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**RESPONSE TO QUESTIONNAIRE by**

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

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

**Background and Contact Details**

CREA is a global feminist human rights organization based in the Global South and led by feminists from the Global South. CREA’s work draws upon the inherent value of a rights-based approach to sexuality and gender equality.

CREA promotes, protects, and advances human rights and the sexual rights of all people by building feminist leadership capacities of activists and allies; strengthening organizations and social movements; creating and increasing access to new information, knowledge, and resources; and enabling supportive social and policy environments.

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**How and where we work, and who we work with**

CREA works at the community/local, national, regional and international levels. As a feminist organization founded by Indian feminists to work at the community level in India and at the regional level with South Asian feminist movements, CREA maintains a strong connection to diverse communities and constituencies on the ground in South Asia. We have also worked for almost a decade in East Africa, in Kenya and Uganda, where we work at the community and national levels, with feminist leaders and movements.

We also have newer work and partners in the Middle East and North Africa region, and have strong partnerships to women’s human rights defenders and feminists in Mesoamerica.

Our community-based and national work feeds into the work we do at the global level, attempting to shape policy through advocacy at the United Nations.

CREA works to centre the needs of those who have historically been marginalized by feminist organizing: namely LBTIQ people, sex workers and women and people with disabilities.

**Common trends in relation to GBV and its impact on the right to health**

Some of the broader issues we have observed, with the communities and movements we work with, across South Asia and East Africa, in relation to violence and its impact on the right to health, include:

* Denial of access to rehabilitation for women and people with disabilities, especially on the grounds of sexual orientation, gender identity, expression, sex characteristics (SOGIESC) and other factors
* Lack of access to Comprehensive Sexuality Education, and denial of access to healthcare services, including specialized mental health services for young people
* The fact that young people’s sexuality is criminalized through statutory rape laws and other sanctions, which make it harder for young people to seek healthcare including mental healthcare
* The fact that young people are not able to exercise autonomy in decision-making about their own health e.g. sexual and reproductive health, including abortion, that complaints about gender-based violence (GBV) are often required to be made in the presence of a parent or guardian, making young people unlikely to seek redress for GBV
* Young people’s access to gender affirming healthcare in the case of trans, intersex and nonbinary young people is heavily restricted and often impossible to access
* GBV online and GBV in its intersection with technologies more generally, and its implications on health
* Sex workers are not able to seek redress to gender-based violence, or seek healthcare services due to widespread stigma, and criminalized / penalized status
* The long-term stresses which are attributed to being a member of a structurally excluded group, such as lesbian, bisexual, intersex, trans and nonbinary, a disabled person, or a sex worker. We are able to observe the long-term impact of experiencing violence, stigma, shame, transphobia and forms of queerphobia regularly, and how often, this long-term stress-related impact is not recognized within healthcare systems.

CREA and our partners also submitted [a report to the Special Rapporteur on Violence Against Women on COVID-19 and its impact on the increase in gender-based violence.](https://creaworld.org/wp-content/uploads/2020/11/SRVAW_COVID-19_CREA-Full-submission.pdf)

**Legal frameworks: criminalisation, the erasure of autonomy and invalidation of consent**

Laws which criminalise same-sex sexual conduct and cross-dressing continue to have a negative impact on LGBTIQ people, sex workers and other structurally excluded persons, such as homeless and/or poor persons. Other laws, such as those criminalising “loitering” or “public nuisance” are frequently used against sex workers and LGBTIQ persons as well.

In Kenya, sex work in itself is not criminalised. Certain aspects are criminalised and essentially lead to criminalisation of sex work. For example, Sections 153 and 154 of the Penal Code Kenya, defines two types of offences with respect to sex work namely “living on the earnings of prostitution” and “soliciting or importuning for immoral purposes.”

