justification for removing children from their parent’s custody or that aims to punish women for using drugs during pregnancy;
* Ensure that sexual and reproductive health services are attuned to the needs of, and available to women and gender diverse people who use drugs
* Protect and expand civil society space, including within the women’s movement, that is inclusive of women who use drugs

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