**QUESTIONNAIRE**

**“Violence and its impact on the right to health”**

I have the honour to address you in my capacity as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, pursuant to Human Rights Council resolution 42/16.

I would like to invite you to respond to the questionnaire below. Submissions received will inform my next thematic report on “Violence and its impact on the right to health”, which will be presented to the Human Rights Council in June 2022.

The questionnaire on the report is available at OHCHR website in English (original language) as well as in French, and Spanish: ([https://www.ohchr.org/EN/Issues/health/pages/srrighthealthindex.aspx](about:blank)).

All submissions received will be published in the aforementioned website, unless it is indicated that the submission should be kept confidential.

There is a word limit of 750 words per question. Please submit the completed questionnaire to ohchr-[srhealth@un.org](about:blank). The deadline for submissions is: **18 January 2022.**

Tlaleng Mofokeng

Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

**Contact Details**

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

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| --- | --- |
| Type of Stakeholder (please select one) | Member State  Observer State  X Other (NGO) |
| Name of State  Name of Survey Respondent | International Network of People who Use Drugs (INPUD)  Contributing organisations: -   * Asteria (Kyrgyzstan) * Le Dispensaire (Canada) * Kenya Network of People who Use Drugs (KeNPUD,Kenya) * Metzineres (Spain) * Recovering Nepal Women (RN, Nepal) * South African Network of People who Use Drugs (SANPUD, South Africa) * Tanzania Network of People who Use Drugs (TANPUD, Tanzania)   Drafted by Jake Agliata  With contributions from Judy Chang and Gaya Arustamyan |

# Background

Within the framework of Human Rights Council resolution 42/16, the Special Rapporteur on the highest attainable standard of physical and mental health has identified sexuality, gender based violence and femicide as one of her priorities during her tenure (See [A/HRC/47/28](about:blank) paras 50-64). In compliance with her mandate and in line with this priority she has decided to devote her next thematic report to the 50th session of the Human Rights Council in June 2022 to the theme of “Violence and its impact on the right to health.”

# Objectives of the report

The Special Rapporteur intends to shed light on who is seen as victims of violence, and who is affected by what type of violence, with emphasis on the violence experienced by women, children, LGBTI persons and conflict related gender based violence. She will also explore the role of men as perpetrators and their experience as victims of violence. Her analysis will look into the responses that survivors of violence receive with a focus on good practices, as well as the obligations, responsibilities, and protections that arise under the right to health framework and other relevant human rights in this connection. She will also report on emerging trends related to the impact of COVID-19 on all forms of violence and related responses.

In her report, the Special Rapporteur will address, inter alia, issues related to gender based violence, (including inter-personal and intimate violence), as well as structural violence. She will also assess the impact of the criminalization of sex work, same sex relations, transgender persons, abortion, drug use etc. on the enjoyment of the right to health. The Special Rapporteur would like to identify good practices and examples of comprehensive health responses to survivors of violence, and to identify lessons learned at the community, national, regional and international levels.

# Key questions

*You can choose to answer all or some of the questions below. (750 words limit per question).*

When responding to the questions below, please use the glossary with definitions at the end of the questionnaire, and refer to all or some of the forms of violence in focus for this study as applicable in your country, countries or region in focus:

1. **Please describe, share data and information on the characteristics, number of cases, and the profile of victims and perpetrators in your country/ies or region(s) regarding:**
   1. **gender based violence against women**
   2. **gender based violence and other forms of violence against children:**
   3. **gender based violence against LGBTI or other persons based on real or imputed sexual orientation, sex characteristics, and gender identity:**
   4. **violence against persons with disabilities, including GBV.**
   5. **gender based violence against men**
   6. **conflict gender based violence, including sexual violence**
   7. **Please share analysis and available evidence on the impact of COVID on the above**

While the criminalised status of drug use and possession makes it hard to determine the exact population size estimate, the UNODC approximate that women make up one third of the global population of people who use drugs (275 million) and people who inject drugs (12.7 million).[[1]](#footnote-1) Women who use drugs face amplified risk of violence in their everyday lives due to the compounding effects of the criminalization of drug use and possession, stigma, gender discrimination and cultural prejudice. Due to a severe lack of data regarding gender-based violence experienced by women who use drugs and a gap in research concerning the lived experience of the community, this issue too often goes unrecognized, undocumented, and unaddressed at national and global levels. To gather available information at the country level regarding all aspects of violence towards women who use drugs, INPUD conducted a survey of community-led and community-based organisations who represent and serve women who use drugs across several countries (Canada, Kenya, Kyrgyzstan, Nepal, South Africa, Spain and Tanzania).

