**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>).

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](mailto:srhealth@un.org). 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.

|  |  |
| --- | --- |
| Type of Stakeholder (please select one) | Member State  Observer State  Other (please specify) NGO |
| Name of State  Name of Survey Respondent | Suriname  Stichting Projekta |
| Email | projekta@sr.net |
| Can we attribute responses to this questionnaire to your State publicly\*?  \*On OHCHR website, under the section of SR health | Yes No  Comments (if any): |

# 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](https://undocs.org/A/HRC/47/28) 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

* 32 percent of ever-partnered women reported at least one act of physical and/or sexual violence by an intimate partner in their lifetime and 6 percent reported at least one act in the 12 months prior to data collection.
* Approximately 17 percent of all respondents reported having been forced into sexual intercourse by a non-partner in their lifetime (2 percent in the past 12 months)
* In 15–64 age bracket, approximately 50,000 women in Suriname are estimated to have experienced one act or more of physical and/or sexual violence perpetrated by their male partners. Of these women, over 9,000 women are likely to still be in an abusive relationship
* Lower educational attainment is associated with higher prevalence of current physical IPV.
* Unmarried women with partners showed higher rates of both physical and sexual violence over their lifetime than currently married women.
* Women between the ages of 25 and 29 were more likely than women from any other age group to be currently experiencing physical IPV (9 percent).
* Women who were married or lived with a partner at a young age had higher lifetime physical and/or sexual IPV prevalence than those whose first union was at 19 years or older.
* Lifetime physical IPV was higher among women who identified their ethnicity as African (34 percent).
* Lifetime sexual IPV was higher among those who were financially independent, which is counter-intuitive.
* Women in non-consensual marriages were more likely to have experienced physical (43 percent) and sexual (38 percent) IPV than those who choose their own partners (21 percent and 24 percent, respectively).
* Women who identified as Roman Catholic experienced the highest prevalence of life - time physical IPV (34 percent).
* Women who were never married experienced a higher prevalence of physical IPV (32 percent) than women who were married at least once before (22 percent).
* Women whose partners’ ages ranged from 35 to 44, were unemployed, engaged in some form of substance abuse, or had prior relationships experienced higher levels of physical and sexual IPV.
* Roughly one in four respondents (26 percent) had experienced sexual violence as an adult or as a minor, either from a partner and/or a non-partner. The prevalence of NPSV (non partner sexual violence) (14 percent) is almost double that of sexual IPV (7 percent).
* Of all respondents, 4 percent (lifetime) reported having been forced into sexual intercourse by a non-partner.
* Of the respondents, 13 percent reported being touched sexually or made to sexually touch another when they did not want to at least once in their lifetime.
* Of the women surveyed, 4 percent indicated they were victims of attempted intercourse at least once by a non-partner.
* The majority of women reported one perpetrator, in many instances a family member or friend. The majority of such experiences (85 percent) were left unreported to police.

• Sexual harassment (at work, on the job, on public transport, and in virtual spaces) was experienced by 25 percent of women, with the highest prevalence being in the form of electronic messages with sexual content (19 percent) and being groped in a public space (9 percent).

<https://publications.iadb.org/publications/english/document/National_Women%E2%80%99s_Health_Survey_for_Suriname_en.pdf>

* 1. gender based violence and other forms of violence against children:

The incidence of violent child discipline is very high in Suriname

* 88 percent of children aged 2‐14 years were subjected to at least one form of violent psychological or physical punishment by household members.
* 9 out of 10 children aged 1 to 14 years experienced violent disciplining in the past month.
* 8 out of 10 children aged 1 to 14 year experienced shouting, yelling or screaming, as a form of discipline.
* Only 7 out of 100 children under age 15 were disciplined in a NON-violent way.
* The incidence of violent discipline is higher (89%) for boys than girls (86%).
* 92% for those living in a poor household versus 81% for those living in the richest households experienced violene.
* For each type of violent disciplining, the highest incidence is found for children aged 3-4 years and slightly decreases for the following age groups.
* 24 percent of the respondents think that physical punishment is necessary for disciplining, while 63% of the children under 15 year experienced any physical punishment in the last month.
* The respondents (24%) who justify child discipline by physical punishment are almost evenly distributed by sex (21-24 %) and age group (23- 27%).
* Comparison by educational level shows a higher incidence among those with no education (38%), the poorest quintile (32% versus the richest with an incidence of 18%) and those living in the rural interior area (43% versus 18% for the rural coastal area).

