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SPECIAL PROCEDURES
SPECIAL RAPPORTEURS, INDEPENDENT EXPERTS & WORKING GROUPS

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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 ☐X Other (please specify) **NGO**
Name of State Name of Survey Respondent	International Planned Parenthood Federation Estelle Wagner
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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 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

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

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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

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**.

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

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 Work

At the heart of IPPF's mission is the commitment to provide and enable services and champion sexual and reproductive health and rights for all, especially the under-served, so that all people are free to make choices about their sexuality and well-being, in a world free from discrimination, including sex workers. In September 2022, IPPF's Board of Trustees adopted the IPPF Sex Work Policy (SWP), from which this submission is drawn. This policy takes a harm reduction, human rights-based approach, adopting evidence-based positions that best respect, protect and fulfill the human rights of sex workers.

Based on these values, the SWP takes the following positions:

1. IPPF condemns and works to end all forms of stigma, discrimination and violence against sex workers and lack of legal redress, and supports comprehensive efforts to dismantle systemic inequalities, including gender inequalities.
2. IPPF supports the recognition of sex work as work.
3. IPPF condemns forced labor and human trafficking, and supports sex workers in distinguishing between sex work and such violations.
4. IPPF supports the decriminalization of sex work because this is a crucial step in respecting, protecting and fulfilling the human rights of sex workers. IPPF does not support criminalization, "end demand", the Nordic Model, the "equality model," or regulations that target sex work differently from other forms of labor because these are incompatible with respecting, protecting and fulfilling the human rights of sex workers. Strong evidence demonstrates the positive impacts of decriminalization on public health and human rights. Decriminalization is unanimously favoured by every global and regional sex worker-led network, countless national-level sex worker-led organizations, and major international or UN health and human rights organizations.[3]
5. IPPF supports sex worker-led and centered SRHR programming and service delivery,
6. IPPF supports sex workers' leadership, community empowerment, and organizational sustainability.
7. IPPF supports feminist movements which stand in solidarity with sex workers.

This policy improves IPPF's ability to invest in and deliver sex worker-led and centered SRHR programming and service delivery. Sex workers experience intersecting forms of stigma and discrimination that cause significant challenges their participation in civil society and enjoyment of their human rights, including sexual and reproductive rights. All people, including sex workers, have the human right to available, accessible, acceptable and high-quality (AAAQ) sexual and reproductive health care and services, free from stigma, discrimination and violence.

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[3] WHO, UNAIDS, Amnesty International, the International Lesbian, Gay, Bisexual, Trans, and Intersex Association (ILGA) World, Human Rights Watch, Transgender Europe, and many others.

Abortion

The principles of harm reduction neutrality, humanism and pragmatism present a conceptual framework for making menstrual regulation and abortion information and care available directly to women and make the case for why it is imperative that we do so. The three core principles, as described by Erdman[4] and their application to abortion can be summarized as:

Neutrality: Harm reduction strategies are absent of any moral judgment about an underlying activity, regardless of its legal or social status. Harm reduction is only concerned with the risks and health-related harms of an activity, not whether the activity is considered right or wrong.

- Public health professionals have a responsibility to provide information about technologies, such as misoprostol, to minimize women's personal and social harms of unsafe abortion regardless of the legal or moral status of abortion.
- It is the obligation of all states to support and refrain from standing in the way of public health professionals' duty to mitigate the harms associated with unsafe abortion.
- Public health professionals should ensure client confidentiality and not police women's adherence to the abortion law.

Humanism: All individuals have a right to having their health needs being understood and addressed by others, regardless of their assigned moral status or deviance from legal or social norms.

- Public health professionals are obligated to proactively reduce barriers to care especially for women who face challenges accessing services when seeking to terminate a pregnancy.
- Principles of woman-centered care must be prioritized and enacted. This includes meeting women "where they are" — in places they choose to seek abortion information and care.
- Women have a right to participate in the design and implementation of all programs designed to serve them. Furthermore, every effort must be made to ensure the participation of those who face major challenges accessing services.

Pragmatism: Harm reduction recognizes that individuals may choose to engage in an activity regardless of any legal or social prohibition. Harm reduction is grounded in realistic evidence-based assessments not moral imperatives.

