Gendering the Scene:

Women, Gender-Diverse People, and Harm Reduction in Canada

Canadian HIV/AIDS Legal Network
Réseau juridique canadien VIH/sida

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About the Canadian HIV/AIDS Legal Network:

The Canadian HIV/AIDS Legal Network promotes the human rights of people living with, at risk of or affected by HIV or AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education and community mobilization. The Legal Network is one of the world's leading advocacy organizations working on the legal and human rights issues raised by HIV and AIDS.

The Legal Network acknowledges that the land on which we live and work is traditionally known as Turtle Island and home to the the Haudenosaunee, the Wendat, and the Anishinaabe, including the Mississaugas of the New Credit First Nation. We are all Treaty People. As settlers and as human rights advocates working for health and justice, we are called to honour the Calls to Action of the Truth and Reconciliation Commission in our work. We must do our part to address the ongoing injustices and resulting health inequities faced by Indigenous Peoples, which contribute to the disproportionate impact of the HIV epidemic on Indigenous communities. We are actively committed to this effort, working in collaboration with our Indigenous colleagues and others.

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Background

At writing, Canada is facing an unprecedented overdose crisis that is killing at alarming rates. Despite a recent shift in federal policy related to harm reduction, exemplified by the December 2016 introduction of an updated "Canadian Drugs and Substances Strategy" (CDSS) that replaced the "National Anti-Drug Strategy" and restored the pillar of harm reduction (in addition to prevention, treatment, and enforcement), more than 14,700 apparent opioid-related deaths were reported between January 2016 and September 2019.[1] These were due in large part to the increase of highly potent synthetic opioids (e.g. fentanyl and its analogues) in the market. Canada's ongoing fixation on criminal prohibition as the primary approach to addressing drug use has led to a situation in which people who use drugs continue to face criminalization, political and social hostility, and limited access to harm reduction and health services. Punitive laws not only infringe upon their human rights, but also hamper their access to and limit the expansion of harm reduction and other health services.

In particular, women and gender-diverse people who use drugs are tragically excluded from conversations about people who use drugs.[2] Despite the fact that there are marked differences among men, women, and gender-diverse people[3] in terms of their drug use and how laws and policies affect their drug use, less attention is paid to their access to health services, including the need for gender-competent, culturally safe, and trauma-informed care and harm reduction services. This is especially the case in relation to gender-diverse people who use drugs, for whom there is a troubling lack of data — a shortcoming with implications for their access to health services. As researchers have noted, women — especially marginalized women — are differentially affected by drug-related risks and harms in comparison to men who use drugs.[4] Determinants of women's and gender-diverse people's health, such as stigma, colonialism, racism, homophobia, transphobia, poverty, housing insecurity and homelessness, pregnancy and parenting, mental health challenges, physical and sexual violence, and repressive laws, policies, and law enforcement that affect women and gender-diverse people who use drugs are not sufficiently accounted for in the design of health strategies directed at people who use drugs, including in Canada.[5] For Indigenous women and gender-diverse people, discrimination, racism, structural and colonial violence, and intergenerational trauma continue to be additional barriers to discussing substance use and seeking support for problematic substance use.[6]

> *"More nuanced data collection and reporting are … required to ensure that the differential impacts of the overdose crisis on transgender, two spirit, and non-binary persons are understood and can be addressed with overdose prevention and response interventions.* ***This can be further extended to substance use research in general, as the experiences of gender diverse people are underexplored, thereby reinforcing inequity****."*
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> – A. Collins et al., "Gender and the overdose crisis in North America: Moving past gender-neutral approaches in the public health response," *International Journal of Drug Policy* 69 (2019) 43–45.

Despite differences between men, women, LGBTQ2S, and gender-diverse people in their substance use and access to health and other harm reduction services, there is a little data specific to LGBTQ2S and gender-diverse people in Canada or globally. Their invisibility in research related to substance use is a shortcoming that hampers our understanding of the distinctive barriers they face to health care. In this report, we will note data about LGBTQ2S and gender-diverse people when the underlying research makes those distinctions. Unfortunately, most of the research available and consulted distinguishes only between "men" and "women" and these limited distinctions are consequently reflected throughout the report.

Women and gender-diverse people consequently face additional barriers to health and harm reduction services and care for drug dependence, leading to drug use practices that increase their risk of HIV and hepatitis C virus (HCV) infection, other injection-related harms, overdose, and death.[7] Not surprisingly, a comprehensive review by the former United Nations (UN) Reference Group on HIV and injecting drug use found that compared to their male counterparts, women who inject drugs have substantially different needs and experience significantly higher mortality rates, increased likelihood of injection-related problems, faster progression from first drug use to dependence, higher levels of risky injection and/or sexual risk behaviours, and higher rates of HIV infection.[8]

In Canada, while reported overall illegal drug use in 2017 was higher among men (19%) than women (11%), women reported higher rates of use of both psychoactive pharmaceutical drugs and sedatives[9] — important distinctions that may lead to overlooked harms.[10] Research has also shown that LGBTQ2S individuals have higher rates of drug use and misuse compared to heterosexual peers,[11] and studies in the U.S. and Australia have shown that bisexual women report the highest rates of substance use among women, followed by lesbians.[12] Among transgender people in Ontario, a 2017 study indicated that the prevalence of cocaine and amphetamine use was higher than in the age-standardized reference population.[13] Women who are heavy substance users also rarely use a single substance.[14]

Research from Ontario further indicates that men were more likely to die of single-opioid use involving fentanyl or heroin, while deaths involving oxycodone, morphine, or hydromorphone were more common among women. Opioid-related deaths among women were also more likely to involve non-opioid prescription drugs, such as antidepressants, benzodiazepines, antipsychotics, and antihistamines, which has implications for the design and implementation of overdose prevention programs.[15]

Harm reduction: Harm reduction refers to "policies, programmes and practices that aim to minimise negative health, social and legal impacts" associated with substance use, substance use policies and laws, and is grounded in justice, human rights, and the principle of meeting people where they are. It "encompasses a range of health and social services and practices" that apply to criminalized and prescribed substances, including supervised consumption services, needle and syringe programs, non-abstinence-based housing and employment initiatives, drug checking, overdose prevention and reversal, psychosocial support, and the provision of information on safer drug use.[16] As the Centre of Excellence for Women's Health describes, "Harm reduction refers to the full range of supports and strategies that help women reduce harm, support wellness and address determinants of health without requiring abstinence."[17] Among Indigenous communities, harm reduction is also understood as a way of life that encompasses love, non-judgment, and non-interference, rooted in Indigenous Knowledges and worldviews, and focused on "mitigating the egregious harms of colonization and all that colonization has wrought."[18]

Substance use treatment or drug dependence treatment: For the purposes of this paper, "substance use treatment" and "drug dependence treatment" refer to evidence-based models of treatment for problematic substance use that improve the physical or mental health of the individual concerned and are consistent with human rights, such as opioid agonist therapy, an effective treatment for opioid dependence.

HIV, HCV, and overdose

HIV disproportionally affects women who use drugs in Canada. In 2016, the proportion of reported HIV cases among girls and women 15 years and older attributable to injection drug use was 27.3% compared to 10.9% for boys and men. There was also a disproportionately higher percentage of HIV attributable to injection drug use among Indigenous women than among non-Indigenous women.[19] Correspondingly, research has shown that women living with HIV consume illegal drugs more frequently than women not living with HIV in Canada, which has consequences for their HIV care and treatment.[20] In particular, researchers have found that drug use among women with HIV appears to have greater impacts on HIV and clinical outcomes than among men with HIV, including lower optimal adherence to treatment[21] — underscoring the need to integrate HIV and harm reduction services specifically designed for women. HCV is also a major concern for women who use drugs. In a national study of people who inject drugs, 68% of women were seropositive for HCV (with no significant differences in prevalence between participants who identified as men and those who identified as women).[22] Notably, demographic and social factors associated with HCV among Indigenous communities included being female and snorting and injecting drugs.[23] As with much research, gender-diverse people were excluded from these surveillance studies.

Globally, studies have shown that women who have sex with women (WSW) and inject drugs have higher rates of HIV than non-WSW who inject drugs, as well as higher-risk injection practices than heterosexual women.[24] While there remains limited understanding of the differential effects of drug use on LGBTQ2S people and an urgent need to better capture this data, researchers have noted that there are fewer culturally competent resources, services, or programs for LGBTQ2S and gender-diverse people struggling with problematic substance use.[25] The emerging evidence base indicates that the majority of the treatment infrastructure in North America and elsewhere fails to respond to the unique needs and diversity of LGBTQ2S people, who are "often less likely to adhere to treatment for substance [use], partly because of negative interactions with health-care services that are not well equipped" to address their needs.[26] In particular, WSW and transgender people who use drugs may not seek health care because of previous or anticipated experiences of discrimination.[27] More broadly, LGBTQ2S substance use "must be understood within the context of the stigma, prejudice, and discrimination to which LGBTQ people are constantly exposed."[28]

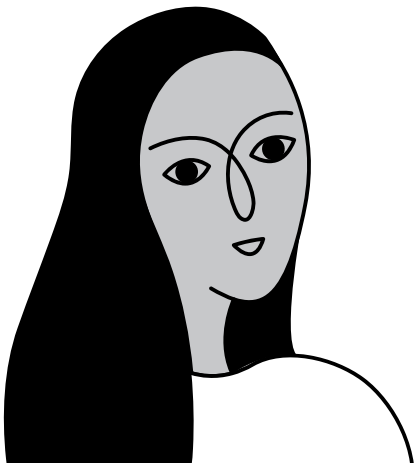
There is also evidence to suggest that people who sell sex and use drugs face increased risk of health harms, including HIV and viral hepatitis.[29] Research indicates sex workers who inject drugs are more likely to rent, borrow, and re-use equipment, and less likely to carry injecting equipment in places where there are criminal implications for possession and their engagement in sex work subjects them to increased risk of exposure to police.[30] A study conducted in Vancouver's Downtown Eastside, for example, found that sex workers who worked on the street were deterred from accessing health, social, and needle and syringe programs, because of their need to avoid the areas where these services were located, which exposed them to violence and policing.[31] Researchers have also posited that sex workers risk losing work if their clients or employers find out that they inject drugs, which can deter sex workers from seeking harm reduction services when needed.[32] Moreover, sex workers who use drugs face multiple barriers to health care, particularly in northern and rural communities where sexual and reproductive health services are already less accessible than they are in urban settings.[33]

In one Ontario study, women who inject drugs were more likely than their male counterparts to report injecting with and lending previously used needles and other used injection paraphernalia (i.e. water, cooker, or filter).[34] Significantly, some research has shown that women's first experience of injection drug use is often with a sexual partner who both supplies drugs and equipment and injects them.[35] This puts them at greater risk of acquiring blood-borne infections such as HIV and viral hepatitis

because they are last in the drug division and injection process and more likely to use drug solution from equipment that may have already been shared by other people.[36] Some women have described assisted injection as an act of intimacy with partners.[37] Even in the longer term, women who inject drugs are more likely than men who inject drugs to be dependent on a sexual partner for help acquiring drugs and injecting, and being injected by someone else has been found to be an independent predictor of HIV infection[38] — meaning that this dependence increases women's HIV risk.[39] There is considerable evidence that people who require help with injecting are vulnerable to a broad range of drug-related harms,[40] not only increasing their risk of infection (because they are "second on the needle") but increasing their risk of overdose (because they have no control over the dose they receive) and violence.[41]

Multiple studies have also found that women who inject drugs have greater overlap between sexual and injection social networks than men do, and that they are also more likely to have a sexual partner who injects drugs, increasing their risk of acquiring HIV and HCV through sexual transmission as well as through unsafe drug injecting.[42] Research has shown that some women who inject drugs report transactional sex relationships where the intimacy with their partner is tied to shelter, food, drugs, safety, and/or protection, which may leave the women in particularly vulnerable positions and therefore potentially less able to negotiate safe sex and safe injection behaviours.[43]

In addition to HIV and HCV, people who use drugs are at risk of overdose, and women and gender-diverse people who use drugs have not been spared by Canada's overdose crisis. In 2018 and 2019, women comprised approximately 25% of accidental apparent opioid-related deaths in Canada,[44] with great variation between provinces, from 57% of overdose deaths in New Brunswick to 44% in Manitoba and 42% in Saskatchewan.[45] Indigenous women are particularly affected. In 2017, just under 40% of all fatal overdoses within Indigenous communities in B.C. were among Indigenous women (compared with a rate of 17% for non-Indigenous women), attributed in part to barriers to health services for Indigenous people such as systemic racism, stigma, poverty, and insecure housing.[46] Similarly, in Alberta between 2016 and 2018, 49% of overdose deaths among Indigenous peoples were among Indigenous women (compared with a rate of 23% for non-Indigenous women).[47] As the National Inquiry into Missing and Murdered Indigenous Women and Girls concluded, the overrepresentation of Indigenous people among those experiencing overdoses is "another iteration of the legacy of colonial violence and the intergenerational trauma it carries, the socio-economic marginalization that circumscribes access to health- and wellness-promoting resources, and the institutional racism that continues to create barriers to treatment, not only for substance use but also for the many other harms caused by colonialism and intergenerational trauma."[48]



Gender-based violence

Gender-based violence is a particularly acute determinant of health for women and gender-diverse people who use drugs. As researchers have noted in the context of heterosexual relationships, for many women, their "experiences of sexual abuse, interpersonal violence, and other forms of gender-based violence are central to their use of substances."[49] Women who use drugs are "more likely than their male counterparts to experience sexual violence, and other forms of violence."[50] Intimate partner violence is also more commonly reported among women who use drugs.[51] Global research has shown that the odds of intimate partner aggression are three times greater when drug use is involved.[52] In a 2017 Statistics Canada survey, women who stated that they had used drugs during the month preceding the survey recorded an overall rate of "violent victimization" including sexual and physical assault that was five times higher than that of women who did not report drug use.[53] Indigenous women who use drugs also experience disproportionately high rates of gender-based violence, rooted in racism and the devastating historical and inter-generational impacts of colonization.[54]

In turn, violence can lead to drug practices that increase drug-related harm and create barriers to care. Gender-based violence has been linked to elevated rates of syringe sharing, inconsistent condom use, and accidental overdoses.[55] Power imbalances and the threat of violence in intimate relationships can make it difficult for women to access harm reduction services, enter and complete drug dependence treatment (if desired), and practice safer drug use and safer sex.[56] Intimate partners, for example, may perpetuate violence if they learn of women's drug use, or forbid women to visit health services or to enter drug dependence treatment. Some women who wish to enter treatment may feel compelled to leave a violent partner. Even without this opposition, if the partner also continues to use drugs, this may make it difficult for a woman to stop or reduce her own use.[57]

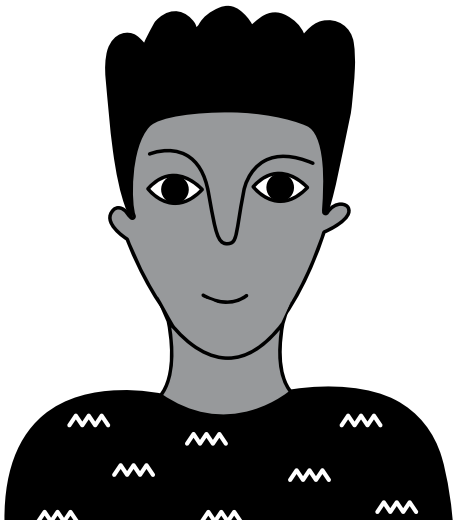
Women and gender-diverse people who use drugs and sell sex are also at increased risk of experiencing violence, both from the state and others within the community.[58] In particular, women and gender-diverse people who use drugs and engage in sex work on the street are subject to heavy policing and high rates of violence and exploitation that likely mediate the impact of harm reduction and HIV prevention efforts.[59] In a 2017 study of transgender Ontarians, for example, a history of transphobic assault, homelessness or under-housing, and sex work was associated with greater drug use among transgender people.[60] These harms are not intrinsic to sex work or drug use, but due to multiple structural determinants of health — chiefly criminalization and the broader repressive legal environment facing women and gender-diverse people who use drugs and sell or trade sex.[61]

In one Canadian study, WSW who use drugs were also more likely to report violence, including sexual violence, than non-WSW who use drugs.[62] In that study, WSW who use drugs were significantly more likely to report being attacked by strangers, acquaintances, police officers, and security guards and significantly more likely to report being beaten and strangled than women who did not report having sex with women.[63] As the researchers noted, "WSW are situated within cultures and practices of homophobia and heterosexism. Therefore, they may be more vulnerable to violence due to homophobic and heterosexist stigma, policies, and practices, such as being removed from a housing shelter for their sexual activities."[64]

The impact of stigma, misogyny, violence, and trauma

According to the UN Office on Drugs and Crime (UNODC), women affected by drug dependence are more stigmatized than men, as well as more likely to suffer from co-occurring mental health issues.[65] Canadian scholars have observed that women who use criminalized drugs "have long been vilified as more deviant than men who use similar drugs," yet "prior to the 1990s, moral condemnation of women did not lead to more services; rather, women's experiences remained largely invisible and unaddressed."[66] Such stigma has fuelled the regulation of women, especially poor, Indigenous, and racialized women, and intersected with "the regulation of sexuality, reproduction, mothering, and drug consumption."[67] Women and gender-diverse people who work in the sex industry also face additional stigma. Several studies have identified stigma as a significant barrier to accessing health care and drug dependence treatment for people who use drugs. Judgmental, unsympathetic, or hostile attitudes and views held by health professionals are likely to discourage individuals with drug-related problems from accessing services.[68] The stigma that women and gender-diverse people who use drugs face may also be reflected in their interactions with social service providers, including child protection authorities. As a result, many parents who use drugs face the very real threat of losing their children because of their drug use[69] — a profound source of stress that may contribute to mental health issues and deter them from seeking supports.[70]

While a 2012 Canadian survey of mental health indicated that a similar proportion of women and men identified as experiencing both mental health and substance use issues,[71] some evidence suggests that women may be more likely to engage in substance use as a way of coping with the impacts of trauma, abuse, and violence.[72] There is also a large body of research that suggests that many people experiencing drug dependence, especially women, Indigenous people, and racialized people, take drugs as a form of self-medication in order to address the symptoms of PTSD and the emotional and psychological consequences that stem from the violence, poverty, and racism they have experienced.[73] All too often, however, little or no attention is paid to systemic violence and the underlying issues that contribute to mental health issues among women and gender-diverse people who use drugs. In a study of women who use crack cocaine in Vancouver, for example, women reported that health care providers focused on problematic drug use with minimal attention to their underlying mental health concerns and other factors, including depression and grief in relation to violence that contributed to crack use.[74] In Canada, Indigenous women who use drugs have described how colonial policies and programs such as the devastating impact of residential schools, mass removal of Indigenous children from their families into the child welfare system, displacement from traditional lands, and destruction or banning of Indigenous traditions not only cause the violence they face, but also perpetuate intergenerational and multigenerational trauma that leads to drug use.[75] As the National Inquiry into Missing and Murdered Indigenous Women and Girls found, "using drugs and alcohol is, for many Indigenous people living with a history of trauma and violence, one of the only ways of managing significant pain, suffering, shame, and despair within broader systems and institutions that fail to provide other forms of meaningful and adequate support."[76]