From existing data, it is estimated that rates of gender-based violence are two to five times higher among women who inject drugs than women who do not inject drugs.[[2]](#footnote-2) In some countries 30-40% of women who use drugs report abuse by police, including sexual violence and extortion, while many more report abuse by intimate partners or other people known to them.[[3]](#footnote-3) Intimate partner violence can include women who are coerced by their partners to claim responsibility for a drug offence. Because of the criminalized status of women who use drugs, this violence occurs with impunity either because the direct perpetrators are law enforcement officials, who face minimal to no consequences, or because victims of violence fear reporting incidences of violence to police due to the fear of being exposed as belonging to a criminalized group or a lack of faith in, and access to, justice mechanisms.

Our survey respondents in Tanzania, South Africa, and Kenya report that violence against women occurs at twice the rate of violence against men, owing to a male dominated culture where women often have no agency outside of family life. For women who use drugs these dynamics are even more severe due to their criminalized status.

Metzineres, a co-operative shelter for women who use drugs in Barcelona, reports that all 307 women and gender non-conforming people who participate in their services during 2021 have survived gender-based violence. Sixty-three experienced violence during childhood, whilst 89 experienced violence from their partners, 55 from their family members, 59 from people known to them and 47 from people unknown to them. In terms of institutional violence, 34 people have experienced violence from the social care system and 38 from the health care system, whilst 28 people experienced violence in the penal system, 40 in the judicial system and 32 at the hands of police.

Worldwide, the extremely high rates of violence experienced by women who use drugs is driven and accelerated by punitive responses to drug use, the lack of political will for supporting effective interventions that address the specific needs of this population, the lack of protective legislative frameworks and high levels of stigma and discrimination experienced by women who use drugs.

Within the context of the COVID-19 pandemic, women who use drugs were at greater risk of violence, particularly intimate partner violence. From April to June 2020 INPUD conducted research into the impact of the pandemic on people who use drugs through a global survey disseminated in six languages[[4]](#footnote-4). Most respondents noted lockdown conditions in their countries were bringing a higher police presence into communities, increasing the possibility of police violence. Thirty-five percent of respondents also noted that intimate partner violence towards women who use drugs was more prevalent during lockdown conditions. In Tanzania one drug user-led network reported that by their own estimations violence against women who use drugs rose by 80%, mostly attributed to intimate partner violence. Sexual violence, such as coercive sexual activities, increased where it was reported in Tanzania that women were forced to exchange sex for money by male partners. Most instances of violence during the pandemic have remained largely undocumented, and according to drug user-led networks in Tanzania and Nepal, those which have been reported are often dismissed due to women who use drugs not being taken seriously by the police.

1. **Please describe whether the legal framework prohibits and sanctions these forms of violence and the definitions and forms of violence included in the legal system. Please explain redress options for survivors of violence, (the pathway they go through if they decide to file a complaint), levels of impunity and if access to comprehensive physical and mental care for GBV-survivors is recognized as a form of reparation.**

While most States do sanction or prohibit violence, the enforcement of drug criminalization and related policies override the intent of legal frameworks that prohibit violence, and in some cases directly sanction human rights violations specifically due to the stigma created or reinforced through punitive drug enforcement. At the global level the criminalization of drugs is endorsed and enabled through the framework of the three UN international drug control treaties and conventions, which bring hundreds of substances under international control and criminalize virtually every aspect of the unauthorised production and distribution of scheduled substances. These are the [Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol](http://www.unodc.org/pdf/convention_1961_en.pdf); the [Convention on Psychotropic Substances, 1971](https://www.unodc.org/pdf/convention_1971_en.pdf), and the [Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988](https://www.unodc.org/pdf/convention_1988_en.pdf).

In a 2010 report, former Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Anand Grover noted that “criminalisation of drug use and possession are implicated in violation of several human rights, including the right to health.”[[5]](#footnote-5) The Special Rapporteur noted that those who use drugs may avoid seeking medical attention for fear that disclosing their drug use will result in arrest, imprisonment or forced treatment. Individuals can also be denied access to medical treatments on the grounds of their prior or current drug use, which is not accepted as justification for denying such treatments per global jurisprudence on the right to health. Targeted abuse and violence towards people who inject drugs authorized by State authorities under criminalisation may further increase risk of physical or mental illness.

