I. SUMMARY

This submission concerns the systematic human rights abuses and widespread discrimination against women who use drugs in Estonia. The country’s drug laws are already among the harshest and most punitive in the world, but in combination with entrenched sexism towards women and a broader stigma against drug use, they have allowed for marginalization and mistreatment of women who use drugs by virtually every State institution, including law enforcement, medical professionals, and child protection services. This submission provides detailed documentation and analysis of what women who use drugs endure in Estonia; how their treatment conflicts with both international human rights and constitutional obligations; and recommendations for the Estonian Government to rectify and remedy these abuses.

II. INTRODUCTION

Estonia’s systematic mistreatment of women who use drugs violates international and regional human rights obligations. The country is well integrated into both international and European human rights systems: Only one month after independence on 20 August 1991, it signed 28 treaties and agreements, most of which it ratified or acceded to within months. Among the treaties to which it is bound are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention Against Torture (CAT), the Convention on the Rights of the Child (CRC), the European Convention on Human Rights (ECHR), the European Social Charter (ESC), and the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention).

Estonia’s discrimination and mistreatment of women also violates the country’s constitutional obligations. The Estonian Constitution enshrines equality before the law for all citizens,

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1 CEDAW, Estonian Women’s Roundtable—www.enu.ee/enu.php?keel=1&id=624; the timing suggests that Estonians viewed these global bodies and agreements as a means of integrating into the international community from which they were isolated during the Soviet era.

2 Formally the Convention for the Protection of Human Rights and Fundamental Freedoms

prohibiting discrimination on the basis of sex, race, nationality, and other grounds, and recognizes that “everyone is entitled to protection of his health,” including citizens of foreign states and stateless persons in Estonia, unless otherwise provided by law. The right to health provision also requires that “the national government facilitates voluntary provision of welfare services and provision of welfare services by local authorities.” The Estonian Constitution also holds that treaty provisions supersede laws that conflict with a treaty ratified by the Estonian legislature, the Riigikogu, obligations that are undermined by the country’s discriminatory drug policy. It also establishes the Chancellor of Justice, an independent body tasked with examining issues related to women’s rights and gender equality, with the authority to challenge legislative or executive actions that infringe on the constitution.

To meet its international, regional, and constitutional obligations, Estonia has enacted several laws and policies, such as the Gender Equality Act, the Victim’s Support Act, and the Equal Treatment Act. It has also established several departments and initiatives within its Ministry of Social Affairs responsible for advancing these policies and monitoring compliance; these include the Gender Equality Department, the Gender Equality Council, the Victim Support Department, the Gender Equality and Equal Treatment Commission, and the Equality Policies Department. Most recently, Estonia established a “Welfare Development Plan 2016-2023” that makes equality and nondiscrimination an official government priority.

However, despite these constitutional and international commitments to human rights, Estonia has critical gaps in the realization of women’s rights. The Committee on the Elimination of Discrimination Against Women (CEDAW Committee) expressed concern that because the Equality Commissioner and the Ministry of Social Affairs have expanded their mandates to address all forms of discrimination without corresponding funding increases, their attention to gender equality is diluted, including in matters of health. A recent report by the Commissioner for Human Rights of the Council of Europe acknowledged Estonia’s efforts to promote gender equality while nonetheless highlighting the mixed results and continued challenges. The report noted that Estonia ranked 20th out of the European Union’s 28 member states in the 2017 Gender Equality Index; that 70% of Estonian respondents to an E.U. survey agreed with the statement “the most important role of a woman is to take care of her home and the family” (against an E.U. average of 44%); and that sexist political speech is common.

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4 CEDAW, Art. 12
6 Id.
7 Id. at Ch. IX, Art. 123.
8 Id. at Ch. XII.
Moreover, Estonia has not dedicated sufficient attention or resources to the right to health and other social rights. An analysis of the Estonian Constitution, conducted in 2002 under the purview of the Ministry of Justice, offered no guidelines on the scope of these rights. In considering the second periodic report of Estonia on the implementation of the ICESCR, the Committee on Economic, Social and Cultural Rights (CESCR) concluded that individuals “are unable to claim violations of their economic, social and cultural rights” and that the Equal Treatment Act does not prohibit discrimination on all grounds with respect to all economic, social and cultural rights. It urged that legal professionals and judges should be trained “on the scope of economic, social and cultural rights” and how to fulfill them on a domestic level. Estonia was called to take legislative action to rectify these shortcomings, and to provide in its next periodic report information about court cases and complaints related to discrimination and the subsequent responses.

Current Estonian policies discriminate against women with drug dependence in a myriad of systematic ways that largely go unnoticed or unchallenged. This analysis focuses on key violations perpetrated by Estonian authorities across multiple agencies: discrimination against women with drug dependence and women with HIV/AIDS; denial of crucial medical care to women who use drugs and/or have HIV/AIDS (including lack of access to drug and HIV treatment therapies); forced and arbitrary drug testing and detention; disclosure of private medical records; the deliberate tearing apart of families, including separating children from their mothers; and the condemnation of women to a life of violence and fear. As this submission, outlines, Estonia has failed in its obligations to safeguard the fundamental rights of women who use drugs, including the rights to equality, health, liberty and security of person, privacy, family, and freedom from gender-based violence.

It is hoped that this submission will reveal gaps Estonian authorities must address if they wish live up to the global and domestic human rights commitments they affirm on the world stage.

This submission was prepared by the Estonian Association of People Who Use Psychotropic Substances (LUNEST), the Eurasian Harm Reduction Association (EHRA), the Canadian HIV/AIDS Legal Network (CHALN), and the Human Rights Clinic of the University of Miami School of Law (HRC). The submission draws on interviews with women who use drugs as well as analyses by various human rights bodies. Utilizing a methodology developed by EHRA and CHALN, 38 in-depth interviews took place during a research mission in August 2017: 29 in Ida-Viru and nine in Tallinn. All interviewees were female, aged 26–46, and were either Estonian citizens or legal permanent residents. Thirty-three of the respondents had Russian as their first language, and six were Estonian native speakers. Twenty interviews were transcribed.

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14 Id.
15 Id. at para. 8.
16 Please see Appendix I for a description of these organizations.
and analyzed through thematic content analysis. Interviews of women who use drugs were further complemented with interviews with advocates.

III. STATEMENT OF FACTS

There are three State agencies that have significant power over women who use drugs and make up the main perpetrators or facilitators of abuse against them:

- Police (Eesti Politsei)
- Child protection services (Lastekaitse)
- Medical doctors and public health authorities

Violations include:

- Restriction or deprivation of parental rights based on drug use or drug dependence, including separating children at birth and forcing mothers to sign away parental rights.\(^\text{17}\)
- Child protection services conducting invasive and warrantless searches—without procedural rules—of the homes of women who use drugs, often disclosing confidential information such as their HIV status and/or other health conditions, such as drug use.\(^\text{18}\)
- Women who use drugs being forced to stop taking medically prescribed methadone or participating on opioid substitution therapy (OST) under the threat of termination of their parental rights.\(^\text{19}\)
- To regain custody of their children, women must undergo an abstinence-based rehabilitation center for 12 months, immediately find a job—often in areas with high unemployment—and equip their apartments to an ambiguous “high standard.”\(^\text{20}\)
- Police working in collaboration with child protection services to extract confessions from women who use drugs by threatening to separate them from their children.\(^\text{21}\)
- Police officers conducting forced drug testing on women they merely suspect of using drugs, either on the street or by taking them into custody; if the women refuse, the tests are conducted via urinary catheter, a painful and medically unnecessary procedure that carries health risks.\(^\text{22}\)


\(^\text{18}\) Id.

\(^\text{19}\) Id. at pp. 6-7.

\(^\text{20}\) Id. at 7.

\(^\text{21}\) Id. at 8.

\(^\text{22}\) Id. at pp. 8-9
• When women call the police in situations of aggressive behavior by their male partners, the police often inform child protection services, which may result in the loss of custody of the child. The police may also prosecute a woman for a drug offense, instead of protecting her from GBV.23

• Women being made to endure obstacles accessing HIV testing, and/or being denied access to drug dependence treatment, antiretroviral therapy (ART), and/or Hepatitis C treatment.24

• Private medical records that reveal drug use or HIV status are disclosed without consent to loved ones and employers, leading to further ostracization and even job termination.25

• Women who use drugs and who have children lack sufficient social support, including rehabilitation services structured around their motherhood status; insufficient mental health care; and very limited legal and financial support.26

In addition to directly harming women who use drugs, these violations cumulatively deter such women from seeking medical assistance or reporting abuses from intimate partners or police, forcing them to suffer in silence.

IV. STATEMENT OF LAW

Estonia’s treatment of women who use drugs violates numerous international human rights conventions, including:

• ICCPR—Articles 2, 7, 17, and 26.
• ICESCR—Articles 2, 3, 6, 10, 11, and 12.
• CEDAW—Articles 1, 2, 5, and 12.
• CRC—Articles 2, 9, and 37.
• CAT—Article 2.

A. Estonia Discriminates Against and Denies Equal Treatment to Women with Drug Dependence and Women Living with HIV/AIDS

Estonia’s current policies discriminate against women with drug dependence based on both gender and HIV status. The stigma against women who use drugs leaves them especially vulnerable to criminal persecutions for drug crimes. In terms of drug laws and drug enforcement, Estonia is more repressive than Russia.27 Illegal possession with no intent to supply is considered an misdemeanor or a criminal offence, depending on the quantity of illicit substance; possession with the intent to supply or an act of supply is a criminal offense

23 Id. at pp. 9-10
24 Id. at pp. 10-11.
25 Id. at pp. 12-13.
26 Id. at pp. 13-14.
27 Id. at p. 2; Please see Appendix III for a discussion of alternatives to drug criminalization, drawing on comparative examples and international recommendations.
regardless of the type and amount of illicit drug. \textsuperscript{28} Although women are often minor links in the drug supply chain, they suffer a disproportionate burden in the justice system.\textsuperscript{29}

Moreover, it is the de facto criminalization of drugs for personal use that makes them even more vulnerable, depriving them of protection, access to HIV/AIDS treatment, adequate harm reduction measures, and reproductive health services. Further, for women who are also HIV positive, the stigma and mistreatment they must contend with from not only society, but public health officials prevent them from getting the help and services that they need.

1. **Women who use drugs face pervasive stigma and discrimination, impacting many facets of their lives.**

Women who use drugs are subject to entrenched and widespread discrimination that permeates through every aspect of their day to day lives.\textsuperscript{30} Discrimination on the basis of sex is prohibited in virtually all major human rights treaties. Under Article 26 of the ICCPR, all persons are equal before the law and entitled to equal protection.\textsuperscript{31} Further, Article 2(2) of the ICESCR obliges states to guarantee and safeguard the rights therein without discrimination.\textsuperscript{32} Additionally, Article 3 of ICESCR also places a duty on the state to ensure “the equal right of men and women to the enjoyment of all economic, social, and cultural rights. . .”\textsuperscript{33} Similarly, Article 2(1) of the CRC requires that children’s rights be respected and ensured without discrimination of any kind.\textsuperscript{34} This language of equality and fair treatment regardless of sex is also laid out in the Universal Declaration of Human Rights (UDHR), the foundational document of the international human rights system.\textsuperscript{35}

CEDAW institutes wide-ranging protections for women that prohibit gender bias. Article 1 prohibits “any distinction, exclusion or restriction” made on the basis of sex that undermine

\begin{itemize}
\item[30] Please see Appendix IV for a discussion of the experiences of women who use drugs, common violations, and recommendations to address them.
\item[31] International Covenant on Civil and Political Rights (ICCPR), Art. 26, “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,” Dec. 16, 1966.
\item[32] International Covenant on Economic, Social, and Cultural Rights (ICESCR), Art. 2, “The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,” Dec. 16, 1966.
\item[33] ICESCR, Art. 3 “The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant,” Dec. 16, 1966.
\item[34] Convention on the Rights of the Child (CRC), Art. 2(1), “States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status,” Nov. 20, 1989.
\item[35] Universal Declaration of Human Rights (UDHR), Art. 1, “All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.”
\end{itemize}
women’s ability to equally enjoy their human rights and fundamental freedoms. Article 2 obligates states to “condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women . . .” Estonian public authorities violate women’s fundamental equality by denying access to critical health and social services, misuse of police powers, and destruction of families.

The systematic and intense nature of discrimination against women who use drugs flagrantly disregard Estonian law. Gender disparities in accessing medical care violates Article 12 of the Estonian Constitution, which affirms that all citizens are equal before the law and cannot be discriminated against, including on the grounds of sex. The Gender Equality Act (GEA)—adopted in 2004 as the principal act overseeing gender equality—prohibits sex-based discrimination and requires government authorities to actively promote gender equality in all areas of life, including healthcare. The GEA also promulgated the principle of “gender mainstreaming,” which requires that all government policies, activities, and initiatives be oriented to “take into consideration the interests, necessities and opportunities of men and women, and would not place one of the gender groups in a worse position than the other.” Under the GEA, the Estonian government must “understand that inequalities between men and women can be found in almost any area of life” and take into account the gender equality implications of any political decision or proposal. Women are the primary caregivers of children and the existing services do not take this into account or other gender-specific issues such as sexual and reproductive health into consideration. These principles are violated by the gross mistreatment of women who use drugs by public authorities and the lack of treatment services to meet the unique needs of women with drug dependency.

There is a harsh stigma against women who use drugs because drug use conflicts with the notion of the woman as a mother and caretaker. In her report, the Commissioner for Human Rights in Europe noted that while Estonia has made strides in promoting gender equality, it needed to make greater effort to address persistent gender stereotypes and prejudices about the traditional roles of men and women in society. In the CESC Committee’s review of Estonia,

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36 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Art. 1. “For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field,” Dec. 18, 1979.
37 CEDAW, Art. 2(b).
38 Constitution of Estonia, Art. 12, “Everyone is equal before the law. No one may be discriminated against on the basis of nationality, race, colour, sex, language, origin, religion, political or other views, property or social status, on other grounds,” June 28, 1992.
40 Id.
the Committee expressed concern at the persistent social stigma against drug users, particularly among the police, social workers, child protection officers and medical professionals and recommended that Estonia work to combat stigma against drug users, especially women.42 Under CEDAW, the Estonian government must abolish any laws, traditions, and customs that discriminate against women,43 as well as take steps to “modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices,” that are predicated on sexist views.44 Fear and contempt toward drug use compounded by endemic sexism, inequality, and misogyny in the case of women who use drugs, resulting in their experiencing exacerbated human rights violations and threats to health and wellbeing.45 Women are severely stigmatized for their drug use in contrast to men. In Estonia, child protection services consider drug use and drug dependence sufficient reasons for restricting or depriving parental rights, assuming that any substance use puts a child in danger and thus is contrary to the child’s interests, even when a parent takes medically prescribed methadone.46 Mothers are therefore afraid to get help in fear of retaliation and may be forced to choose between their health and their families. Estonia does not care about these mothers because they use drugs, trampling on their rights and destroying their families.47

2. Stigma and discrimination are magnified for women who are HIV positive.

When women who use drugs are also HIV positive, they experience compounded stigma and discrimination. HIV-related stigma is multi-layered, tending to build upon and reinforce negative connotations through the association of HIV and AIDS with already-marginalized behaviors, such as sex work, drug use, and homosexual and transgender sexual practice.48 HIV prevalence in Estonia is one of the highest in Europe (by December 31, 2017 a total of 9492 HIV cases were reported, and the number of newly diagnosed HIV cases attributed to injecting drug use is 41.9 cases per million).49 HIV in Estonia is primarily spread among people who use drugs (50% prevalence in Tallinn and 60% in Ida-Viru county), and women represent 40%

42 CESCR Concluding Observations on Estonia, 27 March 2019, para. 44-45, http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4sIQ6QSmlBFEDzFEovLCuW1SKyyprlxEitT1iPv5t6GoOiIeUbYK%2fAGvhE93KLAxM4z30cuUy4UF06QnIsZDcil3ru4bIJOV1bQqfTumayrWAHmbmL8hR8qa%2fe%2hxB
43 CEDAW, Art. 2(f).
44 Id. at Art. 5(a).
46 The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Sessional Working Group with respect to Estonia, para. 36.
47 Interview with LUNEST (2018).
of new HIV cases as of 2013. Women who are HIV positive know that their status will subject them to discrimination and ill-treatment by public authorities.

