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QUESTIONNAIRE

Contact Details

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

	☐ Member State ☐ Observer State ☒ Other (please specify)
Name of State Name of Survey Respondent	European Sex Workers Rights Alliance (ESWA)
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Background

Within the framework of Human Rights Council resolution 51/21, the Special Rapporteur on the highest attainable standard of physical and mental health has identified health equity as a strategic priority, ranging from the underlying determinants of health to the need to eliminate structural and systemic barriers in accessing health care services, goods, and facilities, particularly among persons living under vulnerable or marginalised circumstances. In compliance with her mandate and in line with these priorities, the Special Rapporteur on the right to health has decided to devote her next thematic report to the Human Rights Council, to be held in June 2024 to the theme of "Drug policies and responses: a right to health framework on harm reduction".

Objectives of the report

All persons are entitled to the enjoyment of the highest attainable standard of physical and mental health, which includes the underlying determinants of health and timely and appropriate health care. In the present report, the Special Rapporteur intends to explore the ways in which harm reduction intersects with the enjoyment of right to health and related human rights. Relying on the frameworks of the social and commercial,[1] determinants of health, the Special Rapporteur will examine the laws, policies, and practices that give rise to the need for harm reduction, as well as the laws, policies, and practices that take a harm reduction approach, aiming to address the negative health, social, and legal outcomes in various contexts.

Harm reduction has been primarily developed in the context of drug use, including needle and syringe programs, supervised injection and drug use facilities, opioid substitution therapy, overdose prevention, and community outreach programs, as well as

[1] See: www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health

access to legal assistance, social services, housing, and adequate food. However, in this report, the Special Rapporteur will take a broadened view of harm reduction to examine how this approach can intersect with the right to health and related human rights in other realms, including but not limited to sex work, abortion, and safe sex.

The Special Rapporteur also intends consider harm reduction as key public health interventions for populations that are often stigmatised and discriminated against. She will explore how the laws, policies, and practices that give rise to the need for harm reduction can disproportionately impact certain people, such as those in situations of homelessness or poverty, persons who use drugs, sex workers, women, children, LGBTIQ+ persons, persons with disabilities, persons who are incarcerated or detained, migrants, Indigenous Peoples, Black persons, persons living with HIV or hepatitis, and persons living in rural areas. Taking an anti-coloniality and anti-racism approach, the Special Rapporteur will explore how in some contexts criminalisation and stigmatisation can serve as a legacy of colonialism and slavery.

Definitions

Most commonly, harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.[2] For the purposes of this report, the Special Rapporteur defines harm reduction in a broader sense, including the policies, programmes, and practices that aim to minimise the negative health, social, and legal impacts associated with various behaviours and related policies and laws, as exemplified above.

Questionnaire

The questionnaire can be downloaded below in English (original language), French and Spanish (unofficial translations). Responses can address some of the questions or all of them, as feasible or preferred.

- Download the questionnaire (WORD): English | Français | Español

How and where to submit inputs

Inputs may be sent by e-mail by 15 November 2023.

E-mail address	ohchr-srhealth@un.org
E-mail subject line	Contribution to HRC report - SR right to health
Word limit	500 words per question
File formats	Word and PDF
Accepted languages	English, French, Spanish

Treatment of inputs/comments received

Please note that all responses will be published on the official webpage of the mandate of the Special Rapporteur by default.

Key Questions

[2] See also: https://undocs.org/Home/Mobile?FinalSymbol=A%2F65%2F255&Language=E&DeviceType=Desktop&LangRequested=False, para. 50.

You can choose to answer all or some of the questions below. (500 words limit per question).

Inputs may be sent by e-mail **by 15 November 2023**.

1. While the concept of harm reduction has traditionally been applied to drug use, the Special Rapporteur is taking a broadened approach to harm reduction. What types of harm reduction policies, programmes, and practices are in place in your community, and what is their purpose or aim? How successful have they been at achieving that aim? Please provide data, as possible.

Sex workers' communities recognise the importance of harm reduction – and some its components can be applied to sex work. However, the harm reduction framework is not fully adaptable to sex work. Sex work is not inherently harmful – sex work similarly to other forms of labour in particular precarious and informal work, carries health risks. Therefore, a labour rights and health safety approach to sex work is the best approach to minimising potential harm that can occur in sex work.

Both groups, sex workers and drug users are subjected to repressive and discriminatory laws, policies and practices. Sex workers who use drugs face double stigma, discrimination and criminalisation. In addition, sex workers who use drugs are stigmatised in their communities. Sex workers who use drugs (especially those who inject drugs) experience stigma and discrimination from both sex worker and drug user communities.

Sex workers who use drugs are subjected to a great degree of violence. Given the criminalization of both sex work and drug use, the prevailing stigma, and the fact that reporting a crime can backfire on them, they are unlikely to report acts of violence against them.

