**Submission of Questionnaire on Racism and the Right to Health**

The HIV Legal Network and the Centre on Drug Policy Evaluation (CDPE) are grateful for the opportunity to complete this questionnaire and inform the Special Rapporteur on the highest attainable standard of physical and mental health's forthcoming report to the General Assembly on the theme of racism and the right to health.

## Contact Details

Please provide your contact details in case we need to contact you in connection with this survey. Note that this is optional.

| | |
|---|---|
| Type of Stakeholder (please select one) | ☐ Member State<br>☐ Observer State<br>☒ Other (please specify): Civil Society |
| Name of State<br>Name of Survey Respondent | HIV Legal Network<br>Centre on Drug Policy Evaluation |
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| Can we attribute responses to this questionnaire to your Institution publicly*?<br><br>*On OHCHR website, under the section of SR health | **Yes** No<br><br>Comments (if any): |

## Key Questions

***1. What are the main ongoing manifestations of racism, and related forms of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly including in underlying determinants of health, health outcomes and access to health care?***

Canada's drug control framework is rooted in, and reinforces, systemic racism, and acts as a persistent barrier to realizing the right to health. Colonial, racist, and anti-immigrant beliefs drove the development of early drug and alcohol laws in Canada: in 1869, the *Gradual Enfranchisement Act* first criminalized selling alcohol to Canada's Indigenous people.[i] By 1908,

anti-Asian sentiment led to the passage of the *Opium Act*, Canada's first anti-drug law,[ii] which was followed by the criminalization of cannabis in 1923, stemming from anti-Black racism.[iii]

Today, this punitive approach to drugs continues to shape Canada's drug control framework under the federal *Controlled Drugs and Substances Act* (CDSA).[iv] Under section 4(1) of the CDSA, unauthorized possession of a substance for personal use (or "simple drug possession") is a criminal offence.[v] The penalty for contravening this provision depends on the substance and how it is "scheduled" and can range from a fine to a maximum 7-year sentence. "Trafficking" is prohibited under section 5 of the CDSA and defined to include any act of selling, administering, giving, transferring, transporting, sending, or delivering of a controlled substance – or offering to do any of these things – unless authorized by a regulation, whether for a profit or for free. The maximum penalty upon conviction for trafficking, or possession for the purpose of trafficking, is life in prison.

Canada's approach to drugs has done catastrophic harm, fuelling deadly stigma, epidemics of preventable illness and death, and widespread, systematic, and egregious violations of human rights. Criminalizing drugs has erected barriers to health care[vi] and exacerbated health-related harms, particularly for racialized communities.[vii] For instance, drug criminalization contributes to stigma and discrimination against people who use drugs,[viii] deterring them from accessing health and social services and emergency care in case of overdose. Criminalization can also impede practices of safer drug use because of fear of police or public detection, leading to infections and overdose,[ix] and hampers efforts to scale up safe supply programs. As a result, criminalization has contributed to a drug poisoning crisis that, between January 2016 and September 2021, has resulted in nearly 27,000 overdose deaths across Canada,[x] and is driving new HIV and hepatitis C (HCV) infections in Canada[xi] – with Indigenous and Black people disproportionately affected. Despite the evidence base and growing calls for decriminalization, including in the United Nations system common position on drugs,[xii] Canada has not decriminalized simple drug possession.

Systemic racism also influences the social determinants that lead people to problematic drug use,[xiii] including poverty, colonization, racism, precarious immigration status, lack of access to education and health services, discrimination, and trauma.[xiv] Prohibitive drug policies obscure such determinants and the reasons why people use or traffic drugs.[xv] For some, selling drugs is the only viable option to meet basic life needs or to support one's own drug dependence.[xvi] In Canada, Black women are overrepresented in federal prisons for drug-related offences, often related to a need to alleviate their situations of poverty, while some have reported being forced to sell drugs with threats of violence to their families.[xvii] Evidence also indicates that some marginalized Black people turn to substance use as a coping strategy to overcome cumulative hardship and stressful life conditions.[xviii] Indigenous women who use drugs have described the ways in which colonial policies and programs like residential schools, the mass removal of Indigenous children from their families into the child welfare system, and the banning of Indigenous traditions perpetuate intergenerational trauma that lead to drug use.[xix]

As a result of racial profiling and systemic racism, racialized communities are also overcharged and overincarcerated for drug offences.[xx] The Ontario Human Rights Commission has concluded that the gross overrepresentation of Black people among drug charges "raise concerns of

systemic racism and anti-Black racial bias, because the over-representation of Black people in drug possession charges does not align with what is known about drug use within Black communities."[xxi]

At the same time, drug offences are often used as justification to take children into state custody and separate them from their families, contributing to an overrepresentation of Indigenous, Black, and racialized children in state care. One study found that problematic substance use in childhood is often rooted in avoidable causal adversities, like loss of parents and families, and worsened by inadequate public policies and services (e.g., concerning child protection and social welfare).[xxii] By focusing on criminalization, rather than community supports, Canada's prohibitionist drug control framework worsens the underlying determinants of health, severely erodes access to health care, and results in detrimental outcomes for Black, Indigenous, and racialized communities.