Laws and policies that affect women and gender-diverse people who use drugs

On the whole, women and gender-diverse people who use drugs are disproportionally affected by stigma, more likely to have experienced gender-based violence, including from intimate partners and law enforcement, and more likely than men to use drugs to cope with mental health issues that may arise from stigma, gender-based violence, trauma, colonialism, and other forms of systemic violence. Moreover, as elaborated upon below, a number of repressive laws, policies, and law enforcement practices disproportionately affect women and gender-diverse people who use drugs — further impeding their access to health services and contributing to drug-related risks.[77] Understanding and accounting for these gender-specific challenges is critical to ensuring the meaningful access of women and gender-diverse people to vital harm reduction and other health services and to upholding their right to health.

i. Drug laws

The impact of punitive drug policies is increasingly falling on women, and the rate of incarceration of women — especially racial, ethnic, religious, and sexual minorities — is increasing at an unprecedented rate.[78]

– UN General Assembly Special Session on the World Drug Problem, *Women's declaration calling for global drug policies that support women, children, and families*, 2016

In Canada, the *Controlled Drugs and Substances Act* (CDSA) prohibits people from possessing, importing, exporting, trafficking in, or producing a "controlled substance," which includes synthetic cannabinoids, opioids, cocaine, methamphetamine, and barbiturates, among others. Punishments for these offences vary, ranging from a maximum $1000 fine, a six-month term of imprisonment, or both for a first offence of possession involving a synthetic cannabinoid,[79] to a series of mandatory minimum sentences for trafficking that can also leave an accused vulnerable to life imprisonment in some circumstances.[80] Importing, exporting, or producing a controlled substance can also subject a person to mandatory minimum sentences, up to life imprisonment depending on various factors including the type and amount of the substance.[81] Notably, the 2017 *Good Samaritan Drug Overdose Act* exempts both an overdose victim and witnesses from charges pertaining to drug possession for personal use ("simple possession") and charges for breaches of conditions associated with simple possession when they seek emergency help for an overdose victim, although the immunities that the law confers do not protect people from drug trafficking or other criminal charges or from child welfare involvement.[82]

Mandatory minimum sentences in relation to drug offences were first introduced in 2012, when the federal government passed the *Safe Streets and Communities Act*.[83] The law purported to target only those who traffic in drugs, while offering alternatives to incarceration for those struggling with problematic drug use — including through the expansion of drug treatment courts (DTCs). But the reality is that the burden of harsher enforcement falls most heavily on those with drug dependence, including women and gender-diverse people who use drugs and engage in small-scale dealing.[84] Studies have shown that of the most vulnerable, street-involved people who use drugs, many are engaged in low-level tasks such as carrying drugs and steering buyers towards dealers.[85] The Department of Justice's review of the evidence of mandatory minimum sentences in 2002 concluded that they are "least effective in relation to drug offences" and that "drug consumption and drug-related crime seem to be unaffected, in any measurable way, by severe mandatory minimum sentences."[86]

Justice Canada's own studies have also shown that DTCs present serious problems with accessibility, including the inability of such courts to engage women, Indigenous people, sex workers, racialized minorities, and youth, as well as difficulties in retaining them once they have entered.[87] Evaluations of DTCs have shown that, compared to men, women participants experience greater degrees of poverty and mental illness and are more likely to have children and family responsibilities, which impede their ability to complete the program; in particular, lack of appropriate housing is a major factor in women's attrition.[88] Yet many DTCs are exclusionary of women and lack programming that provides adequate housing or childcare for women, posing additional barriers to access.[89] More broadly, the coercive characteristics of the DTC system —which typically require applicants to plead guilty to charges and agree to comply with a variety of bail conditions and a rigorous treatment program — result in encroachment on the substance use treatment sphere and can contort the judicial protections of defendants to the point of undermining health needs and infringing on human rights.[90]

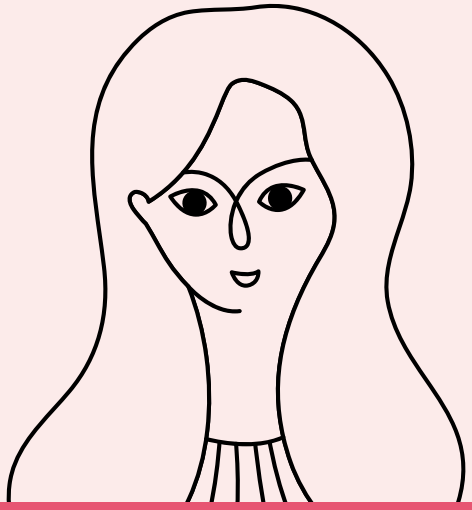
At the same time, scaling up *voluntary* health and harm reduction services for people who use drugs involves unnecessary legal hurdles. Because unauthorized possession of a controlled substance is a crime, service providers for people who use drugs must seek a federal exemption in circumstances where they may be providing care and services in relation to a controlled substance, to protect them from prosecution. Under the CDSA, an exemption from federal drug laws can be issued by the federal Cabinet (i.e. "Governor in Council") (s. 55(1)(z)) or the federal Minister of Health for a "medical or scientific purpose" or "otherwise in the public interest" (s. 56).[91] Until 2018, for example, practitioners were required to obtain an exemption under s. 56(1) of the CDSA before they could prescribe and administer methadone.[92] And supervised consumption services, where people can use drugs in a safe, hygienic environment with sterile equipment under the supervision of trained staff or volunteers, operate under an exemption from federal drug laws issued by the federal Minister of Health on a case-by-case basis for a "medical purpose" (s. 56.1) to protect clients and staff from prosecution.[93] High barriers to obtaining a federal exemption have delayed the opening of supervised consumption services across Canada, and hampered the response to the overdose crisis.[94]

Because men constitute the majority of those charged with drug-related offences (81.8% versus 18.2%), the impacts of drug prohibition on women and gender-diverse people are largely overlooked.[95] However, criminal drug laws affect people who use drugs in myriad ways beyond arrest and incarceration. As Women and Harm Reduction International Network and TalkingDrugs have emphasized, "Because the war on drugs is fuelled by the criminal justice system, people of all genders experience the violence and harassment of law enforcement in relation to drug use in their everyday lives."[96] Police surveillance, harassment, intimidation, and in some cases, the mere presence of police or the threat of police scrutiny in the vicinity of people who use drugs or health services have been documented to force people to rush injections and engage in riskier injection practices. These have also been shown to displace drug markets and consumption activities, thus negatively affecting access to harm reduction and other health services and exposing people who use drugs to great risk of harm and violence.[97] Police may also target women by threatening to tell their partners or other people within their community that they are informants in an effort to coerce the women to divulge information about alleged criminal offences.[98] In a study of women who used crack cocaine in Vancouver, avoiding police was a primary concern; women who were forced to smoke outside because of unstable housing sought to minimize the risk of police scrutiny and possible criminal charges by opting not to carry their own smoking equipment (which increased the likelihood of having to share equipment) and consuming drugs in alleys, where they were vulnerable to rape and sexual assault.[99] Research in Vancouver has also shown that a significant number of people who use drugs are detained by police without being arrested. Many also report having their drugs or harm reduction supplies confiscated by police — forcing them to acquire more drugs and share harm reduction equipment.[100]

Among all drug charges, women accused of import/export offences, which are subject to mandatory minimum sentences, accounted for the highest proportion (29%), while possession offences were the lowest (17%).[101] A 2009 study of women serving a federal sentence (i.e. a prison sentence of 2+ years) for a drug offence indicated that roughly 35% were incarcerated for a drug import/export offence, 60% for a trafficking offence, and 4% for a simple possession offence.[102] Moreover, a greater proportion of women serving a federal sentence for a drug offence (versus other offences) were Black, particularly for drug importation/exportation.[103] As the Correctional Investigator of Canada noted in 2017, 54% of Black women in federal prisons were serving sentences for drug-related offences,[104] many of whom were carrying drugs across borders as a way to alleviate their situations of poverty, including some who reported being forced into these activities with threats of violence to their children and/or families.[105]

In recent decades, there has been a substantial increase in the proportion of women in Canada serving a federal sentence for a drug offence.[106] Whereas only 16% of federally incarcerated women were serving sentences for drug offences in 1981, this proportion increased to about 28% (a 175% increase) by 2007.[107] In 2016-2017, 30.2% of federally incarcerated women were serving a sentence for "serious drug offences or conspiracy to commit serious drug offences" (i.e. trafficking, importing and exporting, and production[108]) compared to 17.5% of men.[109] According to the Correctional Investigator of Canada, federally sentenced women are twice as likely to be serving a sentence for drug-related offences as their male counterparts,[110] while Indigenous and Black women are more likely than white women to be in prison for that reason.[111] Globally, too, a higher proportion of women (35%) than men (17%) are in prison for drug-related offences.[112]

As discussed further below, incarceration poses additional health risks for women and gender-diverse people who use drugs because they are not provided access to health and harm reduction measures that is equivalent to that available in the community as a whole. Numerous studies have shown that incarceration is associated with increased risks of acquiring HIV and HCV among people who inject drugs.[113] Moreover, a 2019 study of women living with HIV — 72% of whom reported recent drug use — found that recent incarceration was linked to reduced chances of a suppressed viral load.[114]



ii. Sex work laws

Sex work–specific criminal offences in Canada prohibit everyone from impeding traffic or pedestrians, or communicating for the purpose of offering or providing sexual services in a public place next to a school ground, playground, or daycare centre.[115] Sex work–specific criminal laws also prohibit everyone from purchasing sex,[116] materially benefitting from sexual services,[117] procuring sexual services,[118] and advertising sexual services,[119] although sex workers are provided immunity from prosecution for the sale and advertising of their own sexual services.[120] The prohibitions on material benefit, procuring, and advertising capture all "third parties," or the people who work with, provide services to, or associate with sex workers including drivers, security, bookers, webmasters, business owners, and receptionists of outcall agencies (e.g. escort agencies) or in-call establishments (i.e. residential or commercial locations from which sex workers work such as massage parlours). Immigration laws also prohibit migrants who do not have Canadian citizenship or permanent resident status from working in sex work–related industries, including individuals who are otherwise legally authorized to work in Canada, and such involvement can lead to deportation.[121]

The criminalization of both drug possession and sex work subjects sex workers who use drugs to multiple layers of marginalization, caused by the compounded effects of criminalization, stigma, and discrimination.[122] As one researcher noted, "The combined stigmatisation and criminalisation of sex work and drug possession increases the incidence of violence against sex workers who use drugs."[123] Because both sex work and drug use are criminalized, violent perpetrators — including people posing as clients, members of the public, and law enforcement officers — often feel that they can act with impunity, as sex workers who use drugs are unlikely to report acts of violence and abuse.[124] According to the Global Network of Sex Work Projects and the International Network of People who Use Drugs, sex workers who use drugs experience significant police harassment and abuse, including invasive strip and cavity searches, arrest, and detention/imprisonment. Moreover, sex workers who use drugs, and those who are suspected of selling sex and/or using drugs, "are identified through racist, misogynistic, and classist stereotyping" — with people from racialized and trans communities disproportionately profiled.[125]

Repressive laws and law enforcement practices thus impede the access of sex workers who use drugs to harm reduction and other health care services, and other supports, which exacerbates their likelihood of contracting HIV and other blood-borne and sexually transmitted infections.[126] For example, studies of women in Vancouver who use drugs and engage in sex work on the street found that they are subject to heavy policing and high rates of violence and exploitation that likely mediate the impact of harm reduction efforts and expose them to many health and drug-related harms.[127] The consequences of repressive laws and law enforcement practices on the health of women who use drugs and sell sex on the streets are severe. A 2016 study of sex workers who inject drugs in Vancouver revealed elevated rates of HIV infection due to drug use patterns and other structural factors (rather than sexual risks), and called for increased access to harm reduction programs and drug dependence treatment.[128] In a 2014 Toronto study of sex workers who work on the street, 94% of whom reported using drugs, 65% of the respondents rated their health condition as only fair to very poor compared to 9.5% of Toronto residents; 44% did not have access to a regular medical doctor, compared to only 7% among the general Toronto population.[129]

iii. Child protection laws

> *Stigmatizing and false information about the relative risks of harm from drug use by pregnant women, the parenting ability of such women, and the health and safety of their children is used to justify preventing certain women from becoming pregnant or parenting.*[130]

While research has found that substance use in women peaks during their reproductive years,[131] women and gender-diverse people who use drugs have been neglected in the provision of sexual and reproductive health care.[132] A systematic review of overall contraceptive use among women with opioid and other substance use found that they have an unmet need for contraception.[133] One study of women who inject drugs in Vancouver showed that only 5% of the women they surveyed reported using hormonal contraceptives, mostly due to difficulty accessing health care services and financial hardship, as well as their mistaken belief that their drug use would prevent pregnancy.[134] In rural, remote, and Indigenous communities, access to sexual and reproductive health care is even more challenging. Correspondingly, researchers have found rates of unintended pregnancy to be high among women who use drugs compared to women who do not use drugs.[135] In a 2009 national survey, nearly seven percent (6.7%) of women in Canada reported using illegal drugs in the three months prior to pregnancy and 1% reported using illegal drugs during pregnancy.[136] According to a more recent study, the number of infants born in Ontario to women with a diagnosis of opioid dependence (including prescription and non-prescription opioids) increased 16-fold from 2002 to 2014.[137]

Among women and gender-diverse people who use drugs who are pregnant and/or have children, child protection laws and the ways in which they have been interpreted and enforced by social service and health care providers have been identified as a source of major concern and fear, with negative impacts on parents' well-being as well as their access to health care. Numerous studies have shown that the very real threat of child welfare involvement and having their children removed from their care is one of the greatest barriers for pregnant people and parents when considering accessing harm reduction services, drug dependence treatment, and pre- and post-natal care.[138] The resulting lack of prenatal care and other services for pregnant people who use drugs means they are more likely to miscarry or give birth prematurely and have infants with low birth weights, less likely to access harm reduction services and use sterile drug equipment, less likely to access voluntary drug dependence treatment programs and interventions to prevent vertical transmission of HIV, as well as more likely to have their children removed from their care.[139]

In Canada, people who use drugs and are pregnant cannot be forced to attend drug dependence treatment. Forced treatment would be a violation of and antithetical to their rights, as recognized by the Supreme Court of Canada in a 1996 decision, *Winnipeg Child and Family Services v. G.(D.F.)*.[140] In this case, which involved a young Indigenous woman who was pregnant and used drugs, the Supreme Court held that Canadian law does not recognize the fetus as a legal person possessing rights; a court consequently has no power, including under its *parens patriae* jurisdiction (i.e. the power of the court to act instead of a parent for the protection of a child), to order the detention and treatment of a pregnant person for the purpose of preventing harm to the fetus.[141] As the Court noted, citing the Royal Commission on New Reproductive Technologies,

> "... considering the interests of [a woman's] fetus separately from her own has the potential to create adversary situations with negative consequences for her autonomy and bodily integrity, for her relationship with her partner, and for her relationship with her physician. Judicial intervention is bound to precipitate crisis and conflict, instead of preventing them through support and care. It also ignores the basic components of women's fundamental human rights — the right to bodily integrity, and the right to equality, privacy, and dignity."[142]

Moreover, the Court acknowledged that making pregnant women liable for "lifestyle-related" fetal damage may deter those with alcohol or drug use problems from seeking prenatal care for fear of detection and involuntary confinement and mandatory treatment, or might persuade women who would otherwise choose to continue their pregnancies to undergo an abortion.[143]

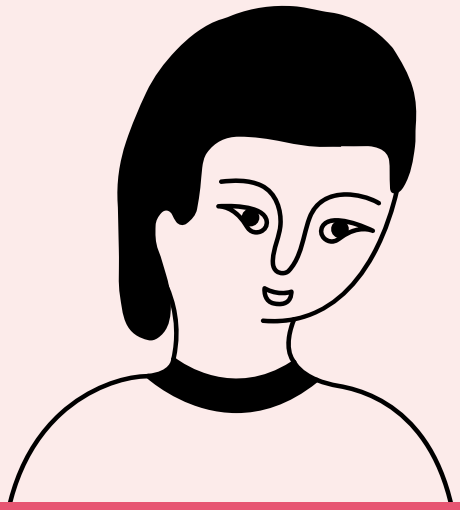
Social determinants of health including poverty and lack of access to adequate housing and food also have enormous implications for fetal and neonatal outcomes related to drug use. In addition to the need to raise levels of social assistance and increase access to social housing and nutritious food for pregnant people, Women and Harm Reduction International Network and the International Network of Women who Use Drugs have described harm reduction for pregnant women as including access to evidence-based information on how to manage drug use during pregnancy, prenatal care, support during labour and birth, advice on breastfeeding, and postnatal support.[144] This includes, for example, opioid agonist therapy (OAT) during pregnancy, because opioid withdrawal in pregnancy can be harmful to both birthing parent and fetus, and "rooming-in" hospital programs to more effectively address neonatal abstinence syndrome.[145] While access to services is far from adequate, researchers in Canada have documented an increasing number of programs and services that are shifting their service paradigms to assist parents to reduce harms associated with problematic drug use in pregnancy and to retain custody of their children.[146] Some provinces have also developed policies to improve access to drug dependence treatment for pregnant people, which include giving pregnant people priority access to OAT programs and providing treatment programs specifically designed for pregnant people.[147]

Upon birth, child protection legislation may affect the parental rights of women and gender-diverse people who use drugs. In Canada, provincial and territorial governments are responsible for assisting children "in need of protection" via child protection authorities, which are mandated to prevent and address child maltreatment.[148] Although most provincial and territorial child protection laws and policies do not make specific reference to parents and drug use as a ground of intervention,[149] maternal drug use has long been equated with inadequate parenting;[150] a significant portion of families involved, or at risk for involvement, in the child welfare system are affected by drug use.[151] Researchers have documented maternal drug use as being a frequent basis for children's out-of-home placement, so that drug use is a proxy for neglect or mistreatment, rather than determining whether drug use has affected parenting or child welfare. As one study of Indigenous families that had engagement with the child welfare system concluded, "the way that the child welfare system currently deals with caregivers who are engaging in substance use perpetuates colonial violence. Current child welfare policies and practices continue to take on an individualistic approach that divorces people from the systemic factors that influence the use of substances, such as ongoing colonialism, and the factors that create barriers to ending or reducing the use of substances, such as criminalization."[152] Rather than applying principles of harm reduction, the current child welfare system is abstinence-focused and penalizes parents who use substances, relying on risk assessment tools that deem substance use to be inherently risky.[153] This is especially pervasive among low-income families of colour.[154]

