**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.

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| --- | --- |
|  | X Member State  Observer State  Other (please specify) |
| Name of State  Name of Survey Respondent | Portugal, Lisbon Ares do Pinhal (NGO) |
| Email | claudia.pereira@aresdopinhal.pt |

**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]](#footnote-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 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]](#footnote-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.

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| --- | --- |
| **E-mail address** | ohchr-[srhealth@un.org](mailto: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 |

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# 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**.

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.

*R: Portugal was one of the first countries to devise a policy that prioritizes harm reduction in dealing with drug users. The NSP, which began in 1993 under the Portuguese Directorate-General for Health and the National Program for HIV/AIDS Infection, represents the effectiveness of the measures and strategies adopted, namely the reduction in the number of diagnosed cases of HIV infection in the group of people who inject drugs (PWID). Furthermore, in 2001, the government decided to decriminalize the use, possession and consumption of all drugs.* *However, the approach to addictions in Portugal did not stop at the decriminalization of drug use. In addition to reinforcing all the intervention that already existed in the areas of prevention, treatment and reintegration, Decree-Law no. 183/2001 of 21 June also created responses in the area of harm reduction were also created, such as Outreach Teams, Support Offices, Low Threshold Substitution Programs, Shelter Centres with the inclusion of technical teams in the area of addictions and Contact and Information Points, which today make up the National Harm Reduction Network. However, the drug consumption rooms (DCR) that had a legal framework only opened in 2021, 20 years after they were approved.*

*In 25 years of working in the field and with a Harm Reduction policy, we have seen a decrease in infectious diseases, namely HIV, which in 2001 was 60% serology positive to 14% in 2023, HCV positive in 2001 was 80% to 55% in 2023 and Tuberculosis in 2001 was 14% to less than 1% in 2023.*

1. 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.

*R: In Portugal, with the implementation of the law decriminalizing drug use in 2001, addiction began to be seen as a health issue and not as something criminal. This meant that people who use drugs (PWUD) began to be seen as people and some of them as addicts, with appropriate treatment and responses. Since this change in the law (updated in September 2023) which, despite considering the use and possession of drugs to be illegal, makes an exception for those who are in possession of an amount equal to or less than 10 doses of a substance per day (table of quantities is included in the law), they are referred to a specific commission which will assess their use profile and then refer them to the appropriate structures, whatever their profile.*

*This allowed PWUS to be seen as people with vulnerabilities who needed (some) appropriate responses. The police, hospitals, courts and the population in general now saw this problem from a health perspective, with obvious benefits.*

*This law has also given rise to a number of complementary responses to this problem, such as the opening of addiction treatment centers in all the country's districts, the opening of inpatient facilities for withdrawal and investments in harm reduction, namely in street teams, an outpatient methadone program and a reception center for PWUD.*

*Although a path has been opened up with this law, there are still blockages, both on a personal level and in some institutions, with the creation of barriers that are not in line with the population in question, such as waiting times, the number of appointments until admission, etc.*

1. How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use? Please provide disaggregated data, including but not limited to gender, age, race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.
2. 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.

*R: It seems to me that in areas such as the homeless population, mental health in general and the treatment of infectious diseases. Although harm reduction approaches must be at the service of those who need it most and those who are least able, they should not be exclusive to them, because when we talk about harm reduction, we are talking about democratization, ease and effectiveness of access to services, health or social, for everyone, because it implies an approach of acceptance, humility, humanism and understanding that is necessary across the spectrum of the helping relationship that must exist in the various services.*

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

*R: In Portugal, and in Lisbon in particular, there are several responses to PWUD, including a municipal reception center (CAEM Sta Bárbara) that houses people with disabilities, LGBTIQA+ people and/or couples, people with pets, migrants with or without legal status in the country and with a specific place for alcohol and drug use, supervised by a technical team that provides medical and psychosocial care and nursing screening and DRID screening for residents. Several municipal street teams for homeless people and PWUD, Housing First project run by various organizations, reception center for PWUD, general reception center, outpatient methadone and NSP programme, mobile drug consumption room (DCR), fixed drug consumption room (DCR), oral health programmes for homeless people.*

*Nucleus of NGO and official partners to assist homeless people. Decentralized consultations for diagnosis and treatment of Hepatitis C, HIV, general health and mental health.*

*There is a lack of programs specifically designed to meet the needs of women and the LGBTQIA+ population. In prisons in our country it is still very difficult to have the same kind of responses that exist in the community, be it OST, NSP access to HCV treatment and other DRID. Migrants are often excluded from treatment and health services because they don't have documentation or because of communication difficulties. The existence of the services I mentioned is not accessible in the same way outside the country's capital. In these places, the response is scarce and increases the stigmatization of these populations, and in the case of the homeless, it is increasingly common for them to travel to the capital in search of support, putting pressure on the services.*

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

*R: In our country, some judicial institutions and/or judges give PWUD convicts the chance to serve their sentence in a therapeutic community, with the aim of rehabilitating them.*

1. 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.).
2. 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.

*R: Yes there are many, for example, outpatient methadone and NSP, outreach teams delivering NSP programme, mobile drug consumption room (DCR), fixed drug consumption room (DCR).*

1. See: [www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health](http://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health) [↑](#footnote-ref-1)
2. See also: <https://undocs.org/Home/Mobile?FinalSymbol=A%2F65%2F255&Language=E&DeviceType=Desktop&LangRequested=False>, para. 50. [↑](#footnote-ref-2)