Chemsex, which refers to the use of drugs in a sexual context, concerns mainly gay, bisexual, and other men who have sex with men. Chemsex has emerged as a public health concern and is accompanied by societal and cultural stigma, such as society's lack of acceptance, the impact of the HIV epidemic, internalised homophobia, coming-out issues, experiences of discrimination and violence, and normalisation of drug use in the gay community. People engaged in chemsex often have hard time finding reliable and easily accessible information.

It has been recognised that for both communities, sex workers and drug users there is a critical role of peers and communities in harm reduction. Such organisations are often run by volunteers with little financial or human resources. Some funding sources are available only for more prominent established NGOs, meaning smaller grassroots and community-led organisations cannot access them. Such organisations often have no core funding at all. Another specific challenge is the lack of official documentation or other legal requirements granting safe status to the members of the organisations, for instance, in the case of sex workers. Their precarious situations create additional difficulties for

them in organising and speaking up for themselves, as some may fear that raising their voice could result in losing their job and/or legal status.[3]

Further, reaching the communities online, is another obstacle, as social media companies may also limit public participation and harm reduction services online. For instance, sex workers' organisations found that their accounts were deleted without prior notice[4].

National Ugly Mugs (NUM) is a pioneering national organisation that provides greater access to justice and protection for sex workers who are often targeted by dangerous individuals and face obstacles to reporting, access to service and police protection.

2. How do legal frameworks affect the harm reduction policies, programmes, and practices (whether related to drug use or otherwise) that are available in your community, country, or region? Are there laws or policies that either facilitate or serve as a barrier to adopting or implementing certain harm reduction policies, programmes, and practices? Aside from legal and regulatory barriers, are there other obstacles in place? Please provide specific examples.

Harm reduction aims to reduce the risks and harms that may accompany various activities such as sex work and drug use. Effective harm reduction programs do not seek to discourage or reduce sex work or drug use but to reduce avoidable harm. This understanding of harm reduction is critical, especially concerning the legal frameworks. In the European context, the so-called Swedish model criminalising clients of sex workers as a strategy to abolish prostitution has now been adopted in Norway and Iceland (2009), Canada (2014), Northern Ireland (2015), France (2016), the Republic of Ireland (2017) and Israel (2018), and thanks to the official Swedish foreigner policy[5] continues to be debated[6] in many other regions countries[7]. The Swedish model law seeks primarily to discourage, reduce, and abolish sex work, which stands in firm opposition to what the harm reduction approach aims to do. Such (sexual) humanitarian[8] regimes of care or governing in the name of advancing higher moral principles have a particular resonance in countries which take pride in their welfare model and progressive humanitarian politics, of which gender equality is one[9]. In general, people who sell sex can perceive social services that focus on (prostitution) exit strategies and prostitution abolition

[3] See: Fundamental Rights Agency of EU: Protecting Civil Society, 2023 Update, Chapter 5.2 Spotlight: Participation of organisations representing groups at risk of exclusion. http://fra.europa.eu/en/publication/2023/civic-space-2023-update

[4] The Impact of Online Censorship and Digital Discrimination on Sex Workers, ESWA, February 2022, The Impact of Online Censorship and Digital Discrimination on Sex Workers - European Sex Workers' Rights Alliance (eswalliance.org)

[5] See: https://www.diplomatie.gouv.fr/IMG/pdf/joint_statement_-_france_and_sweden_cle08dbbd.pdf

[6] See e.g: https://www.europarl.europa.eu/doceo/document/TA-9-2023-0328_EN.html or https://www.osce.org/files/f/documents/7/f/489388_2.pdf

[7] See: https://cne.news/article/3856-german-christian-democrats-want-to-implement-nordic-model-to-regulate-prostitution or https://english.elpais.com/elpais/2018/12/07/inenglish/1544171107_204329.html

[8] See the SEXHUM Project websites and outcomes: https://sexhum.org/ in which the concept of 'sexual humanitarianism', refers to the increasing way in which some migrant groups and individuals are understood and targeted by humanitarian concerns, policies and interventions as uniquely and specifically vulnerable in relation to their sexual behaviour, which often legitimises harmful anti-sex work and anti-immigration initiatives.

[9] Governing in the Name of Caring—the Nordic Model of Prostitution and its Punitive Consequences for Migrants Who Sell sex https://vuolajarvi.weebly.com/uploads/1/3/1/5/131576300/governinginthenameofcaringprintvuolajarvi2018.pdf

instead of harm reduction as punitivist[10]. The failure of the Swedish approach has been noticed for instance, by the Council of Europe GREVIO[11] monitoring mechanism, which is concerned that the support provided by the social services and public health care sector to women victims of domestic and sexual violence who are in addiction and/or prostitution fails to focus on their victimisation. Another concern brought to the attention of GREVIO relates to the attitudes which women victims of violence who are in addiction and/or prostitution face when turning to the health sector. The Swedish approach to sex work, accompanied by a 'zero-tolerance' approach to drug use[12] has created a hostile environment for interventions that seek to reduce the potential damages of drug use or reduce the risks and/or harms that may accompany sex work, rather than preventing or eliminating drug use itself or prioritising wellbeing and safety of sex workers. The Study[13] on the impact of the French Prostitution Act echoes the negative consequences of the Swedish model law. Being pushed into isolated, dark places leads to new obstacles to conducting harm reduction work.