Section 175 of the Sexual Offences Act defines the offence “exploitation of prostitution.” This section indicates that anyone encouraging sex work with the expectation of gain for himself or herself is guilty of an offence. Section 15 of the Act refers to the offence of “child prostitution” and criminalises the procuring of, or permitting, children under the age of 18 “to be sexually abused or to participate in any form of sexual activity or in any obscene or indecent exhibition or show.” Section 19 criminalises all aspects of engaging of persons with mental disabilities in sex work. Overall, the Sexual Offences Act criminalises any action compelling anyone, including a child or person with mental disabilities, into sexual intercourse for purposes of gaining from it, or supporting sex work in any way such as by offering premises for sexual acts to take place.

Criminalizing / penalizing abortion also has severely negative impact on women, trans people, young people and others.

The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2012) provide direction and focus in provision of reproductive health services. Abortion is illegal in Uganda excpet in the case of exceptional instances which include severe maternal illnesses threatening the health of a pregnant woman victims, of incest, rape and defilement. This provisions are similar in Kenya and most of East Africa.

In Kenya, abortion is restricted, however most supportive policies are not enacted, such as the National standards and guidelines on access to safe and legal abortion. Despite court rulings to hold the Ministry of Health responsible and accountable to ensure girls and women can access comprehensive sexual and reproductive health services, the implementation and follow up has been non-existent. For those health service providers that know about the law, they are afraid to offer services because they can be arrested and some do not offer services due to conscientious objection.

In India, Protection of Children from Sexual Offences (POCSO) Act, 2012 criminalizes all sexual activity with and between persons below the age of 18 years. The law mandates reporting in case of knowledge that such sexual activity has or is likely to occur and failure to do so incurs a criminal penalty. This places service providers in an ethical and legal dilemma of whether to report the person seeking abortion to the police or whether to deny them care. Interviews with service providers reveal that many young people leave their facilities for fear of mandatory reporting or seek alternatives, which may often be more unsafe for them ([See](https://www.nls.ac.in/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-Abortion-Services-in-India.pdf)).

Non-governmental organizations are also scared that conversations on abuse and violence may compel young people to open up and share their experiences of violence, which will then in turn put the NGO at the risk of having to report that. Similar instances have also been reported by school counselors, who also avoid topics around violence due to the burden of having to report. This shows POCSO’s sprawling negative impact on prevention, safety and awareness info on violence as well as in limiting young people’s access to mental health services around issues of violence for young people.

In our work with sex workers and their movements, we see that criminalisation/ penalisation and legal sanctions on various aspects sex work combined with restrictions on migration (such as through ‘anti-trafficking’ laws), create serious impediments in accessing healthcare services for sex workers.

Even though sex work is not always criminalized in many contexts, there is an atmosphere of police intimidation and harassment which forces sex workers to abandon safe sex practices and peer networks. For instance, sex workers may be discouraged from carrying condoms in the fear of arbitrary searches and subsequent harassment by police officials. ([see](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6289426/)) One of the most pernicious violations of sex workers’ rights is the forced medical tests including HIV testing, they are forced to undergo when picked up in raids under provisions of the Immoral Traffic Prevention Act or Indian Penal Code. The results of the HIV/AIDS tests can be used by courts to incarcerate adult sex workers in rehabilitation homes against their wishes for long periods of time on the grounds that “they cannot take care of themselves” ([see](https://www.sangram.org/upload/resources/health-status-of-sex-workers-india-cedaw-submission-15-feb-2019.pdf)). Sex workers are also subjected to moral policing and victim blaming by police officials and medical professionals which hinders their ability to file medico-legal cases in the event of GBV. (see)

In Bangladesh, sex work is not criminalized, but associated activities such as soliciting in public, living off the earnings of sex work and keeping a brothel are criminalised (Suppression of Immoral Traffic Act 1993). However, there is a system of quasi-legal brothels operating in Bangladesh. Represents a small portion of sex industry (estimate 4000 brothel based workers out of 100,000 total). Sex workers are certified by local authority, swears an affidavit, pays a fee to police and magistrate issues a certificate. ([see](https://www.nswp.org/country/bangladesh)). During COVID-19, many sex workers resorted to street-based sex work, which increases the risk of violence, condom-less sex and no pay or low pay. Sex workers also experienced greater vulnerability to gender-based violence from their spouses, partners and brothel owners due to financial precariousness([see](https://www.unaids.org/en/resources/presscentre/featurestories/2021/january/20210112_sex-work-bangladesh-myanmar)).