Service providers who work with women and gender-diverse people who use drugs attribute this in part to a lack of training about substance use among social workers in the child protection system.[155] Yet parents with substance use issues face barriers to drug dependence treatment and harm reduction services, including stigma from health care and social service providers, lack of childcare and women- and family-centred programs, and child welfare policy including the "duty to report" and the harmful conflation of child abuse and neglect with parental substance use. All of these factors make it difficult for parents who use drugs to disclose that they need help, for fear of losing custody of their children. Even when services are available, standard child welfare interventions do not address the underlying trauma, mental health, or systemic factors that affect substance use.[156] As a result, many parents are unable to access harm reduction and other health services.[157] Treatment services supportive of parents are limited in Canada, and parents who are able to retain custody sometimes find themselves in the position of having to temporarily place their children in the custody of child welfare in order to access residential treatment.[158]

Consequently, poor and low-income families, mother-led families, racialized and Indigenous parents, and parents living with disability continue to be overrepresented in the child welfare system, and many are likely to have also been in foster care as children.[159] In a three-month sampling of children and families investigated by child welfare services in Ontario in 2013, it was found that Indigenous and Black families are far more likely to be investigated by child welfare services for maltreatment or risk of maltreatment of children 14 years and under than are white families.[160] In particular, the child welfare system has placed grossly disproportionate numbers of Indigenous children in foster care, with serious implications for many Indigenous peoples' livelihood, health, and wellness,[161] with parallels between the apprehension of Indigenous children today and the trauma and fear related to the "Sixties Scoop" — the mass removal of Indigenous children from their families into the child welfare system.[162] In a study of the impact of child custody loss on women who use drugs in Toronto — for whom drug use was identified by almost all participants as a central area of concern for child protection services — trauma and profound isolation were identified as key impacts of separation, which women dealt with through increased use of drugs and alcohol.[163] This coping strategy was "synergistically reinforced by heightened structural vulnerability observed in increased exposure to housing instability, intimate partner violence, and initiation of injection drug use and sex work," which varied in severity according to women's social positioning.[164] Numerous other studies have also found child removal to be linked to destabilizing health behaviour, including increased odds of maternal drug use as well as elevated mental health distress and housing instability.[165] At the same time, research has found that children kept with their parents, even within homes facing significant adversity, often have better social outcomes than those placed in foster care.[166] It is critical to address the significant barriers to engagement with both child welfare and substance use treatment in order to support parents, children, and their families. As advocates have highlighted:

> Child welfare and other front line service workers have interpreted motherhood drug use as inherently dangerous and neglectful, if not abusive. This is often not the case and when there are legitimate concerns, respectful, strengths-based conversations, provision of information, and service referrals can go a long way to mitigating or eliminating such concerns.[167]



Spotlight on Motherisk

Between 2005 and 2015, the Hospital for Sick Children in Toronto operated the Motherisk Drug Testing Laboratory, which tested individuals' hair to screen for the presence of drugs and alcohol.[168] During that period, the Motherisk laboratory tested more than 24,000 hair samples from over 16,000 different individuals who were primarily mothers from five provinces at the request of child protection authorities. The results of these tests could be used as evidence in child protection proceedings that could result in the loss of the tested individual's parental rights.

Following a high-profile case that questioned the validity of Motherisk testing,[169] the Ontario Government ordered an independent review of the Motherisk laboratory, which concluded that the hair-strand drug and alcohol testing used by the Motherisk Drug Testing Laboratory was "inadequate and unreliable for use in child protection and criminal proceedings and that the Laboratory did not meet internationally recognized forensic standards" and furthermore that Motherisk's "hair-testing evidence in child protection and criminal proceedings has serious implications for the fairness of those proceedings and warrants an additional review."[170] Indigenous women were found to be overrepresented in testing, and the Commission noted that Black women were also most affected.[171] Testing also "reflected a narrow approach to substance use, focused on abstinence" and parents were told that abstinence was a precondition to having their children returned.[172]

As advocates have noted, drug testing as an assessment tool for parental capacity is rooted in systemic discrimination against people who use drugs and many people have expressed concerns about the weight placed on the use of drugs to determine parenting skills and capacity.[173] In the Commission's final report, Justice Beaman concluded that testing was imposed on people who were among the poorest and most vulnerable members of society, with scant regard for due process or their rights to privacy and bodily integrity.[174] Scholars have also underscored how drug use and individual behaviour (i.e. failure to be abstinent), rather than structural violence or racial injustice, was identified as the problem by Ontario child protection agencies and the Motherisk Drug Testing Laboratory.[175] Following concerns about the reliability of testing conducted at the Motherisk laboratory, several provinces, including B.C., New Brunswick, Nova Scotia, and Ontario, imposed a moratorium on the use of hair-strand drug and alcohol testing in child protection cases.[176]

Women and gender-diverse people who use drugs and access to harm reduction

Laws, policies, and law enforcement practices that criminalize activities related to drug use continue to pose systemic barriers to the scale up of gender-sensitive harm reduction services. Against the backdrop of these major structural barriers, access to harm reduction services in Canada remains highly variable across jurisdictions.[177] Gender-sensitive services are lacking, with many harm reduction services "gender-blind" or more commonly male-focused.[178] Women and gender-diverse people who use drugs may face unique barriers to harm reduction services, including gender-based violence, child care needs, concerns about the involvement of child protection authorities, trauma, and mental health concerns.[179] The needs of women, Indigenous, racialized, or LGBTQ2S people are rarely discussed in provincial or territorial harm reduction policies[180] and they are not well-integrated into the planning and implementation of harm reduction programs.[181] Where such services exist, access is even more limited for women and gender-diverse people[182] — and services providing culturally safe and culturally appropriate care for Indigenous and racialized women are even rarer.[183] While data and research on women and gender-diverse people who use drugs remain scarce, they are consistently reported to have less access to harm reduction and drug dependence treatment services.[184]

Gender-based violence and harm reduction: a focus on Violence against Women shelters

Drug use and gender-based violence are deeply interconnected. Women and gender-diverse people who use drugs experience high rates of gender-based and intimate partner violence[185] as well as violence from police.[186] In Saskatchewan, a provincial consultation of Violence against Women (VAW) shelter workers conducted in 2004 revealed that a larger proportion of women staying in shelters had "active addictions or are in the early stages of recovery" than ever before.[187] In Ontario in 2019, VAW shelters that are members of the Ontario Association of Interval and Transition Houses were reporting that upwards of 70% of women who accessed their services also used substances and/or had mental health issues.[188] In a 2014 nationwide survey of VAW shelters in Canada, respondents indicated that 19% of women reported seeking shelter as a result of drug or alcohol dependence.[189] It is thus essential that links between violence and drug use be taken into account when planning and implementing harm reduction services and that harm reduction services provide or be linked to services that support those experiencing violence.[190] It is equally imperative that services that provide support to women and gender-diverse people who experience violence account for the specific needs of those who use drugs.[191]

Despite evidence of the co-occurrence of drug use and gender-based violence, some shelters have been hesitant to implement policies and practices to support residents using substances while seeking shelter services[192] and many staff feel unequipped to support substance use. As noted in a 2019 Report of the House of Commons Standing Committee on the Status of Women:

> [S]helter and transition house policies often inhibit access for women who struggle with complex mental health and substance use challenges, and … women may hesitate to disclose these challenges when seeking shelter services. Shelters and transition houses are generally under-equipped to properly support women with complex mental health or substance use issues.[193]

Some residential housing, shelters, and transition houses serving women affected by violence have policies prohibiting alcohol and/or drug use on their premises.[194] Researchers that studied the situation in Ontario observed that "some shelters have been hesitant to integrate harm reduction strategies into their services to support substance-using women" because they "believe problematic substance use falls outside of the scope of VAW services and is more effectively addressed by other agencies. Many shelters screen out women for most types of substance use during intake."[195] The authors further describe these shelters as adopting "low or zero tolerance (abstinence-based) approaches" that include an inability to return to shelter if visibly inebriated and agency values that view substance use as an impediment to goals.[196] In the same 2014 survey mentioned above, of the 338 women and 201 accompanying children turned away from shelters, 8% were turned away for "alcohol and drug issues."[197] According to a VAW worker in Ontario, women who use drugs often get on a "do not admit list" with other services, leaving them with "nowhere to go."[198] As the National Inquiry into Missing and Murdered Indigenous Women and Girls concluded, strict policies against substance use in shelters "further marginalize the already marginalized."[199]

At the same time, a number of shelters pose major barriers to gender-diverse people, including a lack of or limited understanding of the contexts and concerns affecting them, which may manifest as stigma, discrimination, and hostility on the part of staff. As researchers have noted, "transgender and gender-diverse individuals do not experience equal access to safety and supports in the VAW sector and many sexual violence and intimate partner violence services are not adequately responding to the unique needs of transgender and gender-diverse survivors of violence. Consequently, these individuals often do not report this type of violence or risk discrimination and re-traumatization when doing so."[200] These barriers are undoubtedly compounded for gender-diverse people who use drugs.

Encouragingly, Ontario has developed standards for VAW shelters stipulating that all women ("whether they identify as two-spirited, cisgender or transgender women") must be provided with access to shelter services, including women who use substances, meaning abstinence-based policies of refusing access to shelter for those who use drugs is no longer permitted.[201] However, these standards do not outline or recommend effective approaches and techniques for serving substance-using clients, such as the provision of needle and syringe programs, naloxone training and naloxone kits on-site, managed distribution programs, or a safe space for people to store and access their supplies readily and independently.[202] As one study noted, "Even when a shelter does seem to be the appropriate place for a woman with an addiction, shelter workers often do not feel equipped or able to understand and meet her needs."[203] Efforts need to be made to recruit new employees, and train new and existing employees of shelters and transition houses to properly support women and gender-diverse people who use substances, and additional funding is necessary to support these efforts.[204]

In addition to the urgent need for shelter spaces and transitional housing for women and gender-diverse people fleeing violence, there is also a broader need for a variety of housing and shelter alternatives in communities in order to meet the needs of different populations. A lack of safe and affordable housing increases risks of violence and harm, and women and gender-diverse people who use drugs should have access to housing and shelter without limitations based on their drug use.

Gender-sensitive harm reduction programs: a focus on SCS

Some harm reduction interventions may act as "one form of micro-environmental intervention" that can reduce the risks of violence for marginalized women and gender-diverse people who use drugs. Supervised consumption services (SCS) can provide a refuge from various forms of violence that women and gender-diverse people may experience on the street.[205] As discussed above, SCS operate under a federal exemption from the criminal prohibition on unauthorized possession of a controlled substance; strikingly, clients and staff may continue to be at risk of prosecution for *trafficking* under section 5 of the CDSA in relation to activities such as assisted injection or drug sharing, given the broad definition of this offence, unless an exemption also covers such activities.[206]

SCS have been found to disrupt drug scene dynamics such as gender power relations, enabling women and gender-diverse people to assert agency over drug use practices.[207] However, research on InSite — one of the first SCS in Canada — has also shown that some people are unable to access the facility due to the perceived threat of violence in the surrounding area.[208] Rules banning assisted injection in SCS services may also put women at higher risk by denying them access to a supervised space where prompt overdose response is available.[209] Such findings confirm the need expressed by researchers, service providers, and people who use drugs in Canada for a wide range of services, including gender-sensitive SCS.[210]

Gender-sensitive harm reduction programs require incorporating sexual and reproductive health services such as pregnancy testing and other resources into harm reduction programs; having flexible, low-threshold services that are friendly to women and gender-diverse people and accessible for people with children, with the assurance that their substance use alone will not be a reason to report them to child protection authorities; and providing links between harm reduction services, drug dependence treatment programs, shelters, and violence prevention services.[211] These services must also be culturally appropriate, taking into consideration the specific needs of WSW, trans women, gender-diverse people, Indigenous and other racialized women, and women with disabilities, among other considerations.[212] In an assessment study of SCS in Toronto and Ottawa, women who use drugs were more supportive than men of multiple services being offered in SCS, including women-only operating times, hygiene services, drug counselling, access to prescribed morphine or methadone, support from other people with lived expertise of drug use, social workers, showers, and Indigenous staff.[213] Similarly, the International Network of Women who Use Drugs has described some key elements that would make harm reduction services more accessible for women who use drugs, such as:

- Ensure that female staff are available, or that needle and syringe programs and overdose prevention education services are available to women where they live through mobile outreach or the engagement of other people who use drugs;
- Establish women-only hours and provide childcare and additional services and commodities specific to parents;
- Provide quality and routine gynecologic care such as treatment for STIs, access to contraception, and gynecological check-ups at harm reduction sites;
- Make access to harm reduction services low-threshold for women, including by eliminating drug treatment waiting lists and ensuring take-home doses of opioid agonist therapy (OAT);
- Provide shelter and other services that mediate the impacts of violence, homelessness, or other hardships to women who use drugs without requiring abstinence or sobriety.[214]

At a time when Canada is experiencing a devastating overdose crisis, particular care must be given to women's access to SCS. This is especially pressing given research that has shown that fentanyl-adulterated opioids simultaneously exacerbate women's vulnerabilities to both overdose and physical and sexual violence.[215] In one study, women attending low-threshold SCS or "overdose prevention sites" (OPS) in Vancouver reported being targeted by predators who took advantage of their loss of consciousness to assault or rob them.[216] Even in the face of an overdose epidemic, women's discussions about safety and their reasons for accessing OPS continued to focus on the need to protect themselves from violence, with safety concerns being more significant for homeless and vulnerably housed women, many of whom were Indigenous.[217] However, because OPS were mix-gendered and most frequented by men, female participants, especially Indigenous women, were still routinely harassed and

expressed fear that violence could prevent them from accessing the sites.[218] Creating women-only services was identified as a need by the women who participated in that study, although they believed such sites would be a "luxury."[219]

Spotlight on SisterSpace

SisterSpace is the first and only OPS in Canada dedicated to women, including "trans women, genderqueer women, and non-binary people who are significantly femme-identified." Located in Vancouver's Downtown Eastside, the site opened in 2017 and is run by Atira Women's Resource Society in partnership with Vancouver Coastal Health, the City of Vancouver, B.C. Housing, B.C. Women's Hospital, and Provincial Health Services Authority. In addition to supervised injection and overdose prevention services, SisterSpace offers primary care services such as chronic disease management, pregnancy testing, and screening and treatment for sexually transmitted infections, as well as housing support, legal advocacy, food, and other related services.[220] Atira is an organization that also provides family care services, outreach programs for homeless women, and counselling related to violence.[221] "Bad date" reports from a program that serves sex workers are also posted on the wall of SisterSpace.[222] Perhaps most importantly, SisterSpace offers social and emotional support as well as physical and emotional safety.[223] Services are violence- and trauma-informed, meaning staff recognize in their daily practice the relationship between women's experiences of violence and their substance use. Having integrated services has been identified as a necessary way to increase the impact of the program.[224]

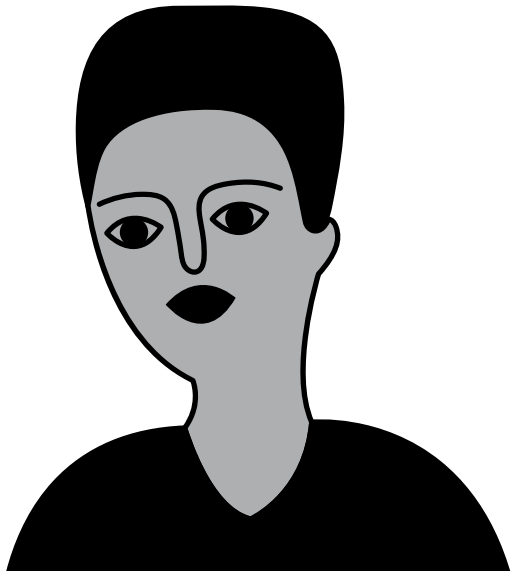
Between May 2017 and July 2018, there were over 16,000 visits to SisterSpace.[225] The site is open from 6:00 a.m. to noon and from 6:00 p.m. to midnight; these expanded hours were meant to better meet the needs of women who do sex work and other women in the community seeking a women-only space that is available throughout the night.[226] In order to make SisterSpace as accessible as possible, there is no assigned area to use substances and "guidelines" rather than "rules" were designed by workers — people with lived expertise of drug use — to structure interactions at the site without creating barriers for women.[227] In a 2017 survey with women accessing SisterSpace, 80% said that having a women-only injection site was very important to them, including because they did not necessarily feel safe in spaces dominated by men.[228]

Women-only services and services for gender-diverse people

Women and gender-diverse people often face significant barriers in accessing mixed-gender services because it may mean being in the same location as men who have victimized them or want to harm them.[229] Studies show that, compared to traditional mixed-gender programs, women in women-only substance use treatment programs have better retention and better treatment outcomes.[230] However, in the context of SCS, these single-gender services are largely non-existent. Until the 2017 opening of SisterSpace in Vancouver, there was only one other SCS known to focus exclusively on women who use drugs, based in Hamburg, Germany.[231]

Women-only sites should be implemented in settings where there are a sufficient number of women who use drugs and who are particularly vulnerable to the effects of gendered violence and gendered power relations, according to operational guidance developed by the BC Centre on Substance Use.[232] SisterSpace remains unique in Canada but other sites have established women-only hours. For example, Regent Park Community Health Centre's OPS in Toronto is for women, trans, and non-binary people on Thursdays.[233] Services also include support from people with lived expertise of drug use, STI testing, "bad date" and "bad drugs" reports as well showers, nursing, and primary care.[234] Toronto's Indigenous Overdose Strategy also calls for 24/7 SCS that are women-only as well as SCS that are Indigenous-led and Two-Spirit only.[235]

Integrating SCS in shelters or supportive housing for women and gender-diverse people who use drugs or implementing mobile drug consumption services may also facilitate access to services for women and gender-diverse people at risk of violence.[236] These services may take different forms. In one Vancouver women's supportive housing building, 21 "Brave Buttons" were installed in the rooms. These buttons allow residents to request safe consumption monitoring. Pushing the button sends a text message to workers and building staff, requesting an in-person check within five minutes. After three minutes, a reminder text is sent and support workers can respond to confirm the resident is safe.[237] Mobile SCS may also facilitate access for marginalized women who may feel uncomfortable accessing existing structures.[238]