Due to criminalisation of drug use and possession, otherwise referred to the as ‘war on drugs’, it is extremely challenging for people who use drugs to seek redress and recourse to justice in cases of violence. Understandably, people who use drugs avoid contact with law enforcement officials due to fear of arrest and/or harassment. As one community member from the United Kingdom noted: “The Law says one thing, but the reality is different as drug users cannot go to the police for help without risking exposure.” Generally, the community lack access to justice mechanisms such as legal aid - either due to limited financial resources, lack of information on processes and procedures, a dearth of culturally competent legal services or mistrust in the overall legal system, and rarely come forward for physical or mental health care due to the rampant stigma and discrimination against people who use drugs within these settings. As a result of this multitude of factors, violence, including gender based violence against people who use drugs, happens with impunity.

At the State level, some states do have legal frameworks addressing violence against women who use drugs. For example, in Kyrgyzstan, if a who woman who uses drugs reports gender-based violence and is in need of access to health or social services, drug use alone cannot be used as a reason for refusing that help. However, the overall effectiveness of these policies is still limited because of rampant stigma and discrimination against women who use drugs, making people distrustful of State-run services. In Nepal, legislation that addresses gender-based violence has been enacted, but women who use drugs have not been able to access justice due to difficulties associated with filing a report and fear of reprisals from law enforcement for pursuing legal action.

The options for redress are very limited for women who use drugs experiencing violence. Criminalization discourages women from reporting instances of violence to law enforcement, either for fear of reprisal over their drug use or because they do not have faith their report will be taken seriously. For instance, the sole recourse for reporting violations of restraining or protective orders is to contact the police. As one community member from Canada reported, this limited its capacity to keep her safe due to fear of repercussions connected to her drug use. In Tanzania, gender norms that discourage women from speaking in front of men increases the difficulty of reporting gender-based violence to law enforcement officials, whom in the main are cisgender men.

1. **Please share examples of the types of structural and institutional violence with origins within the State, (perpetrated or condoned by the State) or perpetrated by those not representing or affiliated to the state in your country/ies of region, and who is affected. In particular, describe structural/institutional violence in medical settings against women and girls, LGBTI persons and persons with disabilities or any other individuals or groups relevant in your country/ies or regions.**

Much of the structural and institutional violence perpetrated against women who use drugs comes as a consequence of enforcing drug criminalisation. Many of the State institutions set up to protect people from violence are also the same institutions designed to punish people who use drugs. Law enforcement and the criminal justice system, including prisons and other forms of involuntary detention, are often the drivers of structural and institutional violence against women who use drugs. This is compounded by the societal stigma and discrimination surrounding drug use. Furthermore, people who use drugs fear and avoid reporting intimate partner violence or other experiences of violence. In healthcare settings, including compulsory drug detention and private rehabilitation centres, women who use drugs experience structural and institutional violence. This belies an inherent paradox: that for the most marginalized groups such as people who use drugs, people who use drugs, LGBTQI communities and sex workers, places of care often translate into settings of inhumane treatment, structural violence, and discrimination. Because of the stigma and discrimination that is driven by criminalization, many people who use drugs perceive and experience health institutions as a system of oppression, rather than care.

Criminalisation drives unnecessary intrusion and intervention into the lives of women who use drugs through the arms of the State apparatus. Globally, people who use drugs face institutional violence at the hands of police or other law enforcement officials, such as drug enforcement agents, or within the carceral system[[6]](#footnote-6). Additionally, as criminalized communities, people who use drugs have little recourse to justice.

According to TaNPUD, police in Tanzania have been reported to falsely accuse women of drug use, or act on the word of a man who accuses a woman of using drugs. One woman from Tanzania reported witnessing a woman carried by her neck and beaten after attempting to exercise her rights to the officers detaining her. Sexual assault and rape of women who use drugs by police have also been reported in Tanzania. In one case HIV was transmitted and the police officer left unaccountable for his actions, as occurs in most cases of police violence against women who use drugs. Community members have reported having police assistance withheld unless they agree to become informants. Combined factors such as these foster distrust towards law enforcement and dilute the effectiveness or viability of reporting gender-based violence through State-sponsored mechanisms.

Prisons, involuntary detention centres and other forms of incarceration supported by the State, including medical settings such as drug treatment centres in Nepal or Thailand, are institutional settings where women who use drugs face additional risks of physical or sexual violence. Overincarceration for drug-related offences significantly contributes to overcrowding, which can in turn lead to inhumane conditions that amplify health risks and the possibility of violence.