In India, sex work is not criminalized per se but activities such as brothel keeping, living on earnings of sex work, procuring, inducing or detaining for prostitution, with or without consent, prostitution in areas notified by Police and near public places and soliciting are criminalized. (Immoral Traffic (Prevention) Act (ITPA), 1956)([see](https://lawyerscollective.org/our-initiatives/law-and-sexuality/)). Sex workers face routine harassment, blackmail and extortion from police officers and are often subjected to misguided raid and rescue interventions. Conflation of sex work with trafficking results in adult sex workers being detained in ‘shelter’ homes, often in horrifying conditions with no access to justice or communication with the outside world ([See](https://www.opendemocracy.net/en/beyond-trafficking-and-slavery/scandals-in-indias-raid-and-rescue-shelters-is-awful-distracting-from/)). During COVID-19, sex workers lost their primary sources of income and became trapped in debt, exposing them to more violence at the hands of both moneylenders and police officers. ([see](https://www.epw.in/engage/article/locked-down-sex-workers-and-their-livelihoods))

The 2021 version of an ‘anti-trafficking’ bill in India has also been deemed dangerous by critics and activists. Upon review, it is clear that the 2021 bill conflates sex work with trafficking in persons, and lacks a rights-based approach to preventing and ending the harm done by trafficking. Activists and critics note that ‘trafficking’ is not carefully defined, leaving it open to abuse, and further that, “Particularly concerning is the bill’s over-reliance on criminalisation as a method of deterrent. This undermines labour law. While it is understandable that forced labour and trafficking offences are linked to criminal offences, this current bill brings common labour relations, such as recruitment, poor working conditions, non-payment of wages, and other irregular work arrangements, under the domain of criminal law.” (Bosc, Birla, Wadhawan, 2021) ([See](https://www.opendemocracy.net/en/beyond-trafficking-and-slavery/indias-new-trafficking-bill-undermines-access-to-work-and-labour-rights/).)

Violence faced by sex workers is, importantly, not seen as “violence” by the state in many of these contexts, due to the prevailing criminalized and stigmatized status held by sex workers. Sex workers are also not seen as being able to withhold or withdraw consent to sex, and are seen as not possible victims of sexual violence, such as rape, by law enforcement. Sex workers are often left to their own devices when it comes to addressing violence at the hands of family members and/or clients and other related actors, such as managers, or brothel owners (who are in some contexts, also criminalised themselves).

The lack of an intersectional lens in policies is also a pervasive problem across the countries where we work. For example, in India, women with disabilities (WWD) face other intersecting forms of discrimination and violence, which are largely ignored, caste being one of them. The Rights of Persons with Disability Act of India operates on a premise of analysing and understanding violence which WWDs face through centering the fact that they are disabled. An intersectional approach would instead show how WWDs at the caste margins face more and specific encounters with violence. The impact of intersecting forms of discriminations and violence is not addressed in other policies which are meant to deal with marginalized groups and specific violence-related issues either, such as the Protection of Children from Sexual Offences Act (2012) or the Scheduled Castes and Scheduled Tribes, (Prevention of Atrocities) Act, 1993.

**Conceptualisation of legal capacity**

When it comes to redress options for women and people with disabilities, the concept of “legal capacity” plays a significant role in shaping their experiences with redress mechanisms or if they are able to access those at all.