Workers with lived expertise of drug use and adapted policies

Other important considerations for gender-sensitive SCS include having gender equity, policies and staff training on gender-based violence, and codes of conduct for clients.[239] Having female staff, including women who have current or past experience of drug use[240] (or "peers"[241]) and often live in the area, is also extremely important to promote accessibility and the feeling of safety for women. Some workers may share experiences of loss of family members and friends in the overdose crisis, of abusive relationships and ways to develop safety plans, or challenges in accessing care.[242] Working with a personal history of drug use allows staff and volunteers to share knowledge, build trust, and form meaningful relationships; this is valued by clients and co-workers and helps create compassionate and non-judgmental work environments and insights that would otherwise be absent.[243] Significantly, involving people with lived expertise of drug use has resulted in increased diversity within harm reduction and drug dependence treatment interventions, with socially and economically marginalized women and Indigenous people who use(d) drugs taking a particularly prominent role in emerging programming.[244]

The support worker model led by people with lived expertise of drug use has been essential to SisterSpace's ability to provide a safe space for women, including highly marginalized and underserved women.[245] Evaluations of other low-threshold OPS run by people who use drugs in Vancouver have shown that the engagement of lived expertise contributes to improved engagement with OPS services, fosters the enactment of harm reduction practices, and promotes health and social benefits among people who use drugs, including women.[246] In an evaluation of Street Health's OPS in Toronto, where the majority of clients are women, participants credited its non-clinical character and clear policies prohibiting inappropriate conduct, including sexual harassment and gender-based, homophobic, or transphobic comments, as well as the fact that the majority of the OPS staff team are women with lived experience of drug use as factors contributing to making it a welcoming space.[247] Sex workers who use drugs not only have specific health needs but also benefit from peer-led services — and ideally staff who belong to both communities (sex workers and people who use drugs) and have first-hand experience of the additional barriers this can present.[248] Other studies have suggested that women with lived expertise of drug use are particularly well-positioned to provide services that respond to gender-specific needs.[249]

Pregnant people

A recent survey conducted in Europe identified only three SCS that did not allow access to people who are pregnant.[250] Similarly, Health Canada policies and guidelines do not impose restrictions regarding access to SCS for people who are pregnant. Instead, B.C. guidelines on OPS provide that pregnant people — together with youth, overly intoxicated individuals, first-time injectors, and non-self injectors — require specific considerations when seeking to access OPS. Similarly, the Registered Nurses' Association of Ontario (RNAO) produced guidelines on implementing SCS that identify pregnant people as a "priority population" that have "unique circumstances, experiences, and health inequities."[251] In particular, people who are pregnant and use drugs are less likely to access services and "denying access to pregnant participants is unlikely to result in abstinence from drug use," but "rather increase [the] possibility of overdose death due to limitations in service delivery."[252] It may also be an opportunity to assist pregnant people in accessing prenatal care. However, more guidance on appropriate policies and procedures for pregnant people is necessary, and both B.C.'s operational guidance on SCS and the RNAO SCS guidelines recommend having policies and protocols in place to respond to pregnant people accessing SCS.[253]

A need for a wide range of services including low-threshold, flexible services

Research conducted in Vancouver and evaluations of OPS in Toronto show that women appreciate the low-barrier approach of and small, intimate spaces associated with OPS. Indigenous and more marginalized women in particular have expressed feeling more comfortable in a non-medical environment run by people with lived expertise of drug use.[254] As noted above, OPS are lower-threshold SCS designed primarily to prevent overdoses. They emerged as unsanctioned, volunteer-run services operating in makeshift environments in B.C. in 2016 and Ontario in 2017, in response to the onerous process for receiving an exemption from federal authorities to operate.[255] Like more traditional SCS, OPS provide a safe space where people are able to consume drugs under the supervision of trained volunteers and/or staff, but tend to be lower budget, more flexible in design, serve even more marginalized populations, and often offer fewer ancillary services than SCS, although they can also operate (like SisterSpace) as integrated programs with additional services.

According to research conducted in Vancouver, "the operational models of low-threshold OPS enhanced access among women by accommodating drug use practices not permitted at federally sanctioned SCS, including assisted injections and injecting partnerships."[256] Data collected from the originally unsanctioned Moss Park OPS in Toronto confirmed that women were more likely to require assistance to inject when they accessed the site, and that women receiving assisted injection were more than twice as likely to experience overdose than women who did not (while no association between assisted injection and overdose was found among men).[257] Additionally, studies have long shown that women, along with youth and people with disabilities, are more likely than men to require help from others to inject.[258] As discussed above, women are more likely to be injected by an intimate partner and are less likely to know how to inject.[259] Studies have also reported women's experiences of theft, violence, and abuse by intimate partners in relation to assisted injection as well as on the streets.[260]

For example, women who use drugs in Vancouver's Downtown Eastside have described being injected by partners who controlled the money and the drugs that they generated through sex work, thus demonstrating how assisted injection practices "can be shaped by gendered power relations that subordinated women and restrict their agency."[261] Some women also described being raped, robbed, or coerced to give up drugs when seeking assistance injecting, particularly in alleyways or other marginal spaces.[262] Providing assisted injection in a hygienic and safe environment disrupts these dynamics, including reliance on

abusive partners, and mitigates the harms. In British Columbia, OPS guidelines from the BC Centre for Disease Control have recently evolved to allow for peer-to-peer assisted injection.[263] Currently, 20 SCS operating with a federal exemption permit peer-assisted injection as part of a pilot project;[264] the pilot exemption is necessary given the criminal prohibition on trafficking, which continues to prevent assisted injection by health care professionals or drug sharing between SCS clients.

Similarly, expanding supervised consumption services to include supervised inhalation is necessary to fully address the needs of women and gender-diverse people. Physical violence is common in crack-smoking environments and often driven by gender power dynamics with particular consequences for women who smoke crack.[265] In a study conducted among people accessing a safer smoking room run by people who use drugs in Vancouver, all participants (half of whom were women) reported that their decision to smoke crack in the safer smoking room was motivated by the need to minimize their exposure to the social violence within unregulated crack smoking settings. But as with access to assisted injection, access to supervised inhalation services in Canada is limited and there is only one federally exempted supervised inhalation service running in Canada, which opened in March 2018 at ARCHES in Lethbridge, Alberta.[266]

Calls are also growing in Canada for a greater range of medical options to be available to address the critical issue of unsafe drug supply that is contributing to a high toll of overdose deaths in Canada.[267] In a context where the drug supply in North America has been contaminated with illicitly produced opioids that are typically exponentially more potent than the previous supply of heroin and fentanyl, people are inadvertently consuming lethal doses and dying of overdose.[268] Safe supply programs, which currently exist in Vancouver, Ottawa, Toronto, London, and select other settings, provide access to a safe supply of drugs by prescribing an opioid of known dose to people who are dependent on opioids.[269] As the Canadian Association of People who Use Drugs describes, "Meaningful and purposeful expansion of the provision of safe and regulated drugs to compete with the black market will significantly curtail [the risk of overdose, poisoning, infection, disease transmission, and death], and is a necessary step to stop the ongoing overdose crisis."[270] However, despite strong evidence for heroin assisted treatment and Canadian innovations in injectable OAT, scale-up remains slow, and new pilot interventions to divert people from the toxic illicit drug supply continue to be notable exceptions.[271]

While recent findings about women's experience at OPS confirm the need for a wide range of SCS, legal and policy barriers at both federal and provincial levels prevent the rapid scale-up of low-threshold services or the expansion of innovative services including assisted injection, drug splitting/sharing, and supervised inhalation. Despite important efforts by the current federal government to facilitate and expedite the SCS exemption process, it remains an overly burdensome and unnecessary process, as illustrated by the emergence of OPS in 2016 that operated without any federal exemption. Since then, mechanisms have been put in place to legalize OPS, including through a federal class exemption in Ontario and Alberta for the implementation of OPS as a temporary, urgent measure. But new provincial authorities are now jeopardizing these mechanisms and the scale-up of low-threshold SCS in Canada, including those serving women.

For example, in late October 2018, the Ontario Minister of Health announced that provincial funding would only be available for a maximum of 21 sites offering SCS in the province, all of which would need to conform to a new model of "Consumption and Treatment Services" (CTS). By imposing a series of requirements for SCS, the new CTS model effectively terminates the low-threshold, flexible OPS model.[272] Inhalation services are not included in the CTS model and service providers must seek a federal exemption before applying for provincial funding.[273] In March 2019, the Ontario government announced that three operating OPS in Ontario would no longer receive funding, including Street Health in Toronto.[274] Fifty-six percent of its OPS clients are women and 0.5% identify as trans, gender non-conforming, or non-binary.[275] Designed to facilitate access for women and members of LGBTQ2S communities, the proportion of women accessing the service is notably higher than many other harm reduction programs in Toronto.[276] Street Health OPS currently runs with a federal exemption that was issued in early 2019 but receives no funding from the provincial government, forcing the community to again mobilize to fund and preserve Street Health's life-saving services.[277]

Access to harm reduction for women and gender-diverse people in prison

Substance use

Women are the fastest-growing prison population in Canada and the number of federally sentenced women in prison[278] has increased by more than 30% from 2009 to 2019, in contrast to the decrease in the male in-custody population over roughly the same period (-4%).[279] In particular, the population of Indigenous women in federal prisons has increased by 53% since 2008 and as of 2020, Indigenous women accounted for 41.4% of all federally incarcerated women.[280]

Regardless of the offence for which they were sentenced, 76% of federally incarcerated women have had a lifetime alcohol or substance use issue,[281] meaning a growing number of women who use drugs are behind bars, while nearly all federally sentenced Indigenous women (92%) were assessed as having moderate or high substance use needs.[282] Thirty percent of federally incarcerated women (compared to 21% of men) also reported lifetime injection drug use; more than half of these women reported sharing injection equipment.[283] For women convicted of drug possession for personal use, a 2006 study found that at admission, 65.7% had an identified "substance abuse" need, compared to 64.1% of women convicted of drug trafficking and 14.1% of women convicted of drug importation.[284] A national survey of federal prisoners conducted in 2007 also showed that, during their last months in the community, 29% of women engaged in injection drug use.[285]

Not only do many incarcerated women have a history of substance use, they also have a history of social and economic marginalization, including intergenerational poverty, mental

illness, and inadequate access to education, employment, housing, nutritious food, and health care.[286] Three-quarters of federally incarcerated women are mothers, and 57% of them were the primary caregivers to their young children prior to incarceration, with over half reporting experiences with child protection services due to problematic substance use, mental health concerns, or issues of abuse/neglect.[287] Incarcerating mothers can wrest families apart and leave many children vulnerable.[288] Once incarcerated, women and gender-diverse people can face substantial barriers to sustaining family relationships, intensifying their experiences of marginalization within the prison system.[289] Confronted with costly telephone calls and restrictive visiting policies, for example, women and gender-diverse people serving federal sentences have challenges in preserving the familial relations that are crucial to their successful re-integration post-release.[290] This is particularly acute for parents with substance use dependence, as punitive drug policies preclude much-needed harm reduction approaches in prison that allow women and gender-diverse people who use drugs to avoid severe health complications that may inhibit them from caring for their children.[291]

> *Gender-specific health-care services at least equivalent to those available in the community shall be provided to women prisoners.*
>
> — Rule 10, United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), UN Doc. A/RES/65/229, 16 March 2011

Injection drug use in prison and access to harm reduction services

Research has shown that current programs and services available to incarcerated women living with and at risk of HIV and HCV have been marked by inconsistent implementation and accessibility, both within individual institutions and across the system as a whole.[292] A lack of harm reduction and other health measures has led to significantly higher rates of HIV and HCV in prison compared to the community as a whole[293] — a harm that has been disproportionately borne by the rapidly growing population of women behind bars.[294] A 2016 study indicated that about 30% of people in federal facilities, and 30% of women (compared to 15% of men) in provincial facilities are living with HCV, and 1–9% of women (compared to 1–2% of men) are living with HIV.[295] Indigenous women, in particular, have much higher rates of HIV and HCV than non-Indigenous prisoners. For example, Indigenous women in federal prisons are reported to have rates of HIV and HCV of 11.7% and 49.1%, respectively.[296]

Studies suggest that the incarceration of people who inject drugs is a factor driving Canada's HIV and HCV epidemic.[297] In a 2007 national study of federal prisoners, 14% of women admitted to injecting drugs while in prison, many of whom shared their injection equipment.[298] An earlier national study of women in federal prison indicated that 19% engaged in injection drug use, 27% engaged in tattooing, 16% were body piercing, and 9% were slashing with razors or knives, or using some other form of self-injury (a practice that is considerably higher among incarcerated women than the overall Canadian population and reported to be a means of relief from distress).[299] However, bleach continues to be the main measure available to sterilize injection equipment in federal prisons, despite the fact that it is ineffective in preventing HIV and HCV transmission[300] and is no longer provided in the community for this purpose among people who inject drugs.[301] As the Canadian Human Rights Commission has acknowledged, bleach is "suboptimal at best in preventing disease transmission," and the impact of denying women in prison sterile injection equipment "is greater because of the higher rate of drug use and HIV infection in this population. This impact may be particularly acute for federally sentenced Aboriginal women."[302]

Needle and syringe programs in prison

Acknowledging the health benefits of needle and syringe programs in prison, the Correctional of Service Canada (CSC) announced that it would implement a "Prison Needle Exchange Program" (PNEP) in two federal prisons, including one women's institution, beginning in June 2018 as "the initial stage of a phased approach" — with plans to gradually introduce the program in all federal prisons. While this was a welcome announcement, details of the PNEP revealed serious deficiencies that are not in keeping with public health principles or professionally accepted standards for such programs. Most fundamentally, CSC's PNEP violates prisoners' confidentiality at many points without reasonable justification and participation is contingent on the approval of both prison health staff and security staff.[303]

As the Correctional Investigator has observed, "Too much of what should be an exclusively health and harm reduction program has been shaped by security concerns," leading only a handful of individuals to enroll in the program.[304]As of the time of writing, only nine federal prisons (five of which are women's institutions) out of 43 currently have a PNEP and no provincial or territorial prison system in Canada offers this program. The Correctional Investigator has also recommended that CSC "revisit" the program and participation criteria with the aim of "building confidence and trust, and look to international examples in how to modify the program to enhance participation and effectiveness."[305]

Drug dependence treatment in prison

In spite of the overwhelming evidence of the health benefits of opioid agonist therapy (OAT) and World Health Organization guidelines that state OAT should be available to people in prison and be equivalent to community treatment options,[306] federal and provincial prisoners continue to experience barriers to OAT, including long waiting lists and inappropriate medication terminations.[307] A number of provincial and territorial prisons also still do not offer OAT to prisoners.[308] CSC's "Priority Admission Criteria" for admission to OAT includes "Pregnant offenders who are currently or were formerly opioid dependent and are at a high risk for relapse."[309] In a 2007 national survey of federal prisoners, however, only 11% of women respondents reported participating in CSC's "Methadone Maintenance Treatment Program" (now OAT program), with Indigenous women more likely than non-Indigenous women to report that they tried to join the program in the past but were not on the program currently.[310]

Notably, although a CSC Directive on "Health Services" directs prison health care professionals to provide health services to "ensure health services are sensitive to the needs of Aboriginal and women offenders, and offenders with special needs,"[311] service providers have observed that women in prison struggle to get the same level of access to health and harm reduction services either as women outside prison or as men inside prison.[312] For example, the federal correctional service offers an "Aboriginal Offender Substance Abuse Program," a high-intensity program geared toward Indigenous men who have a history of drug use, which has demonstrated more beneficial effects for Indigenous men than mainstream substance use programs.[313] But the program is only available to Indigenous men, despite research suggesting that allowing Indigenous women to participate in culturally appropriate and gender-specific programming in prison leads to greater engagement and responsiveness[314] and calls from the Correctional Investigator to provide trauma-informed programming and interventions for Indigenous women.[315] CSC does offer a Women Offender Substance Abuse Program (WOSAP) to address gender-specific needs,[316] but some women have criticized the frequency with which the program is run, which has posed problems for women waiting for a specific program module, or those for whom substance use treatment was required for parole but were on waiting lists.[317]

Moreover, federal prisoners are subject to the *Drug-Free Prisons Act*, a law that has been described as a means to "combat drug use in penitentiaries and ensure that criminals are held accountable for their drug or alcohol abuse while in prison"[318] and that empowers correctional authorities to cancel an individual's parole if they test positive for illegal drugs or do not provide a urine sample, and stipulates that a condition of an individual's release includes abstention from the use of drugs or alcohol.[319] While punishing prisoners for using drugs, the law does not supplement the meagre options for prison-based substance use treatment, particularly for women and gender-diverse people.

Overdose prevention in prison

Naloxone

The overdose crisis has also been acute in prisons, with an increasing number of reported drug overdoses behind bars.[320] According to CSC, between 2012/2013 and 2016/2017, Indigenous women accounted for a disproportionate number of overdose incidents in women's federal prisons, the majority of women who overdosed had a history of "substance misuse," and all had an identified mental health disorder.[321] As in federal prisons, women in provincial prisons are also overdosing — some fatally.[322] While an increasing number of prisons in Canada equip health care and correctional staff with naloxone, a drug used to treat an opioid overdose, no Canadian prison provides prisoners with direct access to naloxone.[323] Given that correctional staff are not always immediately available in overdose situations, providing naloxone kits to prisoners would enable them to administer naloxone to fellow prisoners in the event of an opioid overdose.

Overdose prevention sites

In June 2019, CSC introduced an "overdose prevention site" at Drumheller Institution, a men's federal prison in Alberta,[324] in response to high rates of overdose at that institution, correctional officers' concerns of prisoners having unsupervised access to injection equipment, and ostensibly as an alternative to a needle and syringe program. The program — an unprecedented harm reduction measure in correctional settings — has yet to be evaluated. Concerns have been raised about the measure of confidentiality that can be afforded to prisoners who participate.[325] As advocates have noted, more comprehensive harm reduction measures in prison are a laudable goal, but OPS should not replace needle and syringe programs in prison, which have been proven to function well behind bars and protect prisoners' health.[326] As of writing, overdose prevention sites do not exist in women's prisons in Canada.

Gaps in overdose prevention services also persist for people who are released from correctional settings — a time when people are at significantly increased risk of fatal drug overdose.[327] People being released from prison should be provided with naloxone training and take-home naloxone kits and those receiving OAT in detention should be connected to community-based drug dependence treatment to ensure uninterrupted continuity of care on release.