Grassroots organisations have sometimes had to extend their rounds, exploring different places to stay in contact with people, and have sometimes had to be innovative in their prevention work. The law has pushed sex workers to operate under more risky conditions with dangerous implications for their health. Many sex workers in the research highlighted a worrying decrease in condom use as well as increased difficulties in continuing treatment for those who are HIV-positive. Besides the criminalisation of clients, the 2016 law in France also included the creation of an "exit program" providing eligible sex workers access to financial aid, a temporary residence permit of six months and the support of an accredited organisation to access housing and employment. Criticism of the exit program stems from the misrepresentations of the sex industry that it produces. Since support is given only to people who assent to stop doing sex work, this can be seen as a fundamental infringement of their human dignity and an unrealistic condition for financial reasons for most sex workers. Moreover, sex workers are obliged to give up an activity that is not itself illegal. The Swedish model law and its approach significantly redirect funding from harm reduction programmes to exit programmes, which are conditional on the cessation of sex work.

3. How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use? Please provide disaggregated data, including but not limited to gender, age, race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.

4. Beyond reducing the adverse health, social, and legal consequences of drug use, what other areas can benefit from harm reduction policies, programmes, and practices in furtherance of the right to health and related human rights? Examples may include, but are not limited to, the decriminalisation of sex work, the decriminalization of abortion, and safe sex programmes.

[10] See Governing in the Name of Caring—the Nordic Model of Prostitution and its Punitive Consequences for Migrants Who Sell sex https://vuolajarvi.weebly.com/uploads/1/3/1/5/131576300/governinginthenameofcaringprintvuolajarvi2018.pdf

[11] See: https://rm.coe.int/grevio-inf-2018-15-eng-final/168091e686 see para (15), (131), (211)

[12] https://transformdrugs.org/blog/drug-policy-in-sweden-a-repressive-approach-that-increases-harm

[13] Hélène Le Bail, Calogero Giametta, Noémie Rassouw. What do sex workers think about the French Prostitution Act?: A Study on the Impact of the Law from 13 April 2016 Against the 'Prostitution System' in France. [Research Report] Médecins du Monde. 2019, pp.96. ffhal-02115877 Available: https://sciencespo.hal.science/hal-02115877/document

Decriminalisation of sex work plays a vital role in advancing harm reduction policies. Such a policy shifts the focus away from a criminal justice approach, and instead, the funding can be directed towards services that the community needs. Decriminalisation also allows policymakers to plan better and design interventions where consultation with target groups is not burdened by illegality or the assumption of immorality. Meaningful involvement of affected communities in the design of such policies and interventions is crucial to planning such policies. In a decriminalised context that reduces moral panics, it is possible to set up funding for services provided by community members themselves and their organisations.

Example of Belgium[14]

The COVID-19 pandemic that has wreaked such havoc on sex workers around the world has spurred action to protect the health, rights and well-being of sex workers. In March 2022, Belgium became the first country in Europe to decriminalise sex work and the only other country in the world to do so after New Zealand. Efforts to decriminalise sex work have received strong and influential support from academic experts and the Belgian Minister of Justice.

5. What type of harm reduction policies, programmes, and practices, as well as mental health and other support (e.g., housing, legal, social, educational, and economic), are available for people who use drugs in the community, institutions, or detention facilities? Please share examples of the impact of criminalisation, discrimination, stereotypes and stigma on the different groups of the population e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).

6. Are there alternative measures to institutionalisation or detention? For example, are there outpatient or inpatient facilities available in your country for people using drugs? Please provide additional details (are they compulsory, voluntary; number available in urban and rural areas; entity in charge; type of support provided and type of staff working in these facilities/centres)?

7. Please provide examples of harm reduction policies, programmes, and practices adopted or implemented with international cooperation or through foreign assistance in your country, as well as their impact on different groups within the population. What types of challenges can arise from reliance on foreign assistance? Please also provide examples focusing on the need for, and impact of, harm reduction policies, programmes, and practices on different groups of the population (e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).

[14] https://www.nswp.org/news/sex-workers-belgium-celebrate-historic-vote-decriminalisation-parliament https://www.reuters.com/article/belgium-sexwork-decriminalisation-idUSL5N2X54FF

8. Are there programmes of research and innovation related to harm reduction from a right to health perspective (e.g., needle and syringe programmes, supervised injection and drug use facilities, opioid substitution therapy, and others beyond the area of drug use), including outreach and education programmes, in your community, country, or region? Please provide good practices and examples.