- Women are attempting to self-induce abortion in both legally restricted and liberal settings; public health professionals thus have a responsibility, in terms of respecting women's choices but also in order to reach the most women possible and to mitigate as much harm as possible, to provide information about the safest and most effective services and methods that are available to women, including information on how to use medicines used for menstrual regulation and medical abortion (such as misoprostol) safely and effectively.

The strength of the harm reduction approach is that it shifts the conversation about abortion from the legal status to focus on protecting women's health. The key challenge is how women can obtain information about safer abortion methods, including medical abortion medicines (such as misoprostol and mifepristone). Harm reduction respects

[4] . Erdman, Access to information on safe abortion: a harm reduction and human rights approach Harvard J Law Gen, 34 (2011), pp. 413–462

women's reproductive autonomy and their right to complete and current information to aid in their decision making.

A harm reduction approach provides a legal and ethical framework for health professionals and reproductive justice and human rights advocates to assist women in obtaining correct information about and accessing safe methods of abortion, including misoprostol and mifepristone. While it is only one of a broader set of strategies to ensure that women have access to rights-based, high-quality services and should not stand alone, it is a pragmatic and evidence-based approach that can greatly support women's ability to protect their reproductive health and live the lives they choose.

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.

Sex Work

Criminalization of sex work reinforces societal biases which portray sex workers as 'immoral,' exacerbating violence, discrimination, and stigma, while hampering their access to health, social services and justice.[5] Criminalization has a negative impact on sex workers' right to family life, both through direct violations and through the stigma it fuels. Many sex workers have their parental rights restricted or denied if they are arrested, charged or suspected of engaging in sex work.[6] As a result of stigma, sex workers' children are denied access to education and health care.[7] Sex workers' right to health and physical safety are jeopardized, increasing their risk of HIV, STIs, and sexual and physical violence. Police may confiscate condoms, safe sex information and medications, and use them in courts as evidence.[8] Punitive policies relating to HIV and STI exposure, non-disclosure, and transmission deter sex workers from seeking testing, treatment and care for fear of legal consequences.[9] Criminalization also poses challenges for outreach, hampering sex workers' access to health services. Health care providers in general, and sex worker peer health care providers in particular, face policing and other reprisals when conducting outreach to communities of sex workers.[10]

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[5] Fiona Scorgie and others, 'Human Rights Abuses and Collective Resilience among Sex Workers in Four African Countries: A Qualitative Study' (2013) 9 Global Health <https://doi.org/10.1186/1744-8603-9-33>.

[6] G Ragesh, 'Human Rights Violations against Female Sex Workers by Police Personnel' (2015) II International Journal of Research and Scientific Innovation 101; Lauren Medlicott, 'Abused and Denied Help: Sex Worker Mums Lose Access to Kids' (openDemocracy, 25 July 2022) <https://www.opendemocracy.net/en/5050/sex-work-social-services-mothers-children/> accessed 25 August 2022.

[7] Marlise Richter and Kholi Buthelezi, 'Stigma, Denial of Health Services, and Other Human Rights Violations Faced by Sex Workers in Africa: "My Eyes Were Full of Tears Throughout Walking Towards the Clinic That I Was Referred To"' in Shira M Goldenberg and others (eds), Sex Work, Health, and Human Rights: Global Inequities, Challenges, and Opportunities for Action (Springer Cham 2022) <https://doi.org/10.1007/978-3-030-64171-9_8>.

[8] Skye Wheeler, 'Interview: Outlawed and Ostracized: Sex Workers in South Africa' (Human Rights Watch 2019) <https://www.hrw.org/news/2019/08/07/interview-outlawed-and-ostracized-sex-workers-south-africa> accessed 25 August 2022; Sharmus Outlaw and others, 'Nothing About Us, Without Us: Sex Work, HIV, Policy Organizing' (Best Practices Policy Project and Desiree Alliance 2015) Transgender empowerment <http://www.bestpracticespolicy.org/wp-content/uploads/2015/10/NOTHINGABOUTUS_REPORT_COLOR_2015.pdf>.

[9] Lucy Platt and others, 'Associations between Sex Work Laws and Sex Workers' Health: A Systematic Review and Meta-Analysis of Quantitative and Qualitative Studies' (2018) 15 PLOS Medicine <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6289426/>.

[10] Sharmus Outlaw and others, 'Nothing About Us, Without Us: Sex Work, HIV, Policy Organizing' (Best Practices Policy Project and Desiree Alliance 2015) Transgender empowerment <http://www.bestpracticespolicy.org/wp-content/uploads/2015/10/NOTHINGABOUTUS_REPORT_COLOR_2015.pdf>..