When women do seek medical treatment, they are treated like pariahs by doctors and other medical professionals. Under Article 2(1) of the ICCPR, Estonia has a duty to “respect and to ensure to all individuals within its territory . . . the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, . . . or other status.” The Commission on Human Rights (CHR) has confirmed that “other status” in anti-discrimination provisions covers health status, including HIV status. Further, Article 26 of the ICCPR states, “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law.” A woman in Narva stated, “In hospital during labor the doctor that helped me to deliver forced me to put on a mask. It was already hard to breathe, and with this mask . . . They told me to stop panting and put on the mask so I won’t spit my HIV on them.” With treatment like this, HIV positive women would rather suffer the consequences of untreated HIV. One respondent recalls avoiding undertaking measures to prevent mother-to-child transmission to her baby, “I didn’t go to the maternity clinic only because I have a disease [HIV] … they would have thrown me out immediately.” In their review of Estonia, the CESCR Committee expressed concern that stigma of HIV . . . they would have thrown me out immediately.” “In their review of Estonia, the CESCR Committee expressed concern that stigma of both HIV status and drugs prevented many women who use drugs and have HIV from accessing antiretroviral therapy. Due to the mistreatment of women with HIV by Estonian authorities, women are putting their lives and their children’s lives at risk to avoid the pain and embarrassment that goes along with seeking treatment.

Women who use drugs suffer from compounded discrimination as both women and drug users. Human rights violations against women who use drugs manifest as a result of a range of interrelated structural, systemic, and sociocultural drivers. The discrimination and stigma that

50 The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Sessional Working Group with respect to Estonia, Para. 21.
51 ICCPR, Art. 2.
53 ICCPR, Art. 26, “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”
55 Id. p.12.
56 CESCR Concluding Observations on Estonia, 27 March 2019, para. 44-45, http://docstore.ohchr.org/Services/XMLFiles/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEsvLCuW1SKyxyprlxEitT1iPv5tsGoOileU5hYK%2fAGvhE93KLAM4z30cuUy55FO6QpnZDci3ru4bJJOV1bQgfTunuyrWAHmbHbL8hI8g%2fe1a%2bbxB
women with drug dependency face results in a number of human rights violations, including denial of critical medical care, arbitrary detention, invasions of privacy, the loss of family, and no recourse from violence.

B. Estonia Systematically Denies Critical Medical Care to Women Who Use Drugs and Have HIV/AIDS

Women who use drugs and have HIV/AIDS face significant challenges accessing a broad set of healthcare services including HIV treatment, care, and support, as well as harm reduction services. These women victimized by an unforgiving and punitive drug policy that discourages them from pursuing state-administered harm reduction programs. As noted in the previous section, this harsh policy is underpinned by a pervasive social stigma towards people who use drugs—even among medical professionals—which intersects with sexist attitudes that regard drug-dependent women as an affront to traditional feminine sensibilities and values. The toxic brew of entrenched social stigma, institutionalized sexism, and political neglect manifests in OST programs, HIV testing, and ART remaining out of reach to those most in need. The CESCR Committee observed that many HIV-positive people do not seek the treatment available for fear of stigma and the public disclosure of confidential medical information, which will be elaborated upon in a later section.

Women who use drugs are forced to fend for themselves by a system that regards them as unworthy of rights. In one particularly distressing case, a woman found to be at risk of suicide was nonetheless rejected by a psychiatry clinic because of her drug use; to be admitted, she would have to quit doing drugs, which clinic personnel callously stated would be unlikely before she committed suicide. Such as the contempt for women who use drugs even by medical professionals.

The failure to ensure equal access to medical facilities, whether for physical or mental health, violates the right to health set forth in several international and regional human rights treaties. CEDAW requires that women enjoy equality with men under the law in all respects (Article 2), including equal access to health care services (Article 12). As a party to the ICESCR, Estonia recognizes the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Article 12), yet this is undercut by how few women are allowed the opportunity to enjoy this right. Under the ESC, state parties must observe the right to protection of health—such as by working with public and private stakeholders to address diseases and other causes of ill health (Article 11)—and must recognize the right to social and medical assistance, which obligates that governments assist underserved individuals in

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59 CESCR Concluding Observations on Estonia, 27 March 2019, para. 46. http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEov1LCuW1SKyxyprlxEitT1iPy5tGoO1leUhYK%2fJAgshE9hLM4z30eauUy4UFO6QpIzZDclJryq4bJJOV1bQqfTumayrW4Hmbm4.8b8kga%2fela%2FhbsB
accessing medical assistance without social, political, or economic consequences (Article 13). In 2005, the U.N. Commission on Narcotic Drugs passed a resolution formally recognizing the “adverse impact of drug use on women’s health, including the effects of fetal exposure” and urged member states to implement “broad-based prevention and treatment programs for young girls and women” and to “consider giving priority to the provision of treatment for pregnant women who use illicit drugs.” In violation of the foregoing provisions, Estonia fails to ensure that women who use drugs have special health services for drug-dependency, HIV/AIDS, and gender-based violence. In short, women’s right to enjoy the highest attainable standard of health is a casualty of its war on drugs.

1. Vital Opioid Substitution Therapy is Woefully Inadequate, Inaccessible, and Impractical

Despite OST’s proven effectiveness in mitigating opioid dependence, OST is largely out of reach to those who need it most, and the options that are available are either insufficient or impose a burden on participants: Of all existing options for OST, only methadone is available for free, while buprenorphine is offered only at one center in Tallinn and only for money.

Consequently, OST coverage in Estonia is less than 20 percent, meaning most women who use drugs are denied their fundamental right to health. This widespread inadequacy and inaccessibility stems from neglect and discrimination by State and medical authorities and an OST programmatic framework that is ill-suited and indifferent to women’s needs.

Estonian authorities are directly complicit in depriving women of their right to medical treatment for their dependence. The low access to OST—despite being technically available, even to pregnant women—is largely a consequence of doctors and child protection services consciously withholding information about OST programs. As articulated in greater detail in later sections, an additional barrier is erected by child protection services, which essentially force women to choose between seeking treatment and keeping custody of their children. Estonia is obligated by Article 28 of its constitution to facilitate access to welfare services, which should include mandating medical professional not to deprive women of the opportunity to access treatments like OST. The government should also bear in mind its obligations under

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61 UN Commission on Narcotic Drugs, Women and substance use”, Res. 48/6, 48th session, March 2005.
62 This issue is not unique to Estonia; women make up approximately one third of people who use drugs—NGO Reporting Guidelines on CEDAW & Rights of Women Who Use Drugs, IWRAW Asia Pacific at 4.
64 International Human Rights Day, 10 December 2015: a call to end violence against women who use drugs
68 Id.
Article 12 of CEDAW, Article 12 of the ICESCR, and Article 11 of the ESC, each of which require Estonia to safeguard and promote the right to health of citizen and residents.

The quality of OST is abysmal because it often fails to accommodate the special needs of women with children. Most drug treatment programs are organized so that only two options are available: either 12 months at an in-patient rehabilitation center or daily attendance at an OST clinic for at least six months (if patients are found clean after that, the number of visits is reduced to every two days or just twice a week). Neither choice is viable for women already balancing child rearing with gainful employment. (The consequences regarding the right to family and the rights of children is discussed in Section E.) Flexible take-home options are severely restricted regardless of how far or inconvenient daily attendance would be. By failing to take into account the needs of women who are still disproportionately responsible for raising children, Estonia is violating Article 2(f) of CEDAW to “take all appropriate measures” to modify or abolish laws, regulations, customs and practices that discriminate against women.

2. The Right to Health of Women Who Use Drugs is Undermined by Barriers to HIV Testing, Antiretroviral Therapy, and Critical Medical Care

Estonia condemns women who use drugs to a lifetime of needless suffering by failing to promote, safeguard, and provide crucial services for sexual and reproductive health. CEDAW General Recommendation No. 24 elaborates on the Article 12 right to health by urging that “special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups” and that “issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health.” Systematic failure to provide ART access is a clear violation of CEDAW, especially since many women in need of such services are low income and thus constitute a vulnerable and disadvantaged group warranting special attention.

Estonia displays a flagrant disregard for the health of women who use drugs. Research by the WHO has found that people who use drugs generally have low access to HIV testing and ART.70 The ESC obligates Estonia to protect the health of its people (Article 11) and to ensure the right to social and medical assistance (Article 13). As a party to CEDAW, it must ensure parity between men and women in the provision of health care services. The lack of access to HIV testing and ART among women who use drugs, many of whom are low income, warrants assistance by the government. In contravention of both treaty obligations and HIV treatment

69 European Commission. Eurobarometer Gender Equality Survey 2017, finding that 70% of Estonian respondents agreed with the statement, “The most important role of a woman is to take care of her home and the family”, www.ec.europa.eu/commfrontoffice/publicopinion/index.cfm/Survey/getSurveyDetail/instruments/SPECIAL/surveyKy/2154.

guidelines, many women who use drugs endure delays in HIV treatment that often leads to worsening health conditions, lower treatment efficiency, and a higher risk of HIV transmission to their partners.  

Therefore, women in Estonia must contend with the dual agonies wrought by HIV/AIDS and drug dependence, despite remedies that should be available by Estonian law and policy.

Women who are HIV positive and/or drug dependent are denied admission to hospital or treated improperly because of their status, jeopardizing their health and the health of their children and other dependents. Documented examples include being turned away despite acknowledged health problems; segregation into special wards for HIV-positive women; and general disinterest and neglect by health professionals toward women who use drugs. One woman explains why she was unable to prevent mother-to-child HIV transmission [PMTCT] to her baby:  

I didn’t go to the maternity clinic only because I have a disease [HIV]... My mother worked in a hospital at that time. Once they’ve learned that I had hepatitis, they submit me to all the tests. Had they learned that I had HIV, they would have thrown me out immediately. This happens very fast here. They would find any pretext. That’s why I did not want to go [to have PMTCT].

Another woman with HIV recounts her experience at a psychiatric hospital, where she was admitted following a suicide attempt related to her struggle with drugs. After only one or two days, she was allowed to leave without ever seeing a psychiatrist. On top of this callous disregard for her health and safety, the woman was told by a doctor that her prior miscarriage was the result of HIV eating her baby, illustrating the indignity and disrespect that is casually heaped upon women with HIV. These violations not only shock the conscience, but defy modern medical knowledge, professional ethics, and multiple human rights obligations. These women endure layers of physical and emotional pain while already battling HIV or drug dependence. Estonian clinics and hospitals should not be rejecting the neediest patients based on their health status.

C. Women Endure the Humiliation and Violations of Forced Drug Testing and Arbitrary Detention

Similar to medical professionals, law enforcement exhibits pervasive prejudice towards women who use drugs, further violating their rights. This manifests in various degrading and painful practices that effectively criminalize the very existence of women who use drugs, consequently

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71 The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Sessional Working Group with respect to Estonia, para. 49.
73 Id. at p. 11.
74 Id.
75 Id. at 12.
preventing them from seeking state medical or welfare services. The government thereby violates the right to health per Article 12 of ICESCR, which includes the right to be free from interference such as torture or medical experimentation, the rights to social and medical assistance and to social welfare under the ESC, and its constitutionally-mandated duty to facilitate access to medical care.

Estonian law enforcement is not only derelict in their duty to protect and serve women who use drugs, but directly violate their rights by abusing their legal authority. Police are known to stop women they believe are drug dependent and force them to undergo a saliva drug test on the spot. Those who refuse are taken to a police station and forced to pass the urine test; if they refuse police may force women to have a urinary drug test through a urinary catheter, a procedure regulated by Government Decree. One woman recalls police pulling up to her in a car, asking her for documents, and demanding her to take a drug test, all on the sole basis that she had a “reputation of an addict.” Knowing that she would be taken to the police station if she refused, she complied with the demands; after passing the first drug test, she was made to take a second one. This practice violates prohibitions against torture or cruel, inhuman or degrading treatment enshrined in several human rights treaties, include Article 2 of the CAT, Article 7 of the ICCPR, and Article 3 of the ECHR. It also violates the freedom of movement and the right to liberty and security set forth in Articles 9 and 10 of the ICCPR and Articles 2 and 3 of the ECHR. Moreover, the use of urinary catheters is medically dubious and poses significant risks of infection to the urethra, bladder, and kidney. The government is thus directly violating the right to health set forth under international and domestic law, including the ICESCR, the ESC, and the Estonian Constitution.

The state is so invested in apprehending people who use drugs that authorities will go to disturbing lengths to extort women merely suspected of using drugs into complying with forced drug tests. The following example highlights the many coercive tools used to bludgeon women into submission to state authority:

If I refuse [drug testing], they take away the child by default. In a moment. And later, nobody knows... I understand to what it can lead. It is not a fact that I will get him back, therefore I really say: Yes, I use and am afraid... Yes, I was threatened that the child will be taken away. And I agreed, of course, to test. Yes, I played a fool. And the threat is that if they take me to a drug test lab, then they will use physical force. That is, they will take urine with a catheter.

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76 ESC, Articles 13 and 14.
77 Constitution of Estonia, Article 28.
78 Decree of the Government No 88 of June 19, 2014 “Rules for taking bio samples”.
80 Article 12.
81 Article 11.
82 Article 28.
Threatening to use physical force or to separate a mother from her child is a traumatizing experience that directly undermines mental health—in violation of Article 12 of the ICESCR and Article 11 of ESC—and violates several rights of children, as elaborated in Section E. The CESCR Committee’s Concluding Observations similarly identified this practice as both a human rights violation in itself and a major barrier to the health and wellbeing of women who use drugs and their children.\textsuperscript{83}

If women test positive for drugs, they face punitive consequences that are economically harmful and discourage them from exercising their right to social services.\textsuperscript{84} They must pay a fine plus reimburse the cost of the drug test—a total of more than €100—which is unaffordable for many women who use drugs, who often live below the poverty line. Those who cannot pay the fine are incarcerated, resulting in the \textit{de facto} criminalization of drugs for personal use. To make matters worse, debt collectors in Estonia are permitted to seize all but €140 from all financial accounts of debtors—not only from official salaries, but from pensions and other social benefits. Thus, women unable to pay their hefty fines risk falling into a poverty trap, which forces them to work “underground”—without the protections and benefits of an employment contract—to avoid potentially losing their often-meager income. All this flies in the face of Estonia’s obligation to promote the right to an adequate standard of living per Article 11 of ICESCR and to provide social, legal, and economic protection under Articles 16 and 17 of the ESC.

In addition to directly harming women, these practices lead to a total loss of confidence in state services, thus depriving women of their right to drug and HIV prevention, treatment, care, and effective social reintegration.

\textbf{D. Rampant Disclosure of Medical Records Violates Privacy and Discourages Access to Healthcare While Promoting Social Stigma and Marginalization}

Women live in fear of having their most sensitive medical details disclosed to loved ones and the wider public, making them a target of abuse, marginalization, and even job termination. The disclosure of medical records violates the right to privacy under Article 17 of the ICCPR and under Article 8 of the ECHR, in addition to being yet another deterrence to women seeking their highest available standard of health. Further, ICESCR General Comment No. 14 clarifies that the right to privacy is indelibly tied to the right to health.\textsuperscript{85} Several women reported that they did not want to get tested for HIV nor start ART largely because their HIV status would then be disclosed to employers, partners, and relatives.\textsuperscript{86} These disclosures are predicated on

\textsuperscript{83} CESCR Concluding Observations on Estonia, 27 March 2019, para. 46, http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEfDzFEOvLCuW1SKyxyVrLxEiT1iPy5tGoOiHeUhYK%2fAGvhE93KLaXxM4z3OcuUy4UFO6QpIsZDcil3ru4bHJAVA1bQqfTumayrWAHmbmL8h8qga%2fe1a%2bhsB

\textsuperscript{84} The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Professional Working Group with respect to Estonia, para. 53.

\textsuperscript{85} Id. at para. 3.

\textsuperscript{86} Id. at para. 53.
protecting the public from potential HIV exposure. Given the pervasive stigma of HIV, women are subsequently met with social shunning and loss of employment, losing their right not only to privacy, but to social, legal, and economic protection under Article 16 of the ESC.

The disclosure of medical records also undermines the right to work, as enshrined in Article 6 in ICESCR and Article 1 in the ESC. In fact, the CESCR Committee in its Concluding Observations explicitly identified this practice as a major barrier to women’s right to health, discouraging them from taking advantage of otherwise available medical services.\(^\text{87}\) The specter of having the most intimate health details disclosed to everyone they know haunts women at every corner, with most women who participated in the study citing the disclosure of their health status—whether drug use, HIV, or both—as the main reason for their unemployment.\(^\text{88}\) In one particularly disquieting account, a woman suddenly fell ill while working at a sewing factory and was rushed to the hospital. When asked if she took any pills, she informed the nurse of her HIV medication. The very next day, she came back to work to discover that her employer had already been told by the nurse of her HIV status, subsequently requesting that she resign because she was HIV-positive.