“Legal capacity” simply refers to the right to make decisions and have that right respected. It is the ability to hold a right and exercise the same right on an equal basis with others. However, legal capacity can be formal (law) or informal (practice), thus subject to varied implementation depending on context. For instance, in Africa women generally are assumed to have little to no power in decision-making. Persons with disabilities especially are assumed to lack ‘legal capacity’. Therefore, when gender meets disability, legal capacity is completely withdrawn formally and informally. A good example of this is Section 129 of the Penal Code Uganda and Section 146 Penal Code Kenya which creates the offence of “defilement of an imbecile”. The underlying assumptions of these offence, is that a person with disability cannot ever consent to sex. Section 43(4) (e) of the Sexual Offences Act presumes people with ‘mental impairment’ cannot give consent for intimate sexual relationships.

This also applies to young people who are under the legally stipulated age of consent in diverse contexts. Young people are often not seen as able to give or withdraw consent, and their expressions of consent or withdrawal of consent are not taken to have legal validity.

A second assumption around legal capacity is that women with disabilities often cannot legally exercise autonomy in decisions on their sexual and reproducitve health. Women and people with disabilities are in many cases legally required to seek the approval or consent from family members or legal guardians in order to make decisions about their own bodies, in relation to their sexuality or in reproductive matters.

In Kenya, in Federation of Women Lawyers (Fida) & 3 others v Attorney General & 2 others, East Africa Center for Law & Justice & 6 others (Interested Party) & Women’s Link Worldwide & 2 others (Amicus Curiae) [2019] eKLR, the courts held that while the right to life is still absolute, abortions can be legal in the case of rape, incest or disability. However, for women with disabilities, consent by a guardian is still needed to get an abortion. The Reproductive Health Bill of 2014 of Kenya has a strong definition of “informed consent” that ensures that women themselves make the decision to undergo reproductive health procedures. However, under the section on abortion, the Bill still allows guardians or parents to make the decision for a “mentally unstable person”—which includes women with intellectual or psychosocial disabilities—to undergo what amounts to a forced abortion. There are a number of reported cases in Kenya of forced sterilization of women with disabilities, and it is the guardians who are consenting to sterilization on their behalf. Forced sterilization is a violation of one’s right to bodily autonomy. Women with disabilities have a right to make an informed decision on sexual and reproductive health which includes but is not limited to family planning, safe consensual sex, marriage and family.

In Uganda and Kenya, we have the Domestic Violence Acts which make progressive provisions on protections of victims of domestic violence. In both countries, the Acts recognise that persons with disabilities are more vulnerable to violence and need specific types of support and protection to access services. However the same Acts perpetuate denial of legal capacity by requiring a guardian to be present/consent in order for a victim with disability to access health care services. This is also true in the case of young people, or ‘minors’, in many contexts. Evidence-gathering protocols require law enforcement officials to have parents or guardians present when young people or children are giving testimonies about violence, even if numerous studies often show that children and young people in diverse contexts face violence often at the hands of family members or relatives. This may impede the process and prevent the young person or child from an honest recantation of the extent of the violence, and asking for specific healthcare remedies. For example, young people may be less likely to ask for the morning-after pill or request a pelvic examination following a sexual assault, in the presence of a parent or guardian, for fear of stigma and punishment.

This erasure of autonomy and individual consent of structurally exclued people, in policy and legislation, is also seen in India’s Transgender Persons (Protection of Rights) Bill of 2019. The controversial Bill gives natal family members and guardians, often perpetrators of violence against trans persons, a dangerous amount of control in the decisions about trans people’s lives, for example about where they live, how they can access healthcare, and so on. The Bill also makes it mandatory for trans people to undergo surgical procedures in order to be recognized legally as “transgender”, by the state. However, the Bill also provides a mandate to the state to provide gender-affirming treatments and surgeries to trans people, and necessary health insurance schemes which would cover these treatments, which can be considered progress, however limited.

This Bill in India gives family members (by virtue of blood, marriage or adoption) power over decisions in the lives of young trans people ([see](https://feminisminindia.com/2019/08/05/critique-transgender-persons-protection-of-rights-bill-2019/)). In case their family cannot take care of them, they may be sent indefinitely to a rehabilitation centre. This is in complete disregard to the lived realities of families and immediate communities being the primary sites of violence and abuse for transgender and gender non conforming young people. There is no acknowledgement of their chosen family or friends who are better placed to support and take care of them.