Criminalization fosters a climate of impunity for perpetrators of violence, as sex workers must work clandestinely and may not report abuse due to fears of legal repercussions.[11] Sex workers whose rights are violated by the police and the judicial system often have no legal recourse at all. Criminalizing any element of sex work turns sex work into a criminal business exchange. It is not possible to criminalize only one half of a transaction without stigmatizing the other half and without increasing sex workers' risk and vulnerabilities to violence and discrimination in the transaction as well. Even where sex work is considered only an administrative offence, sex workers are subjected to harassment, extortion, illegal detainment, and violence perpetrated by police and other law enforcement officials on the basis of these local regulations.[12]

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.

Sex Work

Sex work benefits from harm reductions policies by minimizing human rights violations of sex workers. Any degree of criminalization harms sex workers and renders them more susceptible to other forms of legal oppression.[13] Evidence shows that any model in which the sale, purchase, or benefit from sex work is criminalized does not stop sex workers from working and does not eliminate sex work.[14] Moreover, these forms of criminalization have a negative effect on sex workers' health, wellbeing and livelihood. Their vulnerability to violence and other rights violations is increased as they are forced to work clandestinely and take risks to mitigate the consequences imposed on them by criminalization.[15]

Modelling estimates have indicated that the decriminalization of sex work could reduce HIV infections by 33 to 46% over the next decade.[16] As attested by UNAIDS, the decriminalization of sex work "is key to changing the course of the HIV epidemics among sex workers and in countries as a whole."[17] In New Zealand, where sex work has been decriminalized since 2003, street based sex workers are much more likely to report

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[11] Ragesh (n5).

[12] 'Issledovanie Sredi Seks-Rabotnikov Ukrainy Po Narusheniyam Prav Cheloveka so Storony Sotrudnikov Militsii' (Kirovohrad Regional Branch of the Charitable Organisation "All-Ukrainian League" LEGALIFE 2014) <https://www.nswp.org/node/2351>; 'Failures of Justice: State and Non-State Violence against Sex Workers and the Search for Safety and Redress' (SWAN 2015) <https://swannet.org/resources/failures-of-justice-state-and-non-state-violence-against-sex-workers-and-the-search-for-safety-and-redress-2/>.

[13] 'Sex Work and the Law: Understanding Legal Frameworks and the Struggle for Sex Work Law Reforms' (Global Network of Sex Work Projects 2014) Briefing Paper <https://www.nswp.org/resource/nswp-publications/sex-work-and-the-law-understanding-legal-frameworks-and-the-struggle-sex>.

[14] 'The Impact of "End Demand" Legislation on Women Sex Workers' (Global Network of Sex Work Projects, 2018) Policy Brief <https://nswp.org/resource/nswp-policy-briefs/policy-brief-the-impact-end-demand-legislation-women-sex-workers>; 'Smart Guide on Challenging the Introduction of the Nordic Model' (Global Network of Sex Work Projects 2017) <https://nswp.org/resource/nswp-smart-guides/smart-sex-workers-guide-challenging-the-introduction-the-nordic-model>.

[15] For example, a Swedish sex worker and human rights advocate, Petit Jasmine, was forced to interact with her violent ex-husband in order to see her children. She had been separated from them by social services because he told them about her work. He murdered her during a custodial visit. Melissa Gira Grant, 'Sex Workers Rise Up After Fatal Stabbings' (In These Times, 22 July 2013) <https://inthesetimes.com/article/sex-workers-rise-up-after-fatal-stabbings>.

[16] Kate Shannon and others, 'Global Epidemiology of HIV among Female Sex Workers: Influence of Structural Determinants' (2015) 385 The Lancet 55.

[17] 'Services for Sex Workers' (Joint United Nations Programme on HIV/AIDS 2014) Guidance Note 3.

violence they experience to the police.[18] Decriminalization of sex work in New Zealand ended the practice of courts removing sex workers' children from their homes because parents were found to be, or suspected to be, sex workers.[19] In New South Wales (NSW), Australia, decriminalization of sex work improved worker safety and health interventions in comparison to other legislative models in the country, and reduced incidents of police corruption to zero (which had previously been a significant issue for sex workers in NSW).[20]

Abortion

A harm reduction approach to prevent unsafe abortion integrates a set of policies, programmes and practices to ensure that in a highly restrictive, criminalized or stigmatized environment, any woman who requires menstrual regulation or termination of an unwanted pregnancy is provided with essential information and resources to do so safely.