Similar issues and violations are found to be proliferate within private rehabilitation centres, which fall under the jurisdiction of the State who are thus responsible for monitoring and addressing occurring human rights violations. The Working Group on Arbitrary Detention has noted many of these facilities, both State run and private, detain people against their will. Detention in these centres are often presented as an ‘alternative to incarceration’ even though people are still deprived of their liberty. In private rehabilitation centres people are often brought into detention by law enforcement, family members, or medical officials. Staff at private rehabilitation centres often intimidate people into signing consent forms under the threat of violence to them or their families.[[7]](#footnote-7) The fact that incarceration within these settings often occurs without due process is a subversion of human rights obligations. Results of the Working Group’s study into arbitrary detention and drug polices noted that in States such as Russia, private rehabilitation centres employ practices such as flogging, beating, starvation, humiliation, electric shocks, and coerced physical labour.[[8]](#footnote-8) RN Women further reported that in Nepal, women forcibly detained within ‘treatment’ centres are particularly vulnerable given the lack of oversight mechanisms and minimum quality standards. The Working Group on Arbitrary Detention recommends that States close without delay any private treatment facilities which hold people against their will.[[9]](#footnote-9)

In State-run and community health settings women who use drugs experience structural violence as a result of stigma and discrimination. Survey respondents in Canada reported that an Indigenous female drug user died in hospital because of medical negligence, whilst another respondent from Kenya reported rude and dismissive behavior from health personnel that led to disruption of hepatitis C treatment.

1. **Please also share information on the impact of criminalization of sex work, same sex relations, transgender persons, abortion, drug abuse, harmful practices in obstetric care, female genital mutilation on the violence experienced by the affected individuals and their enjoyment of the right to health.**

Criminalization of drugs, combined with wider gender equalities and discrimination are the primary drivers of violence perpetrated against women who use drugs. Globally, drug offenses are one of leading causes of incarceration for women. Although women comprise only 6.9% of the global prison population, 35% of women have been convicted of a drug-related offense, compared to 19% for men. This number is dramatically higher in countries such as Thailand (82%), Cambodia (73%) or Brazil (68%).[[10]](#footnote-10) In Europe and Central Asia one in four women are incarcerated for drug-related offenses, a much higher rate than men.[[11]](#footnote-11) In Latin America over 70% of women experiencing incarceration were charged with drug-related offenses.[[12]](#footnote-12)

In its resolution 61/143 of 19 December 2006[[13]](#footnote-13), the General Assembly stressed that violence against women includes ‘arbitrary detention of liberty’, in acknowledgement that contact with the criminal justice system has unique implications for women, including a higher risk of physical or sexual violence and denial of gender-specific health needs. The resolution urges States to review and, where appropriate, amend or abolish policies which have a discriminatory impact on women. Similarly, the Bangkok Rules stress the importance and urgency of reducing incarceration for women. The criminalization of drugs must be considered one of these policies which needs to be prioritized and promptly addressed.

Incarceration and arbitrary detention has a profoundly negative impact on the health of women and puts them at further risk of physical or sexual violence at the hands of law and prison personnel. Harm reduction services are rarely available in prisons or other carceral settings, resulting in a higher likelihood of incarcerated women sharing injecting equipment and increased risk of HIV and HCV transmission. Opioid agonist treatment (OAT) is also rarely available in prisons, leading to harmful and painful withdrawal symptoms. Various human rights bodies and the Special Rapporteur on torture consider withholding of OAT an inhumane practice which should be immediately stopped.[[14]](#footnote-14) In their 2015 review of Russia, CEDAW highlighted the absence of OAT programmes for women who use drugs as a concern which impacts the right to health.[[15]](#footnote-15)

Criminalization makes women who use drugs easy targets for law enforcement, who as previously stated are common perpetrators of physical or sexual violence against women who use drugs. Because the threat of incarceration is always present, most women who use drugs feel unsafe in health settings, as in some settings medical staff are required to report to law enforcement agencies, hence making the threat of incarceration ever more rampant.