India’s 2018 ‘anti-trafficking’ Bill (which was passed in the lower house, but not in the upper house), saw even the administration of hormones for early sexual maturity as an aggravated form of trafficking, once again reflecting the state’s refusal to recognize individual consent and autonomy in the case of certain groups, such as trans people.

**Accessibility of legal proceedings**

Accessibility of legal proceedings and mechanisms is also an obstacle for women and people with disabilities. Particularly within the context of the pandemic, many countries have chosen to move court proceedings online, undertaking remote court hearings and other online measures. This shift to remote hearings has made an already difficult-to-navigate redress system even less accessible to structurally excluded people, such as people with disabilities who may be facing violence and human rights violations.

[OHCHR’s 2020 COVID-19 response also highlighted the following recommendations for states and other stakeholders:](https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf)

* Ensure that reporting mechanisms, hotlines, emergency shelters and other forms of assistance are accessible to and include persons with disabilities.
* Carry out monitoring of the situation of persons with disabilities, particularly those living in isolation, by engaging in proactive outreach including through community and voluntary networks.
* Raise awareness and provide training about the risk of violence faced by persons with disabilities, in particular women and girls with disabilities, and promote support networks including fostering peer support.

**Institutional violence and medical abuse**

We are in particular concerned about the effects of institutionalisation and violence within institutions faced by women and people with disabilities. In our report to the SRVAW in 2020 (linked above), we found that “WWD are often especially vulnerable to being institutionalized, since providing home-based care is considered more complex in the case of women. Tikiri Kumara Jayawardena, President, Wellassa Organization of Persons with Disabilities, Sri Lanka says that families opt to institutionalize women and girls with disabilities to ‘protect’ them from abuse. However, this tends to overlook abuse that may occur in institutional settings.”

We understand that sex workers, transpersons and LBQ persons are quite likely to be at risk of being incarcerated, especially if they are poor, homeless, or otherwise structurally excluded, and face high volumes of violence when in custodial care. In India, the state criminalises many avenues of income for trans persons, such as begging, through ‘anti-begging’ laws, and public nuisance laws, leaving trans people vulnerable to arrest, abuse at the hands of law enforcement and incarceration.

Once incarcerated, structurally excluded people such as trans persons can face unique forms of violence. Across South Asia, for example, a genital examination-based decision results in segregation of prisoners, which deeply negatively impacts trans and intersex persons in particular. In many contexts, court verdicts and government policies have clear provisions for placing trans persons in the wards of their choosing, rather than assigning them to a ward in alignment with the sex assigned to them at birth (e.g. NATIONAL LEGAL SERVICES AUTHORITY (NALSA) VS. UNION OF INDIA judgment in India), however, we find that across the board, trans persons are subjected to invasive examinations at the outset and often placed in the ward aligning with the sex assigned to them at their birth. [(See,](https://www.humanrightsinitiative.org/download/1606377171Lost%2520Identity%2520Transgender%2520Persons%2520in%2520Indian%2520Prisons.pdf) and [see](https://www.southasiamonitor.org/spotlight/manifold-challenges-faced-imprisoned-transgender-persons-south-asia)).

Intersex surgeries and so-called “Conversion” therapies, or coercive change efforts, at times done in formal medical settings, are pervasive across South Asia and East Africa.

In a baseline study on Intersex Realities in East Africa by SIPD (Support Initative of People with Congenital Disorders), they note that, “Culture, religion and morality are used by sections of communities to reproof intersex people as a population haunted by witchcraft, and whose redemption lies in the same. As a result access to education, health care, legal services and justice becomes a challenge. In all the three East African countries surveyed, religion encouraged various divine interventions and rituals, as well as overarching silence as a solution” ([See](https://sipdug.org/wp-content/uploads/2019/03/SIPD-Baseline-Survey-on-Intersex-in-East-Africa.pdf)). The study found that in up to 30% of cases, mutilations would be performed without a single test to understand whether the intersex condition would have any long-term health implications for the infant. In only 10% of cases did they find that no unnecessary interventions were made, and the infant was not abandoned. African intersex activists have repeatedly called for an end to the violence against intersex infants and people ([see](https://www.astraeafoundation.org/stories/public-statement-african-intersex-movement/)).