This approach is based both on human rights and public health principles. In human rights terms, it empowers women to autonomously make decisions about their reproductive lives that are right for them. On public health grounds, the approach underscores the ethical responsibility of health systems and providers to minimize risk of harm to women who seek services in restricted settings.

Harm reduction in the context of unsafe abortion is a strategic combination of policies and activities that provides women with the information, support and services to achieve a pregnancy termination using the safest methods available in a restrictive setting. Harm reduction strategies typically:

- Provide information to women on all methods of terminating an unwanted pregnancy from the least safe methods (e.g. introduction of foreign bodies or instruments into the uterus) to safer methods (e.g. self-use of misoprostol) and encourage women to choose safe options for a termination;
- Establish effective links to high quality services for treatment of incomplete abortion, emergency medical care and;
- Follow-up care including ensuring completeness of termination, additional counselling and contraceptive services.

It is both a public health and human-rights based approach that empowers women and creates the necessary conditions to allow an individual to exercise her rights and decide on the outcome of her pregnancy in a setting that is restrictive. In addition, the harm reduction approach underscores the ethical responsibility of health systems and providers to minimize risk of harm to women seeking a restricted service. This approach supports the efforts of health systems to provide information and services in a manner that is respectful and enabling of the rights of women, and can contribute to advocacy efforts with health authorities and policy makers to increase access to safe methods of abortion.

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[18] Lynzi Armstrong, 'From Law Enforcement to Protection? Interactions Between Sex Workers and Police in a Decriminalized Street-Based Sex Industry' (2017) 57 The British Journal of Criminology 570 <https://doi.org/10.1093/bjc/azw019>.

[19] Stéphanie Wahab and Gillian Abel, 'The Prostitution Reform Act (2003) and Social Work in Aotearoa/New Zealand' (2016) 31 Affilia 418.

[20] Christine Harcourt and others, 'The Decriminalisation of Prostitution Is Associated with Better Coverage of Health Promotion Programs for Sex Workers' (2010) 34 Australian and New Zealand Journal of Public Health 482 <https://doi.org/10.1111/j.1753-6405.2010.00594.x>; Basil Donovan and others, 'The Sex Industry in New South Wales' (The Kirby Institute, Faculty of Medicine, University of New South Wales 2012) A Report to the NSW Ministry of Health <https://kirby.unsw.edu.au/sites/default/files/kirby/report/SHP_NSW-Sex-Industry-Report-2012.pdf>.

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.).

Sex Work

Globally, sex workers experience high rates of HIV infection, sexually transmitted infections (STIs), unintended pregnancies, social marginalization and gender-based violence, yet are often excluded from mainstream sexual and reproductive health (SRH) programming.[21] Regrettably, some SRH programs advocate against sex workers' rights and/or disseminate stigmatizing messaging undermining sex workers' right to health. Due to widespread conflations of sex work with human trafficking, SRH programs for sex workers may be excluded from international and national HIV and health funding. The most notable policy of this kind is the United States President's Emergency Plan for AIDS Relief (PEPFAR) anti-prostitution and sex trafficking clauses (often called the Anti-Prostitution Pledge),[22] which require non-U.S.-based organizations receiving HIV funding from the U.S. Agency for International Development (USAID) to sign statements that they oppose "the practices of prostitution and sex trafficking" as intertwined elements, in opposition to evidence-based best practices.[23]

Over the last decade, many international institutions, human rights organizations, researchers, and sex worker-led organizations and networks have jointly advocated for a rights-based approach to promoting sex workers' SRHR.[24] Specialized guidance and reports have been published which address intersectional forms of oppression

[21] 'Protecting the Rights of Sex Workers' (*UNAIDS*, 2 June 2017) <https://www.unaids.org/en/resources/presscentre/featurestories/2017/june/20170602_sexwork>.

[22] AAPD 14-04 "Implementation of the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003, as amended – Conscience Clause Implementation, Medically Accurate Condom Information and Opposition to Prostitution and Sex Trafficking" (2014)(revised from AAPD 12-04 and ADS 303) <https://www.usaid.gov/work-usaid/aapds-cibs/aapd-14-04-w>.