In many States drug criminalization is further utilised to justify the denial of reproductive health rights. In Canada, community members report that healthcare providers will deny contraception, or other reproductive health services, for women who use drugs. At the most extreme end this has led to forced sterilizations or abortions initiated by the State.[[16]](#footnote-16) State persecution of pregnant and parenting women who use drugs has additional repercussions for the health of both women and their children. Drug use alone is often enough to revoke reproductive and parental rights. Stigmatization of women who use drugs contributes to the spread of misleading or false information regarding the effects of drugs on reproductive health and pregnancy. This in turn may lead to ‘zero tolerance’ policies regarding drug use during pregnancy, which can violate the reproductive health rights of women and lead to loss of child custody. A community outreach worker from Kyrgyzstan reported being arrested while she was pregnant. She spent several more years in prison and had the baby whilst incarcerated. Her baby spent the first nine months of their life in prison before being released into the custody of their grandmother. By the time of release, her child was two years old.

In many States, criminalization of drug use and possession is further utilized to justify the denial of sexual health rights. Some estimates indicate that up to a third of women who inject drugs also participate in sex work.[[17]](#footnote-17) Due to the criminalization of sex work, along with drug use and possession, female and transgender sex workers who inject drugs face intersecting stigma for their drug use, sex work and gender identity, forcing them to work on the street where they face higher possibilities of experiencing physical or sexual violence. Because of the nature of working in a criminalized environment, sex workers who use drugs are also further discouraged from seeking options for redress or justice from the State, out of fear of repercussions over either their sex work or drug use.

1. **Please share information on the health and other type of responses provided by the State and/or other actors in your country/ies or regions in focus to survivors of each/some of the aforementioned forms of violence. Please assess what works well and not so well, and whether COVID-19 impacted the response and how.**

Globally, there have been several recommendations and responses issued by UN bodies and human rights treaties and working groups that are relevant for women who use drugs experiencing violence.

Gender-based violence: UNODC has noted that gender based violence perpetrated by members of law enforcement are among the most under-reported instances of violence and are least likely to end in a conviction.[[18]](#footnote-18) Recommendations made by the OHCHR concerning human rights standards and practice for police calls for police to “exercise due diligence to prevent, investigate and make arrests for all acts of violence against women, whether perpetrated by public officials or private persons, in the home, in the community, or in official institutions.”[[19]](#footnote-19) Several recommendations were made to States in the updated Model Strategies and Practical Measures on the Elimination of Violence against Women in the Field of Crime Prevention and Criminal Justice (GA resolution 65/228) on the need to address this problem through training of law enforcement which emphasises a victim-centered approach to gender-based violence[[20]](#footnote-20).

Many states have health services designed for victims of violence which provide food, housing, new clothing, psychosocial support, and other critical services for victims of violence. In Kyrgyzstan clinical guidelines for doctors and healthcare workers specify that gender-specific needs for women who are victims of violence exist, but here as elsewhere, women who use drugs are not able to access these sources of support due to an inherent fear of institutional care as well as being deemed ineligible due to their criminalized status.

Mass incarceration: The Working Group on Arbitrary Detention, in their recent report on arbitrary detention and drug policies, calls into question whether States which permit overcrowding due to the enforcement of drug criminalisation are in violation of article 10 of the International Covenant on Civil and Political Rights, which calls for people deprived of liberty to be treated with humanity and dignity.[[21]](#footnote-21) Similar principles and recommendations are outlined in the Nelson Mandela Rules and the Bangkok Rules.

Sexual and reproductive health rights: CEDAW makes unequivocally clear that forced, coercive and otherwise involuntary sterilisation or abortion is a violation of State parties’ obligations concerning the right to health and further reflects discrimination towards women due to their health status.[[22]](#footnote-22) This position was restated in 2013 by the Special Rapporteur on torture and other cruel, inhumane, or degrading treatment or punishment who noted forced sterilisation amounts to torture[[23]](#footnote-23). The OHCHR and multiple UN agencies including UN Women, WHO, UNAIDS and UNDP have called on all States to eliminate forced sterilisation.[[24]](#footnote-24)

National services and programmes: In Kenya the State has initiated an anonymous helpline for women have experienced or are experiencing violence. However, many women who use drugs do not use the service for fear of having to disclose their drug use status and due to a general distrust of services whom are not known to practice culturally-competent care for people who use drugs. Many shelters run by the State to house survivors of gender-based violence exclude women who use drugs by requiring abstinence, or a negative drug test prior to entry. This was noted in both Spain and in Kenya, who added that even if a woman who uses drugs is admitted into a shelter, they may be expected to remain abstinent during their stay and be subjected to invasive drug testing. If a drug test is refused, respondents reported that it could be forced using a urinary catheter, a painful and invasive procedure.