CONCLUSIONS

CONCLUSIONS

In the context of a staggering overdose crisis, it is more important than ever to ensure that public health responses are informed by intersectional gender dynamics and that women and gender-diverse people who use drugs have access to the services they need to stay alive and be well.[328] As a matter of public health and human rights, harm reduction services and substance use treatment programs, including those in prison, must address underlying structural inequities that limit the safety of women and gender-diverse people. Such programs should be tailored to the needs of women and gender-diverse people who use drugs, and include multifaceted, low-threshold interventions that address gender-based violence, transphobia, homophobia, and other prejudices, racism, trauma, mental health, housing, and sexual and reproductive health care including prenatal care and supports for parents. Services should be accessible to pregnant people and to people caring for children, and staff should be trained to provide a culturally sensitive and non-judgmental environment that encompasses services driven by lived expertise, mobile, or women-only services, including in rural, remote, and Indigenous communities.[329] Integration of harm reduction policies and practices in VAW shelters, sexual and reproductive health care, and HIV primary care settings should also be prioritized.[330]

Research on Indigenous women who use drugs has called for a trauma-informed approach, "where every effort is made by service providers to avoid re-traumatization of their clients and to establish safe, non-hierarchical relationships."[331] It is also imperative that harm reduction services address the harms of colonization and interrogate the "systems and structures that shape and constrain the lives of First Nations, Inuit and Métis people" including by supporting policies, programs, and practices that are community-based, peer-led, trauma-informed, distinctions-based, and culturally safe, and are grounded in local Indigenous knowledges, traditions, teachings, ceremonies, land, and languages.[332] As the National Inquiry into Missing and Murdered Indigenous Women and Girls noted, addressing the overdose crisis among Indigenous peoples requires Indigenous-specific solutions, grounded in Indigenous values and delivered in culturally appropriate ways, as well as confronting the structural and institutional inequalities such as poverty and housing that disproportionately affect Indigenous people and contribute to the crisis in the first place.[333]

Persistent and deplorable gaps in service provision are one of the offshoots of repressive laws, policies, and practices that stigmatize and marginalize women and gender-diverse people who use drugs, alienating them from social, health, and harm reduction services.[334] In Canada and around the world, the failure of the war on drugs has come at an enormous cost to women and gender-diverse people as well as their children, for whom women are often the principal caregivers.[335] Women and gender-diverse people who use drugs suffer disproportionately from laws and policies that not only criminalize drug possession and stigmatize drug use, but also those that criminalize sex work and vilify and penalize drug use during pregnancy and while parenting, impeding access to and use of harm reduction services, substance use treatment, VAW shelters, and reproductive and sexual health care. As described in the 2016 Women's Declaration of the United Nations General Assembly Special Session (UNGASS) on the World Drug Problem, "The current global drug control regime institutionalizes laws and practices that disempower women, and violates the principles and values fundamental to women's equality."[336]

Acknowledging the ramifications of punitive drug policy on women, the Committee on the Elimination of Discrimination against Women published its concluding observations on Canada's compliance with the *Convention on the Elimination of all Forms of Discrimination Against Women* in 2016, in which it underlined its concern "about the excessive use of incarceration as a drug-control measure against women and the ensuing female over-population in prison" as well as the "high and rising incarceration rates of Aboriginal women and African Canadian women in federal and provincial prisons across Canada" and "high rates of HIV/AIDS among female inmates."[337] To address these concerns, the Committee made a number of recommendations to Canada, including that it:

- "reduce the gap in health service delivery related to women's drug use, by **scaling-up and ensuring access to culturally appropriate harm reduction services**";
- "**establish a transparent process for exemptions permitting the operation of supervised consumption services** without risk of criminal prosecution of clients or service providers";
- "**Repeal mandatory minimum sentences for minor, non-violent drug-related offences**";
- "**Take measures to prevent overdose deaths**"; and
- "**Expand care, treatment and support services to women in detention** living with or vulnerable to HIV/AIDS, including by implementing prison-based needle and syringe programmes, opioid substitution therapy, condoms and other safer sex supplies."[338]

These recommendations are in line with those made by other UN human rights entities, including UN Special Rapporteurs on the right to health[339] and the UN Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment.[340] Most recently, the UN Chief Executives Board for Coordination unanimously adopted a common position on drug policy calling for increased investment in harm reduction measures, respect for the dignity and human rights of people who use drugs in all aspects of drug and social policies, alternatives to conviction and punishment, including the decriminalization of drug possession for personal use, the provision of equivalent health care services in prison settings, and changes in laws, policies and practices that threaten health and human rights.[341] The *International Guidelines on Human Rights and Drug Policy* also recommend that States "decriminalise the possession, purchase, or cultivation of controlled substances for personal consumption" and take all appropriate measures to "prevent, mitigate, and remediate

any disproportionate or otherwise discriminatory impact on women as a result of drug laws, policies, and practices, particularly where aggravated effects result from intersecting forms of discrimination" and to "ensure the availability of and non-discriminatory access to good-quality gender-sensitive prevention, treatment, harm reduction, and other health care services for women who use drugs."[342] For women in prison, the UN Rules for the Treatment of Women Prisoners call for "gender-specific health-care services at least equivalent to those available in the community," "individualized, gender-sensitive, trauma-informed and comprehensive mental health care and rehabilitation programmes," as well as "specialized treatment programmes" designed for drug-dependent women in prison.[343]

In Canada, there is strong support for the decriminalization of drug possession for personal use from organizations of people who use drugs and other community organizations, harm reduction and human rights advocates[344] as well as public health associations and authorities including the Canadian Public Health Association,[345] Canadian Mental Health Association,[346] Canadian Nurses Association,[347] Toronto Board of Health,[348] Toronto's Medical Officer of Health,[349] Montreal Public Health,[350] Winnipeg Regional Health Authority,[351] and Provincial Health Officer of British Columbia.[352] Support for a regulated, safe market is also growing.[353] Not only would decriminalizing drug possession for personal use reduce stigma and discrimination against people who use drugs, it would also enable the scale-up of harm reduction services such as SCS, curtail the surveillance, harassment, and presence of police in the lives of people who use drugs, potentially reduce the number of people in prison, including those who struggle with problematic drug use and/or are primary caregivers for their children, and leave fewer people who use drugs with the punishing legacy of a criminal record.

In the interim, the federal government should issue a "class exemption" to remove unnecessary administrative burden on service providers and facilitate access to a diversity of SCS across the country.[354] The federal government should also evaluate the impact of the *Good Samaritan Drug Overdose Act*, including through consultations with women and gender-diverse people who use drugs, to determine whether to broaden the current limited immunity from criminal prosecution conferred under the law. At the same time, all levels of government should support diverse approaches to a safe, regulated supply in consultation with people who use drugs, including women, gender-diverse people, and Indigenous people, to enhance uptake and reduce barriers.[355]

More broadly, the federal government should repeal sex work–specific criminal laws in consultation with sex workers and sex worker–led organizations, and ensure that general legal protections governing working conditions and social benefits are available equally to sex workers.[356] The federal government should also work with the provinces, territories, and women and gender-diverse people who use drugs to develop a national framework on shelter and transition house services for women and children affected by gender-based violence to address, among other things, barriers to accessing services for women and gender-diverse people who use substances.[357] Federal and provincial ministries responsible for corrections should ensure that harm reduction and drug dependence treatment services in correctional settings are at least equivalent to what is available in the community. These services should be tailored to meet the specific needs of women and gender-diverse people who use drugs, and particularly the grossly disproportionate number of Indigenous women behind bars. At minimum, these services should include gender-sensitive and trauma-informed needle and syringe programs, OAT, and overdose prevention services — and should also incorporate plans and resources to ensure continuity of care upon release.

With the meaningful participation of women and gender-diverse people who use drugs, steps should also be taken to amend or develop policies for child protection authorities that do not conflate parental substance use with neglect. Policies that protect parents who use drugs from the apprehension of children from the custody without additional evidence of neglect or mistreatment must also be implemented. Investments must be made to train staff to ensure these policies are upheld in practice and that services are provided in a gender-sensitive, trauma-informed, and culturally competent manner. Child protection services must recognize that it is not always in a child's best interests to be removed from a parent or guardian who uses drugs, and must follow a community-based harm reduction framework that focuses on supporting parents in the fulfillment of their roles. This includes increasing the availability of continuous services that are able to address interrelated needs, providing supports to allow parents who drugs to stay with their children, ensuring priority access to substance use treatment for parents in cases where there is a risk of apprehension, increasing the capacity of existing programs to ensure timely access to services, and addressing families' accessibility needs.[358]

Despite growing recognition of the immense toll that the drug war has taken, the manifold and intergenerational burdens of drug prohibition and drug-related stigma on women, gender-diverse people, and their families continue to be largely overlooked. Women and gender-diverse people who use drugs are frequently ignored and sidelined in the formation of laws, policies, and approaches to drug policy and harm reduction.[359] A rights-based, gendered approach to drug policy would recognize drug use as a health issue, eliminate laws criminalizing and penalizing people who use drugs, and uphold the rights of women and gender-diverse people to the highest attainable standard of health by ensuring that all harm reduction and drug dependence treatment services are informed by evidence and their meaningful participation.[360] As women who use drugs declared on International Women's Day 2019, there must be a "complete reform and transformation of the current system of prohibition"; in their words, "We do not ask for charity but for solidarity. We demand to live in safety and freedom."[361] It is time for the world to start listening.

1 Government of Canada, *Opioid-related harms in Canada,* March 2020. Note, however, that reporting is affected by stigma and other barriers faced by people who use drugs — and particularly women and gender-diverse people who use drugs; therefore, these figures may underrepresent the actual number of people affected by overdose. Available at https://health-infobase.canada.ca/substance-related-harms/opioids/.

2 United Nations Office on Drugs and Crime (UNODC), *World Drug Report 2016,* May 2016 at p. vxii. Available at www.unodc.org/doc/wdr2016/WORLD_DRUG_REPORT_2016_web.pdf.

3 We acknowledge the distinctions between men, women, and gender-diverse people in their access to health and harm reduction measures and will note these distinctions to the extent that the underlying research makes them. Unfortunately, the majority of research available and consulted distinguishes only between "men" and "women" and these limited distinctions are consequently reflected throughout the report.

4 See, for example, A. Collins et al., "Gender and the overdose crisis in North America: Moving past gender-neutral approaches in the public health response," *International Journal of Drug Policy* 69 (2019) 43–45, and T. Lyons et al., "Women who use drugs and have sex with women in a Canadian setting: Barriers to treatment enrollment and exposure to violence and homelessness," *Archives of Sexual Behaviour.* 2016 August; 45(6): 1403–1410.

5 See, for example, N. Poole et al., "Women-Centred Harm Reduction," *Gendering the National Framework Series,* 2010 (Vol. 4). Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Available at http://bccewh.bc.ca/wp-content/uploads/2012/05/2010_GenderingNatFrameworkWomencentredHarmReduction.pdf. A. Collins et al., ibid., and T. Lyons et al., ibid. In Lyons' study, women who had sex with women (WSW) and use drugs "experience alarmingly elevated levels of violence and sexual violence compared to non-WSW. The characteristics of violent incidents were also different between WSW and non-WSW. Specifically, WSW were significantly more likely to report being attacked most often by strangers, acquaintances, police officers and security guards and they were significantly more likely to report being beaten and strangled than women who did not report having sex with women. WSW are situated within cultures and practices of homophobia and heterosexism. Therefore, they may be more vulnerable to violence due to homophobic and heterosexist stigma, policies, and practices, such as being removed from a housing shelter for their sexual activities."

6 R. Schmidt et al., *Mothering and Opioids Toolkit: Addressing Stigma and Acting Collaboratively,* Centre of Excellence for Women's Health, 2019. Available at http://bccewh.bc.ca/wp-content/uploads/2019/11/CEWH-01-MO-Toolkit-WEB2.pdf.

7 See, for example, United Nations Office on Drugs and Crime (UNODC), supra note 2 at p. 67. See also A. Collins et al., supra note 4.

8 A. Roberts, B. Mathers, and L. Degenhardt on behalf of the Reference Group to the United Nations on HIV and Injecting Drug Use, *Women Who Inject Drugs: A Review of Their Risks, Experiences and Needs,* National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia, 2010. Available at https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Women%20who%20inject%20drugs.pdf.

9 Statistics Canada, *Canadian Tobacco, Alcohol and Drugs Survey (CTADS): summary of results for 2017,* 2019. Available at www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2017-summary.html.

10 Centre of Excellence for Women's Health, *Women, and Opioids: Media Guide,* May 2018. Available at http://bccewh.bc.ca/wp-content/uploads/2018/05/CanFASD_WomenAndOpiods_180504_1504_MediaGuide.pdf.

11 Drug Policy Alliance, *LGBT Communities and Drug Policy Reform: Toward a Public Health and Safety-Based Approach,* January 2013.

12 Rainbow Health Ontario and Canadian Harm Reduction Network, *LGBTQ People, Drug Use & Harm Reduction,* March 2014.

13 A. I. Scheim, G. R. Bauer, and M. Shokoohi, "Drug use among transgender people in Ontario, Canada: Disparities and associations with social exclusion," *Addictive Behaviors* (2017); 72:151-158. doi: http://doi.org/10.1016/j.addbeh.2017.03.022.

14 N. Poole and C. A. Dell, *Girls, Women and Substance Use*, British Columbia Centre of Excellence for Women's Health and Canadian Centre on Substance Abuse, 2005 at p. 10. Available at www.ccsa.ca/Resource%20Library/ccsa-011142-2005.pdf.

15 Ontario Drug Policy Research Network, *Latest Trends in Opioid-Related Deaths: Exploring differences among men and women,* 2017.

16 Harm Reduction International, *What is Harm Reduction?,* no date. Available at www.hri.global/what-is-harm-reduction.

17 R. Schmidt et al., supra note 6.

18 Canadian Aboriginal AIDS Network and the Interagency Coalition on AIDS and Development, *Indigenous Harm Reduction = Reducing The Harms Of Colonialism,* March 19, 2019 at p. 10.

19 A. Bourgeois et al., *HIV in Canada — Surveillance Report 2016,* Canada Communicable Diseases Report 2017; 43(12):248-56. By comparison, the overall proportion of new HIV cases attributed to drug use in European countries, for example, is less than 5% in 2017. See www.emcdda.europa.eu/news/2019/latest-update-on-drug-related-infectious-diseases-in-europe_en.

20 M. Shokoohia et al., "Substance use patterns among women living with HIV compared with the general female population of Canada," *Drug and Alcohol Dependence* 191 (2018) 70–77.

21 Ibid.

22 Public Health Agency of Canada, *Summary of key findings from I-Track Phase 3 (2010-2012),* October 2014. Available at www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/aids-sida/publication/reports/i-track-phase-3/assets/pdf/i-track-phase-3-eng.pdf.

23 Public Health Agency of Canada, *Hepatitis C virus (HCV) among Aboriginal people surveyed by three national enhanced surveillance systems in Canada,* 2010. Available at http://publications.gc.ca/collections/collection_2011/aspc-phac/HP40-52-2010-eng.pdf.

24 See A. Roberts, B. Mathers, and L. Degenhardt, supra note 8.

25 Rainbow Health Ontario and Canadian Harm Reduction Network, supra note 12, and Drug Policy Alliance, supra note 11.

26 E. Moazen-Zadeh et al., "A call for action on overdose among LGBTQ people in North America," *The Lancet Psychiatry* (2019) 6(9), 725–726. doi:10.1016/s2215-0366(19)30279-2.

27 UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, *What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters,* March 2019 at p. 16. Available at www.unodc.org/documents/commissions/CND/2019/Contributions/UN_Entities/What_we_have_learned_over_the_last_ten_years_-_14_March_2019_-_w_signature.pdf. See also Rainbow Health Ontario and Canadian Harm Reduction Network, supra note 12.

28 Rainbow Health Ontario and Canadian Harm Reduction Network, ibid.

29 M. Ditmore, *When sex work and drug use overlap: Considerations for advocacy and practice,* Harm Reduction International, November 2013. Available at www.hri.global/files/2014/08/06/Sex_work_report_%C6%924_WEB.pdf.

30 A. Roberts, B. Mathers, and L. Degenhardt, supra note 8.

31 K. Shannon et al., "Mapping violence and policing as an environmental structural barrier to health service and syringe availability among substance-using women in street-level sex work," *International Journal of Drug Policy* (2008) 19(2): p. 140-147.

32 S. Pinkham, C. Stoicescu, and B. Myers, "Developing Effective Health Interventions for Women Who Inject Drugs: Key Areas and Recommendations for Program Development and Policy," *Advances in Preventive Medicine* (2012), Article ID 269123.

33 CAPUD reviewer, personal communication, February 2020.

34 A. M. Bayoumi, N. Degani, R. S. Remis, et al., "HIV Infection," in A. S. Bierman (ed.), *Project for an Ontario Women's Health Evidence-Based Report: Volume 2* (Toronto, 2011) at p. 4. Available at www.powerstudy.ca/wp-content/uploads/downloads/2012/10/Chapter11-HIVInfection.pdf.

35 A. Roberts, B. Mathers, and L. Degenhardt, supra note 8 and M. Buchanan et al., "Understanding incarcerated women's perspectives on substance use: Catalysts, reasons for use, consequences, and desire for change," *Journal of Offender Rehabilitation* (2011) 50(2), 81-100.

36 A. Roberts et al., ibid.

37 N. Fairbairn et al., "Social structural factors that shape assisted injecting practices among injection drug users in Vancouver, Canada: a qualitative study," *Harm Reduction Journal* 2010, 7:20.s.

38 This is because they are consequently last in line in the drug division and injection process, exposing them to drug solution from equipment that may have already been used by other injectors. See A. Roberts, B. Mathers, and L. Degenhardt, supra note 8. See also A. Bayoumi, C. Strike, et al., *Report of the Toronto and Ottawa Supervised Consumption Assessment Study,* 2012. Toronto, Ontario: St. Michael's Hospital and the Dalla Lana School of Public Health, University of Toronto. Available at www.catie.ca/sites/default/files/TOSCA%20report%202012.pdf, in which researchers found that in both Toronto and Ottawa, women were considerably more likely than men to report that they injected with a regular sex partner.

39 S. Pinkham, C. Stoicescu, and B. Myers, supra note 32.

40 R. McNeil, W. Small, H. Lampkin, et al., "'People knew they could come here to get help': an ethnographic study of assisted injection practices at a peer-run 'unsanctioned' supervised drug consumption room in a Canadian setting," *AIDS and Behaviour* 2014;18:473-85.

41 N. Fairbairn et al., supra note 37. G. Kolla, K. S. Kenny, M. Bannerman, et al., "Help me fix: The provision of injection assistance at an unsanctioned overdose prevention site in Toronto, Canada," *International Journal of Drug Policy* (2020) Feb;76:102617.