[23] UNAIDS Guidance Note on HIV and Sex Work (n15), Annex 3 'Differentiating sex work and trafficking.'

[24] *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions*, published by WHO, UNFPA, UNAIDS, NSWP, the World Bank, and UNDP in 2013, outlines comprehensive SRH care for sex workers and offers guidance for promoting community-based interventions in SRH and HIV care. Further, WHO's *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations* stresses the vital role of civil society organisations in confronting discrimination and challenging punitive legal and social norms, in tandem with community-led organisations, public health leaders, and policymakers. 'Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions' (WHO; UNFPA; UNAIDS; NSWP; World Bank; UNDP 2013) <https://www.who.int/publications/i/item/9789241506182>; 'Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations' (World Health Organization 2016) <https://www.who.int/publications/i/item/9789241511124>.

experienced by sex workers, including on the basis of age,[25] sexual orientation and gender identity,[26] migration status,[27] HIV status,[28] and drug use.[29]

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.

Sex Work

Sex workers, in all their diversity, have a broad range of SRH needs which are often ignored in favour of narrowly focused HIV and STI care and programming. Furthermore, sex workers' needs may be disregarded entirely by some health providers due to stigmatization and discrimination. IPPF's rights-based participatory programming strives to place sex workers' lived experiences at the center and ensure meaningful engagement of sex workers across all stages of the programming cycle, from research and strategy design to implementation and evaluation. This means considering sex workers' health and wellbeing as embedded in the social and political contexts in they which live.

To serve sex workers, IPPF takes an intersectional, harm-reduction lens, considering not only the accessibility, availability, acceptability, and quality of health care services, but also the multiple identities and layers of oppression experienced by sex workers, which serve as barriers to access, such as those based on gender identity and expression, sexual orientation, occupation, race, ethnicity, ability, relationship status, migration status, language, poverty, the feminization of poverty and economic status, among others. In line with this approach, IPPF commits to the following in all service provision:

- Respect for all

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[25] 'HIV and Young People Who Sell Sex' (World Health Organization 2015) Technical Brief <https://apps.who.int/iris/bitstream/handle/10665/179868/WHO_HIV_2015.7_eng.pdf>; 'Young Sex Workers' (Global Network of Sex Work Projects 2016) Policy Brief <https://www.nswp.org/resource/nswp-policy-briefs/policy-brief-young-sex-workers>.

[26] 'The Homophobia and Transphobia Experienced by LGBT Sex Workers' (MPact Global Action for Gay Men's Health & Rights and Global Network of Sex Work Projects 2018) Briefing Paper <https://www.nswp.org/resource/nswp-briefing-papers/briefing-paper-the-homophobia-and-transphobia-experienced-lgbt-sex>; 'Underserved. Overpoliced. Invisibilised. LGBT Sex Workers Do Matter' (International Committee on the Rights of Sex Workers in Europe) <https://www.eswalliance.org/underserved_overpoliced_invisibilised_lgbti_sex_workers_do_matter>; 'Transgender Europe (TGEU) Sex Work Policy' (Transgender Europe 2016) <https://tgeu.org/sex-work-policy/>.

[27] 'Sex Work Migration Health' (TAMPEP International Foundation 2009) <https://tampep.eu/wp-content/uploads/2017/11/Sexworkmigrationhealth_final.pdf>; 'Working with Refugees Engaged in Sex Work: A Guidance Note for Humanitarians' (Women's Refugee Commission 2016) <https://reliefweb.int/report/world/working-refugees-engaged-sex-work-guidance-note-humanitarians>; 'Migrant Sex Workers' (Global Network of Sex Work Projects 2018) Briefing Paper <https://nswp.org/resource/nswp-briefing-papers/briefing-paper-migrant-sex-workers>.

[28] 'UNAIDS Guidance Note on HIV and Sex Work' (Joint United Nations Programme on HIV/AIDS 2012) <https://www.unaids.org/en/resources/documents/2012/20120402_UNAIDS-guidance-note-HIV-sex-work>; 'Services for Sex Workers' (Joint United Nations Programme on HIV/AIDS 2014) Guidance Note <https://www.unaids.org/sites/default/files/media_asset/SexWorkerGuidanceNote_en.pdf>; 'Advancing the Sexual and Reproductive Health and Human Rights of Sex Workers Living with HIV' (Global Network of People Living with HIV/AIDS and Global Network of Sex Work Projects 2010) A Policy Briefing <https://gnpplus.net/resource/advancing-the-sexual-and-reproductive-health-and-human-rights-of-sex-workers-living-with-hiv/>.