1. **Please specify the budget allocated in your country/ies in focus, to health related response to survivors of all/some forms of violence mentioned above. Please indicate the percentage of the national budget devoted to this; the percentage of the international aid provided or received for this. Please explain the impact of Covid 19 to the funding of responses to all/some forms of violence in your State/institution.**

Globally, funding for health interventions for people who use drugs is already low and dedicated funding for meeting the complex health and social needs of women who use drugs is even lower.[[25]](#footnote-25) There is little financial support offered directly for programmes or initiatives which prevent and violence against women who use drugs or support survivors of violence.

The only available funding for programming for people who use drugs comes through HIV-related funding for key populations such as the Global Fund and PEPFAR. The Global Fund remains the largest donor for harm reduction programmes in low- and middle-income countries representing two-thirds of the total expenditure level for people who use drugs (63%), which is five times higher than the next biggest funder, PEPFAR (13%)[[26]](#footnote-26). However, considering funding levels in the context of UNAIDS’ new resource needs estimates, harm reduction is funded at just 5% of the US$2.7 billion annual requirement by 2025[[27]](#footnote-27). More disaggregated data is missing on the budget allocation for key populations, in particular for people who use drugs and the survivors of the aforementioned forms of violence.

There is also a considerably low level of reporting of domestic public expenditure on key populations, indicating a general lack of investment and commitment for such programmes by national governments in LMICs. It is clear that funding needs and gaps are not being met with the current level of funding availability, due to variances in funding levels across geographic regions. Overall, there is a scarce amount of data on human rights and violence responses, including community mobilisation and access to justice funding such as paralegal programmes. There is an urgent need for all States to take this into consideration in their respective national HIV policies[[28]](#footnote-28).

The funding pie for community-led initiatives, which are both more effective in reach and quality and culturally competent, is even scarcer to the point that data on funding allocations is impossible to obtain. However, we know that community-led initiatives which support survivors of violence, such as Metzineres in Spain or SALVAGE in Tanzania, struggle to fund themselves enough to stay open due to the lack of sustainable financing.

1. **Please describe the needs of survivors of the abovementioned forms of violence as identified by your State/institution. Please share survivor-self identified needs and those of their families, with a focus on health emergency and long-term needs.**

The following needs have been identified as critical in addressing the needs of women who use drugs who have survived violence:

* + - Legal aid and support: with a particular focus on no-cost or low-cost and paralegal programmes. Respondents in Tanzania instance noted the difficulties in navigating the complexities and formalities of the legal system along with the high cost. This risks further traumatizing community members and increases risk of ongoing harassment from perpetrators of violence, law enforcement and the public. For women who experience intimate partner violence, additional legal support may be necessary to help them separate from their partners or others who have harmed them. Parents who have been separated from their children because of criminalization could also need legal support to regain custody
    - Safe, accessible housing: particularly relevant for survivors of domestic violence. Shelters and housing should be non-discriminatory, as respondents in Tanzania reported being denied entry into shelters and safe spaces because of their drug use. Some reported having to return to co-habitation with their abuser as a result
    - Mental health support: a personalized approach that caters to each individual is needed. Abstinence should never be requirement for accessing health support, including mental health support. Community members in Nepal identified psychosocial counselling as a priority for survivors of violence

1. **Please share examples of good practices and examples of comprehensive health responses to survivors of violence and indicate efficient multi-sectorial efforts at the community, national, regional and international levels by State or non-State actors.**

There are a number of good practices from the Implementing Comprehensive HIV and HCV Programmes with People who Inject Drugs: Practical Guidance for Collaborative Interventions (the “IDUIT”) which should be considered by States as part of any comprehensive health response to violence. The IDUIT is based on recommendations from INPUD, UNODC, WHO, UNAIDS, UNDP and USAID.[[29]](#footnote-29)

As mentioned above, legal aid and support are essential elements to ensuring access to justice for survivors. For women who use drugs, poor awareness of one’s rights or the inability to access timely legal support may result in prolonged detention, police abuse or denial of access to adequate health services. The responsibility of States to provide legal aid, including for people who use drugs, has been recognised in UN principles and guidance on access to legal aid in criminal justice systems, and established in a range of treaties including the ICCPR.[[30]](#footnote-30) Members of the community should also be trained to provide paralegal assistance. In Indonesia, the drug-user led network PKNI trained around 120 people who use drugs across eight provinces to provide paralegal assistance in drug-related cases by giving people information about their rights and refer cases to lawyers.[[31]](#footnote-31)