42 S. Pinkham, C. Stoicescu, and B. Myers, supra note 32.

43 A. Roberts, B. Mathers, and L. Degenhardt, supra note 8.

44 Government of Canada, *National Report: Apparent Opioid-related Deaths in Canada,* June 2019. Available at https://health-infobase.canada.ca/datalab/national-surveillance-opioid-mortality.html#ageSexAccidental. Last accessed January 2020. Government of Canada, *National Report: Apparent Opioid-related Deaths in Canada,* December 2019. Available at www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/data-surveillance-research/harms-deaths.html. Last accessed January 2020. In this surveillance data, overdose deaths were disaggregated by male or female sex; for most provinces/territories, data on the sex of the individual was based on "biological characteristics or legal documentation." The age group percentages for Quebec in 2019 may not add up to 100% as data for individuals 19 and under and 60 and over were suppressed due to low numbers of cases.

45 Government of Canada, *National Report: Apparent Opioid-related Deaths in Canada,* June 2019, ibid.

46 First Nations Health Authority, *First Nations Opioid Overdose Deaths Rise in 2018,* May 27, 2019. Available at www.fnha.ca/about/news-and-events/news/first-nations-opioid-overdose-deaths-rise-in-2018.

47 CBC Radio Canada, "Les Premières Nations particulièrement touchées par les surdoses aux opioids," December 3, 2019. Available at https://ici.radio-canada.ca/nouvelle/1416229/drogue-fentanyl-autochtones-statistiques-alberta.

48 National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1a,* 2019 at p. 440.

49 S. Pinkham, C. Stoicescu, and B. Myers, supra note 32.

50 Ibid.

51 See, for example, United Nations Office on Drugs and Crime (UNODC), supra note 2, and S. Pinkham, C. Stoicescu, and B. Myers, supra note 32.

52 See A. Roberts, B. Mathers, and L. Degenhardt, supra note 8.

53 T. Mahony, J. Jacob, and H. Hobson, *Women in Canada: A Gender-based Statistical Report Women and the Criminal Justice System,* Statistics Canada, June 21, 2017. Available at www150.statcan.gc.ca/n1/pub/89-503-x/2015001/article/14785-eng.htm.

54 See N. Poole et al., "Improving Substance Use Treatment for First Nations, Métis and Inuit Women: Recommendations Arising From a Virtual Inquiry Project," *First Peoples Child & Family Review 8:2* (2013); T. Lyons, *Aboriginal Women, Drug Use & Violence: Literature Review Summary,* October 2006.

55 R. McNeil et al., "Negotiating place and gendered violence in Canada's largest open drug scene," *International Journal of Drug Policy,* (2014) May; 25(3): 608–615, citing P. Braitstein et al, "Sexual violence among a cohort of injection drug users," *Social Science & Medicine* (1982). 2003; 57(3):561–569 and N. El-Bassel et al., "HIV and intimate partner violence among methadone maintained women in New York City," *Social Science & Medicine* (2005); 61(1):171–183.

56 S. Pinkham, C. Stoicescu, and B. Myers, supra note 32.

57 Ibid.

58 M. Ditmore, supra note 29.

59 K. Shannon et al., supra note 31. See also E. Argento et al., "Prevalence and Correlates of Nonmedical Prescription Opioid Use Among a Cohort of Sex Workers in Vancouver, Canada," *International Journal of Drug Policy* (2015) January ; 26(1): 59–66. doi:10.1016/j.drugpo.2014.07.010.

60 A. I. Scheim, G. R. Bauer, and M. Shokoohi, supra note 13.

61 L. Platt et al., "Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies," *PLOS Medicine*, December 11, 2018.

62 T. Lyons et al., supra note 4.

63 Ibid.

64 Ibid.

65 United Nations Office on Drugs and Crime (UNODC), supra note 2. See also UNODC, *HIV/AIDS prevention and care for female injecting drug users,* 2006. Available at www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf. See also T. Azima, I. Bontella, and S. Strathdee, "Women, drugs and HIV," *International Journal of Drug Policy* 26 (2015): S16–S21.

66 S. Boyd, D. MacPherson, and Vancouver Area Network of Drug Users, "The Harms of Drug Prohibition: Ongoing Resistance in Vancouver's Downtown Eastside," *BC Studies* 200: Winter 2018/19: pp. 87-96.

67 Ibid., and R. Schmidt et al., supra note 6.

68 UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters, supra note 27 at p. 20.

69 See, for example, T. Azima, I. Bontella, and S. Strathdee, supra note 65; R. Stone, "Pregnant women and substance use: fear, stigma, and barriers to care," *Health & Justice* 3(1) (2015): 2; and T. Meixner et al., "Conceptualizing integrated service delivery for pregnant and parenting women with addictions: Defining key factors and processes," *Canadian Journal of Addiction*, 7(3), 57-65.

70 K. Kenny, "Mental Health Harm to Mothers When a Child Is Taken by Child Protective Services: Health Equity Considerations," *Canadian journal of psychiatry*, (2017) 63(12):706743717748885.

71 The prevalence of a concurrent disorder was 1.4% of men and 1.1% of women. See S. Khan, *Concurrent mental and substance use disorders in Canada,* Statistics Canada, August 2017.

72 S. Pinkham, C. Stoicescu, and B. Myers, supra note 32.

73 B. Richie, *Compelled to Crime: The gender entrapment of battered Black women* (New York: Routledge, 1996); M. Buchanan, et al., supra note 35; B. Dansky, et al., "Prevalence of Victimization and Posttraumatic Stress Disorder Among Women with Substance Use Disorders: Comparison of Telephone and In-Person Assessment Samples," *The International Journal of Addictions* (1995) 30(9): pp. 1079–1099; P. Fazzone, et al., *Substance Abuse Treatment and Domestic Violence, Treatment Improvement Protocol (TIP) Series 25,* Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, 1997; National Household Survey on Drug Abuse, *NHSDA Report: Substance Use Among American Indians or Alaska Natives,* May 16, 2003; Office of the Director, National Institutes of Health, *Women of Color Health Data Book,* 74 (2nd ed.), 2002.

74 V. Bungay et al., "Women's health and use of crack cocaine in context: Structural and 'everyday' violence," *International Journal of Drug Policy* (2010) 21(4): 321-329.

75 See, for example, National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, Volume 1b, 2019 at pp. 107 and 112, and N. Poole et al., supra note 54.

76 National Inquiry into Missing and Murdered Indigenous Women and Girls, supra note 48 at p. 439.

77 S. Pinkham, C. Stoicescu, and B. Myers, supra note 32.

78 UNGASS, Women's declaration calling for global drug policies that support women, children, and families, 2016. Available at www.ungasswomen2016.com/English.

79 See s. 4(4)(b)(i) of the *Controlled Drugs and Substances Act* (S.C. 1996, c. 19).

80 See s. 5(3)(a) of the CDSA.

81 See s. 6(3) of the CDSA.

82 *Good Samaritan Drug Overdose Act,* S.C. 2017, c. 4.

83 *Safe Streets and Communities Act,* SC 2012, c 1.

84 Canadian HIV/AIDS Legal Network, *Mandatory Minimum Sentences for Drug Offences: Why Everyone Loses,* 2006; D. Bennett and S. Bernstein, *Throwing Away the Keys: The Human and Social Cost of Mandatory Minimum Sentences* (Vancouver: Pivot Legal Society, 2013).

85 See, for example, D. Bennett and S. Bernstein, ibid.; L. Maher and D. Dixon, "Policing and public health: Law enforcement and harm minimization in a street-level drug market," *British Journal of Criminology* (1999)39,4: 488–412; E. Wood et al., "The impact of police presence on access to needle exchange programs," *Journal of Acquired Immune Deficiency Syndromes* (2003)34,1: 116–118; R. N. Bluthenthal et al., "Collateral damage in the war on drugs: HIV risk behaviours among injection drug users," *International Journal of Drug Policy* (1999) 10 : 25–38; Canadian HIV/AIDS Legal Network, *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs,* 2007, and sources cited therein.

86 T. Gabor and N. Crutcher, *Mandatory minimum penalties: Their effects on crime, sentencing disparities, and justice system expenditures,* Justice Canada (Research and Statistics Division), January 2002.

87 Department of Justice Canada, *Drug Treatment Court Funding Program Summative Evaluation Final Report,* Evaluation Division Office of Strategic Planning and Performance Management, March 2009; Department of Justice Canada, *Drug treatment funding program evaluation,* final report, April 2015; Canadian HIV/AIDS Legal Network, *Impaired Judgment: Assessing the Appropriateness of Drug Treatment Courts as a Response to Drug Use in Canada,* 2011.

88 Department of Justice Canada, *Drug Treatment Court Funding Program Summative Evaluation Final Report,* supra note 87 at p. 26.

89 Ibid.

90 Canadian HIV/AIDS Legal Network, supra note 87.

91 In Canada, for example, supervised consumption services, where people can use drugs in a safe, hygienic environment with sterile equipment under the supervision of trained staff or volunteers, require a specific federal exemption to operate safely and protect both clients and staff from prosecutions. In Canada, SCS are currently offered in "supervised consumption sites," which operate under an exemption from federal drug laws issued by the federal Minister of Health for a "medical purpose" under section 56.1 of the CDSA, and in temporary "overdose prevention sites" (OPS). OPS are essentially lower-threshold supervised consumption sites but the shift in terminology has proved crucial to the rapid rollout of these life-saving interventions in the context of the current overdose crisis. OPS have been approved unilaterally by provincial governments (British Columbia), or under a section 56 class exemption granted to provincial governments by the federal Minister of Health (Alberta and Ontario), or in some cases operate, or have operated, independently of formal provincial or federal approvals.

92 See Health Canada, *Reducing Regulatory Barriers to Accessing Treatment, and New Funding for Innovative Projects,* March 2018.

93 For further discussion of the legal regime governing supervised consumption services and recommendations to further improve it, please see Canadian HIV/AIDS Legal Network, *Overdue for a Change: Scaling Up Supervised Consumption Services in Canada,* 2019.

94 See, for example, Canadian HIV/AIDS Legal Network, ibid.; T. M. Watson et al., "Critical studies of harm reduction: Overdose response in uncertain political times," *International Journal of Drug Policy* (2020)76:1–6; and T. Kerr et al., "Supervised injection facilities in Canada: past, present, and future," *Harm Reduction Journal* (2017) 14(1):18–9.

95 Men are the accused in 81.8% of drug offences, compared to 18.2% for women. See T. Mahony, J. Jacob, and H. Hobson, supra note 53.

96 The Women and Harm Reduction International Network and TalkingDrugs, *Women who Use Drugs and the Violence of Law Enforcement Position Statement,* December 10, 2019,

97 See, for example, G. Bardwell et al., "Implementation contexts and the impact of policing on access to supervised consumption services in Toronto, Canada: a qualitative comparative analysis," *Harm Reduction Journal* (2019) 16: 30; D. Bennett and D. Larkin, *Project Inclusion: Confronting Anti-Homeless and Anti-Substance User Stigma in British Columbia,* Pivot Legal Society, 2018; W. Small et al., "Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation," *International Journal of Drug Policy* 17 (2006) 85–95; and J. Csete and J. Cohen, *Abusing the User: Police Misconduct, Harm Reduction and HIV/AIDS in Vancouver,* Human Rights Watch, May 2003.

98 CAPUD reviewer, personal communication, February 2020.

99 V. Bungay et al., supra note 74.

100 See, for example, D. Bennett and D. Larkin, supra note 97; L. Ti et al., "Police confrontations among street-involved youth in a Canadian setting," *International Journal of Drug Policy* 24 (2013) 46–51; and D. Werb et al., "Effects of police confiscation of illicit drugs and syringes among injection drug users in Vancouver," *International Journal of Drug Policy* 19 (2008) 332–338.

101 A. Cotter, J. Greenland, and M. Karam, *Drug-related offences in Canada,* Statistics Canada, 2013.

102 R. Gobeil, *Profile of Federally Sentenced Women Drug Offenders,* Correctional Service of Canada, May 2009.

103 Ibid.

104 Office of the Correctional Investigator, *Annual report of the Office of the Correctional Investigator, 2016-2017,* 2017.

105 Office of the Correctional Investigator, *Annual report of the Office of the Correctional Investigator, 2012-2013,* 2013.

106 In Canada, women who receive a sentence of two years or more are housed in one of five federal women's prisons (located in British Columbia, Alberta, Ontario, Quebec, and Nova Scotia) or the "healing lodge" (located in Saskatchewan).

107 R. Gobeil, supra note 102.

108 See Public Prosecution Service of Canada, *6.2 Mandatory Minimum Penalties for Particular Drug Offences under the Controlled Drugs and Substances Act,* January 17, 2018: "The Act amends the CDSA to provide for [Mandatory Minimum Penalties] when an accused is convicted of certain serious drug offences including trafficking, possession for the purpose of trafficking, importing and exporting, and production."

109 Public Safety Canada, *2017 Annual Report: Corrections and Conditional Release Statistical Overview,* July 2018.

110 Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2014-2015,* 2015.

111 Ibid.

112 United Nations Office on Drugs and Crime (UNODC), *Women and Drugs: Drug use, drug supply and their consequences, World Drug Report 2018,* June 2018. Available at www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_5_WOMEN.pdf.

113 See, for example, J. Stone et al., "Incarceration history and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis," *The Lancet Infectious Diseases.* (2018) Dec;18(12):1397-1409. doi: 10.1016/S1473-3099(18)30469-9. Epub 2018 Oct 29; M. Tyndall et al., "Intensive injection cocaine use as the primary risk factor in the Vancouver HIV–1 epidemic," *AIDS* 17,6 (2003): 887–893; and H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17,6 (2003): 911–913.

114 E. Erickson et al., "Recent Incarceration as a Primary Barrier to Virologic Suppression Among Women Living with HIV: Results from a Longitudinal Community-Based Cohort in a Canadian Setting," *AIDS and Behavior* (2020) 24, 1243-1251. doi.org/10.1007/s10461-019-02606-5.

115 s. 213 of the *Criminal Code*.

116 s. 286.1 of the *Criminal Code*.

117 s. 286.2 of the *Criminal Code*

118 s. 286.3 of the *Criminal Code*

119 s. 286.4 of the *Criminal Code*

120 s. 286.5 of the *Criminal Code*

121 Sections 183(1)(b.1), 196.1(a), 200(3) (g.1) and 203(2)(a) of the *Immigration and Refugee Protection Regulations.*

122 The Global Network of Sex Work Projects and the International Network of People who Use Drugs, *Sex Workers who use Drugs: Ensuring a Joint Approach,* 2015.

123 M. Ditmore, supra note 29.

124 The Global Network of Sex Work Projects and the International Network of People who Use Drugs, supra note 122, and Canadian HIV/AIDS Legal Network, *The Perils of "Protection": Sex Workers' Experiences with Law Enforcement in Ontario,* 2019.

125 Ibid.

126 See, for example, The Global Network of Sex Work Projects and the International Network of People who Use Drugs, supra note 122. See also M. L. Rekart, "Sex-work harm reduction," *Lancet* (2005) 366(9503):2123–34.

127 K. Shannon et al., supra note 31. See also E. Argento et al., supra note 59.

128 T. Kerr et al., "Sex Work and HIV Incidence among People who inject Drugs," *AIDS* (2016) 30(4) Feb 20: pp. 627–634.

129 Street Health and the Regent Park Community Health Centre, *Street Based Sex Workers Needs Assessment Survey: Toronto, Barrie and Oshawa,* 2014. Available at www.streethealth.ca/downloads/sex-workers-needs-assessment.pdf.

130 UNGASS, supra note 78.

131 J. L. Cook, C. R. Green, S. de la Ronde, et al., "Epidemiology and effects of substance use in pregnancy," *Journal of Obstetrics and Gynaecology Canada,* (2017) 39(10), 906–915.

132 See, for example, S. Pinkham, C. Stoicescu, and B. Myers, supra note 32, and "Sexual/Reproductive Care." *Sexual/Reproductive Care | The Homeless Hub,* www.homelesshub.ca/about-homelessness/health/sexualreproductive-care.

133 M. Terplan, D. J. Hand, M. Hutchinson, et al., "Contraceptive use and method choice among women with opioid and other substance use disorders: a systematic review," *Preventive Medicine* (2015) 80, 23-31.

134 A. E. Weber, M. Tyndall, P. M. Spittal, et al., "High Pregnancy rates and reproductive health indicators among female injection-drug users in Vancouver, Canada," *The European Journal of Contraception and Reproductive Health Care,* (2003) 8:1, 52-58

135 See, for example, M. Terplan, D. J. Hand, M. Hutchinson, et al., supra note 133.

136 Public Health Agency of Canada, *What Mothers Say: The Canadian Maternity Experiences Survey,* 2009. Available at www.phac-aspc.gc.ca/rhs-ssg/pdf/survey-eng.pdf. Note, however, illegal drug use has been found to be vastly under-reported when only relying on self reports from surveys and researchers acknowledge that this data is likely to be an underestimate of the true consumption of illegal drugs during pregnancy.

137 A. Ambasta and M. Malebranche, "Opioid use disorder in pregnancy," *CMAJ* (2019)191 (38) E1057; DOI: https://doi.org/10.1503/cmaj.190391.

138 Other barriers include stigma and judgment from health care and social service providers, lack of childcare limiting their ability to participate in or attend treatment, limited financial resources, lack of transportation, limited family or social support, the criminalization of drug possession, and lack of treatment and care that addresses both drug use and prenatal care. See, for example, Canada FASD Research Network's Action Team on Prevention from A Women's Health Determinants Perspective, *Substance Use During Pregnancy: An Overview of Key Canadian Policy and Practice Areas,* 2014. Available at http://bccewh.bc.ca/wp-content/uploads/2014/09/Canadian.Policy-on.Subst-Use-+-Preg.Sept-2-2014web.pdf; L. Shulga et al., *Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users,* International HIV/AIDS Alliance, 2011; International AIDS Society, *Women who Inject Drugs: Overlooked, Yet Visible,* 2019.

139 Canada FASD Research Network's Action Team on Prevention from A Women's Health Determinants Perspective, supra note 138, and N. Poole et al., supra note 5. See also Women and Harm Reduction International Network and the International Network of Women who Use Drugs, *Illicit Drug Use in Pregnancy: An Appropriate Response,* 2012. Available at www.inpud.net/Illicit_Drug_use_in_Pregnancy_An_Appropriate_Response-WHRIN_INWUD_2012.pdf.

140 *Winnipeg Child and Family Services v. G.(D.F.),* 1997 3 SCC 925 [G.(D.F.)]

141 Ibid, at para 15.

142 Ibid, at para 37.

143 Ibid, at para 44.

144 Women and Harm Reduction International Network and the International Network of Women who Use Drugs, supra note 139.

145 See A. Ambasta and M. Malebranche, supra note 137, and K. Kenny, supra note 70, and K. Kenny et al., "Family Separation and Maternal Self-rated Health: Evidence from a Prospective Cohort of Marginalized Mothers in a Canadian Setting," *Maternal and Child Health Journal* (2019) 23:1232–1239.