Intersex activists in South Asia, such as in Nepal for example ([see](https://intersexasia.org/wp-content/uploads/2019/09/2018-CEDAW-Nepal-NGO-Intersex-IGM.pdf)), have repeatedly called for the state to act in favour of the rights of intersex people, and to end non-consensual and coercive medical interventions on intersex infants. Intersex activists in Nepal note that intersex children can be subjected to infanticide and child abandonment, intersex genital mutilation, forced marriage and stigmatisation, abuse and bullying, among other forms of violence.

Trans people face enormous burdens within medical institutions, and their right to reproduction is often not discussed with them by their medical care providers, including about their right to access to contraception, or explore ways to preserve their fertility options.

For example, trans and gender non-conforming persons in India report experiences of shame, ridicule and discrimination in public healthcare settings, with most private healthcare settings being inaccessible to them. They are denied treatment and care in alignment with their needs and with their gender and in cases where they are living with HIV/AIDS, they face double discrimination ([See](https://scroll.in/pulse/856285/transphobia-among-indian-doctors-study-aims-to-uncover-reasons-for-bias-against-transgender-people)).

Due to lack of knowledge on gender identity, coupled with stigma and insensitivity, many healthcare providers fail to seek crucial medical information related to a patient’s transition, or what courses of hormones or anti-retroviral (ART) medication they may be on. As a result, they often risk misdiagnosis and administer incorrect treatment which can cause long-term harm. ([see](https://www.forbesindia.com/article/new-year-special-2022/discrimination-against-transpersons-plagues-indias-health-care-system-its-time-to-overhaul-it-aqsa-shaikh-harikeerthan-raghuram/72791/1))

Transgender and gender non-conforming persons are often excluded from public discourse on abortion policy and access to sexual and reproductive health and rights. For example, [researchers and activists in Sri Lanka](https://www.researchgate.net/publication/345337282_Acts_of_Agency_Exploring_a_Feminist_Approach_to_Abortion_Research_in_Sri_Lanka) noted in a study that trans people are almost never a part of the debate and the discussion about access to abortion, though they have a right to be; their study documents transmasculine persons’ views on reproductive rights and the need for trans people to have the right to access safe and free abortions. Trans people in Sri Lanka also noted the need to have reproductive options discussed with them, “As a trans person transitioning medically, it is my experience that not a single doctor will ever ask you, ‘Do you want to preserve your eggs?’ The idea is, ‘Oh, now you’re a man.’ No one talks you through the options. We are left with no avenues to produce offspring”[[1]](#footnote-2).

This can also be true for women and people with disabilities, where reproductive options are not openly and transparently discussed with women with disabilities, including access to contraception. They are not made aware of the pros and cons of various reproductive avenues, and birth control options, as it intersects with their disability / treatment they are receiving / condition, are not clearly and carefully discussed.

In India, sex workers living with HIV/AIDS are often abused with moralistic slurs in hospitals, accused of ‘spreading disease in society and are made to wait for inordinately lengths of time to access ART ([see](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjnjfHbxrj1AhWTSWwGHQsmBcAQFnoECBoQAQ&url=https://www.sangram.org/upload/resources/health-status-of-sex-workers-india-cedaw-submission-15-feb-2019.pdf&usg=AOvVaw3LBbHxErsxh0-Vn5Pe8Lct)), especially during COVID-19.