The systematic practice of disclosing medical records also impacts the ability of women with drug dependence to access treatment: since many doctors, healthcare worker, and social workers wrongly believe treatments like OST are no better than using street drugs, they often inform the loved ones and employers of patients undergoing OST.\(^\text{89}\) In one case, a woman on OST had informed child protection services about her new job, yet the following day was told by her boss that he received calling him that she “[had] problems with drugs.”\(^\text{90}\) Another woman was ousted to her parents and in laws as a methadone user by social workers, whose disclosure was detailed to the point of including doses and drug test results.\(^\text{91}\)

The result of these practices, unsurprisingly, is that women are deprived of social and economic rights, which worsens their chances for social reintegration, recovery, and optimal health. They are forced to suffer alone, essentially punished for trying to get clean or contracting HIV in violation of their rights.

\section*{E. Estonia’s Drug Policies Destroys Families by Needlessly Separating Children from their Mothers.}

\(^\text{87}\) CESCR Concluding Observations on Estonia, 27 March 2019, para. 46, \url{http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1SKxyprlxEitT1iPv5tsGoOileUbYK%2fAGvhE93KLxM4z30cuUy4UFO6QpIsZDciI3ru4bJJOV1bQqfTumayrWAHmbmL8hJ8qa%2feIa%2bbxB}


\(^\text{89}\) *The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia*, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Sessional Working Group with respect to Estonia, para. 52.


\(^\text{91}\) *Id.*
Estonia’s unduly punitive drug policies tear families apart, deprive women of family and forgets about the best interests of the child. Due to their drug use, women are deprived of their parental rights and given no say in their children’s life. Whether a woman is reunited with her child is completely up to the discretion of child protective services.\(^2\) Child protective services representatives argue that children who are living in “risk groups” cannot speak up for themselves and that they are working in the best interests of the child.\(^3\) Yet, children both young and older suffer physical, emotional, and mental trauma because they are forcibly separated from their mothers. Additionally, Estonian authorities not only interfere with the family, but also intrude on the privacy accorded to the home. This violates numerous international and regional human rights standards focusing on the right to family.

1. Women in Estonia constantly fear that they will be deprived of their parental rights.

Estonia violates the right of women to form a family when their children are ripped away from them by child protective services solely because of their drug dependency. When speaking about her experience in the hospital after giving birth, a woman in Tallinn said, “When I gave birth, I was told the following day that I would not see my child since I was an addict.”\(^4\) This violation triggers international and regional human rights law. Under Article 17 of the ICCPR, “No one shall be subjected to arbitrary or unlawful interference with his family.”\(^5\) Additionally, Article 10(1) of the ICESCR states that: “. . . the widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society.”\(^6\) Regionally, Article 8(1) of the ECHR states that, “[e]veryone has the right to respect for [their] family life.”\(^7\) Additionally, Article 17 of ESC provides for, “the right of mothers and children to social and economic protection, including the establishment or maintenance of appropriate institutions or services.”\(^8\) Women have lost cases to restore custody of their child because of their low social status (having no regular job) or because there were people with disabilities in their families.\(^9\) Child protective services also coerce women into signing documents which limit their parental rights under the threat that their other children will be taken away.\(^10\) There are currently three known cases of women fighting to restore their parental rights and in need of quality legal and social support.\(^11\) A woman in Tallinn recalled, “. . . in court, I said, ‘Give me the flat, I will get back my child and everything will be fine.’

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\(^2\) Interview with LUNEST (2018).
\(^3\) Eleri Rattasepp, “Child protection specialist: families with drug-dependent parents have rights in children, not just mothers,” (April 20, 2018, 4:00PM), http://m.epl.delfi.ee/arvamus/article.php?id=81830651
\(^5\) ICCPR, Art. 17 (1); see also UDHR, Art. 12, which also enumerates the right of the family to be free from arbitrary interference.
\(^6\) ICESCR, Art. 10.
\(^7\) ECHR, Art. 8(1).
\(^8\) ESC, Art. 17.
\(^10\) Id. at p. 6.
\(^11\) Id. at p. 8.
And they said that I should choose between the flat and my son. They said that they will give [the flat] to me if I waive my parental rights.⁠⑩²

A common thread in these cases is that while deprived of their parental rights, Estonia does not devote adequate services to helping these women maintain their families. Moreover, the CESC R Committee has urged Estonia to investigate cases of deprivation of parental rights for using drugs and punish those responsible.⁠⑩³ Under human rights law, the family is lauded as an essential component of life and requires the utmost respect and protection. Therefore, Estonia’s goal in managing drug dependency should be to keep families together, not tear them apart by child protective services, public health authorities, and the police are responsible for preventing women from making healthy choices or directly violating their human rights.⁠⑩⁴

2. Women with drug dependence are forced to make an untenable choice between their health and their children.

Women seemingly must choose between getting help for their drug dependency or providing for their families. Although OST is an effective treatment option for pregnant women, fear of child protection services, to which doctors disclose medical information, is the main obstacle to OST.⁠⑩⁵ (See Section D.) The fear of the deprivation of parental rights is a further disincentive for women seeking OST to safely treat their drug dependence.⁠⑩⁶ As stated previously, the options available to women with drug dependency do not take into account their role as mothers or as working women. Spending 12 months at a rehabilitation center is not viable for women with children because children are not allowed to stay there.⁠⑩⁷ This violates Article 10 of the ICESCR’s objective to provide families with the “widest possible protection” by not making OST accessible to working women with children.

For the majority of women who participated in the study, the disclosure of their health status (drug dependence and/or HIV) was the main reason for their unemployment. As noted previously, unemployment, in turn, decreases their chances for social reintegration and limits

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⑩² Id.
⑩³ CESC R Concluding Observations on Estonia, 27 March 2019, para. 44-45, http://docstore.ohchr.org/Services/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1SKyypYK%2fAGvhE93KL4z30cuUy4UFo6QpIsZDci3ru4bJJOV1bQqfTumayrWAHmbmL8hRqa%2feIa%2bxB
⑩⁵ Id. at p. 13.
⑩⁶ The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Sessional Working Group with respect to Estonia, para. 36; see also Family Law Act, 2009, www.riigiteataja.ee/en/eli/530102013016/consolidate. Although a discriminatory provision for the deprivation of parental rights due to a parent using drugs was repealed in 2009, child protection services still consider drug use and dependence grounds for restricting or depriving parental rights, assuming that any substance use puts a child in danger and thus is contrary to the child’s interests, even when a parent takes medically prescribed methadone.
their ability to regain custody of their children, given current juridical practice. Estonia’s government does not value women who use drugs as mothers, therefore they are afraid to get help in fear that they will be retaliated against. Child protective services does not view OST as a positive step that women are making to improve their families. Instead, the use of OST is used as another reason to deprive women of their families. If the mother is addicted to drugs, Estonia must devote services to helping her not only keep her liberty but help her maintain her family.

3. Children suffer exponentially when they are taken away from their mothers.

The best interests of the children of women who use drugs are severely undermined when they are taken away from their mothers arbitrarily. Under Article 9(1) of the Convention on the Rights of the Child, “... a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.” Further, Under Article 9(3) of the CRC, “States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.” In a number of cases, newborn babies were taken away from their mothers right after the delivery and placed in a prenatal clinic in Tartu (130-170 km from their birthplace). The mothers were not allowed to participate in any decision-making related to the child’s health and were poorly informed about the child’s status. Despite a lack of legal grounds, they were not permitted to take their child home from the hospital with them. Under international human rights standards, this State action against mothers who use drugs is in direct violation of her ability to form a family free from arbitrary interference and violation of the child’s right to be a part of that family. Whether or not a mother is able to see her child is up to the complete discretion of child protective services.

Estonia’s child protective services claim to be operating in the child’s best interest, but the impact on the children has been more harmful than helpful. In General Comment No.16 of the CRC Committee, the best interest of the child is not defined rigidly, but instead examined on a case by case basis. To keep a child away from their mother only on the basis of her drug dependency is inconsistent with the guidelines from the CRC Committee. When the child is first taken, there is no access to the child. Then the child protective services will check to see if the woman poses a risk to the child. If they are satisfied that there is no risk, the mothers

108 Id.
109 Interview with LUNEST (2018).
110 CRC, Art. 9.
112 Id. at p. 16.
113 Id. Interview with LUNEST (2018).
114 General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1).
115 Interview with LUNEST (2018).
are allowed to visit the child. If child protective services determine that there is a danger, they will be deprived of their rights.\textsuperscript{116} One woman noted that the person who had custody of her child stopped answering her phone calls.\textsuperscript{117} In some instances, for a woman to restore custody she cannot be on drugs and if she is currently on methadone it will lower her chances of getting her child back.\textsuperscript{118} Estonian authorities are using these children as a tool of abuse by keeping them away from their mothers. A woman in Tallinn recalled the coercion she faced by Estonian authorities, “There was a hearing to give my mother custody and they told me that they will give my son to my mother if I waived my parental rights. It was my first child. I had to do it so that they [social workers] would not take him to an orphanage. My mom took him. He spent two or three months with her, she also had a little son of her own, he was also two-years old. He was hyperactive, a little bit troubled and my mother couldn’t handle it so eventually she gave my son back to an orphanage.”\textsuperscript{119}

However, child protective services representatives argue that they are working in the best interests of the child who cannot speak for themselves. Child protective services have responded to criticisms from the report in a local Estonian news website.\textsuperscript{120} They contend that the paper is one-sided and that primary goal is to “monitor the situation, help and support families.”\textsuperscript{121} Further they state that they are working from an order from the court. However, from the statements of the women in Estonia and representatives from an Estonian NGO, “families” only include the child and even then, children are often left worse off in the hands of someone other than their parents. And still, despite a court order, the way child protective services operate violates the overarching right to family.

The children suffer physical, mental, and emotional trauma when they are torn away from their mothers and unable to maintain a relationship with them. For the older children, to be separated from their mothers is a very traumatic experience and has had lasting effects on them, physically and emotionally.\textsuperscript{122} In one case, child who had been in the orphanage but was reunited with his mother suffered from obesity, stress, and emotional problems.\textsuperscript{123} A representative from an Estonian NGO noted that child protective services perform surveillance on the children, watching them and taking pictures, looking for a reason to take the child away.\textsuperscript{124} The children are aware of this and constantly fear that they will be taken away from

\begin{itemize}
  \item \textsuperscript{116} Id.
  \item \textsuperscript{117} Id.
  \item \textsuperscript{118} Id.
  \item \textsuperscript{119} “Human Rights Violations in Estonia. Situation Overview of Violations Faced by Women who Use Drugs in Tallinn and Ida-Viru County” (22 January 2018), p. 17.
  \item \textsuperscript{120} Eleri Rattasepp, “Child protection specialist: families with drug-dependent parents have rights in children, not just mothers,” (April 16, 2018, 4:00PM), \url{http://m.epl.delfi.ee/arvamus/article.php?id=81830651}.
  \item \textsuperscript{121} Id.
  \item \textsuperscript{122} “Human Rights Violations in Estonia. Situation Overview of Violations Faced by Women who Use Drugs in Tallinn and Ida-Viru County” (22 January 2018), p. 18; The impact on the children of being separated from their mothers violates Art.37 of the CRC, “States Parties shall ensure that: (a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.”
  \item \textsuperscript{123} Interview with LUNEST (2018).
  \item \textsuperscript{124} Id.
\end{itemize}
their mothers. Younger children may also be negatively impacted by this separation. At, this formative stage, the child’s relationship with their parent is critical and the absence of that can have lasting effects. These women have not been proven to pose a real threat to the child’s health and wellbeing. For these women, the only reason why they are not able to see their children is due to their drug dependency and the child suffers for it.

4. Estonian authorities repeatedly violate the sanctity of the family home.

Estonia violates the right to privacy and family when child protective services operate like police and barge into the homes of women who use drugs. As noted previously, violations of the privacy and family trigger both international and regional human rights standards. Under Article 17 of the ICCPR, everyone has the right to protection under the law from arbitrary interference with their privacy, home, and family. To barge into the family home violates Article 8(1) of the ECHR, “[e]veryone has the right to respect for his private and family life, his home and his correspondence.” This interference by Estonian authorities is in direct conflict with the human rights standards on privacy and family.

In Estonia, child protection services visit mothers who live with drug dependence to inspect the child’s living conditions. Unlike the police, during such home inspections they conduct a house search without a search warrant and sometimes the police accompany the child protection service representatives. They inspect kitchen refrigerators to see how much food parents have, search wardrobes to see the number of clothes in the household, and talk to neighbors about the parents, often disclosing confidential information such as their HIV status and/or other health conditions, such as drug dependence of parents. This type of behavior by authorities is unethical and in violation of the women’s right to privacy in their own home. A woman from Kohta-Järve said, “Next day, I’m at home and someone starts banging on my door. No one ever banged this hard. And I realized that something bad is going to happen . . . [I] opened the door and there were these social workers. They immediately entered the room. They didn’t even try to discuss anything with me, they didn’t speak at all. Just: ‘That’s it, we are calling your mom. Look at yourself, we can’t leave the child with you’.”

These visits are conducted without notice as a method to catch the mothers performing poorly. One woman reported that child protective services came to her place of work, a hair salon and pulled her to a separate room in front of the client. The woman’s apartment was

125 Id.
126 ECHR, Art. 8; ICCPR, Art.17. “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation.”
127 ICCPR, Art. 17.
129 Id.
130 Id.
131 Interview with LUNEST (2018).
132 Id.
above the salon and the children were upstairs. Child protective services used this as a strike against the woman for leaving the children unsupervised. Estonia’s policies are damaging the family unit and child protective services is a major culprit.

F. Women who use drugs are especially vulnerable to gender-based violence (GBV), yet they are unable to seek help from Estonian authorities fearing persecution.

Estonian authorities have failed to respond adequately to gender-based violence. In the Commissioner’s report, “women’s unequal status in society, resulting from an unbalanced distribution of social, political and economic power, is one of the drivers of gender-based violence against women, which remains a pervasive human rights violation in Europe, including in Estonia.” According to a study by the International Network of People Who Use Drugs (INPUD), “as a result of criminalization, discrimination, and stigmatization, women who use drugs are disproportionally affected by violence.” Estonian authorities focus more on persecuting women who use drugs than providing recourse from GBV. This leads women to not report GBV and are left to handle it alone. Moreover, women are also unaware of the social services available to them either due to a lack of promotion by social services in their communities or worse, that these women are unworthy of help and excluded from these services. This violates numerous international and regional human rights standards.

1. Police do not protect women who use drugs from gender-based violence.

Police are ill-equipped to effectively address cases of GBV for women who use drugs. GBV violates fundamental rights to equality and non-discrimination, life, health, security of person, privacy, and freedom from torture and cruel, inhuman or degrading treatment. Under the CEDAW Committee’s General Recommendation No.35, “Women’s right to a life free from gender-based violence is indivisible from and interdependent on other human rights . . .” Further, it establishes that States have the obligation of due diligence to take measures to prevent, as well as to investigate, prosecute, punish and provide reparations” for cases of GBV against women. Further, this inaction by authorities triggers Article 18 of the Istanbul Convention which states that parties have a general obligation to, “protect women from further acts of violence.” Specifically, under Article 5 of CEDAW, States are to take measures to change stereotypes of women and work to achieve the elimination of prejudices that unfairly

133 Id.
134 Id.
136 “A Call to End Violence Against Women Who Use Drugs,” International Network of Women Who Use Drugs (INPUD), www.inpad.net/sites/default/files/A%20call%20to%20end%20violence%20against%20women%20who%20use%20drugs.pdf
137 General Recommendation No.35, CEDAW Committee, para 15.
138 Id. at para 24(2).
139 Istanbul Convention, Art. 18.
place men above women. This is violated by public authorities who are prejudiced against these women because they suffer from drug dependency.

The current culture of police or social services contacting child protective services instills fear in women and violates their right to be free from gender-based violence. The way police manage domestic violence cases with women in Estonia violates the international and regional standards listed above. When women do not report domestic violence, the cycle of abuse continues until the women end up gravely injured or dead. A woman from Narva spoke of her experience with gender-based violence as a young teenager, “When I was 13, I sort of started messing around. At first my skull was sort of broken and I was in a coma for 2 days. Then I was raped when I was 14, I ran away from home. I lived on the streets for half a year.”

According to several documented cases, when women call the police in situations of aggressive behavior by their male partners, the police often inform child protection services, which may result in the loss of custody of the child. Again, there is a theme of police, social services, and child protective services working together to seemingly tear women away from their children. Police may also prosecute a woman for a drug offense, instead of protecting her from GBV. When asked why she didn’t go to the hospital after being beaten by her boyfriend, a woman from Tallinn replied, “Because I believed that it was normal.” The fact that women would rather suffer physical violence at the hands of their partner than call the police for help is a sign that something must be done to change the way Estonian public authorities respond to GBV.