<https://statistics-suriname.org/wp-content/uploads/2020/03/Suriname_MICS_2018_Snapshots_English-resized.pdf>

* 1. gender based violence against LGBTI or other persons based on real or imputed sexual orientation, sex characteristics, and gender identity:
  2. violence against persons with disabilities, including GBV.
  3. gender based violence against men
  4. conflict gender based violence, including sexual violence
  5. Please share analysis and available evidence on the impact of COVID on the above

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.

* Current legislation on domestic violence such as the Domestic Violence Protection Act don’t indicate specific definitions or classifications for GBV. Domestic violence is defined in general terms such as physical, mental, sexual and financial abuse, without explicitly mentioning gender components of DV.
* Redress options are minimal, and access to care for survivors remains a non-recognized form of reparation.

In a study conducted in 2017 by Mr. Maya Manohar, partially aimed at making an inventory of the current support system for protecting children in Suriname, in the field of law, education, and social measures, medical and judicial help provides the following information:

* The civil protection of juveniles in Suriname focuses on 8 child protection measures, such as those in the Surinamese Civil Code. This concerns preventive measures such as the supervision of a child and also acute measures with the aim to protect the child against further abuse or other forms of violence.
* Other protective rules for children are mentioned in the penal code (S.B. 2015, No. 44). Physical abuse with physical injury, manslaughter, infanticide, serious neglect, such as leaving children in a helpless state (Article 315, 350 - 362 Penal Code).
* In Title XIII, Crimes against Morality, of the Penal Code, various sexual offenses against children are made punishable.
* Physical sexual abuse of children, child trafficking and neglect are punishable under the Penal Code.

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The Domestic Violence Prevention Act (MSB 2009 No. 84) also contains regulations that offer the child more protection options. In this law, both physical and mental violence is punishable. In reality, there is rarely a report of mental violence experienced by a child. Usually there is a report filed of physical or sexual violence, to which mental abuse is connected. Article 2 paragraph 2 sub c of this Act creates the possibility for a protection order to be requested in court on behalf of a child, by intervention and with the support of another person.

Familiarity with legislation in the community is a gap, which means that enforcement can not be optimal. The results from the qualitative research material indicated that mental violence is not reported. Monitoring the implementation of the policy for the protection of children from a Central Reporting Point can improve the child protection system. Regulations concerning a right to report / duty to report for professional groups working with children should be considered.

<https://www.unicef.org/lac/media/4546/file/PDF%20Sub-study%20national%20response%20policies%20and%20legislation%20.pdf>

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.

* Structural & institutional violence with State origins: police violence against LGBTQI, especially sex workers.
* Lack of gender-sensitive care for girls/women and LGBTQI persons.

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.

In November 2011 Stichting Lobi Health Center in collaboration with Professional Associates for Representation, Equality and Acceptance (PAREA) and Women’s Rights Centre submitted a Stakeholders’ contributions to the 39th session of the Universal Periodic Review (UPR) working group of the Human Rights Council in the occasion of the upcoming review of the Republic of Suriname, November 2021.

Stichting Lobi Health Center is an accredited member of the International Planned Parenthood Federation and is considered by local government bodies as The Family Planning organization.

In the case of the criminalization of abortion the submitted UPR contribution mentioned the following:

Suriname applies a criminal law approach to abortion, making it illegal, regardless of the risk to the pregnant women’s life, pregnancy in the case of rape or incest, or fetal malformation incompatible with life. This makes Suriname one of the less than 20 countries in the world with such inhuman criminal standards that are coercive in reproductive decision making and therewith it violates international human rights law and standards.

Although the Surinamese government claims that it does not enforce the abortion criminal laws, it fails to justify why it does not amend the laws accordingly to the 2017 urge by the IACHR to adopt comprehensive, immediate measures to respect and protect women’s SRHR, including legal and safe abortions, to create an environment in which women can fully enjoy their right to health.

It is public knowledge that because of the illegal status of abortions, women and girls in need of an abortion resort to unsafe abortions with serious health threats. Not seldom, women end up at the emergency room of the Academic Hospital with complications due to unsafe abortions causing serious health threats. Another result of the illegality of abortion is the absence of reliable abortion-related data, because abortions done in hospitals are inaccurately registered as dilation and curettage. Nonetheless, estimated numbers of annual abortions are ranging between 5.000 and 10.000. Furthermore, due to its illegality, abortions are not covered by health insurance packages, causing adverse financial affects hampering access to safe abortion services, including effective pre- and post-abortion counselling services aimed at harm reduction and future unwanted pregnancies as an integrated part of comprehensive SRHR-policies. This means that while safe abortion is available mostly to wealthy women, it is an additional violation of the right to health for poor women and the most marginalized, who might undergo financial risks in order to access this service. Furthermore, abortions, including medical abortions with Cytotec, occur without proper medical guidance and information on the potential risks and adverse effects.