146 See, for example, N. Poole et al., supra note 5, and Centre of Excellence for Women's Health, supra note 6.

147 See, for example, British Columbia Centre on Substance Use, B.C. Ministry of Health, B.C. Ministry of Mental Health and Addictions, & Perinatal Services BC, *A Guideline for the Clinical Management of Opioid Use Disorder—Pregnancy Supplement,* June 1, 2018. Available at www.bccsu.ca/care-guidance-publications/. See also Canada FASD Research Network's Action Team on Prevention from A Women's Health Determinants Perspective, supra note 138.

148 Public Health Agency of Canada, *Provincial and Territorial Child Protection Legislation and Policy 2018,* March 2019. Available at www.canada.ca/content/dam/phac-aspc/documents/services/publications/health-risks-safety/provincial-territorial-child-protection-legislation-policy-2018/64-03-18-2245_Child-Protection_EN-FINAL02.pdf.

149 Only Alberta and Newfoundland and Labrador make explicit reference to a parent or guardian's drug use as a ground for finding a child in need of protection. In Alberta, temporary apprehension of a child due to a mother using drugs occurs under the *Drug-Endangered Children Act*, Statutes of Alberta, 2006 Chapter D-17. According to the Act, a child (i.e. person under the age of 18) is a "drug-endangered child" and could be apprehended by the state if a "guardian exposes the child or allows the child to be exposed to, or to ingest, inhale or have any contact with, a chemical or other substance that the guardian uses to illegally manufacture a drug," "the guardian illegally manufactures a drug in the presence of the child, or causes or allows the child to enter or remain in any place or premises where a drug is illegally manufactured or stored," "the guardian possesses a chemical or other substance with which the guardian intends to illegally manufacture a drug in a place or premises where a child resides," "the guardian exposes the child or allows the child to be exposed to an indoor cannabis grow operation, or to the process of extracting oil or resins from cannabis plants," "the guardian involves the child in or exposes the child to trafficking," or "the child has been or is being, or there is a substantial risk that the child will be, physically injured, emotionally injured or sexually abused because the guardian is exposing the child to other forms of illegal drug activity." In Newfoundland and Labrador, s. 10(3) of the *Children, Youth and Families Act* SNL2018 CHAPTER C-12.3 defines a child in need of protective intervention when a child is being, or is at risk of being, emotionally harmed by the parent's conduct including where a parent is an "abuser of alcohol or drugs."

150 K. Kenny, supra note 70.

151 Canada FASD Research Network's Action Team on Prevention from A Women's Health Determinants Perspective, supra note 138; West Coast LEAF, *Pathways in a Forest: Indigenous Guidance on Prevention-Based Child Welfare,* September 2019. Available at www.westcoastleaf.org/wp-content/uploads/2019/09/Pathways-in-a-Forest.pdf; M. Turpel-Lafond, *Children at Risk: The Case for a Better Response to Parental Addiction Investigative Report,* June 2014. Available at https://rcybc.ca/reports-and-publications/reports/cid-reviews-and-investigations/children-at-risk-the-case-for-a-better-response-to-parental-addiction/.

152 West Coast LEAF, supra note 151.

153 Ibid.

154 K. Kenny et al., "'I felt for a long time like everything beautiful in me had been taken out': Women's suffering, remembering, and survival following the loss of child custody," *The International Journal of Drug Policy* (2015) 26(11).

155 CAPUD reviewer, personal communication, February 2020.

156 West Coast LEAF, supra note 151.

157 R. Schmidt et al., supra note 6.

158 Ibid. See also M. Turpel-Lafond, supra note 151.

159 Community Action for Families, *Principles Informing Our Work,* no date. Available at www.communityactionforfamilies.com/about-us/. See also K. Kenny, supra note 70; A. Niccols, C. A. Dell, and S. Clarke, "Treatment issues for aboriginal mothers with substance use problems and their children," *International Journal of Mental Health and Addiction* (2010);8(2):320–35; and J. Denison, C. Varcoe, and A. Browne, "Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened," *Journal of Advanced Nursing* 70(5), 1105–1116 . The authors did not identify research that documented the impact of child welfare policies on LGBTQ2S families.

160 S. Boyd, "Gendered drug policy: Motherisk and the regulation of mothering in Canada," (2019) *International Journal of Drug Policy* 68, pp. 109-116.

161 Canadian Aboriginal AIDS Network and the Interagency Coalition on AIDS and Development, supra note 18 at p. 6.

162 See, for example, https://indigenousfoundations.arts.ubc.ca/sixties_scoop/.

163 K. Kenny et al., supra note 154.

164 Ibid.

165 See, for example, K. Kenny et al., supra note 145; E. Wall-Wieler, L. L. Roos, J. Bolton et al., "Maternal health and social outcomes after having a child taken into care: population-based longitudinal cohort study using linkable administrative data," *Journal of Epidemiology & Community Health* (2017) Oct 5;7:jech–2017–209542–7; E. Wall-Wieler, L. L. Roos, J. Bolton et al., "Maternal Mental Health after Custody Loss and Death of a Child: A Retrospective Cohort Study Using Linkable Administrative Data," *Canadian Journal of Psychiatry*, (2018) 63(5):322–8; E. Wall-Wieler, L. L. Roos, M. Brownell et al., "Suicide Attempts and Completions among Mothers Whose Children Were Taken into Care by Child Protection Services: A Cohort Study Using Linkable Administrative Data," *Canadian Journal of Psychiatry* (2018) 63(3):170–7; J. Denison, C. Varcoe, and A. Browne, supra note 159; and West Coast LEAF, supra note 151.

166 K. Kenny, supra note 70.

167 Community Action for Families, supra note 159.

168 J. Beaman, *Harmful Impacts: The Reliance on Hair Testing in Child Protection,* Motherisk Commission, 2018. Available at www.attorneygeneral.jus.gov.on.ca/english/about/pubs/motherisk/#_Toc506461675.

169 *R. v. Broomfield,* 2014 ONCA 725.

170 S. Lang, *Report of the Motherisk Hair Analysis: Independent Review,* Ministry of the Attorney General, 2015. Available at www.attorneygeneral.jus.gov.on.ca/english/about/pubs/lang/#toc-194.

171 S. Boyd, supra note 160.

172 *R. v. Broomfield,* [2014] O.J. No. 4903.

173 Community Action for Families, supra note 159.

174 J. Beaman, supra note 168.

175 S. Boyd, supra note 160.

176 Public Health Agency of Canada, supra note 148.

177 E. Hyshka et al., "Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks," *Harm Reduction Journal* (2017) 14:50.

178 Harm Reduction International, *Women and harm reduction, Global State of Harm Reduction 2018 briefing,* 2018.

179 A. Roberts, B. Mathers, and L. Degenhardt, supra note 8.

180 E. Hyshka et al., supra note 177.

181 Canadian Drug Policy Coalition, *Getting to tomorrow: A report on Canadian drug policy,* 2013.

182 International Network of Women who Use Drugs, *Bringing State Commitments to Gender Equality into Action: Addressing the Needs of Women Who Use Drugs,* April 2016.

183 See for example, C. Bourassa, "Addressing the Duality of Access to Healthcare for Indigenous Communities: Racism and Geographical Barriers to Safe Care," *Healthcare Papers, Rural and Remote Health Services,* (2018) 17:3, 6-10.

184 N. Poole and C. A. Dell, supra note 14 at p. 6-7 and 10.

185 N. Poole et al., supra note 5.

186 UNODC, Practical guide for service providers on gender sensitive services, 2016.

187 A. Stensrud, *Toward a Better Understanding of the Needs of Shelter Users: A Consultation with Shelter Residents and Workers,* Provincial Association of Transition Houses and Services of Saskatchewan, March 2005. Available at http://pathssk.org/wp-content/uploads/2011/04/PATHS-Report-Toward-a-Better-Understanding-of-the-Needs-of-Shelter-Users.pdf.

188 M. Ham, Executive Director at Ontario Association of Interval & Transition Houses, telephone conversation, July 29, 2019. See also A. Hovey et al., "Understanding the Landscape of Substance Use Management Practices in Domestic Violence Shelters across Ontario," *Journal of Family Violence* (2019) 35, pp.191–201, https://doi.org/10.1007/s10896-019-00056-0.

189 S. Beattie and H. Hutchins, *Shelters for abused women in Canada,* Statistics Canada, 2014. Available at www150.statcan.gc.ca/n1/pub/85-002-x/2015001/article/14207-eng.htm.

190 N. Poole et al., supra note 5.

191 International Network of Women who Use Drugs, supra note 182. See also, S. LeBlanc for Out of the Cold Emergency Shelter, *Harm Reduction and Shelters: A jurisdictional scan of harm reduction initiatives in Canada,* November 2018, and N. Poole et al., supra note 54.

192 A. Hovey et al., supra note 188.

193 *Surviving abuse and building resilience—a study of Canada's systems of shelters and transition houses serving women and children affected by violence: Report of the Standing Committee on the Status of Women,* 42nd Parliament, 1st Session, May 2019. Available at http://publications.gc.ca/collections/collection_2019/parl/xc71-1/XC71-1-1-421-15-eng.pdf.

194 Ibid. See also A. Hovey et al., supra note 188; Provincial Association of Transition Houses and Services of Saskatchewan, *Shelter Standards,* Revised February 2019, stipulating that "Alcohol, non-prescription marijuana, and illegal drugs are not permitted in the shelter." Available at https://pathssk.org/wp-content/uploads/2019/05/Shelter-Standards-rev-Feb-2019.pdf. See also Newfoundland Department of Health and Community Services, *Provincial Transition Houses Operational Standards,* June 2010, describing one admission criteria as women "must not … be under the influence of drugs or alcohol." Available at www.health.gov.nl.ca/health/publications/transition_operational_standards_2010.pdf.

195 A. Hovey et al., supra note 188.

196 Ibid.

197 S. Beattie and H. Hutchins, supra note 189. For a discussion of reasons why shelters may advocate for abstinence-based (versus harm reduction-based) programming, see A. Hovey et al., supra note 188.

198 M. Alexander, *Harm Reduction in VAW Shelters: Realities of Service,* Ontario Association of Interval and Transition Houses (OAITH), 2013.

199 National Inquiry into Missing and Murdered Indigenous Women and Girls, supra note 75 at p. 147.

200 J. Tabibi, M. Kubow, and L. Baker, *Gender Diversity in the VAW Sector: A Discussion Paper Informed by November 2016 Knowledge Exchange,* Centre for Research & Education on Violence Against Women & Children, 2017.

201 See Ministry of Community and Social Services, *Violence Against Women (VAW) - Emergency Shelter Standards,* 2015, section 2.9 Use of Substances: "The ministry expects that shelters provide access to all women seeking shelter services, including women who use substances. The shelter will have a policy and procedure that outlines how they will provide support to women who use substances, which could include the assessment of immediate safety needs and relevant community supports. The written policy and procedure will outline how the shelter will respond to women who are in possession of substances and or use substances on shelter premises."

202 A. Hovey et al., supra note 188.

203 A. Stensrud, supra note 187.

204 *Surviving abuse and building resilience—a study of Canada's systems of shelters and transition houses serving women and children affected by violence: Report of the Standing Committee on the Status of Women,* supra note 193; A. Hovey et al., supra note 188.

205 N. Fairbairn, "Seeking refuge from violence in street-based drug scenes: Women's experiences in North America's first supervised injection facility," *Social Science & Medicine* 67 (2008) 817–823.

206 Section 2(1) of the CDSA defines "traffic" to mean, "in respect of a substance included in any of Schedules I to V [of the Act], (a) to sell, administer, give, transfer, transport, send or deliver the substance, (b) to sell an authorization to obtain the substance, or (c) to offer to do anything mentioned in paragraph (a) or (b), otherwise than under the authority of the regulations."

207 J. Boyd et al., "Gendered violence & overdose prevention sites: A rapid ethnographic study during an overdose epidemic in Vancouver, Canada," *Addiction,* (2018) 1113:12, pp. 2261-2270. DOI: 10.1111/add.14417.

208 R. McNeil et al., supra note 55.

209 G. Kolla et al., supra note 41.

210 Canadian HIV/AIDS Legal Network, supra note 93.

211 International AIDS Society, supra note 138.

212 The issue of access to substance use treatment was also considered by the National Inquiry into Missing and Murdered Indigenous Women and Girls. The Commission recommended that wise practices for the delivery of substance use treatment programs include treatment programs that support whole families, providing children with mental health supports while parents receive substance use treatment; culturally grounded treatment programs, such as land-based programs and programs engaging Elders; enhanced availability of local treatment programs, including in northern communities and within urban centres; timely access to treatment programs, in order to support individuals when they are feeling ready for care; and follow-up care, including ongoing mental health supports for individuals recovering from addictions, and engaging their families and communities to support them. Participants noted that aftercare is particularly important when individuals have travelled outside of their home communities for treatment. See National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls,* supra note 75 at p. 138. Available at www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1b.pdf.

213 A. Bayoumi, C. Strike et al., supra note 38.

214 International Network of Women who Use Drugs, supra note 182.

215 J. Boyd et al., supra note 207.

216 Ibid.

217 Ibid.

218 Ibid.

219 Ibid

220 See Atira's website at: https://atira.bc.ca/what-we-do/program/sisterspace/. See also Women's Hospital, "Women-only overdose prevention site opens," news release, May 16, 2017.

221 https://atira.bc.ca/what-we-do/programs/

222 M. Thulien, T. Nathoo, J. Worrall, et al., *SisterSpace, Shared using rooms, Women-only overdose prevention site: Three-month development evaluation,* August 2017. Available at www.atira.bc.ca/sites/default/files/SisterSpace_Report_August2017.pdf

223 Ibid.

224 Ibid.

225 SisterSpace, Program Update, August 2018. Available at https://atira.bc.ca/sites/default/files/SisterSpaceUpdate_July%2031%202018.pdf.

226 Ibid.

227 M. Thulien, T. Nathoo, J. Worrall, et al., supra note 222. See also B.C. Centre for Excellence for Women's Health and Atira, *SisterSpace: Canada's First Women-Only Shared Using Room,* a 2018 video available at www.youtube.com/watch?v=UU-QwGwUJmg&feature=youtu.be.

228 M. Thulien, T. Nathoo, J. Worrall, et al., supra note 222.

229 Atira, supra note 220.

230 A. Niccols, C. A. Dell, and S. Clarke, supra note 159.

231 The site, operated by RAGAZZA and located in Hamburg, Germany, provides services to women who use drugs and also engage in sex work. Women have reported feeling more relaxed, comfortable, and safe at the site than in spaces accessible to men and said they could speak more openly about their problems and trust staff more easily. One SCS site in Biel, Switzerland, offers women-only services for two hours per week. See European Harm Reduction Network, *Drug consumption rooms in Europe Models, best practice and challenges,* 2014.

232 British Columbia Centre on Substance Use, *Supervised Consumption Services: Operational Guidance,* 2017.

233 See website at www.torontocentralhealthline.ca/displayservice.aspx?id=186647.

234 See Regent Park Community Health Centre's pamphlet at www.regentparkchc.org/sites/default/files/files/Women's%20OPS%20and%20Drop-in%20Flyer.pdf. (Last accessed March 2020.)

235 City of Toronto, *Toronto Indigenous Overdose Strategy: Summary Report,* January 2019.

236 R. McNeil et al., supra note 55.

237 See, Brave Technology Cooperative, *Snapshot: April 2019* at https://static1.squarespace.com/static/5ae19ee7f79392f31975dcd5/t/5d07d114f4e9b10001f49c01/1560793400063/BraveSnapshot+-+24+April+2019.pdf.

238 A. Collins et al., supra note 4.

239 British Columbia Centre on Substance Use, supra note 232, and G. Kolla, R. Penn, and C. Long, *Evaluation of the Overdose Prevention Sites at Street Health and St. Stephen's Community House,* Street Health and St. Stephen's Community House, 2019.

240 See B.C. Centre for Excellence for Women's Health and Atira, supra note 227.

241 While used commonly in research literature, the terminology of "peer" can be stigmatizing. As the CRISM PWLE working group described: "However, in the field of harm reduction, the term 'peer' has also been used to demarcate an invisible boundary that results in material inequities between harm reduction professionals who use(d) drugs and those who openly do not." CRISM People with Lived Expertise of Drug Use (PWLE) National Working Group, *Having a Voice and Saving Lives: A survey by and for people who use drugs and work in harm reduction,* July 2019.

242 M. Thulien, T. Nathoo, J. Worrall, et al., supra note 222.

243 CRISM People with Lived Expertise of Drug Use (PWLE) National Working Group, supra note 241.

244 Recent research has, however, pointed to unintended negative impacts of health models reliant on care provision by those with lived expertise of drug use, who risk overextending themselves beyond employment parameters with few systems in place for support, may face stigma, workplace discrimination, and/or power imbalances between staff with lived expertise of drug use and staff without, and also risk burnout, relapse, or increased problematic drug consumption, disparity, trauma, and grief. With growing awareness that the participation of people with lived expertise of drug use in harm reduction can have both benefits and unintended consequences, people who use drugs have called for workplaces to increase and promote equitable policies and practices (including equal pay for equal work, the provision of health benefits and resources, policies to address tokenization and devaluing of people who use[d] drugs) and capacity-building. See CRISM People with Lived Expertise of Drug Use (PWLE) National Working Group, supra note 241.

245 Ibid.

246 M. C. Kennedy et al., "Peer worker involvement in low-threshold supervised consumption facilities in the context of an overdose epidemic in Vancouver, Canada," *Social Science & Medicine* 225 (2019) 60–68.

247 G. Kolla, R. Penn, and C. Long, supra note 239.

248 The Global Network of Sex Work Projects and the International Network of People who Use Drugs, supra note 122.

249 J. Boyd et al., supra note 207. See also Street Health and the Regent Park Community Health Centre, supra note 129.

250 International Network of Drug Consumption Rooms, *Online census of Drug Consumption Rooms (DCRs) as a setting to address HCV: current practice and future capacity, Report,* 2018.

251 Registered Nurses' Association of Ontario, *Implementing Supervised Injection Services,* February 2018. Available at https://rnao.ca/sites/rnao-ca/files/bpg/Implementing_supervised_injection_services.pdf.

252 BC Centre for Disease Control, *BC Overdose Prevention Site, Services Guide,* 2019. See also, Registered Nurses' Association of Ontario, ibid.

253 British Columbia Centre on Substance Use, supra note 232.

254 "Specialized overdose prevention strategies needed for women," Vancouver Coastal Health Research Institute, January 13, 2019. Available at www.vchri.ca/stories/articles/2019/01/13/specialized-overdose-prevention-strategies-needed-women. G. Kolla, R. Penn, and C. Long, supra note 239.