Any comprehensive health response to violence against women who use drugs should be made in consultation with survivors of violence within the community, who know their needs better than anyone. Several good community-led and community-based practices exist that are run by INPUD’s survey respondents:

* + - Metzineres in Barcelona is a community-based health initiative which offers women who use drugs and survivors of violence a safe and confidential environment where their health needs can be met. The community in Metzineres offers a safe haven for women who use drugs along with free services such as housing, psychosocial counselling, harm reduction services, laundry and gender specific healthcare.
    - SALVAGE in Tanzania provides women who use drugs and other women who have experienced violence shelter and medical attention. SALVAGE provides information on available legal services and advice for women who are uncertain how to navigate the justice system, and has also conducted public awareness campaigns to call attention to gender-based violence experienced by women who use drugs.
    - Asteria Public Foundation in Kyrgyzstan runs a shelter and safe space by and for women who use drugs. It provides temporary accommodation, food and practical help to women and their children. Asteria also supports women in accessing HIV testing and adhering to treatment.

Community-led research concerning violence against women who use drugs should be supported by the State in order to bridge the current gaps in data and research and practice, which is necessary to inform appropriate State responses. For example, RN Women in Nepal has compiled research concerning violence against women who use drugs in rehabilitation centres across the Kathmandu valley. This research documented evidence of violence against women who use drugs occurring in State-run and private rehabilitation centres and has been presented to the Ministry of Home Affairs, as well as included in other human rights submissions. Also, the aforementioned SALVAGE in Tanzania conducted a survey amongst women who use drugs and their families during the COVID-19 pandemic. Together with the Tanzania Network of People who Use Drugs (TaNPUD), they presented the findings of their survey to UNAIDS as part of an effort to galvanize global support and funding for masks, feminine hygiene products, food, and other nutritional items.

1. **Please describe State and other actors initiatives and measures to prevent these forms of violence, specific budget allocated to prevention, and good practices in this regard.**

Decriminalization of drugs is a crucial step that must be taken to curb violence against the community. As discussed, drug criminalization and associated State policies are the primary drivers of violence against people who use drugs and also discourages those who do experience violence from seeking help, redress, or justice from the State. Decriminalization would reduce the overall number of incarcerated women, reduce the possibility of violent police encounters, allow more women to access critical sexual and reproductive health services, and help survivors of violence feel safer when seeking out State-run services or methods of legal redress.

Efforts to decriminalize drug use are being implemented in a growing number of States and local jurisdictions. The Global AIDS Strategy 2022-2026 contains three ‘10-10-10’ social enabler targets which call on States to remove punitive laws and policies which criminalise key populations as well as addressing stigma, discrimination and gender-based violence at a structural level.[[32]](#footnote-32) These targets were also included in the 2021 Political Declaration on HIV/AIDS.[[33]](#footnote-33) Decriminalization of drug use and possession was recommended by the Working Group on Arbitrary Detention in their study on arbitrary detention and drug policies. Additionally, all States must eliminate forced sterilization and abortions, entirely in line with global human rights jurisprudence concerning the right to health and prevention of torture.

State interventions that address stigma and discrimination against women who use drugs should also be implemented alongside decriminalization. This should include efforts to destigmatize women who use drugs while pregnant. Such interventions have been recommended by the CESCR in their State reviews of countries such as Estonia and Ecuador.[[34]](#footnote-34)

To increase access to justice for women who use drugs, procedures for identifying and appropriately responding to perpetrators of violence in a manner which protects women from future instances of violence are necessary. These should be created and implemented in meaningful consultation with women who use drugs, who know better than anyone what is needed to eliminate violence. Community-led documentation of violations, such as those undertaken by community-led and community-based organisations in Spain and Tanzania, should be established as an accountability and monitoring mechanism for survivors of violence. Legal aid providers also need to be adequately informed of the needs of women who use drugs, so they can be prepared to address their needs in legal environments.

All States must hold their law enforcement agencies accountable for violence committed against women who use drugs. Perpetrators of violence within the criminal justice system – including prison guards and people who work in drug detention facilities – must be brought to justice by the State, as recommended by the CESCR in its 2019 State review of Estonia.