[According to a study of 3,000 sex workers](https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%2520Documents/Ind/INT_CEDAW_NGO_Ind_17395_E.pdf) conducted by Sangram and VAMP in India, 37% of sex workers said they faced physical violence from the police and 51% said they faced verbal abuse. The agencies found “people in positions of authority routinely demand sexual favors from sex workers for speedy redress of grievance or accessing entitlements. They regularly verbally abuse sex workers using specific sexual innuendo and language. The law enforcement is regarded by sex workers as the most repressive state agency. Police abuse sex workers, illegally detain, sexually assault and torture them in custody.”

Institutions of learning, such as universities and boarding schools have failed to ensure that these institutions of learning are safe environments for all students. Campuses in Kenya have continued to have an increase survivors of gender-based violence who are abused while on school premises on the counts of their gender and sexual orientation. There has been an increase in killings of female students (femicide) in campuses and without any reform and justice for the survivors.

The Minister of Education issued a statement banning students who are LGBTIQ from going to boarding schools ([see](https://educationupdates.co.ke/angry-kenyans-react-to-cs-magohas-statements-on-banning-of-gay-students-from-boarding-schools/)).

We also noted the inability of young people to access information within medical establishments, without fear of stigma or being ‘reported’ to parents and guardians.

**GBV responses and good practices**

Many GBV responses are not accessible for women and people with disabilities, to trans people, lesbian and bisexual women, or sex workers. Many GBV responses rely heavily on penalisation and criminalisation, which make survivors, especially structurally excluded persons who may themselves be criminalised, unlikely to pursue legal justice mechanisms.

We have seen a mushrooming of “Women’s safety” apps, often as initiatives by ministries / governments in collaboration with NGOs or tech start-ups. These apps often rely on law enforcement, which doesn’t take into consideration the relationship between law enforcement and many groups and citizens. For example, upon activation the app may send a report to the closest police station. Due to eroded public trust in the police in many contexts, especially in South Asia and East Africa, and especially in relation to GBV response, many survivors end up not reporting / not using these technologies. Sometimes, these apps also centre protectionist and prohibitionist approaches to women’s safety, and are not responsive to data on GBV, such as the fact that the perpetrators of GBV are often known to the victim / survivor. Women’s safety is conceptualised in a highly limited way, and doesn’t take into consideration the reality of women’s lives in diverse contexts. The Internet Democracy Project did a careful study of several women’s safety apps in India ([see](https://genderingsurveillance.internetdemocracy.in/safety-app/)), and found that very few centre the autonomy of women users, and that many rely on measures which ultimately don’t strengthen women’s rights.

Many governments are either failing to document, or are wilfully ignoring gender-based violence against sex workers, women and people with disabilities, LBT people and others.

For example, in India’s existing system, the lack of a separate data base for recording violence against women with disabilities makes it more difficullt to identify and address issues. Despite National Policy for the Persons with Disabilities mandating this, and National Platform for the Rights of the Disabled’s continuous demands for the need of a separate category for recording violence against women with disabilities, there has been no such data maintained. This has further served as a bottleneck for various disability rights groups to advocate against the violence faced by WWDs in India.

In India, collectivization of sex workers in the form of national networks such as AINSW and NNSW have helped sex workers mobilize together, make connections with civil society and strengthen their advocacy with state actors and police officials. VAMP and SANGRAM are examples of civil society organizations that use a rights-based approach to support the work of sex worker organizing through capacity building, research, monitoring, documentation and national and global advocacy ([see](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjm3prsyLj1AhXxjOYKHY0tBI8QFnoECAIQAQ&url=https://www.awid.org/sites/default/files/atoms/files/changing_their_world_2_-_vamp_-sex_workers_movement_in_indias_southwest.pdf&usg=AOvVaw1Pt90RG1mNXGlav89Kl-AU)).

Community demands for equality and recognition of trans people’s gender identity were recognized by the National Medical Commission of India, which in 2021, issued an advisory stating that medical institutions shouldn’t teach students in a way that is derogatory or insulting to the LGBTQIA+ people and authors of medical textbooks should amend all unscientific and discriminatory information about the community.([See](https://www.hindustantimes.com/india-news/amend-discriminatory-info-on-lgbtqia-nmc-to-institutes-101634149481724.html))

In countries in South Asia, INGOs like the Family Planning Association are abortion-supportive and LGBTIQ-friendly, and provide community organizers and activists structural support for their work.