2. There is an overall lack of access to services to help women who use drugs seek recourse from GBV.

The fact that many women in Estonia are not aware of services for domestic violence violates the right to be free from violence. Many women had not even heard about the special services designed to help victims such as shelters, case management, or individual or group therapy. Moreover, the women would not be accepted by the shelters due to their drug use. Yet, nine out of the 37 interviewed respondents experienced repeated cases of violence by their intimate partners, and often required medical assistance. Under Article 14 of ESC, parties are to “promote and provide services . . . [which] would contribute to the welfare and development of both individuals and groups in the community.” Moreover, gender-based violence is a

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140 CEDAW, Art. 5.
142 Id.
143 Id.
144 Id.
145 Id.
146 Id.
147 Id.
serious public health threat among women who use drugs. In a report by Open Society Foundations, the exposure to GBV intensifies the risk of HIV by “limiting women’s ability to negotiate safer sex and injection practices.” Additionally, violence can also be a factor in women not choosing to get clean. This is unacceptable when the services are available to the women. Estonia needs to devote resources to training their police to deal with domestic violence in helpful and proactive ways. What is the point of calling police to help when it is clear that they either do not have the tools to successfully manage the situation. Further, the majority of victim shelters established under the Victim’s Support Act are based in police stations—the last place women will go given the randomized torment they suffer at the hands of the police. Estonia must do more to make sure that women know about the services available to them within the neighborhoods in which these women live.

V. REMEDIES

To remedy this issue, we hope that the UN Working Group on discrimination against women in law and practice, the Special Rapporteur on Violence against Women, and the Special Rapporteur on Health will urge Estonia to take the following steps, which have also been urged by the CESCRR Committee following its recent review of Estonia:

- Lift legal sanctions for the drug-use-related behavior, such as drug use, possession of drugs for personal use, and distribution of drugs among peers for personal use in small quantities. These activities deserve regulations with means of social and medical support, not criminal justice sanctions.

- Develop gender-sensitive and integrated health services to provide women with quality access to opioid substitution therapy (OST), HIV treatment, and reproductive care. Provide rehabilitation services that enable women to remain with their children.

- Develop guidance and training for child protective services in consultation with people who use drugs, monitor their activities, and put in place an appeals process for their decisions. In addition, develop guidance and training for police and medical authorities in consultation with women who use drugs.

- Create a de-stigmatization program to ensure the modification and elimination of cultural practices and stereotypical attitudes and behavior that discriminate against women who use drugs and/or who are HIV positive, for example a state-sponsored media campaign that highlights the plight of women who use drugs.

149 Malinowska-Sempruch & Rychkova, at 7.
151 CESCRR Concluding Observations on Estonia, 27 March 2019, paras. 45 and 47, http://docstore.ohchr.org/FieldsServices/Files/Handler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1SKvxyprlxEitT1iPv5tsGoOileU6YK%2fAGvhE93KLaXM4z30cuUy4UFO6QplszDci3ru4bJJOVl1bQqtTunuyrWAHmbmL8hJ8qa%2feIA%2bbxB
• Create policies and programs that support keeping mothers with their children, recognizing the value of the relationship between a mother and her child and its importance for a child’s development.

• Ensure gender-based violence (GBV) services and shelters that are tailored to the needs of women with drug dependency.

We further urge the UN Working Group on discrimination against women in law and in practice, the Special Rapporteur on Violence against Women, and the Special Rapporteur on Health to develop and put out a clear statement that drug dependence alone does not warrant termination of parental rights.

VI. CONCLUSION

Estonia has failed to protect the rights of women who use drugs. Draconian drug laws intersect with deep-rooted gender discrimination to reap a heavy toll on women who use drugs. Forgotten by society, they are subject to pervasive stigma and discrimination that impacts many facets of their daily lives. There is an overall lack of access to comprehensive services that can help women address addiction and overcome gender-based violence. Authorities are often indifferent if not complicit in these abuses. Police arbitrarily detain women they merely think are drug users, sometimes forcing them to take a painful and medically dubious drug test. Medical professionals turn away women who use drugs, treating them as pariahs, and will go so far as to disclose their drug use or HIV status to the public. Shelters exclude women living with HIV or who use drugs. Child protection services separate families with impunity. Widespread social and political apathy gives cover to these abuses.

As an E.U. member and developed country, Estonia particularly falls under the radar. Exacerbating the problem is the fact that the victims elicit little sympathy, as many people do not understand the complexities of drug use or the fact that using drugs does not preclude human rights. The plight of women who use drugs in Estonia is a critical international human rights issue that can no longer be ignored.
APPENDIX I
DESCRIPTION OF ORGANIZATIONS
| **Estonian Association of People Who Use Psychotropic Substances** is a probono, voluntary, private-law, non-profit organization of natural persons and legal entities acting in common good. The mission of the association is to represent the Estonian community of people who use drugs and advocate for their human rights.  
Address: Tuuluri 2-18, Kohtla-Jarve, Estonia 30321 |
| --- |
| **Eurasian Harm Reduction Association** ([www.harmreductioneurasia.org](http://www.harmreductioneurasia.org)) is a non-for-profit public membership-based organization which strives for a progressive human rights-based drug policy, sustainable funding advocacy and quality of harm reduction services oriented on the needs of people who use drugs in Central and Eastern Europe and Central Asia.  
Address: Verkių g. 34B, office 701 LT – 04111, Vilnius, Lithuania |
| **The Canadian HIV/AIDS Legal Network** ([www.aidslaw.ca](http://www.aidslaw.ca)) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research and analysis, advocacy and litigation, public education and community mobilization. The Legal Network is Canada’s leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS. (An NGO with Special Consultative Status with the Economic and Social Council of the United Nations)  
Address: 1240 Bay Street, Suite 600, Toronto, Ontario, Canada, M5R 2A7  
Tel: 1(416)595 1666; Fax: 1 (416) 595 0094 |
| **The Human Rights Clinic of the University of Miami School of Law** (HRC, [www.law.miami.edu/hrc](http://www.law.miami.edu/hrc)) works for the promotion of social and economic justice globally and in the United States, with a particular focus on gender justice. HRC draws on international human rights laws and norms, along with domestic law and policy. It engages in multidimensional advocacy strategies, which include documentation and report-writing, litigation, media engagement, work with legislative and administrative bodies, campaigning, community organizing, and global networking to develop practical solutions and promote accountability on the part of state and non-state actors. Since its founding in 2010, HRC has litigated and engaged in advocacy before international and regional human rights bodies on issues of domestic violence and other forms of gender-based violence, including Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the European Court of Human Rights, the African Court on Human and Peoples’ Rights, the African Commission on Human and Peoples’ Rights, United Nations treaty monitoring bodies, and the United Nations Human Rights Council.  
Address: 311 Miller Drive, Room E295A, Coral Gables, Florida 33146 USA |
APPENDIX II
Human Rights Violations in Estonia. Situation Overview of Violations Faced by Women who Use Drugs in Tallinn and Ida-Viru County
Introduction

In August 2017, a research mission to Estonia was organised with a goal to assess the situation regarding the protection of human rights of women who use drugs. The research project was organised in partnership between international and local organisations – Eurasian Harm Reduction Association (EHRA), the Canadian HIV/AIDS Legal Network (CHALN), and Estonian Association of People Who Use Psychotropic Substances (LUNEST).

Research methodology, developed by EHRA and CHALN, was based on in-depth interviews carried out by international and local experts. During the field trip to Estonia 38 interviews were conducted (29 interviews in Ida-Viru County and 9 in Tallinn). One of the interviews has been excluded from the data set because of the unstable mental state of the responded at the time of the survey. 20 interviews were transcribed and 37 were analysed through thematic content analysis. To ensure personal data protection and participants safety, their names were coded and there is no reference of their real names in the report.

Representatives of local community-based organisations and activists have been involved in the field work planning and acted as gatekeepers to ensure the linkage between researchers and women from the most oppressed groups. Local activists were also important partners in research results’ interpretation and subsequent advocacy strategy development.

All 37 respondents were female, aged 26 - 46 years old, mean age 35 years. All have either Estonian citizenship or hold a permanent residence permit in Estonia. 33 of respondents spoke Russian as their first language and four were Estonian native speakers.

The majority of participants (28 persons) live in Ida-Virumaa and nine in the country’s capital Tallinn. All participants have housing, including three who are provided with temporary social housing.

Twelve participants have professional education (equal to a college level), 18 have full secondary education and 7 have not finished school. All of the participants are literate, and only eight participants are currently employed.

Four respondents are married and 11 are in civil marriage. 35 participants have children, and seven of them have three or more children.

All of the participants are drug dependent and 20 of them were getting opioid substitution treatment at the time of the interviews. 21 of the participants reported having HIV infection for which they were getting HIV treatment.

Fourteen participants have a history of imprisonment, including lengthy number of years spent in prisons (up to 13 years). Two participants reported having a large amount of sentences (16 and 22 court cases). All criminal cases were related to drug possession, drug-related theft or other drug-related crimes.
**Background**

**HIV in Estonia**

HIV prevalence in Estonia is one of the highest in Europe (by December 31, 2017 a total of 9492 HIV cases were reported\(^1\), and the number of newly diagnosed HIV cases attributed to injecting drug use is 41.9 cases per million\(^2\)). HIV in Estonia is primarily spread among people who use drugs (50% prevalence in Tallinn and 60% in Ida-Viru county), and women represent 40% of new HIV cases as of 2013.

The Government of Estonia should be commended for its efforts and some progress in scaling up harm reduction services among people who use drugs. However, on the other hand human rights violations, and cases of systematic and egregious discrimination against people who use drugs, including women who use drugs, are hindering this progress.

**Drug laws in Estonia**

People who use drugs in Estonia are equally subject to harsh drug laws. Per capita, Estonia prosecutes more people for drug crimes and offenses than Russia – one of the world-renowned leaders in the war on drugs. Due to the social stereotypes and stigma related to narcotics, women who use drugs are the most vulnerable to human rights violations.

In terms of drug laws and drug enforcement, Estonia is more repressive than Russia. A total of 4,982 initial reports on drug-related criminal offenses and misdemeanors were reported in 2015, which was higher than in 2014.\(^3\) Based on initial reporting (not the final results) of drug prosecutions\(^4\), Estonia prosecutes 3.7 persons per 1,000 for drug offenses and crimes. This is much higher than in Russia, with 2.3 persons per 1,000 in 2015. Furthermore, seven out of ten reported offenses in Estonia were related to use and possession\(^5\), and drug overdoses are fueled by the country’s repressive drug policies.\(^6\)

Since joining the European Union in 2004, Estonia has significantly reformed its domestic laws. However, as a former Soviet republic, drug laws remain archaic, with their roots in the Soviet legal system and resemble those of the Russian Federation.


\(^3\)Ibid.

\(^4\)Information about Russian drug crimes statistics is available on the official website of the Ministry of the Interior (https://xn--b1aew.xn--p1ai/reports/item/7087734/) and the website of the Judicial Department of the Supreme Court (http://www.cdep.ru/index.php?id=79).

\(^5\)Ibid.

The consumption or possession of narcotic drugs or psychotropic substances in small quantities is punishable by a fine of up to EUR 1,200 or detention of up to 30 days. This fine is significant for an Estonian, where the current minimum wage is EUR500. People who are convicted also have to pay financial compensation to cover the drug laboratory’s forensic examination costs.

Any act of illegal possession or dealing in drugs not intended solely for personal use is considered a criminal offense, regardless of the type and amount of illicit drug. Activities such as the illegal manufacturing, acquisition, theft or robbery, storage, transport, or delivery of narcotic drugs or psychotropic substances with the intent to supply are punishable by up to three years imprisonment regardless of the quantity. A prison sentence by 6-20 years imprisonment or even a life-sentence are carried out depending on the quantities involved and other aggravating circumstances identified, such as organized crime.

Poorly drafted drug laws, especially the ease with which the police can turn any simple possession into a case of trafficking, make people who use drugs very vulnerable to the misuse of police powers, arbitrary detentions, ill-treatment, and other human rights violations. Consequently, this prevents Estonian authorities from respecting, protecting, and fulfilling the right to health to women who use drugs.

Results

According to Estonian drug laws, family and public health law, there are three State agencies which hold significant power with respect to women who use drugs:

- The police
- Child protection service (Lastekaitse)
- Medical doctors and public health authorities

In every interview conducted, the activities of these three State agencies were reported as either preventing women from making healthy choices or directly violating their human rights, including their right to health.

The right to health is either violated directly due to a lack of access to drug dependence treatment or antiretroviral therapy (ART), or indirectly as a result of the cumulative effect of violations of other interrelated human rights - the right to non-discrimination, the right to be free from ill-treatment, and the right to be free from arbitrary detention.

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8 According to the Ministry of Justice of Estonia, the average fine for possession of cannabis in 2015 was EUR80, the average fine for possession of any other drugs was EUR100, and the average fine for possession of any and all drugs was EUR90. Presentation “Drugs, crime, and punishment — what, how much, and to whom?” at the conference “Drugs, crime and punishment – where to draw the line?”, Tallinn University, March 2016. Online: https://www.just.ee/sites/www.just.ee/files/jako_salla.pdf.
The State’s obligation to respect the right to health is gravely and systematically violated in many cases, such as when police officers conduct forced street drug testing on drug dependent women; or when child protection services force drug dependent women to stop taking medically prescribed methadone under the threat of termination of their parental rights; or when the police abuse the vulnerability of drug-dependent women, including women with children, to obtain evidence from them; or when child protection services systematically conduct inspections of houses of drug-dependent women with children in complete disregard of their right to privacy and family life.

The State violates its obligation to protect its citizens and residents when police is ill-equipped to protect women who use drugs from gender-based violence; or when women who use drugs are subject to dubious quasi-judicial drug treatment proceedings; or when the police and health services routinely force women to undergo drug testing with the use of urinary catheters, subjecting them to extreme humiliation, pain and suffering; or when medical doctors and child protection services disclose private medical information of women living with HIV and/or drug dependent women to the police, members of the public, employers, and family members.

The State violates its obligation to fulfill the rights of its citizens and residents when the state authorities do not ensure adequate access and quality of opioid substitution therapy (OST) for women with children; or when drug dependent women have obstacles in accessing HIV testing, Antiretroviral Therapy (ARVT), or Hepatitis C treatment; or when there is very limited social support for drug dependent women with children, or when there are no rehabilitation services available for women with children.

**Deprivation or restriction of parental rights**

Twenty-five women reported the restriction or deprivation of child custody and/or parental rights by the State because a parent was a drug user or a drug dependent person. Four women are or have been at risk of losing the custody of their children because of their drug use. The majority of cases reported happened one or two years ago.

Child protection services often act in a similar way to the police and as such play a role in drug enforcement. These services quite often become one of the main obstacles for the access to effective drug treatment, including OST for women with children. Although they often act like the police, representatives of child protection services are not bound by any procedural rules. Allegedly, trying to protect the best interests of the child, they visit parents who live with drug dependence to inspect the child’s living conditions. Unlike the police, during such home inspections they conduct a house search without a search warrant. They inspect kitchen refrigerators to see how much food parents have, search wardrobes to see the number of clothes in the household and talk to neighbors about the parents, often disclosing confidential information such as their HIV status and/or other health conditions, such as drug dependence of parents.

Below is research participant’s account of social workers behavior in her house:

- Next day, I’m at home and someone starts banging on my door. No one ever banged this hard. And I realized that something bad is going to happen. I said: “Wait, wait, I’m coming already”. I was on crutches so it took me 5 minutes to get to the door. ... I opened the door and there were these social workers. They immediately entered the room. They didn’t even try to discuss anything with me, they didn’t speak at all. Just: “That’s it, we are calling your mom. Look at yourself, we can’t leave the child with you.”
(...) She went to the fridge, searched it, then moved to the children's wardrobe with her shoes on. She opened the fridge - there was food in there, opened the wardrobe - there were clothes. She looked at the crib – it was new, everything was perfect. But: “You are unworthy to be a mother, good bye”.

- Why?

- Because I use drugs. Because my baby was in hospital on methadone since she was born. We went to the social worker with my mom. (…) And she [social worker] told me to write a note saying if I ever use again they will take my children from me and put them in an orphanage.

Woman, 28, Kohtla-Järve

In one particular case, a woman was deprived of her parental rights because the boyfriend with whom she lived was using drugs:

- My boyfriend was put in jail. He is the father of my son. He spent seven months in prison. And Lastekaitse [child services] came and say that I should separate with him, otherwise the children will be taken away if I do not part ways with him. I began to say that I would not separate with him, because he was in jail. I do not want to do this. They insisted that I should do this.