***2. Who are the most affected people and why? Please describe existing disparities in the provision of and access to health services that affect people of different racial and ethnic origin, descent as well as other groups, such as migrants. The lack of data, analysis or health indicators in this regard may also be reflected.***

From 2014 to 2020, police in Canada made over 600,000 arrests for drug offences; two-thirds of those were for simple drug possession.[xxiii] The racist enforcement of drug policy means that Black and Indigenous people are disproportionately charged, prosecuted, and incarcerated for drug offences. While Canada's criminal justice agencies fail to systematically collect and release racially disaggregated data, some examples include:

- Data from 2015 to 2021 indicates that Black people are nearly three times more likely in Ottawa, nearly four times more likely in Toronto, and around 6.6 times more likely in Vancouver to be arrested for simple non-cannabis drug possession than their representation in the population would predict. Similarly, Indigenous people are nearly six times more likely in Regina, five times more likely in Saskatoon, and eight times more likely in Vancouver to be arrested for simple non-cannabis possession than their representation would predict. Disparities were attributed to racial profiling and targeting of Black and Indigenous people by drug law enforcement.[xxiv]

- A 2020 report found that Black and Indigenous people are dramatically overrepresented in drug charges recommended by the Vancouver Police Department.[xxv] Since 2014, Black people accounted for 6.4% of drug trafficking and possession charges, despite comprising only 1% of the city's population, while Indigenous people accounted for 18% of drug charges, but only 2.2% of the city's population.[xxvi]

- A 2018 report[xxvii] and 2020 study[xxviii] found that Black and Indigenous people were overrepresented in cannabis possession arrests across Canada.

Such racial disparities can be attributed to the manifestation of systemic racism in law enforcement. Intensive policing of low-income areas where Black people live has led to arrests of a large and disproportionate number of Black people accused of drug trafficking, and

intensive policing of airline travellers has resulted in arrests of a disproportionate number of Black female couriers.[xxix] A study also found the pre-trial admission rate for Black people was 27 times higher than for white people for drug trafficking or importing charges and 15 times higher for simple drug possession charges. Police decisions to detain accused Black people at a higher rate than white people have resulted in larger proportions of Black people being jailed before trial.[xxx]

Discriminatory surveillance, arrest, and prosecution have extensive health impacts, resulting "in damaged individual and family lives and devastated Black communities forced to cope with increasing violence over generations of incarceration" as well as "intensified levels of stigma."[xxxi] According to the Ontario Human Rights Commission, not only are individuals burdened with a criminal record, but the human cost of racial profiling includes increased fear and intimidation, reinforced anxieties, enhanced feelings of helplessness and hopelessness, and a sense of alienation and mistrust of institutions[xxxii] – all affecting the underlying determinants of health and access to health care. Studies have shown how police encounters act as barriers to accessing health services, including opioid agonist therapy, HIV treatment, and needle and syringe programs.[xxxiii] These barriers can have devastating health impacts, such as overdose and HIV or HCV infection.

The overincarceration of racialized populations is another way that systemic racism operates to deny racialized people the right to health, and drug-related offences are a driving factor in the overrepresentation of Black and Indigenous people in prison. In Canada, almost 20% of Black federal prisoners and 53% of Black women in federal prison are incarcerated for a drug-related offence.[xxxiv] Since the introduction of mandatory minimum sentences for drug offences, which removed judicial discretion in sentencing and imposed prison terms for drug offences in a broad range of circumstances, the overrepresentation of racialized people has worsened.[xxxv] Yet these provisions often fail to penalize profiteers engaged in large-scale trafficking. Instead, the most marginalized people who use drugs, including racialized people, people living in poverty, and/or those engaged in small-scale trafficking related to their drug use, bear the brunt of mandatory incarceration provisions.[xxxvi]

While prisoners have the right to the highest possible attainable standard of health,[xxxvii] prisoners face significant barriers to health care and consequently worse health outcomes. Prisoners face higher rates of mortality than the general population[xxxviii] and recently released prisoners face high risks of overdose.[xxxix] They also face far higher rates of HIV and HCV: a 2016 study indicated that 15% of men and 30% of women in provincial facilities are living with HCV while 1-2% of men and 1-9% of women are living with HIV.[xl] Rates of HIV and HCV are even higher for Indigenous prisoners, and particularly Indigenous women in prison.[xli] Without adequate access to harm reduction and health services, incarceration worsens health outcomes for people in detention.