Use of tele-counselling and M-health (Mobile health) for access to comprehensive non biased and non judegemental sexual and reproductive health infromation also play a significant role. Community-led efforts in Sri Lanka have ensured that LGBTIQ people have mental health support during the pandemic, by setting up traditional call lines and sharing the numbers online.

Mobile health in East Africa with the “Aunty Jane” hotline, “Nena na binti” in Kenya are some examples. “Aunty Kaki” in Uganda, “Aunty Shani” in Tanzania are other examples; we also have observed a toll-free hotline hosted by the Health development initiative in Rwanda. Most of these hotlines give information on access to safe and legal abortion, but due to lack of comprehenisve sexual and reproductive information and other avenues of information, they have expanded to supporting GBV violence survivors. There are also examples of hotlines to support and provide safe space for transgender, intersex and gender non-conforming people in East Africa.

In India, several civil society organizations try to support abortion providers with information and guidance through online chat mechanisms or hotlines. For instance, Hidden Pockets helps connect people to care counsellors who not only provide information on SRHR but also provide counselling for their mental and emotional health ([See](https://www.hidden-pockets.com/)). Similarly Nazariya is a civil society organization which provides peer counselling to LGBT persons facing violence. ([See](https://nazariyaqfrg.wordpress.com/case-work-and-helpline/))

**Needs of survivors**

Self-identified needs of survivors often emphasize the need for space to organize and take action to advocate on their own behalf; therefore, criminalisation and penalisation of groups such as sex workers severely restricts their ability to organize.

Survivors report a desire for comprehensive rights-based approaches to GBV which does not take a punitive approach, and instead, focus on the survivors’ wellbeing and autonomy.

Women and people with disabilities strongly express a need for an approach to GBV which centers accessibility as a core tenet, making mechanisms for redress accessible and inclusive. Without it, women with disabilities are left out, and often do not have the possibility to get support or report violence. Moreover, women with disabilities are often not believed when they disclose the violence, especially sexual violence, due to false yet pervasisve assumption that they are not sexual. Fear of rejection or silencing of the experience of violence may impact a person's wellbeing.

Often, GBV faced by people and women with disabilities has to do with the provision of care and caregivers – however, family members are often required to participate in any reporting of GBV even if they may be the perpetrators. Women with disabilities' autonomy needs to be respected and upheld at all times and in all stages of any redress process. Independent living tools and their widespread use will also support women and people with disabilities.

Women and people with disabilities, LBTIQ people, especially trans people, and sex workers often refrain from reporting violence due to a fear that they will lose custody of their children. Living in contexts where their legitimacy as a parent is constantly questioned, and where punitive policies set in motion ‘rescue’ processes in relation to these groups, it is hard for them to trust redress mechanisms. Survivors who are sex workers, people with disabilities or LGBTIQ people, ask frequently for the removal of structural barriers against them more generally, and the removal of social stigma against them, seeing as how pervasive stigma and discrimination restrict their ability and their desire to seek redress and justice when they face violence.

Survivors have expressed the need for an increase in safe houses and space to seek solace. Most safe houses are overpacked and have little to no resources to ensure survivors of gender-based violence have the basic needs when looking for options to move away from violent environments. These spaces also need to be discrimination and stigma-free, and be affirmative environments for all, where everyone’s human rights are upheld.

1. *(3) (PDF) Acts of Agency: Exploring a Feminist Approach to Abortion Research in Sri Lanka*. Available from:<https://www.researchgate.net/publication/345337282_Acts_of_Agency_Exploring_a_Feminist_Approach_to_Abortion_Research_in_Sri_Lanka> [accessed Jan 18 2022]. [↑](#footnote-ref-2)