- Wait, did you use [drugs] at the time …

- No, I did not use [drugs] at that time. I have not even touched it. Then he [boyfriend] came out of prison and started to use again (…) And then Lastekaitse came to me and said that they would assign two women who would come and check me. They came twice, checked on me, and I did not use it then, really. And they left, my tests were clean. I even signed that they were clean. They left, and a week later Lastekaitse comes and says: you will receive papers that children will be taken away because your tests show drugs. And because of this, everything went downhill. I was not using when the children were taken from me. I started using when they were taken away.

(...)

- ... wait, but why did they deprive you of your parental rights? I do not understand.

- Because I have a boyfriend who is an addict. The civil husband is a drug addict. And I live with him. (…) And they decided that it would be better for the children to be in the orphanage. I phoned my daughter's dad in Finland and asked him to take our daughter. (…) my son's father, he was deprived of parental rights, because he did not go to court. Immediately automatically deprived ...

Woman, 31, Tallinn

According to Estonian laws, OST is available for women during pregnancy and they may enroll in an OST program, drug treatment or social support programs. The study participants confirm that the majority of drug treatment doctors would be ready to provide drug dependence treatment for women before, during and after pregnancy. But the fear of child protection services, to which doctors disclose medical information, is the main obstacle to OST for women with children. Therefore women who use drugs either do not inform their gynecologists about their drug use/dependence, or inform them only after the child is born.
When I gave birth, I was told the following day that I would not see my child since I was an addict. I asked them how they knew that I was an addict? I did not tell you that I was an addict.

**Woman, 33, Tallinn**

In several cases newborn babies were taken away from their mothers right after the delivery and placed in a prenatal clinic in Tartu (130-170 km from their birthplace). The mothers were not allowed to participate in any decision-making related to the child’s health and were poorly informed about the child’s status. Despite a lack of legal grounds, they were not permitted to take their child home from the hospital with them. Yet, in many cases, mothers traveled to Tartu to see their babies and their travel expenses were not reimbursed.

- **With the second child they just took him to an orphanage right from the hospital. ... Just because in Maardu we have a social worker and she said: “We are taking him until the trial”**.

- **Right after the delivery? Did you have to sign anything, any document, or they just took him?**

- **They just took him. But I visited him in hospital.**

**Woman, 34, Tallinn**

In several cases women were forced to sign documents to show their ‘willingness’ to have their parental rights limited. In these cases, child protection services stipulated that if the women refused to sign the papers to voluntarily relinquish their parental rights, their other children would be taken away.

**And they said that either my child goes to an orphanage, or they leave him at grandmother and grandfather, if I write a refusal. Well, I wrote the refusal. Then, when I arrived at prison, I understood what I had done. I sent in an appeal. Then there was a court hearing. In court, they took Sasha from me and my mother became his temporary guardian. I still had a long time left in the prison. I got out of jail at the age of 26. They told my son that I was dead.**

**Woman, 35, Jõhvi**

**There was a hearing to give my mother custody and they told me that they will give my son to my mother if I waived my parental rights. It was my first child. I had to do it so that they [social workers] would not take him to an orphanage. My mom took him. He spent two or three months with her, she also had a little son of her own, he was also two-years old. He was hyperactive, a little bit troubled and my mother couldn’t handle it so eventually she gave my son back to an orphanage.**

**Woman, 26, Tallinn**

- **Yes, a woman come to me and said: "if you don’t sign...". At first she was just asking, trying to persuade me.**

- **Who was this woman?**

- **I don’t know, maybe she was also some kind of social worker. To be honest, I don’t remember.**

- **Did she give you some document to sign?**
- Yes, something like that. She wanted me to sign over my parental rights to his grandmother.

- And the presumed social worker was coming every day?

- Everyday, everyday she would come and make me cry. She was following me to the bus station. (...) In the end she told me: “If you don’t do it now, your child will end up in an orphanage. I promise”.

- And what did you do?

- I signed over my rights.

Woman, 34, Tallinn

A mother of three explains why she has lost custody of all her children under the pressure of child protection services:

I arrived at children’s inspectors and said that I want to see my child. This was the first time I came to them. I only had 10 days of sobriety, it is nothing, in general. They told me that I was eight months pregnant. Let's do it this way -- you write a document saying that you give up your older children, Sasha and Dima, for a short time. And under these terms, we let you keep your newborn… (...) Then [after the youngest baby was taken away] I understood what they have done to me. And I was in a very terrible rage. I remember these six days as a rollercoaster, when I wanted to kill myself, I was ready to strangle myself for all of this. And I understood that I was fooled, that I gave up Sasha and Dima for half a year, so that they leave Dan’ka with me. And now I have limited rights with Dan’ka.

Woman, 35, Jõhvi

Female clients of OST programs are forced to stop OST and get clean, despite the importance of OST for their health and stability. Although a discriminatory provision for the deprivation of parental rights due to the drug dependence of a parent was repealed in 2009, child protection services still consider drug use and drug dependence as reasons for restricting or depriving parental rights, assuming that any substance use puts a child in danger and thus is contrary to the child’s interests, even when a parent takes medically prescribed methadone. Survey participants also report a very poor quality of OST in general, in particular women with children because their specific needs are not accommodated.

Women reported strong evidence of child protection services either forcing them to stop OST and get clean under the threat of losing custody of their children, or not allowing a child to stay with another parent because this parent was a methadone patient. The reason given by child protection services for restricting parental rights was the participation of a parent in a drug treatment program and/or other mental health issues.
This advice in itself is in strike contrast to World Health Organization (WHO) recommendations which state that OST is the most effective type of opioid dependence therapy.\textsuperscript{12} However, in addition to this, there is no single drug dependence treatment center for women with children or during pregnancy.

- Lastekaitse - the children's inspectors who then took my child away from me ... I recently fought with them for ten days when I gave birth to my second child. We were transferred to another hospital where she [child] was given sedatives, they did not allow me to stay with her for ten days. I was not allowed to see her until my tests got clean. But the hospital test will show drugs for 10 days. The drug will keep appearing in urine for ten days. They thought I was using. ... Yes, they offered me rehabilitation, but in order to go there, I had to leave my daughter in orphanage. ... I knew that I would never leave my daughter. I will not give her to anyone. And I said that I will not go to any rehabilitation, because my child is dearer to me, because I won’t put her in an orphanage.

- Why didn’t they let your husband take her? Why not give her to her father?

- Because her father was also on methadone. We both had to go to a rehabilitation to be clean even from methadone.

- Wait, you are not allowed to be on methadone? Or did they have any other reasons?

- No, he did not have any bad tests at all, only methadone, that's it, so they wanted him to be clean from any substance.

\textbf{Woman, 26, Tallinn}

Then, in 15 days, when I came for my child, I was told — we will not give [child] to you. Because I am in methadone program and that I am from a dysfunctional family. Even though I have a two-room apartment and with good repairs. And I felt so insulted...

\textbf{Woman, 34, Narva}

Where mental health issues were established, psychiatric examinations were conducted without informed consent and with an apparent intention to use the psychiatric diagnosis along with the mother’s drug use to substantiate the case to deprive her of her parental rights. No social or medical support was offered in such cases.

I gave birth to him in sobriety. I had already had 1.5 months of sobriety. Yes, I used sometimes. I told them so honestly. Well, I had hopes. I call up children's inspectors. Well, (they say) we had to take him away, for observations, you know, you are a loony. (...) I am shown a paper that I am diagnosed -- manic-depressive syndrome with tendency to suicide. What to do? It turns out that in these 4 days, while I was in the psychiatric hospital, when nobody spoke to me, a psychiatric examination was conducted, which established this horrible psychiatric diagnosis.

\textbf{Woman, 35, Jõhvi}

\textsuperscript{12} Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. Geneva: WHO; 2009.
Women who use drugs are coerced into abstinence in quasi-judicial settings with very limited or no social or legal support. Drug dependence treatment, including opioid substitution therapy is available in Estonia. However the coverage of OST it is assumed to be relatively low (<20 %).\textsuperscript{13}

To regain custody of their children, women have to go to an abstinence-based rehabilitation center for 12 months, immediately find a job (even though the Narva region has an unemployment rate that is double the Estonian average (6%)) and equip their apartments “to a high standard”.

On a number of occasions women lost cases to restore custody of their child because of their low social status (having no regular job) or because there were people with disabilities in their families. There are currently three known cases of women fighting to restore their parental rights and in need of quality legal and social support.

*These social services know me since I was a kid* and in court ... I said: “You didn’t even give me the flat like you were supposed to and now you are saying that I don’t have a place to live with my child. Give me the flat, I will get back my child and everything will be fine”. And they said that I should choose between the flat and my son. They said that they will give [the flat ] to me if I waive my parental rights. Even these kind of arguments... they said it in court.

* The respondent grew up in an orphanage and by law she was entitled to a flat.

**Woman, 33, Tallinn**

- I was on methadone at that time, gave birth on methadone. I didn’t have any problems, you know. And then I moved to that new apartment, it was being renovated, it was still in process. And they came. Again only one room was unfinished, everything else was ready. Plus all my clothes from the wardrobe were on my bed and all this was considered to be a mess.

- But the renovation was still in progress?

- Yes. And they came with the police.

- Social workers with the police?

- Yes. And they looked at all this and decided that this place is not suitable for a child.

**Woman, 34, Tallinn**

Then I was accused that I didn’t have a cradle for the second child, so it was. Like, they put it all together, filed a court case. And the court decided that the city, Kohtla-Järve, will take custody of [my] children.

**Woman, 44, Jõhvi**

None of these women were provided with effective drug treatment before or during the pregnancy. While a number of participants were receiving opioid substitution treatment before the child has been removed, the quality of treatment was low and social support component was provided. Women did not receive social support such as job placement or housing that they needed to be able to provide quality living conditions for their children.

\textsuperscript{13} Drug treatment overview for Estonia. EMCDDA. Online: http://www.emcdda.europa.eu/data/treatment-overviews/Estonia
Child protection services often act together with the police to facilitate the extraction of confessions. Home inspections are often conducted along with the police, where the police are there allegedly to ensure the safety of the representatives of child protection services. In practice, the presence of the police inside or outside of a house serves to apply additional pressure on the parents.

The police often threaten an accused person by using the children in order to extract a confession, an accusation or evidence against somebody else.

There is this Vasya [name changed] in Narva. He has just served five years for selling drugs. (...) My girl was then going to kindergarten, Dashenka was two and a half years old. I was walking on the street in the city and the police took me. (...) They wanted me to testify on Vasya. (...) They say, well, what are we going to do with you? Your child is in the kindergarten, who is going to pick her up, if you have someone to call. She [policewoman] started to play with me. I know she can do it. (...) I told her, write whatever you want, I'll sign it. And I signed that I bought drugs in such and such quantities. (...) And the fact that they [the police] are blackmailing is true. Especially if a woman, a girl has a child, she will give evidence.

Woman, 32, Narva

Gender-based violence

Nine out of the 37 interviewed respondents experienced repeated cases of violence by their intimate partners, and often required medical assistance. Most of these women did not trust the police or social services to be in a position to help them in such cases. None of the women who participated in the study had heard about special services designed to help victims of domestic violence such as shelters, case management, or individual or group therapy. Old and current cases identified in the study demonstrate that no positive shift has taken place and it appears that the police is ill-equipped to protect women who use drugs from gender-based violence (GBV).

When I was 13, I sort of started messing around. At first my skull was sort of broken and I was in a coma for 2 days. Then I was raped when I was 14, I ran away from home. I lived on the streets for half a year.

Woman, 35, Jõhvi

- Have you experienced violence against you?
- Yes, the person with whom I lived, used to beat me. He used to throw me out on the street so that that I go steal, then I could spend the night at his place.
- And if you did not steal, you could not spend the night at his place?
- Yes. I spent the whole day on the street.
- Have you tried going somewhere, to some crisis centre for women? Did you know of any?
- No.
- No? You did not know of such centers?
- I did not know.
- Did you take photos of the beatings? Did you go to the hospital?
- No.
- Why?
- Because I believed that it was normal.
- It is normal that he beats you?
- Yes.

Woman, 33, Tallinn

Police practices discourage women with children from contacting the police in cases of GBV. According to several documented cases, when women call the police in situations of aggressive behavior by their male partners, the police often inform child protection services, which may result in the loss of custody of the child. The police may also prosecute a woman for a drug offense, instead of protecting her from GBV. Thus, women who use drugs prefer not to call the police in cases of GBV.

**Police ill-treatment and arbitrary detention**

According to four women, police recognized them as being drug dependent persons and stopped them on the street to undergo a saliva drug test on the spot. According to these women and other interviewees, if they refuse to take the test, they would have been taken to a police station and been forced to have a urinary drug test through a urinary catheter. This procedure is regulated by the Government Decree.¹⁴ If the test is positive, the person needs to pay a fine and also reimburse the cost of the drug test — a total of more than EUR100 — which is unaffordable for women who use drugs, as many of them live below the poverty line.

The use of urinary catheters has significant health risks of infections of the urethra, bladder, and kidney. Depending on the circumstances, the forced urine tests with use of urinary catheters can also be qualified as torture or a form of cruel, inhuman or degrading treatment or punishment. The reason for this policing practice is the fact that the faces of people who use drugs are familiar to the police. This type of drug testing constitutes arbitrary arrest and has severe consequences for women who use drugs, making them even more vulnerable to losing custody of their children. As a result of such practices, women lose their confidence in state services and this lack of trust represents a barrier to drug and HIV prevention, treatment, care, and effective social reintegration for drug-dependent women.

- They made me take a test for alcohol, because there were empty beer bottles on the kitchen table. My boyfriend drinks beer. Well, when he does not work, he drinks beer. It is his private affair. The test showed nothing. And then they took a drugs test.

- And you did not breastfeed the child for a year already?

- No, he is on the formula, what breast...

¹⁴ Decree of the Government No 88 of June 19, 2014 “Rules for taking bio samples”.
- How did they explain this? Why are they doing this?

- Well, how... That they are obliged to do it.

- Could you have refused?

- This is an interesting question. If I refuse, they take away the child by default. In a moment. And later, nobody knows... I understand to what it can lead. It is not a fact that I will get him back, therefore I really say: Yes, I use and am afraid... Yes, I was threatened that the child will be taken away. And I agreed, of course, to test. Yes, I played a fool. And the threat is that if they take me to a drug test lab, then they will use physical force. That is, they will take urine with a catheter.

**Woman, 34, Kohtla-Järve**

- Everyone at that party had consumed alcohol. Everyone who was there was arrested, including me. That was the first time I came across how a person can be given a runaround. Since I only used drugs during parties, they did not show up in the blood test, and so I was made to run around the Wismari hospital [a hospital in Tallinn, specialising in addiction treatment], through all of the wards, in order to find at least some narcotic substance in me...

- You mean, you used so infrequently that it didn’t show up in the tests?

- Yes. It was not in my blood yet. But since I was admitted in connection with such charges, they put the puzzle together pretty quickly and assumed I was probably a drug addict. They herded me around Wismari hospital, [but] no drugs showed up anywhere. At first they accused me of this, of definitely being [a drug addict], and eventually, many people who were interrogated said that I am using substances. But since the tests didn’t confirm this, they could not use it against me.

- You mean the police wanted to pressure you into admitting that you’re a drug addict?

- Yes. I spent, I think, three months in pre-trial detention, and was then released, as there was no solid evidence against me. So they said I would be punished for negligence — because a person was left without assistance. So, they gave me three months for that. Oh, I also got three years on probation on top of that.

**Woman, Tallinn**

- A police car pulls up and they say: "Your documents. - Sure thing. - Sit down, please, you will take a test for drugs. - Why, what is it? - Well, here, you have a reputation of an addict. - Well, that's all."

- And they take you away for a test?

- No, right there, in the car. If you refuse, then they take you (to the station). And they take the test once, and it did not show anything, they take the second time, and I have nothing.

**Woman, 44, Jõhvi**
Lack of access to drug dependence treatment or antiretroviral therapy, and disclosure of private medical information

Despite the HIV treatment guidelines of 2013, which recommend the initiation of HIV treatment at a CD4 count of >500, most of the respondents’ HIV treatment was delayed, leading to severe health conditions, lower treatment efficiency, and a higher risk of HIV transmission to their partners. Research studies, including those by the WHO, demonstrate that people who use drugs have low access to HIV testing and ART and drug dependence treatment, including OST, is poorly connected to HIV services.\(^{15,16}\)

The women interviewed reported that they did not want to get tested or start ART because of the stigma associated with HIV and cases of people’s HIV status being disclosed at their workplace or at the workplaces of relatives and partners. In the reported cases of disclosure, medical professionals or child protection services acted as if they wanted to protect the public from HIV by sharing information about HIV-positive clients.