***3. Under the right to health, States have a special obligation to refrain from denying or limiting equal access for all persons, comprising minorities, asylum seekers and migrants including undocumented migrants, to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy as well as to ensure equal access to health care and health-related services provided by third parties. Please explain how the above point is***

***implemented in your country, what works well and not so well and illustrate with disaggregated data if possible.***

In Canada, supervised consumption services (SCS), which offer people who use drugs a safe setting, sterile drug use equipment, and connections with health and social services without fear of arrest or harassment,[xlii] require an exemption from the federal government to operate. As a result of strong civil society mobilization led by people who use drugs, 38 federally exempted SCS are currently operating, in addition to several provincially-regulated overdose prevention services.[xliii] With one exception, however, Canada's SCS only permit supervised *injection* (and not inhalation), despite evidence of overdose risk from inhaled substances as well as some evidence of risk of HCV transmission.[xliv] Moreover, while comparatively less is known about the demographic sub-groups of people who access SCS for oral, intranasal or inhalant drug use, recent evidence from a supervised consumption service in Canada allowing inhalation demonstrated that participants were predominantly Indigenous men.[xlv] In the midst of an overdose crisis, the lack of culturally appropriate harm reduction services limits Indigenous and racialized people's access to lifesaving services.

Additionally, Canada fails to ensure prisons provide equivalent access to health services, including harm reduction services for prisoners who use drugs, despite the fact that a significant proportion of prisoners report recent drug use at the time of admission to custody and people continue to use drugs in custody,[xlvi] including via injection.[xlvii] In particular, Indigenous people are more likely to enter prison with problematic substance use;[xlviii] 97% of Indigenous women in federal custody and 86% of Indigenous people in federal prisons reported problematic substance use in the twelve months prior to arrest and 46% of Indigenous women have a history of injection drug use.[xlix]

Yet incarcerated individuals are not provided with adequate drug treatment or harm reduction measures, such as naloxone, opioid agonist therapy (OAT), and needle and syringe programs.[l] In Canada, naloxone is only accessible to prison health care staff.[li] Prisoners are not permitted to have naloxone kits in their cells, where they could use them in the event their cellmates suffer an opioid overdose. As Health Canada itself has noted, "Naloxone is a safe drug and administering naloxone to a person that is unconscious because of a non-opioid overdose is unlikely to create more harm."[lii] Correctional health care staff will not always be immediately available in overdose situations, yet a timely response to an opioid overdose can mean the difference between life and death.

Moreover, while World Health Organization guidelines state that OAT should be available to people in prison and equivalent to community options,[liii] federal prisoners experience barriers to OAT, including long waitlists and inappropriate medication terminations.[liv] Some provincial and territorial prisons do not offer OAT or impose severe restrictions on access.[lv] Limited access can result in acute withdrawal and an increased risk of use, relapse, and overdose.[lvi] This is particularly troubling given the fact that recently released prisoners face some of the highest risks of overdose compared to the general population.[lvii] In Canada, 10% of opioid overdose deaths can be attributed to a prisoner released within the last year.[lviii]

Similarly, access to sterile injection equipment in prison is extraordinarily limited. For thirty years, needle and syringe programs have been available in prison systems around the world of varying sizes and security levels and have been endorsed by numerous health and human rights organizations in Canada and internationally. No matter the context studied, evaluations of these programs – including by the Public Health Agency of Canada and the Canadian Agency for Drugs and Technology in Health – have consistently demonstrated that they reduce needle-sharing and the risk of HIV and HCV infection; do not lead to increased drug use or injecting; reduce drug overdoses; facilitate referrals of users to drug treatment programs; and have not resulted in needles or syringes being used as weapons against staff or other people in prison.[lix] While Canada's federal correctional service introduced a "Prison Needle Exchange Program" (PNEP) in some federal prisons, barriers to access are persistent. Most fundamentally, the PNEP violates prisoners' confidentiality without reasonable justification, and participation is contingent on the approval of prison health staff and security staff.[lx] No working program in the world uses the approach currently adopted in Canada. As a result, prisoners continue to be exposed to the risk of HIV, HCV, and other harms to their health.[lxi]

The discrepancy in prison health services is particularly troubling given the overincarceration of Black and Indigenous people in Canada. Not only are Canada's prison systems failing prisoners generally, but they are disproportionately restricting equivalent access to the right to health for Black and Indigenous people.