Health and social services designed for survivors of violence should be always provided on a voluntary basis and ensure confidentiality, whilst not requiring abstinence as an eligibility criterion. They should be made more accessible for women who use drugs, specifically by ensuring female staff are available and that harm reduction is included in comprehensive health programmes offered to survivors of violence. Moreover, it is important that healthcare workers are properly trained on gender-specific needs for women who use drugs. Reproductive health services should be emphasized and included routine gynaecologic care, such as treatment for STIs and access to contraception. Providing childcare also makes it more likely that all these services will be made more accessible and culturally competent. In response to COVID-19, States should consider initiatives which assist women who use drugs and victims of violence with employment, housing, and transportation to healthcare clinics, including to get OAT and ensure that take-home doses are available to all clients.

Women’s shelters and other women-specific services which provide a safe space for survivors of violence present a very important initiative that all States should be funding and operationalizing, at no cost to those who access them and without requiring abstinence or enforcing regular drug testing of clients. These shelters should also include access to harm reduction, including naloxone, and childcare support.

As a structural determinant of health, structural and institutional violence (including criminalization) not only impedes on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, but systematically works to undermine this right. Urgent policy and programmatic action are needed to bridge the current, glaring divide between drug policies and human rights.

**Glossary of definitions for the purpose of this questionnaire**

* Gender based-violence, is violence directed toward, or disproportionately affecting someone because of their gender or sex. Such violence takes multiple forms, including acts or omissions intended or likely to cause or result in death or physical, sexual, psychological or economic harm or suffering, threats of such acts, harassment, coercion and arbitrary deprivation of liberty. Examples include, sexual violence, trafficking, domestic violence, battery, dowry related violence, coerced or forced use of contraceptives, violence against LGBTI people, femicide, female infanticide, harmful practices and certain forms of slavery and servitude. Gender-based violence may be perpetrated against women, girls, men, boys, and non-binary persons. Gender-based violence, including sexual violence, may linked to a conflict.
* Gender based violence against women (including girls) refers to violence that is directed against a woman because she is a woman or that affects women disproportionately. (CEDAW, [General recommendation 19](about:blank), 1992). It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender based violence affect women to different degrees depending on their experience of varying or intersecting forms of discrimination including on the basis of ethnicity/race, socioeconomic status, age, disability, being lesbian, bisexual, transgender or intersex, etc. [(CEDAW, General recommendation 35, 2017).](about:blank)
* Violence against children refers to all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse against children. (CRC, [General Comment No. 13](about:blank), 2011). Violence experienced by boys and girls may also be a form of gender-based violence.
* Gender based violence perpetrated against LGBTI or other persons based on real or imputed sexual orientation, gender identity, and /or sex characteristics includes killings, imposition of death penalty for homosexuality, death threats, beatings, corporal punishment imposed as a penalty for same-sex conduct, and/or transgender persons, arbitrary arrest and detention, abduction, incommunicado detention, rape and sexual assault, humiliation, verbal abuse, harassment, bullying, hate speech and forced medical examinations, including anal examinations, and instances of so-called “conversion therapy” and forced/coerced medically unecessary procedures on intersex children and adults. (Report of the Independent Expert on protection against sexual orientation and gender identitiy, ([A/HRC/38/43](about:blank), 2018, [OHCHR, Born Free and equal](about:blank), OHCHR, [Background note on human rights violations against intersex perople).](about:blank)
* Conflict related gender-based violence: Conflict can result in higher levels of gender-based violence against **women and girls**, including arbitrary killings, torture, **sexual violence** and forced marriage. Women and girls are primarily and increasingly targeted by the use of sexual violence, including as a tactic of war. M**en and boys** have also been victims of sexual violence, especially in contexts of detention. *Conflict related sexual violence* refers to rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage, and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is directly or indirectly linked to a conflict. That link may be evident in the profile of the perpetrator, (often affiliated with a State or non-State armed group, which includes terrorist entities); the profile of the victim, ( frequently an actual or perceived member of a political, ethnic or religious minority group or targeted on the basis of actual or perceived sexual orientation or gender identity); the climate of impunity, (generally associated with State collapse, cross-border consequences such as displacement or trafficking, and/or violations of a ceasefire agreement). The term also encompasses trafficking in persons for the purpose of sexual violence or exploitation, when committed in situations of conflict”. (Report of the Secretary General [S/2019/280](about:blank), 2019.)
* Systemic or institutional violence refers to institutional practices, laws or procedures that adversely affect groups or individuals psychologically, mentally, culturally, economically, spiritually, or physically. This violence has its origins within or outside the state, and is a major obstacle for the realization of the right to health, a right which is interconnected with rights to the underlying determinants of health.

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