In the quote below, the respondent explains why she could not undertake measures to prevent mother-to-child transmission (PMTCT) to her baby:

*I didn’t go to the maternity clinic only because I have a disease [HIV] … My mother worked in a hospital at that time. Once they’ve learned that I had hepatitis, they submit me to all the tests. Had they learned that I had HIV, they would have thrown me out immediately. This happens very fast here. They would find any pretext. That’s why I did not want to go [to have PMTCT].*

**Woman, 34, Kohtla-Järve**

There were 11 cases when women being denied admission to the hospital or being improperly taken care of because of their drug dependence or HIV status.

*I was given a depression assessment test. The test showed 10 out of 10 points, so they told the father of my child to go bring my clothes immediately, because I would be staying there [Psychiatry Clinic]. … They told me they would admit me. They tried to find out the reasons for my depression, but I refused to talk. … The next ten minutes went like this: They opened their computer, saw what pills I was taking, and then it became clear to them that I’m actually a drug addict. So they told us that they don’t admit drug addicts, and when the father of my child asked what we should do then, they told us to turn somewhere else. [In order to get admitted there,] I would first have to get rid of my drug problem.*

*The father of my child asked: “But you just said that she’s at risk of suicide?” And they said to him that we would be lucky to find help before that happens. And then we left.*

**Woman, Tallinn**

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- Did you try to kill yourself?

- Yes. It was before my first pregnancy. It was drugs. I knew that this is the end, that it is almost impossible to stop using this drug.

- That’s why you cut your veins? And then you were admitted to the psychiatric hospital?

- Yes. I spent one day and slept it off. They observed me and saw that I’m a normal, reasonable person. I talked with them like I’m talking with you now. And they let me go home.

- One day? And no psychiatrist?

- No. One or two days, I don’t remember. I first swallowed the pills and then cut my veins.

Woman, 26, Tallinn

The only thing I didn’t like is that we have a separate room for HIV positive in our hospital in Narva. And everyone knows for whom it is for.

Woman, 32, Narva

- This a very sensitive topic. But these three pregnancies you had before... they told you that you have to make an abortion?

- No, those were just miscarriages.

(...) 

- What did the doctor say to you when it happened?

- He said that HIV ate it.

- HIV?

- Yes, HIV ate my baby.”

(...) 

In hospital during labour the doctor that helped me to deliver forced me to put on a mask. It was already hard to breath, and with this mask…. They told me to stop panting and put on the mask so I won’t spit my HIV on them.

Woman, 34, Narva

According to the women interviewed, child protection services can proactively contact OST patients’ family members or employers to inform them that they are receiving treatment. The main reason for such behavior is a misunderstanding of the importance of OST by the child support services. Interviewees reported that child protection services stigmatize OST patients, wrongly believing that OST is no better than using street drugs.

For the majority of women who participated in the study, the disclosure of their health status (drug dependence and/or HIV) was the main reason for their unemployment. Unemployment, in turn, decreases
their chances for social reintegration and limits their ability to regain custody of their children, given current juridical practice. Six respondents reported violations of their labour rights.

- I had a job at a sewing factory. I felt ill. I fainted. I had a nosebleed. Well, they called an ambulance and they asked if I take any pills or something, so that they can do an injection. Yes, I said that I take pills regularly... I just told the nurse that I take pills. Well, the following day I was asked to leave at my own will.

- And how did they explain this?

- Well, so not to blow it out of proportion. Since you are an HIV-positive, we do not want [you] — sewing equipment, needles. We will not tell anybody anything, but at the same time you write a resignation letter...

- ... And how did they find out?

- Well, the nurse told them.

- That is, the nurse from the ambulance ... told the authorities, yes?

Woman, 34, Narva

The majority of women who participated in the study were unemployed and the main reason for this was the widespread disclosure of their HIV and drug dependence status. The information is often shared by medical staff of OST clinics and by the child protection services. According to participants’ accounts, this problem of HIV status disclosure is less acute than it has been before, while the issue of unlawful disclosure of drug dependency-related data continues to be an issue.

When I was just employed, started to work, I went to child protection services and put my job contract on the table. I go to work the following day and am called in by the owner. And he says: “Vika [name changed], I received a call today and they said that you have problems with drugs.”

Woman, 35, Jõhvi

Altogether, five respondents reported violation of their medical data disclosure.

One day my mother and my partner’s mother called us and told to immediately come to a family meeting. ... We came and you know, I always lied to my mother that everything was fine. And these social workers, even though they are not allowed to talk about me being in the methadone program, my dose there, they told everything to our parents. Our dose, what our drug tests show, do we use [drugs] or not.

Woman, 28, Kohtla-Järve

- Our parents went for a visit. And this doctor lives in the same building where the parents went. We went with my husband to meet them. Afterwards, this doctor then meets with a woman whom my parents were visiting and tells her: "You must wipe all [door] handles after they left and also disinfect all the buttons in the elevator."

- Did these people tell you this?

- Yes. And then these friends told me that this doctor said so when they met her.

- And does she still work in a hospital or in a polyclinic?
- Yes, she still works in a polyclinic. Kalugina, I can even say, I have nothing to hide, the psychiatrist Kalugina.

- Did you try to tell about this to anyone? To the authorities in the clinic?

- No, it's useless. She is an Estonian (...) and she is the chief psychiatrist.

- And these friends, they knew about your status?

- Oh, no.

(...)

- That's when I went to her for methadone, she wrote out [prescription] for pills for me, I have not seen her since ...

- So she knew about you because you went to her?

- Yes.

Woman, 34, Narva

Drug treatment in Estonia is organized in such a way that women can hardly combine it with work, as only two options are available to them – to spend 12 months at an in-patient rehabilitation center or to join an OST program.

Spending 12 months at a rehabilitation center is not viable for women with children. Neither is it viable for the majority of women with temporary work, who cannot be absent for such a long period of time.

OST is a better option for working patients. However, according to national guidelines, the majority of clients have to attend clinics daily. Take-home options are very restricted, even for clients who have to travel for an hour every day to take the medication. It is often impossible to combine such trips with a work schedule, especially considering the desire of OST clients not to disclose their health status to an employer.

**Lack of access to legal and social support services**

The vulnerability of women who use drugs or who are drug dependent is not being addressed in Estonia. All the women interviewed reported very little if any social support, such as job placement or opportunities to improve their housing conditions to meet the standards required by the child protection services. Instead, the child protection services used the lack of good-quality living conditions and/or the lack of a permanent job as a reason for restricting or depriving parental rights and/or taking a child away from the parents.

Women who use drugs often face legal challenges such as police prosecutions, legal proceedings related to the child protection services, and discrimination in labour and public health matters. Yet there is very limited access to free legal support services. Women report that legal support services related to cases of criminal prosecution are of very poor quality. According to the women interviewed, lawyers provided by the State do not provide a legal defense but rather act as an extension of the police.
Respondents were left on their own to cope with their mental health, social, financial, and juridical problems. And the child support services prefer to choose the toughest measure: deprivation of parental rights.

- Lastekaitse provided me some lawyer, but as far as I could see he was on their side. He also didn’t want me to have my children back. He also said that I have to have my own flat. I asked why it should be my own if I’m renting a place for more than a year. Why can’t I just continue doing that? If it is my permanent residence? He said no, they won’t allow it. I don’t know what kind of lawyer that was.

- What did your lawyer do during the hearings?
- I had a lawyer assigned by this Lastekaitse.

- What did he say?
- He said that I should be deprived of my parental rights.

Woman, 31, Tallinn

Public defender... I remember I had one. ... He didn’t even come to the meeting, just discussed it all over the phone with the policeman.

Woman, 28, Kohtla-Järve

Conclusion

Drug laws and drug enforcement practices, combined with stigma related to drugs and HIV, are the main drivers of systematic and serious violations of the human rights of women who use drugs or who are drug dependent. Stigma and human rights violations undermine the State’s efforts in HIV prevention, care, and treatment, and its overall efforts to respect, protect, and fulfill the right to health of women who use drugs or who are drug dependent. For these reasons, the Government of Estonia should address a variety of issues related to the protection of human rights and vulnerable groups of society, such as women who use drugs.
APPENDIX III
REPORT ON ALTERNATIVE POLICIES TO DRUG CRIMINALIZATION
This report explores alternatives to the prevailing but increasingly questionable model of drug criminalization, including recommendations and good practices derived from national policies and international bodies. While existing approaches are not without their flaws and limitations, they can provide a crucial starting point for policymakers and advocates seeking an alternative approach to drug policy.

I. Introduction

Since the establishment of the United Nations (U.N.) Single Convention on Narcotic Drugs in 1961, governments across the world have made concerted efforts to prohibit and penalize the use, sale, and possession of drugs. According to the Global Commission on Drug Policy, the reasoning was that “harsh law enforcement action against those involved in drug production, distribution and use would lead to an ever-diminishing market in controlled drugs […] and the eventual achievement of a ‘drug free world.’” Yet not only has the market for illegal drugs grown dramatically worldwide, but the financial, social, and political costs have been dire.

The consequences of this global, half-century campaign include:

- **Spikes in drug-related violence.** This is particularly pronounced in the Americas, where homicide rates are among the highest in the world; it is estimated that hundreds of thousands of murders are linked to illicit drugs, namely criminal groups contesting territory and trade.

- **Incarceration at an unprecedented scale.** In numerous countries—as varied as Brazil, Iran, Iraq, and Thailand—anywhere from a quarter to half of all prisoners are convicted on drug-related offenses. The United States (U.S.), which has the world’s largest prison population, has seen a four-fold increase in convicts over the last three decades, with drug

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17 This report was drafted by Romney Maron Manassa, a student with the Human Rights Clinic of the University of Miami School of Law under the supervision of the Clinic’s Associate Director, Tamar Ezer. Mikhail Golichenko of the Canadian HIV/AIDS Legal Network (CHALN) further provided review and guidance.


crimes accounting for a quarter of incarcerated Americans and half of those in federal prisons.\textsuperscript{21}

- **Record health epidemics.** Harsh drug policies present an often-deadly barrier to people who use drugs, who could otherwise access life-saving and rehabilitative services such as clean-needle exchanges and opioid substitution therapy (OST). Not only does this force people who use drugs to forgo help and treatment, but it causes unfettered infections from injection drugs like heroin. Consequently, regions with previously low rates of HIV/AIDS, such as the former Soviet bloc, have experienced a tripling in the number of people living with HIV since 2000.\textsuperscript{22}

- **Diverted resources.** The U.S., which has led the global war on drugs, spends around $517 billion annually for its efforts, totaling an estimated $1 trillion since the war was officially launched in 1971—larger than the economies of most countries. The financial burden is even greater on the mostly-poorer nations and regions that serve as the battlegrounds of the war on drugs, including Afghanistan, Central America, and Mexico.\textsuperscript{23}

Unfortunately, there remains little to show for all these costs: Many of the countries with the most draconian drug policies contend with high rates of substance abuse, HIV/AIDS, crime, and overdose deaths. The global illicit drug market is worth an estimated $320 billion.\textsuperscript{24} Hence a growing number of governments, international organizations, civil society groups, and average citizens have begun questioning whether there is a better way—with a few going so far as to implement some of these alternatives.

### II. Alternative Policies and Approaches

Most research indicates that countries that have implemented alternative drug policies—from decriminalization to regulated access—have not experienced any significant or long-term increase in either drug use or drug-related deaths. On the contrary, in some cases, these alternatives have mitigated or reversed these problems and led to other benefits.

#### A. Portugal’s Public Health Approach to Illicit Drugs

In drug reform circles, the Portuguese model is perhaps the most well-known and widely lauded. The southern European nation of 10.2 million is considered a global leader in drug policy, a distinction earned by its wholesale overall of both its drug policy and the ideological and cultural paradigm concerning drugs.


\textsuperscript{24} Supra note 3, p. 5.
About twenty years ago, Portugal was suffering from one of the worst drug epidemics in the world: an estimated one percent of the population was dependent on heroin alone, while half of those in prison were convicted of drug offenses. The subsequent strain on the criminal and public health systems prompted the government, in 2001, to decriminalize the possession or use of any drug, from cannabis to heroin. (Criminal penalties remain for drug producers, dealers, and traffickers.)

Instead, anyone caught with a small amount of an illicit drug will have their contraband confiscated and be summoned to an interview by the “Commission for the Dissuasion of Drug Addiction” (Portuguese acronym: CDT).

There is one CDT in each of Portugal’s eighteen districts, most of which are based in nondescript buildings. Each CDT is comprised of three people—a social worker, a psychiatrist, and an attorney—who together provide a broad range of sanctions as an alternative to legal proceedings. Depending on what they find, these include one or some of the following:

- Fines ranging from 25 to 150 euros, depending on the person’s income.
- Suspension of the individual’s professional license.
- Prohibition on visiting certain places, such as a nightclub.
- Ban on foreign travel.
- Requirement to report periodically to the committee (akin to supervised release).
- Rescission of the right to own gun.
- Confiscation of certain personal possessions.
- Ending certain public benefits.

Those determined by the CDT to be drug dependent may be ordered to attend drug rehabilitation in lieu of sanctions or incarceration. Portugal maintains an extensive public network of treatment facilities, detoxification units, outpatient centers, and other specialized services for substance abuse. This treatment infrastructure is coordinated by the Ministry of Health and is free available to those referred by the CDT or seeking treatment voluntarily.

Portugal is also a pioneer in OST, which gives people who use opioids an alternative substance under a supervised and controlled setting, thereby helping them to wean off or manage their dependence. OST also prevents HIV infections and overdoses. Since drug use is no longer a criminal matter, people who use drugs are no longer in fear of seeking help, and the rate of drug treatment rate has subsequently increased by as much as 60 percent.

Essentially, Portugal redefined drug use from being a moral and legal problem, to a public health one, thus leaving it primarily in the hands of medical professionals rather than police and judges.

The results of this approach have been resoundingly successful: the rate of drug-induced deaths is now five times lower than the European Union average; the HIV infection rate has plummeted from 104.2 new cases per million in 2000 to only 4.2 cases per million in 2015; the percentage of people incarcerated for drug offenses has nearly halved from 44 percent in 1999 to 24 percent as of 2013; and drug use has declined overall among 15- to 24-year-olds, the demographic most at risk of using drugs.29

In short, Portugal’s bold reframing of drug addiction as something to be rehabilitated rather than punished is paying dividends less than a generation later.

B. Uruguay’s State Regulated Drug Market

With the passage of Law 19172 in December 2013, Uruguay become the first country to establish a legal nationwide market for nonmedical cannabis. It already had the distinction of being among the few countries to have never criminalized personal marijuana possession; in 1974, shortly after the global war on drugs began, Uruguay enacted a law giving judges discretion in determining whether the possession of a “reasonable” quantity of drugs was for personal rather than commercial use, as only the latter was a criminal offense.30

The driving force of Uruguay’s legalization effort was, in the words of its defense minister, “a fight on both fronts: against corruption and drug trafficking.”31 The law was officially predicated on reducing crimes and social problems associated with the illegal production and sale of marijuana, the most popular drug in the country.32 One in five Uruguayans had tried cannabis, with an estimated 115,000 being regular users, out of a total population of 3.4 million.33

Uruguay’s response was to not only legalize marijuana, but to have the government play a direct role in its cultivation, production, and sale. This was done largely to placate the international community and drug monitoring bodies such as the International Narcotics Control Board (INCB). Hence the government opted for a strict regulatory system and based its reform on promoting human rights (namely the rights to health and security).34 Uruguay also framed its new policy as a cautious and pragmatic “experiment” that it would be willing to abandon if the results were poor.35

Interestingly, there was little popular support for the measure, with 58-74 percent of the population

31 Id.
expressing opposition.36 The bill passed the lower house by the minimum required votes and won the upper house by only three votes before being signed into law by the president.37

Law 19172 prohibits cannabis use indoors and bans any form of advertising or promotion.38 It also establishes a new regulatory body that oversees implementation of the law: The Institute for the Regulation and Control of Cannabis (IRCCA), whose board includes officials from the Ministries of Public Health; Social Development; and Livestock, Agriculture, and Fishing.

The law provides three legal methods for lawfully accessing cannabis if one is a citizen or legal resident eighteen years or older:

1. **Homegrown:** Each household is allowed six female flowering cannabis plants for personal consumption following registration with the government. Annual production is limited to 480 grams.

2. **Cannabis Clubs:** Cannabis can be grown through registered cooperatives known as “cannabis clubs,” which must have between 15 and 45 members. Up to 99 plants may be cultivated but no more than 480 grams can be dispensed to members annually; any surplus yield must be given to authorities.

3. **Commercial Companies/Pharmacies:** Cannabis can only be grown commercially by companies licensed by the government. Only pharmacies can serve as dispensaries through an opt-in system. Individuals can purchase up to 10 grams weekly but must be registered in a national database.