[29] 'Sex Workers Who Use Drugs: Ensuring a Joint Approach' (Global Network of Sex Work Projects and the International Network of People Who Use Drugs 2015) <https://inpud.net/sex-workers-who-use-drugs-ensuring-a-joint-approach/>; Melissa Ditmore, 'When Sex Work and Drug Use Overlap: Considerations for Advocacy and Practice' (Harm Reduction International 2013) <https://www.hri.global/files/2014/08/06/Sex_work_report_%C6%924_WEB.pdf>.

- Zero tolerance towards discrimination
- Dignified care
- Empowering people in sex work for accessing health
- Working to dismantle barriers for sex workers to access health care and services, including combatting stigma and discrimination
- Integrating SRHR and related health strategies within universal health coverage, which are specifically tailored to the needs of people engaged in sex work

IPPF implements and advocate for sex worker programming that includes comprehensive health care and prevention models that address sex workers' needs (for instance, in terms of opening times and high standards of privacy and confidentiality) and accessible and non-discriminating clinical and support[30] services, encouraging regular training of health care workers on sex workers' rights and needs. IPPF recognizes that many SRH programs are often still not intersectional in practice,[31] and will strive to integrate an intersectional approach in all service provision and advocacy.

IPPF commits to meaningfully engage sex workers and sex worker-led organizations in programming and service delivery. IPPF commits to investing in rights-based, community-led SRHR programming and to directly invest in programs led by sex worker-led organizations. IPPF will advocate for governments, organizations and health providers to apply a sex worker-centered approach to health programming and service delivery.

Abortion

The Palestinian Family Planning and Protection Association (PFPPA) is implementing a harm reduction approach in an environment where legal access to safe abortion is severely restricted. Facing an increasing number of women seeking care for complications resulting from unsafe abortion, PFPPA is implementing a dual approach to address this issue. Firstly, to raise awareness of the harmful consequences of unsafe abortion, PFPPA conducts educational and outreach sessions, home visits, community meetings and dialogues with community and religious leaders. PFPPA also led a mass media campaign, working with television, radio and print media to reach a wider audience with clear messages in support as information on the implications of current abortion laws in Palestine and the consequences of unsafe abortion.

The second strategic approach involves the provision of counselling and consultation services in a safe and confidential setting, as well as information on the safer options available. PFPPA also provides post-abortion services, including treatment for incomplete abortion, as well as contraceptive counselling and modern methods of contraception. Using the harm reduction approach, PFPPA is supporting women to make informed choices and reducing the impact of unsafe abortion in Palestine. In 2014, PFPPA provided over 2,500 women with approximately 5,300 harm reduction services.

Additionally, a study conducted in Uruguay showed that services provided under a model known as "the harm reduction model" – in which providers offer evidence and

[30] Including HIV treatment and care, STI screening and asymptomatic treatments, prevention services for safe sex behaviour (ie free condoms and lubricants), immunization for Hepatitis B, community outreach programmes, harm reduction for alcohol and drug users, and the application of WHO recommended guidelines for HIV and STI management for sex workers.

[31] See for example, Rachel G Logan and others, 'When Is Health Care Actually Going to Be Care?' The Lived Experience of Family Planning Care among Young Black Women' (2021) 31 Qualitative Health Research 1169 <https://doi.org/10.1177/1049732321993094>.

rights-based information and care before and after an abortion, to the extent allowed by the law, and women and girls self-manage the process itself, in other words, taking the abortion pills – contributed to a reduction in maternal mortality.[32] A study conducted at the Buguruni Health Centre in Tanzania – which adapted the harm reduction model to the local context – showed that these type of services are feasible and acceptable, and could provide an opportunity to reduce unsafe abortion.[33]

[32] Labandera A., Gorgoroso M., and Briozzo L. (2016) 'Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: From a university hospital to the entire country', International Journal of Gynecology and Obstetrics, 134 (1), pp. S7-S11 doi: https://doi.org/10.1016/j. ijgo.2016.06.007

[33] Kahabuka C., Pembe A., and Meglioli A. (2016) 'Provision of harm-reduction services to limit unsafe abortion in Tanzania', International Journal of Gynecology and Obstetrics, 136, pp. 210- 214 doi: 10.1002/ijgo.12035