***10. What are the historical and ongoing legacies and impacts of colonialism and slavery on the right to health in your country? And how has the lack of reparations for slavery, colonialism, apartheid and racial discrimination impacted the right to health in your country?***

Colonialism and systemic racism continue to negatively impact the fulfillment of right to health in Canada by shaping the social determinants of health, including access to culturally appropriate health care, and manifesting in the racial profiling, arrest, prosecution, and overincarceration of Indigenous and Black populations for drug offences.

For some Indigenous people, substance use offers a means of coping with difficult life circumstances and ongoing stressors. Many of these challenges are rooted in the history of colonization which has included: criminalization of culture and language; rapid cultural change; creation of the reserve system; systemic racism; forced assimilation as well as emotional, sexual, and physical abuse endured through residential schools and child welfare policies.[lxii] The lasting impacts of trauma on substance use has contributed to the staggering overrepresentation of Indigenous people dying of opioid overdose. In the first half of 2020, Indigenous people accounted for 16% of all overdose deaths in the province of British Columbia despite representing only 3.3% of the province's population – and Indigenous women were 8.7 times more likely to die from an overdose compared to other women in British Columbia.[lxiii] In Alberta between 2016 and 2018, 49% of overdose deaths among Indigenous people were among Indigenous women (compared with 23% for non-Indigenous women).[lxiv]

Furthermore, systemic racism pushes racialized individuals and Indigenous communities into poverty at disproportionately high rates.[lxv] 1 in 5 racialized families (compared to 1 in 20 white families) live in poverty, and approximately 30% of shelter users are Indigenous.[lxvi] While many

working poor work similar hours to the average Canadian, they often earn less money, are more likely to be involved in precarious work, and experience less social security than the average Canadian worker.[lxvii] Situations of poverty, as a form of trauma, can cause some people to use drugs; research has shown that drug couriers often come from vulnerable or marginalized parts of society, and are motivated by poverty or economic hardship.[lxviii]

The historical enslavement of both Indigenous and Black people in Canada further affects mass incarceration today,[lxix] where (as detailed above) there is significantly less access to health care. While accounting for only 3.5% of Canada's total population,[lxx] Black people in 2018-2019 represented 8% of the federal prison population.[lxxi] In Ontario in 2010, Black men were five times more likely to be incarcerated than white men, and Black women were three times more likely to be incarcerated than white women.[lxxii] In 2021, Indigenous people represented 32% of individuals incarcerated in federal corrections,[lxxiii] despite only comprising approximately 5% of the total population in Canada.[lxxiv] Overrepresentation is even worse for Indigenous women – on December 17, 2021, Canada's correctional ombudsperson cautioned that Indigenous women are nearing 50% of the proportion of women incarcerated in federal prisons.[lxxv] Yet, access to culturally safe health services is grossly inadequate. Many of the interventions offered by the Correctional Services of Canada do not account for the history of colonization and intergenerational trauma that has led to drug use for many Indigenous people.[lxxvi] Access to healing lodges, which are environments specifically designed for Indigenous people that provide culturally appropriate services and programs for the care and custody of Indigenous men and women in federal custody,[lxxvii] continues to be inadequate within federal institutions.

The legacies of colonialism and slavery also persist as discrimination within the health care system. Recent research on racism, discrimination, and health in Canada points to health disparities and inequities in health care access and delivery for racialized Canadians.[lxxviii] While there exists little race-based data in Toronto's health care system, Black Canadians consistently attest to inequities and discrimination faced in accessing health care.[lxxix] The operation of systemic racism also results in race-based geographic allocation of health clinics throughout gentrified downtown core cities like Toronto. This leaves Black communities (which are primarily located at the margins of the city) severely under-serviced.[lxxx] Similarly, a 2020 investigation of the British Columbia health care system found that 84% of Indigenous people reported discrimination in the system.[lxxxi] Many Indigenous respondents reported that they had been treated with contempt and judgment, and their health concerns were downplayed or ignored due to racist stereotypes.[lxxxii] This was especially true when it came to stereotypes about substance use. Additionally, there remains poor access to addictions services in First Nations, Métis, and Inuit communities, and poor access to culturally safe services in general.[lxxxiii] Such racist treatment and laws drive people away from services and exacerbate the harms of problematic substance use.

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