Unfortunately, data on the impact of Uruguay’s groundbreaking approach remain sparse, largely due to a lack of transparency. Researchers have not been allowed access to data by state regulatory; although the Ministry of Public Health must submit an annual impact report, it has done so only once, in 2016, which was not made public.

C. **Switzerland’s Four Pillars**

In the 1980s, Switzerland endured a severe and highly visible problem with illegal drugs, particularly opioids. In 1994, after consulting with members of law enforcement, public health, and civil society, the Swiss government responded with a new drug strategy made up of “four pillars:” prevention, treatment, harm reduction, and law enforcement.39

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36 “El 74% de los uruguayos está a favor de la venta de marihuana con fines medicinales”, *El Observador* (5 December 2013), [www.elobservador.com.uy/nota/el-74-de-los-uruguayos-esta-a-favor-de-la-venta-de-marihuana-con-fines-medicinales--20131211](http://www.elobservador.com.uy/nota/el-74-de-los-uruguayos-esta-a-favor-de-la-venta-de-marihuana-con-fines-medicinales--20131211) (Spanish).


The core of the policy was the gradual implementation of OST programs based on public health approaches that centered on treating dependence. Although the Four Pillars policy was the first of its kind on a national level, the first safe injection site opened as early as 1982, in response to alarmingly high HIV rates among people who inject drugs. This was the earliest of several “autonomous centres” established and run by people who use drugs, who were otherwise forced to fend for themselves.40

Over time, cities and cantons (federal states) began shifting their approaches from waging a war on drugs to simply managing their consumption. The Swiss federal structure permits a fair amount of local and canton autonomy, allowing each political unit to experiment with responses to the particularities of drug use in their jurisdictions. Major cities such as Zurich and Berne led the way due to their high-profile drug scenes, providing useful laboratories from which other cantons, and ultimately the national government, could draw from.41

By promoting its Four Pillars approach as a matter of both public safety and social inclusion—and including input from stakeholders across different professions and communities—the Swiss government managed to build a broad and diverse coalition of supporters, including from both its conservative and liberal wings. Like Uruguay, Switzerland was cognizant of going against the grain of harsh drug enforcement; accordingly, it took into account the major U.N. drug conventions by remaining within the general prohibition framework—many drugs remain illegal to consume and sell—but adding a new principle that people who use drugs but who are unable to quit their dependence still have rights, such as the right to life and to health.42

To that end, the country has balanced its continued opposition to drugs with a more humanistic approach focused on the often-marginalized status of people who use drugs. The Four Pillars particularly targeted the 10-15 percent of people who use heroin who were considered heavy consumers and accounted for 30-60 percent of the demand for illegal drugs. Due to the greater availability of OST, backed by the government’s assurance of helping people who use drugs, those struggling with their dependence on drugs now had a steady, legal means for seeking treatment. This not only helped people who drugs to reduce their need for illegal heroin, but it also allowed them to cut off their dependence and exploitation by dealers.43

The results have been dramatic: the number of new registrations by people who use drugs in Zurich, once an epicenter of the drug scene, fell from 850 in 1990 to 150 in 2005. Participants in the program saw a 90 percent reduction in property crimes and an 85 percent reduction in petty theft. Between 1991 and 2004, drug related deaths fell by more than half, while levels of injection-related HIV infections were reduced by 80 percent within a decade of the Four Pillars being adopted. By helping the people who use drugs most heavily, illegal drug sales and trafficking declined, and people who use drugs casually found it more difficult to contact to sellers.44

40 Id. at p. 3.
41 Id.
42 Id. at pp. 3-4.
44 Supra note 2, p. 7; see also supra note 23.
In summary, Switzerland took a pragmatic, multipronged approach to drug policy that generally criminalizes use, possession, and sale, yet provides a way out for those who are dependent. By involving different perspectives, it also managed to change attitudes that were historically harsh towards drug use—in a 2008, close to 70 percent of voters voted in favor of establishing the Four Pillars model in Swiss legislation.

III. **International Recommendations**

Recommendations by various international bodies, including the U.N. Commission on Narcotic Drugs, the U.N Special Rapporteur on the right to the highest attainable standard of health, and Commission on Economic, Social and Cultural Rights, support the reforms adopted in Portugal, Uruguay, and Switzerland, reflecting a growing shift away from punitive drug policy and towards protection of health and human rights.

In 2008, Uruguay sponsored a resolution at the U.N. Commission on Narcotic Drugs (CND) entitled “Strengthening cooperation between the United Nations Office on Drugs and Crime and other United Nations entities for the promotion of human rights in the implementation of the international drug control treaties.” The aim was to ensure that human rights were taken into account when implementing the main international drug control treaties: the previously-mentioned Single Convention on Narcotic Drugs; the Convention on Psychotropic Substances (1971); and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).\(^{45}\) To that end, the resolution urged an “integrated and balanced” approach to drug control that must conform with the Universal Declaration of Human Rights (UDHR), the U.N. Charter, principles of nonintervention and state sovereignty, and fundamental human rights and freedoms. Basically, drug control should not trump human rights and the interests of states and citizens.

Two years later, the U.N. Special Rapporteur on the Right to Health, Anand Grover, submitted a report to the U.N. General Assembly that reaffirmed these principles: “When the goals and approaches of the international drug control regime and international human rights regime conflict, it is clear that human rights obligations should prevail.”\(^{46}\) The report was critical of international drug control bodies lacking consideration of human rights, and credited the global war on drugs for creating “more harms than the harms it seeks to prevent.”\(^{47}\)

The report highlights in great detail the varied ways that drug criminalization negatively impacts the realization of several human rights:

- “Overly punitive” sentencing violates the human rights of people who use drugs, particularly in the 32 jurisdictions where drug offenses are capital crimes.\(^{48}\)

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\(^{45}\) Resolution 51/12: Strengthening cooperation between the United Nations Office on Drugs and Crime and other United Nations entities for the promotion of human rights in the implementation of the international drug control treaties, Commission on Narcotic Drugs (2008)


\(^{46}\) United Nations, Anand Grover, UN Special Rapporteur, “Right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (6 August 2010), para. 10


\(^{47}\) *Id.* at paras. 14-16.

\(^{48}\) *Id.* at para. 17.
• People who use drugs are forced underground and therefore deprived of access to essential medications and treatment, particularly for those with HIV/AIDS.\(^{49}\)

• Drug criminalization creates institutionalized and social stigma and discrimination towards people who use drugs, increasing their risk of physical and mental illness.\(^{50}\)

• Communities that are often already marginalized and persecuted, typically minority groups, bear the brunt of the war on drugs.\(^{51}\)

• People who use drugs or who are drug dependent are subjected to forced tests, medically dubious treatments, and/or abuse masquerading as medical intervention.\(^{52}\)

The report concludes that drug control regimes must prioritize adopting a “human rights-based approach” and urges reform at all levels of policymaking.\(^{53}\) The recommendations include:

• Interventions focused on addressing the harms associated with the use of psychoactive drugs without necessarily discouraging their use. These include needle and syringe programs, substitute medications, drug-consumption rooms, overdose prevention practices, and outreach programs.\(^{54}\)

• OST as an evidence-based approach to treating dependence.\(^{55}\)

• Harm reduction interventions that directly address rampant diseases HIV/AIDS that disproportionately impact communities that use drugs. The report cites Article 12 (c) of the International Covenant on Economic, Social and Cultural Rights (CESCR), which obliges State Parties to take steps to prevent, treat, and control epidemics.\(^{56}\)

• Less restrictive drug control policies, such as decriminalization or depenalization.\(^{57}\) The Special Rapporteur notes that States can liberalize drug policy within the framework of the drug control treaties, citing Article 3(2) of the 1988 U.N. Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which states that obligations to criminalize possession for personal consumption are superseded by the party’s “constitutional principles and the concepts of its legal system.”\(^{58}\) He highlights the case of Argentina, which has taken steps to decriminalize drugs for personal consumption, following a ruling by its highest court that criminal sentences for personal use are unconstitutional.\(^{59}\)

\(^{49}\) Id. at paras. 18-21.  
\(^{50}\) Id. at paras. 22-24.  
\(^{51}\) Id. at paras. 28-29.  
\(^{52}\) Id. at paras. 30-39.  
\(^{53}\) Id. at paras. 48-49.  
\(^{54}\) Id. at para. 50.  
\(^{55}\) Id. at para. 52  
\(^{56}\) Id. at para. 55.  
\(^{57}\) Id. at para. 62.  
\(^{58}\) Id. at para. 63.  
\(^{59}\) Id.
• Parallel policies and programs that address the needs of people who use drugs. Portugal is explicitly identified as a model where “decriminalization occurred alongside other efforts, including significant expansion of drug treatment programmes, drug education and refocusing of police efforts on interruption of trafficking operations.” States are cautioned that policy changes such as decriminalization are less effective without attending reforms in treatment, harm reduction, education, and other interventions.

• Using human rights indicators and guidelines to ensure that drug control policies do not undermine a State’s obligation to the human rights and freedoms of its people.

The report concludes with the following recommendations to Member States:

• Ensure that all harm reduction measures (as itemized by UNAIDS) and drug-dependence treatments, particularly OST, are available to people who use drugs, especially those who are incarcerated.

• Decriminalize or de-penalize the possession and use of drugs.

• Repeal or substantially reform laws and policies inhibiting the delivery of essential health services to people who use drugs.

• Review law enforcement initiatives around drug control to ensure compliance with human rights obligations.

• Amend laws, regulations, and policies to increase access to controlled essential medicines.

The foregoing findings were reaffirmed in a subsequent report by Grover’s successor, Dainius Pūras, which was submitted to the U.N. General Assembly in April 2015. It described the prevailing punitive model of drug policy as a failure stemming from ignorance of the realities surrounding drug use and dependence, and also urged a shift towards human rights and away from criminalization.

Recognizing that the criminalization of drug possession, particularly for personal use, is a driving factor in many human rights violations, the Committee on Economic, Social, and Cultural Rights (CESCR), which monitors the implementation of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), has recently called on states with some of the toughest drug laws to relax or remove prohibitions against mere drug possession. In its Concluding Observations on the combined fifth and sixth periodic reports of the Philippines, CESCR expressed deep concern about the country’s intensifying war on drugs, which it believed was “legitimizing violence against

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60 Id. at para. 67.
61 Id.
62 Id. at paras. 70-71.
63 Id. at para. 77.
64 United Nations, “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras” (2 April 2015) para. 27.
drug users, including extrajudicial killings.” The Committee also highlighted how criminalizing the possession and use of drugs presented barriers to health services and harm reduction, with people who inject drugs suffering higher rates of HIV/AIDS and hepatitis C. The Committee recommended that the Philippines “reconsider the criminalization of the possession and use of drugs; adopt a right-to-health approach to drug abuse with harm reduction strategies, such as syringe exchange programmes; and increase the availability of treatment services that are evidence-based and respectful of the rights of drug users.”

CESCR’s similarly responded to the sixth periodic review by the Russian Federation, which has one of the most draconian drug policies in the world. The Committee noted that Russia has a high level of drug use despite its punitive approach, and that its policy of criminalization has discouraged drug users from seeking medical treatment. As in many other countries with harsh drug policies, people who use drugs in Russia were found to suffer higher rates of infectious diseases such as HIV/AIDS and hepatitis C. CESCR advised Russia to consider decriminalizing drug possession and personal consumption and focus on the human rights and health needs of people who use drugs, including supporting harm reduction and treatment programs.

IV. Conclusion

While strict drug control remains the predominant model institutionally and ideologically, it is far from universal or entrenched: States and international bodies alike are increasingly recognizing the need to be more pragmatic, evidence-based, and human rights-focused in their efforts to address drug use. The punitive model is no longer the default approach: There is increased support for alternatives among policymakers and electorates worldwide that provide some combination of looser restrictions, lighter penalties, harm reduction, and the reframing of drugs as a public health issue best resolved through humane, medically-sound treatments, not State violence. Fortunately, the above models and recommendations provide useful guidance in lighting the way towards a more effective and moral approach to drug use.

65 United Nations, Committee on Economic, Social and Cultural Rights, “Concluding observations on the combined fifth and sixth periodic reports of the Philippines”, E/C.12/PHL/CO/5-6 (26 October 2016), para. 53
66 Id.
67 Id. at para. 54.
70 Id.
71 Id. at para. 51.
APPENDIX IV
REPORT ON WOMEN WHO USE DRUGS
This report outlines key issues and rights violations relevant to the experiences of women who use drugs, as well as recommendations to protect the human rights of women who use drugs.

I. Key Issues

A. Discrimination against Women Who Use Drugs

Globally, women make up approximately one third of people who use drugs. Despite this, the needs, interests, rights, and voices of these women are consistently neglected in laws, policies, and programs that affect their lives. There is a harsh stigma against women who use drugs because drug use is seen to conflict with the notion of the woman as a mother and caretaker. Furthermore, if the woman has HIV/AIDS she is subjected to additional discrimination and abuse by society.

a. Women and Drug-related Criminal Justice

While official statistics from most countries show that men make up the majority of people who sell and use drugs, punitive drug laws and policies adversely affect women and their children. Although all people who use drugs face discrimination, women are more likely than men to be vilified as unfit parents and fallen members of society. It is the harsh criminalization of the personal possession and use of drugs that drives many of the human rights violations that women face. The United Nations (U.N.) Special Rapporteur on violence against women reported to the General Assembly in 2013 that drug laws and policies, “are a leading cause of rising rates of incarceration of women around the world” and expressed concern that in some countries “women who commit relatively low-level drug crimes” are more likely to be given longer prison sentences than men who commit major trafficking offenses. These women are low-level members of the drug organization, often working as drug mules at the request of their partners. Intersections of race, gender, and class put women at a distinct disadvantage and make them targets for harsher drug

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72 This report was drafted by Gabrielle Wynn, a student with the Human Rights Clinic of the University of Miami School of Law under the supervision of the Clinic’s Associate Director, Tamar Ezer. Mikhail Golichenko of the Canadian HIV/AIDS Legal Network (CHALN) further provided review and guidance.
penalties for even minor crimes. For instance, the U.N. Committee on the Elimination of Discrimination against Women (CEDAW Committee)’s observations in a report from the United Kingdom expressed concerns that the large number of women currently imprisoned on drug-related offenses are indicative of the women’s socio-economic status.76 Additionally, women may be subjected to harsher penalties than their male counterparts because they do not have access to “insider information” that allows men to plea-bargain or make deals with the prosecutors in exchange for lighter sentences.77 Further, prosecution of women for drug-related offenses rarely takes into account why women may get involved with drugs in the first place.78 This could include pressures from family, friends, intimate partners, unemployment or underemployment, as well as mental and emotional problems.

b. Criminalizing Pregnancy

Women who use drugs further face specific rights violations due to their criminalized status, including losing custody of their children, coerced abortion, coerced sterilization, and penalization for exposing their children to a controlled substance if they are pregnant while using drugs.79 As mentioned previously, women who use drugs are vilified because their identity as a woman and mother is seen to directly contradict their status as a drug user. Popular media outlets have sensationalized the “crack-baby” epidemic to paint women who use drugs as monsters in society.80

When women do figure in decision making on drug policy, the focus is on concern for the health of the unborn child. While some countries give pregnant women access to treatment services for drug dependence, pregnant women all over the world still encounter major barriers including access to quality treatment and an overall fear of losing custody of their child.81 With this in mind, women are less likely to proactively seek treatment for their drug dependency. This is a harsh reality for women in a number of countries in Eastern Europe and Central Asia where seeking treatment results in the registration as a drug user and, in turn, may be grounds for losing a child.82 In Estonia, police officers, health services providers, and child protective services work together to deprive women who use drugs of their parental rights solely due to their drug dependence.83

The United States has similarly problematic policies when it comes to addressing drug use among mothers. In the United States, fetal assault laws in 38 states make it a crime to give birth to a child

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78 Malinowska-Sempruch & Rychkova, supra note 6, at 8-9.
79 IWRAW, supra note 2, at 9.
80 Malinowska-Sempruch & Rychkova, supra note 6, at 10.
81 Id.
83 Canadian HIV/AIDS Legal Network et al., The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Sessional Working Group with respect to Estonia, Para. 4, (2018).
showing prenatal exposure to narcotics.\(^{84}\) In Tennessee, about 100 women have been charged under the fetal assault law, mostly in rural Tennessee, an area severely lacking in drug treatment facilities, and in Memphis, a majority African-American city.\(^{85}\) Alabama’s chemical endangerment law was passed as a means to protect children from environments where they could be exposed to drugs or controlled substances.\(^{86}\) However, Alabama prosecutors have interpreted this to apply to pregnant women themselves.\(^{87}\) In a national context, pregnant women may also receive a harsher punishment if their embryo or fetus is considered a legally separate person.\(^{88}\) Again, when women’s pregnancies are criminalized, they are deterred from seeking prenatal care. This ultimately results in an attitude of distrust between the pregnant mother and the healthcare provider and potentially greater harm to the child. Drug policies that emphasize punishment and incarceration are not only ineffective but also have serious negative implications for women’s health, social, and economic situations and often violate women’s rights.\(^{89}\)

c. Stigmatization of HIV/AIDS

Women who use drugs and have HIV/AIDS face magnified stigmatization and criminalization. The Joint United Nations Programme on HIV/AIDS (UNAIDS) 2014 compilation data showed that the HIV prevalence among women who inject drugs was 13% compared to 9% among men from the same countries.\(^{90}\) Aside from injection drug use infecting women, there is also the risk associated with sex work.\(^{91}\) In these situations, women are not able to demand condom usage and are often met with sexual violence.\(^{92}\) Further, the stigma associated with HIV prevents many women from seeking and utilizing health services.\(^{93}\) Although drug-related and sex-related HIV risk is a prominent factor in the reality of women who use drugs, it is largely not addressed in programs.\(^{94}\)

Furthermore, violence is both a cause of HIV vulnerability and a consequence of infection. Women who are subject to domestic violence have little control over their sexual lives and ability to protect themselves from infection, and women who disclose their HIV status to partners are at greater risk for violence.\(^{95}\) Even marriage does not protect women from the transmission of HIV where women have little sexual autonomy and are economically dependent on their unfaithful husbands.\(^{96}\) Most


\(^{85}\) Amnesty International, supra note 13, at 18.