255 For a more detailed discussion of the history of SCS and OPS, see Canadian HIV/AIDS Legal Network, supra note 93.

256 J. Boyd et al., supra note 207.

257 See G. Kolla, Z. Dodd, N. Boyce, et al., "Role of overdose prevention sites in the broader response to drug-related harms? Insights from the Toronto Overdose Prevention Site," Abstract, CAHR Conference, April 26-29, 2018. See also G. Kolla et al., supra note 41.

258 R. McNeil, W. Small, H. Lampkin, et al., supra note 40.

259 Ibid.

260 N. Fairbairn et al., supra note 37, citing N. Wright, C. N. Tompkins, L. Sheard, "Is peer injecting a form of intimate partner abuse? A qualitative study of the experiences of women drug users," *Health & Social Care in the Community* 2007, 15:417-425; C. Tompkins et al., "Exchange, deceit, risk, harm: the consequences for women of receiving injections from other drug users" *Drugs, education, prevention and policy* 2006, 13:281-297. See also, K. Shannon et al., "Social and structural violence and power relations in mitigating HIV risk of drug using women in survival sex work," *Social Science & Medicine* 2008;66(4):911–21.

261 R. McNeil, W. Small, H. Lampkin, et al., supra note 40.

262 Ibid.

263 BC Centre for Disease Control, supra note 252.

264 See, www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html#app (consulted on March 28, 2020).

265 V. Bungay et al., supra note 74.

266 At the time of writing, AIDS Saskatoon had been given an exemption to provide this service but was not yet operating.

267 Canadian Association of People who Use Drugs (CAPUD), *Safe supply: Concept document,* February 2019. See also, N. Rai, A. Sereda, J. Hales, and G. Kolla, "Urgent call on clinicians: Prescribe alternatives to poisoned drug supply," *HealthyDebate,* June 19, 2019. Available at https://healthydebate.ca/opinions/safer-supply-opioids.

268 N. Rai, A. Sereda, J. Hales, and G. Kolla, ibid.

269 See, for example, D. Izenberg and S. Marwaha, "Safe supply: The debate around prescribing opioids to people who use drugs," *Healthy Debate,* August 15, 2019. Available at https://healthydebate.ca/2019/08/topic/safe-supply. J. Bieman, "London doctor prescribing opioids to users in bold drug-crisis response," *The London Free Press,* June 20, 2019. T. Lupick, S. Fenn, G. Katic, and A. Kim, "Legal Heroin: As the fentanyl crisis continues, one Vancouver doctor moves people out of the alleys and into a clinic," The Georgia Straight, March 11, 2017. Available at www.straight.com/news/878356/fentanyl-crisis-continues-one-vancouver-doctor-moves-people-out-alleys-and-clinic. A. Woo, "Biometric opioid dispensing machine first of its kind to address demand for safer drug supply," *Globe and Mail,* January 17, 2020. Available at www.theglobeandmail.com/canada/british-columbia/article-biometric-opioid-dispensing-machine-first-of-its-kind-to-address/.

270 CAPUD, supra note 267.

271 G. Kolla, Z. Dodd, J. Ko, N. Boyce, S. Ovens, "Canada's overdose crisis: authorities are not acting fast enough," *The Lancet Public Health* (2019) Mar 25;4(4):e180.

272 T. M. Watson et al., supra note 94.

273 Ministry of Health and Long-Term Care, *Consumption and Treatment Services: Application guide,* October 2018.

274 "'Unacceptable': Toronto board of health chair slams province for supervised injection site cuts," *CBC News,* March 29, 2019.

275 G. Kolla, R. Penn, and C. Long, supra note 239.

276 Ibid.

277 See, www.streethealth.ca/services/overdose-prevention-site-ops.

278 In Canada, the administration of adult correctional services is a shared responsibility, with provincial/territorial governments having jurisdiction over people serving sentences of less than two years, and the federal government, represented by the Correctional Service of Canada, administering sentences of two years or more. There are approximately 25,000 people incarcerated in provincial/territorial institutions, and another roughly 14,000 people incarcerated in 43 federal prisons across the country, including four "healing lodges" that offer Indigenous-specific services and programming (Statistics Canada, 2019). Six of the federal prisons are exclusively for women. Since January 2018, CSC adopted an "Interim Policy Bulletin 584 Bill C-16 (Gender Identity or Expression)," which, among other things, places an individual in a men's or women's institution according to their gender identity, if it is their preference, regardless of their anatomy or gender on their identification documents, unless there are overriding health or safety concerns that cannot be resolved, requires CSC staff to use individuals' preferred name and pronoun in oral interaction and written documentation. CSC's Interim Policy Bulletin on Gender Identity or Expression is available here www.csc-scc.gc.ca/acts-and-regulations/584-pb-en.shtml.

279 The federally incarcerated female population grew from 533 in 2009 to 705 in 2019. See Office of the Correctional Investigator, *Annual Report of the Correctional Investigator 2018-2018,* 2019 and Office of the Correctional Investigator, *Annual Report of the Correctional Investigator 2017-2018,* 2018.

280 Ibid and Office of the Correctional Investigator of Canada, "Indigenous People in Federal Custody Surpasses 30%: Correctional Investigator Issues Statement and Challenge," news release, January 21, 2020.

281 See Office of the Correctional Investigator, *Annual report of the Office of the Correctional Investigator, 2018-2019,* 2019, and S. Farrell MacDonald et al., *Women offenders, substance use, and behaviour* (Research Report R-358). Ottawa, Ontario: Correctional Service of Canada.

282 Office of the Correctional Investigator, ibid at p. 106.

283 Ibid at p. 15.

284 L. Motiuk and B. Vuong, "Re-profiling the drug offender population in Canadian federal corrections," *Forum on Corrections Research,* (2006)18:1, 24-29.

285 D. Zakaria et al., *Summary of emerging findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey.* Research Report R-211, 2010. Ottawa, ON: Correctional Service of Canada.

286 D. Derkzen et al., "Mental health needs of federal female offenders," *Psychological Services* (2013) 10(1): 24-36.

287 M. R. Barrett, K. Allenby, and K. Taylor, *Twenty years later: Revisiting the Task Force on Federally Sentenced Women.* Research Report R-222, 2010. Ottawa, ON: Correctional Service of Canada.

288 S. Boyd and K. Faith, "Women, illegal drugs and prison: Views from Canada," *International Journal of Drug Policy* (1999) 10, 195-207, and G. Eljdupovic and R. Bromwich (eds.), *Incarcerated mothers: Oppression and resistance* (Toronto, ON: Demeter Press, 2010).

289 G. Eljdupovic and R. Bromwich, ibid, and Office of the Correctional Investigator, *Annual report of the Office of the Correctional Investigator, 2013-2014,* 2014. See also V. Michalsen, J. Flavin, and T. Krupat, "More than visiting hours: Maintaining ties between incarcerated mothers and their children," *Sociology Compass* (2010)4, 576-591.

290 Office of the Correctional Investigator, supra note 289.

291 E. van der Meulen et al., "A Legacy of Harm: Punitive Drug Policies and Women's Carceral Experiences in Canada," *Women & Criminal Justice* (2018) 28:2, 81-99. DOI: 10.1080/08974454.2017.1307160.

292 A. M. DiCenso, G. Dias, and J. Gahagan, *Unlocking our futures: A national study on women, prisons, HIV, and hepatitis C,* Prisoners with HIV/AIDS Support Action Network, 2003. Available at www.drugsandalcohol.ie/5394/1/PASAN_Unlocking_Our_Futures.pdf. See also L. Rehman, J. Gahagan, A. M. DiCenso, and G. Dias, "Harm reduction and women in the Canadian national prison system: Policy or practice?" *Women & Health* (2004) 40(4), 57-73.

293 D. Zakaria et al., supra note 285, and F. Kouyoumdjian et al., "Health status of prisoners in Canada: Narrative review," *Canadian Family Physician* (2016) 62:3, pp. 215-222.

294 Office of the Correctional Investigator of Canada, supra note 289.

295 F. Kouyoumdjian et al., supra note 293.

296 D. Zakaria et al., supra note 285.

297 See, for example, M. Tyndall et al., supra note 113; H. Hagan, supra note 113.

298 D. Zakaria et al., supra note 285.

299 A. M. DiCenso, G. Dias, and J. Gahagan, supra note 292; L. Rehman, J. Gahagan, A. M. DiCenso, and G. Dias, supra note 292.

300 World Health Organization, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users, Evidence for Action Technical Papers,* 2004. See also Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons?,* October 2004; R. Carlson et al., "A preliminary evaluation of a modified needle-cleaning intervention using bleach among injection drug users," *AIDS Education and Prevention* (1998) 10,6: 523–532.

301 E. van der Meulen et al., *On point: Recommendations for prison-based needle and syringe programs in Canada,* 2016, and D. Zakaria et al., supra note 285.

302 Canadian Human Rights Commission, *Protecting their rights: A systemic review of human rights in correctional services for federally sentenced women,* 2003.

303 See Canadian HIV/AIDS Legal Network, *The Correctional Service of Canada's Prison Needle Exchange Program: Policy Brief,* 2019. Available at www.aidslaw.ca/site/prison-based-needle-and-syringe-programs/?lang=en.

304 Office of the Correctional Investigator, supra note 281 at pp. 15-17.

305 Ibid at p.18.

306 World Health Organization, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence,* 2009. Available at https://apps.who.int/iris/bitstream/handle/10665/43948/9789241547543_eng.pdf?sequence=1.

307 See, for example, West Coast Prison Justice Society, "Representative human rights complaint against Correctional Service Canada (CSC) on behalf of federal prisoners with opioid use disorder," June 4, 2018, and F. Kouyoumdjian et al., "Physician prescribing of opioid agonist treatments in provincial correctional facilities in Ontario, Canada: A survey," *PLoS One.* 2018; 13(2): e0192431.

308 G. Dias and G. Betteridge, *Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada,* Canadian HIV/AIDS Legal Network and PASAN, 2007.

309 Correctional Service Canada, *Specific Guidelines for the Treatment of Opiate Dependence (Methadone/Suboxone®),* September 2016.

310 J. Thompson, D. Zakaria, and B. Grant, *Summary of the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey for Women,* Correctional Service Canada, 2011.

311 Correctional Service Canada, *Commissioner's Directive 800 Health Services,* 2015, s. 10(b).

312 Canadian HIV/AIDS Legal Network, *"Vectors, vessels and victims": HIV/AIDS and women's human rights in Canada,* 2005.

313 D. Kunic and D. D. Varis, *The Aboriginal Offender Substance Abuse Program (AOSAP): Examining the effects of successful completion on post-release outcomes,* Correctional Service of Canada, 2009.

314 M. Wesley, *Marginalized: The Aboriginal women's experience in federal corrections.* (Ottawa, ON: Aboriginal Corrections Policy Unit, Public Safety Canada, 2012).

315 Office of the Correctional Investigator, supra note 281 at p. 67.

316 F. I. Matheson, S. Doherty, and B. A. Grant, *Women Offender Substance Abuse Programming & Community Reintegration,* Correctional Service Canada, 2008.

317 M. R. Barrett, K. Allenby, and K. Taylor, supra note 287.

318 Government of Canada, "Harper government highlights Royal Assent of the Drug-Free Prisons Act," news release, Ottawa, June 18, 2015.

319 *Drug-Free Prisons Act,* S.C. 2015, c. 30.

320 See, for example, "Response to the 45th Annual Report of the Correctional Investigator 2017-2018," Correctional Service of Canada. Available at www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20172018-eng.aspx#s14. See also Correctional Services Canada, *Annual Report On Deaths In Custody 2015-2016,* 2017. Available at www.csc-scc.gc.ca/research/005008-3010-en.shtml#toc22.

321 L. McKendy, S. Biro, and L. A. Keown, *Overdose Incidents in Federal Custody, 2012/2013 – 2016/2017,* Correctional Service of Canada, 2018. Available at www.csc-scc.gc.ca/research/092/sr-18-02-en.pdf.

322 See, for example, D. Taekema, "Female inmate dead after 2 suspected opioid overdoses at Barton Jail in 12 hours," *CBC News,* April 12, 2019. Available at www.cbc.ca/news/canada/hamilton/female-inmate-dead-after-2-suspected-opioid-overdoses-at-barton-jail-in-12-hours-1.5095997. See also D. Taekema, "5 female inmates suffer suspected drug overdoses at Barton jail in just 5 days," *CBC News,* May 21, 2019. Available at www.cbc.ca/news/canada/hamilton/barton-jail-suspected-overdose-female-inmates-1.5143038.

323 Government of Canada, *Frequently Asked Questions: Access to naloxone in Canada (including NARCAN™ Nasal Spray),* June 30, 2017. Available at www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/announcements/narcan-nasal-spray-frequently-asked-questions.htm.

324 A. Heydari, "Supervised consumption site in federal prison will be 1st in Canada, says union," June 9, 2019, *CBC News,* www.cbc.ca/news/canada/calgary/supervised-consumption-site-drumheller-institution-1.5168155.

325 Canadian HIV/AIDS Legal Network, "Statement: Proposed supervised injection site in Alberta's Drumheller Institution cannot replace a prison-based needle and syringe program," June 12, 2019. Available at www.aidslaw.ca/site/statement-proposed-supervised-injection-site-in-albertas-drumheller-institution-cannot-replace-a-prison-based-needle-and-syringe-program/?lang=en.

326 Canadian HIV/AIDS Legal Network, ibid.

327 See, for example, British Columbia Coroners Service, *BC Coroners Service Death Review Panel: A Review Of Illicit Drug Overdoses, Report To The Chief Coroner Of British Columbia,* April 2018. Available at www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/bccs_illicit_drug_overdose_drp_report.pdf. See also E. Groot, F. Kouyoumdjian, L. Kiefer, et al., "Drug Toxicity Deaths after Release from Incarceration in Ontario, 2006-2013: Review of Coroner's Cases," *PLoS ONE* (2016)11(7): e0157512. doi:10.1371/journal.pone.0157512.

328 J. Boyd et al., supra note 207, and Vancouver Coastal Health Research Institute, supra note 254.

329 M. Shokoohia et al., supra note 20.

330 T. Azima, I. Bontella, and S. Strathdee, supra note 65, and M. Shokoohia et al., ibid.

331 N. Poole et al., supra note 54.

332 Canadian Aboriginal AIDS Network and the Interagency Coalition on AIDS and Development, supra note 18.

333 National Inquiry into Missing and Murdered Indigenous Women and Girls, supra note 48 at p. 441.

334 The Global Network of Sex Work Projects and the International Network of People who Use Drugs, supra note 122.

335 K. Malinowska-Sempruch and O. Rychkova, *The impact of drug policy on women,* Open Society Foundations, 2015.

336 UNGASS, supra note 78.

337 UN Committee on the Elimination of Discrimination against Women, Concluding observations on the combined on the combined eighth and ninth periodic reports of Canada, CEDAW/C/CAN/CO/8-9, November 18, 2016, paras. 44-45.

338 UN Committee on the Elimination of Discrimination against Women, ibid. See also 2015 Truth and Reconciliation Commission of Canada calls to Canada to "close the gaps in health outcomes between Aboriginal and non-Aboriginal communities," to eliminate the "overrepresentation of Aboriginal people in custody over the next decade," and to "amend the *Criminal Code* to allow trial judges, upon giving reasons, to depart from mandatory minimum sentences and restrictions on the use of conditional sentences."

339 See, for example, UN General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/65/255, August 6, 2010; Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, Submission to the Committee against Torture regarding drug control laws, October 19, 2012; Open letter by the Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health, Dainius Pūras, in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which will take place in New York in April 2016, to UNODC Executive Director Yury Fedotov, December 7, 2015.

340 UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, UN General Assembly, UN doc. A/HRC/22/53, February 1, 2013.

341 UN Chief Executives Board for Coordination, Segment 2: common United Nations system position on drug policy, UN Doc. CEB/2018/2, January 18, 2019.

342 International Centre on Human Rights and Drug Policy, UNAIDS, UNDP, WHO, *International Guidelines on Human Rights and Drug Policy,* March 2019.

343 See Rules 10, 12, and 15 of the *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules),* A/RES/65/229, March 16, 2011.

344 Canadian HIV/AIDS Legal Network, "Canada must adopt a human-rights based approach to drug policy," Statement, November, 22, 2018. The statement was endorsed by Amnesty International Canada, Canadian Aboriginal AIDS Network, Canadian Association of People Who Use Drugs, Canadian Drug Policy Coalition Canadian Nurses Association, Canadian Public Health Association, Criminal Lawyers' Association, HIV & AIDS Legal Clinic Ontario (HALCO), Moms Stop The Harm, moms united and mandated to saving the lives of Drug Users (mumsDU), and Pivot Legal Society.

345 Canadian Public Health Association, *Decriminalization of personal use of psychoactive substances,* November 2017.

346 Canadian Mental Health Association, *Care not Corrections: Relieving the Opioid Crisis in Canada,* April 2018.

347 Canadian HIV/AIDS Legal Network, supra note 344.

348 N. Thompson, "Toronto board of health to urge federal government to decriminalize drug use," *The Globe and Mail,* July 16, 2018.

349 E. Mathieu, "Chief medical officer calls for decriminalization of all drugs for personal use," *The Toronto Star,* July 9, 2018. Available at www.thestar.com/news/gta/2018/07/09/chief-medical-officer-calls-for-decriminalization-of-all-drugs-for-personal-use.html.

350 Direction régionale de santé publique de Montréal, « Décriminalisation des drogues pour usage personnel, » news release, July 27, 2018.

351 Winnipeg Regional Health Authority, *Position statement on harm reduction,* December 2016.

352 BC Office of the Provincial Health Officer, *Stopping the Harm: Decriminalization of people who use drugs in BC,* April 2019.

353 C. Bains, "B.C. doctor [Medical Health Officer of Vancouver Coastal Health] calls for illicit drug regulation to save lives," Canadian Press, July 26, 2019; CAPUD, supra note 267; BC Centre for Disease Control, *2018 BC Overdose Action Exchange,* October 2018.

354 Canadian HIV/AIDS Legal Network, supra note 93.

355 See, for example, BC Centre for Disease Control, supra note 353.

356 See Canadian Alliance for Sex Work Law Reform, *Safety, Dignity, Equality: Recommendations for Sex Work Law Reform in Canada,* 2017.

357 *Surviving abuse and building resilience—a study of Canada's systems of shelters and transition houses serving women and children affected by violence: Report of the Standing Committee on the Status of Women,* supra note 193.

358 West Coast LEAF, supra note 151.

359 International Network of People who Use Drugs, *Drug User Peace Initiative: A War on Women Who Use Drugs,* 2014.

360 E. van der Meulen et al., supra note 291.

361 International Drug Policy Consortium, *The Barcelona Declaration,* 2019. Available at https://idpc.net/alerts/2019/04/the-barcelona-declaration.

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