This PHD thesis by a local gynaecologist Lachmi Kodan describes how healthcare providers ownership combined with government commitment can improve the maternal death surveillance and response (MDSR) cycle, aimed to reduce maternal deaths in Suriname. One of the conclusion of the study states the following:

Delay in care was dominated by insufficient care in the health facilities (phase III delay) as decided by the review committees, which is one of the characteristics of obstetric transition stage III. Perinatal deaths concomitant with the maternal deaths decreased significantly over time with improved perinatal care in Suriname.24 Urbanization and better transportation might have contributed to a significant decreasing trend in maternal deaths in the rural interior of Suriname.25 Phase I delay has not improved yet indicating that universal access to care is still an issue in Suriname. The passing of the National Basic Health Insurance Law in 2014 was intended to achieve universal health coverage and make equitable health care available to everyone.26,27 However, several gaps in this system and the deteriorating financial position of the country since 2015 have left those, who were financially dependent on the government for their insurance, uninsured, probably delaying their decision to seek health care.

<https://www.verloskundesuriname.org/uploads/7/5/4/5/75459511/phd_thesis_-_l._kodan.pdf>

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.

* The Violence against Children (VAC) study 2017 – 2018 in Suriname study showed that government child protection programmes are inadequate, due to a myriad of reasons, e.g. a lack of a coordinated approach and a tracking system in the support process, lack of case management and monitoring systems; and lack of defined processes and protocols for professional groups working with children present. There is a shortage of social workers in public service and at NGO level, as well as of adequate childcare and guidance of traumatized children.
* 1 government-run shelter active for female victims of DV.
* Private shelters Stricris & Hadassah.
* Stichting Stop Geweld tegen Vrouwen (Stop Violence Against Women Foundation) focuses on the guidance of victims, perpetrators and family members (children). Prevention, information and influencing policy are also part of the integrated approach.

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.
2. 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.
3. 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.

* Based on the recommendations of the Violence against Children Study, in 2018, the Government of Suriname initiated setting up a coordinated mechanism for the child protection services through the IKBen network of service providers both at public and NGO level. Processes and procedures were discussed and a set of tools were developed and a system for case work and case management was proposed. Although the initial steps are hopeful, this system is still not fully implemented among all service providers working in the chain of child protection.
* Network of NGOs against violence: active network of 35 national- and community organizations that are committed to combating sexual and domestic violence, under the leadership of Projeka-foundation. A priority list against sexual and domestic violence has been created, which is supported by these organizations.
* Hadassah Shelter: a crises shelter under the management of a local foundation called Weid Mijn Lammeren, houses vulnerable children and women. Their housing, well-being and guidance are taken care of. The young people and women go through a process in which they are guided to independent living and live in society.

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.

* Hear Us Now: a multi-year program to increase awareness and build capacity on gender equality and sexual and domestic violence through the activities of sports-, culture- and community organizations with a special focus on inclusiveness. This program has resulted in an active network of 35 national- and community organizations that are committed to combating sexual and domestic violence. A priority list against sexual and domestic violence has been created, which is supported by these organizations. Executed by Stichting Projekta (or Projekta Foundation), funded by the European Fund for Democracy and Human Rights.
* Strengthening of Community Based Organisations against domestic violence with the focus on Violence Against Children and Gender Based Violence: pilot (8 months) that builds on the Hear Us Now program. The pilot included action research on the effectiveness of community-based awareness strategies on Domestic Violence with emphasis on child abuse. Executed by Stichting Projekta, funded by Unicef Suriname.
* iGROW: The iGROW programme creates a more supportive school environment for students in lower secondary vocational education and training on issues relating to ASRHR and GBV. The iGROW programme pilots a whole school approach to creating a supportive environment on issues relating to ASRHR and GBV. The programme centers on improving the professional development of teachers and school leaders, and on strengthening the collaboration between schools and civil society. Executed by VVOB Suriname, funded by Belgium and the European Union.

**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](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT/CEDAW/GEC/3731&Lang=en), 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).](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GC/35&Lang=enhttps://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GC/35&Lang=en)
* 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](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f13&Lang=en), 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](https://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/38/43), 2018, [OHCHR, Born Free and equal](https://www.ohchr.org/Documents/Publications/Born_Free_and_Equal_WEB.pdf), OHCHR, [Background note on human rights violations against intersex perople).](https://www.ohchr.org/Documents/Issues/Discrimination/LGBT/BackgroundNoteHumanRightsViolationsagainstIntersexPeople.pdf)
* 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](https://undocs.org/en/S/2019/280), 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.