\(^{86}\) Id. at 18-19.

\(^{87}\) Id. at 19.

\(^{88}\) Id.


\(^{91}\) See Malinowska-Sempruch & Rychkova, supra note 6, at 13.

\(^{92}\) Id.

\(^{93}\) Id.

\(^{94}\) Id.


\(^{96}\) Id. at 58.
shockingly, according to the United Nations Population Fund, 60 to 80% of HIV-positive women in sub-Saharan Africa have been infected by their husbands, their sole partner. Additionally, the disclosure of an HIV-positive status can also trigger violence. Rates of non-disclosure are especially high among women seeking prenatal care, a time of particular vulnerability and economic dependence. Operating in secrecy, women who are aware of their status may still not be able to receive adequate treatment for fear that their partner may find out. Unable to receive healthcare, the transmission of HIV from mother to child skyrockets without proper prevention. In South Africa, “AIDS is a leading killer of women in pregnancy, and HIV has increased the childhood mortality rate in Africa by 100%.”

B. Gender-based Violence

Gender-based violence (GBV) has a substantial impact on women who use drugs. This group of women is particularly vulnerable to violence due to their criminalized status. Violence against women involves intimate partner violence and violence perpetrated by law enforcement officers through punitive drug policies. In a recent survey in Kyrgyzstan, 81% of women in harm reduction programs reported surviving sexual, physical or other injurious violence at the hands of their partner, family or police. Similarly, in Georgia, 80% of women in harm reduction programs reported experiencing violence in the year prior to the survey, 74% at the hand of their intimate partner. GBV is often justified by the idea that criminalized behavior like drug use is incompatible with the expected gender role of a woman as a mother and caretaker. When violence is perpetrated by police, who are supposed to protect those in need, women are less likely to seek out legal protection for fear of more violence and potential arrest. Fear of experiencing police violence remains a huge obstacle for women who use drugs seeking safety, emergency medical care and legal protection from GBV. GBV against women who use drugs presents a plethora of health and human rights issues that have been largely unaddressed, including the lack of services to address drug dependence and access to preventative measures against HIV/AIDS.

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98 Id. at 58.
99 Id. at 59.
100 Id.
101 Id.
104 Union Step to the Future, Domestic Violence and Women who use Drugs in Georgia, Gori, Georgia, 2012.
106 Malinowska-Sempuch & Rychkova, supra note 6, at 16.
108 IHRD, supra note 34, at 1.
Additionally, services designed to treat drug dependency do not see addressing GBV as a part of their mandate. Moreover, domestic violence shelters explicitly ban women who use drugs.

C. Lack of Access to Essential Health Services

There is a notable service gap in the resources available to women who use drugs. Most harm reduction interventions and services are designed for men and, therefore, fail to respond to the specific needs of women who use drugs. In the context of sexual and reproductive health rights, a woman’s access to adequate healthcare can ride on the disclosure of her status. Since many service providers are not trained to deal with women who use drugs, women are unlikely to disclose this information while seeking an abortion, to the detriment of their health. This, in turn, excludes women from a host of interventions, including HIV prevention and opioid substitution therapy. For example, in Ukraine, there are 174 opioid substitution therapy sites and the number of participants is 9,154, including 1,706 (19%) being women. Furthermore, some sites, 29 out of the 174 have no women among their patients at all. This is an indicator of unequal access to treatment for women who use drugs. The opioid substitution therapy (OST) program provides for uninterrupted OST in the case of in-patient hospitalization, the right to receive OST in healthcare institutions in other administrative and territorial units, and the possibility of issuing OST as a prescription. However, strict drug policy regulations ensure a low level of accessibility of the program for people who use drugs. Women reported that the geographical coverage of these programs is poor, which leads to them traveling hours at a time to receive the OST medication. In Estonia, the low access to OST—despite being technically available, even to pregnant women—is largely a consequence of doctors and child protection services consciously withholding information about OST programs.

II. Human Rights Violations of Women who use Drugs

Women who use drugs have inalienable human rights to equality and non-discrimination, family, health, and freedom from violence. The chart below sets out the key rights implicated by common violations experienced by women who use drugs and the corresponding provisions in international human rights law. This draws on the following core international human rights treaties: International Covenant on Civil and Political Rights (ICCPR), International Covenant on

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109 Id.
110 Id.
111 IWRAW, supra note 2, at 10.
112 Id. at 12.
113 Id.
114 Id.
116 Id.
117 Id.
118 Id. at 16.
119 Canadian HIV/AIDS Legal Network et al., The situation with the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia, Committee on Economic, Social and Cultural Rights (CESCR) Parallel Submission for 62nd Pre-Sessional Working Group with respect to Estonia, Para. 43, (2018).
120 Id.
Economic, Social, and Cultural Rights (ICESCR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on the Rights of the Child (CRC), and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

<table>
<thead>
<tr>
<th>Rights Violations</th>
<th>International Human Rights Instruments</th>
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<tr>
<td><strong>Right to Equality and Non-Discrimination</strong></td>
<td><strong>ICCPR</strong></td>
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<td></td>
<td>• Art. 2(1): “Each State Party . . . undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind . . .”</td>
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<td>• Art. 3: “The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights . . .”</td>
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<td>• Art. 26: “All persons are equal before the law . . .”</td>
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<td></td>
<td><strong>ICESCR</strong></td>
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<td></td>
<td>• Art. 2: “The States . . . guarantee that the rights enunciated in the present Covenant will be exercised without discrimination.”</td>
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<td><strong>CEDAW</strong></td>
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<td>• Art. 1: Defines discrimination as “any distinction, exclusion, or restriction” made on the basis of sex that undermine women’s ability to equally enjoy their human rights and fundamental freedoms.</td>
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<td>• Art. 2: Obligates states to condemn discrimination against women, refrain from enacting discriminatory policies, and pursue any measure that would end gender-based prejudice and unequal treatment.</td>
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<td>• Art. 5: “. . . Modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices . . .”</td>
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<tr>
<td><strong>Right to Health</strong></td>
<td><strong>ICESCR</strong></td>
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</table>
| | • Art. 12: “The States Parties to the present Covenant recognize the right
of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

**CEDAW**
- Art. 12: “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure . . . access to health care services, including those related to family planning.”

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<tr>
<th><strong>Right to Family</strong></th>
<th><strong>ICCPR</strong></th>
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<tr>
<td><strong>Art 17</strong>: “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.”</td>
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<td><strong>Art. 23(1)</strong>: “The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.”</td>
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**ICESCR**
- Art. 10(1): “The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children.”

**CRC**
- Art. 9(1): “. . . a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine . . . that such separation is necessary for the best interests of the child.”
- Art. 9(3): “States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact...
with both parents on a regular basis, except if it is contrary to the child's best interests.”

**Right to be Free from Gender-based Violence**

GBV violates fundamental rights to equality and non-discrimination (ICCPR: Art. 2(1), 3, 26; ICESCR: Art. 2; CEDAW: Art.1, 2, 5), life (ICCPR: Art. 6), health (ICESCR: Art. 12), security of person (ICCPR: Art. 9), privacy (ICCPR: Art. 17), and freedom from torture and cruel, inhuman or degrading treatment (ICCPR: Art. 7; CAT).

Moreover, GBV can prevent women from exercising further economic and political rights.\(^\text{121}\)

**CEDAW General Recommendation No. 35**

- Para. 15: “Women’s right to a life free from gender-based violence is indivisible from and interdependent on other human rights . . .”
- Para. 21: “Gender-based violence against women constitutes discrimination against women under article 1 and therefore engages all obligations under the Convention.”
- Para. 24(2)(b): “States parties will be held responsible should they fail to take all appropriate measures to prevent, as well as to investigate, prosecute, punish and provide reparations for, acts or omissions by non-State actors that result in gender-based violence against women . . .”

### III. Recommendations

Women who use drugs face many unique challenges in receiving not only adequate healthcare, but in fair and equal treatment by society. However, it is not too late for countries to step up and change their law, policies, and programs. The following recommendations, drawn from Concluding Observations and General Recommendations from the CEDAW Committee and, reports from the U.N. Office on Drugs and Crime (UNDOC), NGOs, and experts can guide countries in the right direction.

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A. Combat Discrimination against Women Who Use Drugs

- Explicitly address intersecting forms of discrimination in law and policy.\textsuperscript{122}
- Adopt temporary measures to accelerate the modification and elimination of cultural practices and stereotypical attitudes and behavior that discriminate against or are disadvantageous for women, for example, creating a state-sponsored media campaign that promotes equality for all women.\textsuperscript{123}
- “Adopt the legislative measures and targeted policies necessary to address multiple forms of discrimination and promote the integration into society of disadvantaged and marginalized groups of women facing intersecting forms of discrimination.”\textsuperscript{124}
- Address the situation of women and girls in detention through the development of comprehensive gender-sensitive policies, strategies and programs aimed at facilitating their access to justice and ensuring compliance with their fair trial guarantees.\textsuperscript{125}

B. Protect the Family Unit

- Develop humane policies for protecting families against arbitrary removal of children and reevaluate definitions of child abuse and neglect to ensure they are based on evidence rather than the assumption that prenatal drug exposure alone is indicative of child abuse.\textsuperscript{126}
- Create policies and programs that support keeping mothers with their children, recognizing the value of the relationship between a mother and her child and its importance for a child’s development.

C. Address Rights Violations in Drug Policy

- Promote drug policies and programs that are “evidence-based, respectful of human rights principles, gender-sensitive, and that emphasize health and social inclusion.”\textsuperscript{127}
- Review drug policy with the goal of shifting from a criminal to a public health and harm reduction approach.\textsuperscript{128}
- Ensure women who use drugs are involved in policy and program planning, implementation, and evaluation.\textsuperscript{129,130}
- Research the ways women are involved in the drug trade and analyze the discriminatory

\textsuperscript{125} Malinowska-Sempruch & Rychkova, \textit{supra} note 6, at 20.
\textsuperscript{126} Amnesty International, \textit{supra} note 13, at 66.
\textsuperscript{127} Id.
\textsuperscript{129} Id.
\textsuperscript{130} Malinowska-Sempruch & Rychkova, \textit{supra} note 6, at 20.
effect that current drug policies can have on them.\textsuperscript{131}

- “Develop specific guidelines, indicators and targets that address the needs of women who inject drugs regarding harm reduction services, sexual and reproductive health, pre- and post-natal care and other key interventions.”\textsuperscript{132}
- Ensure that drug laws make a clear distinction between high-level trafficking and minor level offences, such as couriering and low-level dealing, and impose penalties proportionate to the crime in consideration of factors, such as socio-economic status.\textsuperscript{133}
- Consider decriminalizing the use and possession of drugs for personal use as it leads to the mass incarceration of women and young girls.\textsuperscript{134}
- Ensure women who use drugs can access gender-sensitive harm reduction and drug dependence treatment services without fear of arrest or stigma and discrimination.\textsuperscript{135}

D. Combat Stigmatization of HIV/AIDS

- Ensure that HIV policy and program planning respects human rights and are in line with international guidance and protocols. For example, planning should provide for consultation with multiple stakeholders, including local community advocates. Furthermore, the goal should be to reduce the stigma associated with HIV.\textsuperscript{136}
- Create programming to raise awareness about HIV/AIDS, testing for the virus, and preventative measures, including education of local communities.

E. Address GBV against Women Who Use Drugs

- Coordinate legislative, policy, program and advocacy initiatives to address and redress police violence against women who use drugs.\textsuperscript{137}
- “Train police on supportive and non-judgmental approaches to dealing with women involved with drugs and GBV, including referrals to appropriate services as well as a method of redress for women to pursue in the case of police abuse.”\textsuperscript{138}
- Provide safe and quality shelters to women who use drugs facing GBV without discrimination.
- “Ensure availability and accessibility of appropriate, good-quality, nondiscriminatory antiviolence services for all women in need, regardless of their drug use status and

\textsuperscript{131} Id.
\textsuperscript{133} Id.
\textsuperscript{134} Committee on Economic, Social, and Cultural Rights (CESCR), Concluding observations on the sixth periodic report of the Russian Federation*, para. 51 U.N. Doc. E/C.12/RUS/CO/6 (Oct. 16, 2017); see CESC, Concluding observations on the combined fifth and sixth periodic reports of the Philippines*, para. 54 U.N. Doc. E/C.12/PHL/CO/5-6 (Oct. 26, 2016); see generally Malinowska-Sempruch & Rychkova, supra note 6, at 7.
\textsuperscript{135} Id.
\textsuperscript{136} UNODC, supra note 58, at 8.
\textsuperscript{137} L. Gilbert et al., Feasibility and preliminary effects of a screening, brief intervention and referral to treatment model to address gender-based violence among women who use drugs in Kyrgyzstan: Project WINGS (Women Initiating New Goals of Safety), Drug and Alcohol Review (January 2017), 36, 125–133.
\textsuperscript{138} Malinowska-Sempruch & Rychkova, supra note 6, at 20.
F. Improve Access to Health and Other Services for Women Who Use Drugs

• Focus on addressing gaps in the healthcare system so that all communities have access to comprehensive, quality treatment, and services.  

• Collect sex-disaggregated data on drug use, HIV prevalence and coverage of harm reduction services components.

• Ensure access to sustainable, non-discriminatory and non-prejudiced services, such as shelters, sexual and reproductive health services, legal aid and counselling, and employment for all women.

• Take steps to remove barriers to women’s access to health services, education and information, including information on sexual and reproductive health, and allocate resources for programming directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS.

• Monitor the provision and quality of health services to women to ensure equal access and quality of care.

• “Require all health services to be consistent with the human rights of women, including the rights to physical integrity, privacy, confidentiality, and informed consent.”

• “Implement training and guidelines to ensure drug testing of pregnant women is only conducted with informed consent, including an explanation of the potential ramifications of a positive test.”

• Train health services works comprehensively, by instituting mandatory, gender-sensitive courses on women’s health and human rights, in particular gender-based violence.

• Ensure the integration of respectful and good quality harm reduction, drug treatment, and reproductive health services to enable pregnant women with opiate dependence to have easy access to opiate substitution therapy, or for women living with HIV to prevent transmission from mother to child.

• “Expand access to residential drug treatment centers that prioritize admission of pregnant women and allow children to stay with their mothers.”

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139 Id.
140 Amnesty International, supra note 13, at 66.
141 UNODC, supra note 60, at 7.
142 Malinowska-Sempruch & Rychkova, supra note 6, at 20.
144 Id. at para. 31(d).
145 Id. at para. 31(e).
146 Amnesty International, supra note 13, at 67.
147 Malinowska-Sempruch & Rychkova, supra note 6, at 20.
148 Id.
IV. Conclusion

The impact of drug use has a disproportionate effect on women who use drugs around the world. The stigma and discrimination associated with drug use conflicts with society’s notion of a woman as mother and caretaker. Forgotten by society, they are susceptible to violence from both the police and intimate partners and especially vulnerable to contracting HIV. There is an overall lack of access to services that can help women address addiction and overcome gender-based violence. Moreover, women who use drugs are unfairly persecuted by the criminal justice system in comparison to their male counterparts. This violates their innate human right to equality and non-discrimination, health, family, and freedom from violence. This is a critical international human rights issue that can no longer be ignored.