Submission to the Committee on Elimination of Discrimination Against Women

Pre-Sessional Working Group 77 (02 March – 06 March 2020)

South Africa

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Submitting organization:

Harm Reduction International (HRI) is a leading NGO dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. HRI promotes the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

HRI is a non-governmental organization with Special Consultative Status with ECOSOC.

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INTRODUCTION

HRI welcomes the opportunity to submit information to the UN Committee on the Elimination of Discrimination Against Women (CEDAW) ahead of its review of the periodic report of South Africa and the adoption of the List of Issues Prior to Reporting at its 77th Session (2-6 March 2020). This submission considers the rights of women who use drugs, by providing background information and reporting on violations denounced by women in Durban.

The analysis is based on primary qualitative research conducted by HRI and the South African Network of People who Use Drugs (SANPUD) in Durban, South Africa, in 2019 (to be published in early 2020). The research revealed that women who use drugs in Durban experience violence, abuse, and discrimination, most acutely from law enforcement officers. These widespread and recurring violations appear to be rooted in the criminalisation of drugs, and in the profound stigma attached to drug use (women systematically reported of being treated as 'animals', called 'paras' as shorthand for parasites, and seen by police and prison staff as 'frogs' or 'cockroaches').

BACKGROUND: ABUSES AND DISCRIMINATION OF WOMEN WHO USE DRUGS

There are an estimated 3.2 million women who inject drugs worldwide, constituting 20% of all people who inject drugs.[1] Accounting for the concealing effects of criminalisation, gender power imbalances and stigma, this number is likely to be an underestimate.[2] Women who use drugs face multiple and intersecting forms of discrimination on the basis of their sex and drug use. In many cases, they may be socioeconomically marginalised and have intersecting identities or belong to specific marginalised groups, such as women living with HIV/AIDS, sex workers, and/or undocumented migrants, further compounding the exclusion and inequality they face.[3] Their particular experience of marginalisation is partly due to the historic and systematic inequality between men and women, but also to dominant punitive and prohibitionist approaches to drug control, which have a disproportionate impact on women.[4]

The limited data that is available suggests that women who inject drugs are at greater risk of HIV and viral hepatitis acquisition than men who inject drugs.[5] This increased vulnerability is a product of a range of environmental, social, and individual factors affecting women, which also affect their ability to engage in health promoting services such as harm reduction.

[1] Degenhardt, L. et al., 2017. 'Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review.' *Lancet Global Health*, 5(12), pp.1192-1207.
[2] International AIDS Society, 2019. *Women who inject drugs: Overlooked, yet visible*. Geneva: International AIDS Society.
[3] CEDAW AND WWUD, p. 8.
[4] Ibid., p.9.
[5] Des Jarlais D. C. et al., 2012. 'Are females who inject drugs at higher risk for HIV infection than males who inject drugs: an international systematic review of high seroprevalence areas.' *Drug Alcohol Depend* 124(2), pp.95–107.

VIOLATIONS OF THE RIGHTS OF WOMEN WHO USE DRUGS IN DURBAN

1. Law and policies that compound discrimination (Article 2 CEDAW)

Article 2 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) mandates governments to take all relevant measures to tackle discrimination against women in all Its forms, and pursue by all appropriate means a policy of eliminating discrimination against women. This requires addressing not only measures that are overtly discriminatory but also laws and policies that, while ostensibly neutral, have the effect of discriminating – or enabling discrimination, against women.

1.1 Criminalisation of drug use and possession for personal use as a discriminatory measure

Pursuant to the Drugs and Drug Trafficking Act (1992), drug use and possession are criminalised in South Africa, with no distinction between possession for use and possession of larger amounts for sale or trafficking. The Act also empowers police to search premises, vehicles and containers for illegal substances without a warrant if they have "reasonable grounds" to suspect an offence has been committed.[6]

Criminalisation fuels stigma, which in turns heightens discrimination and negatively impacts on the enjoyment of fundamental rights. Most notably, stigma dissuades women from accessing health services, and can push women who use drugs into hidden and unsafe spaces.

Female sex workers who use drugs are subject to even greater stigma, and are more vulnerable to harmful consequences. These women are more likely to work in less safe conditions than their colleagues who do not use drugs, and as a result are more likely to experience violence and higher-risk sex.[7] In some cases female sex workers face losing clients if their drug use is known, leading to a lack of engagement with harm reduction services.[8]

1.2. Discrimination by public authorities

1.2.a. Background

The criminalisation of drug use drives greater interactions between women who use drugs and law enforcement agencies and officers. Drug use is also exploited by police officers as justification for abuse, with aggressive policing techniques that include arresting women for carrying injection or smoking equipment, planting drugs, harassment, soliciting bribes, sexual abuse, and violence.[9]

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[6] Republic of South Africa, 1992. *Drugs and Drug Trafficking Act.*

[7] Pinkham, S. & Malinowska-Sempruch, K., 2008. 'Women, harm reduction and HIV.' *Reprod Health Matters,* 16(31), pp.168–81; Azim, T. et al., 2015. 'Women, drugs and HIV.' *Int J Drug Policy*, 26(Suppl 1), pp.16-21; Rusakova, M. et al., 2015. 'Why are sex workers who use substances at risk for HIV?' *The Lancet,* 385(9964), pp.211–2; Deering, K. N., 1999. 'Client demands for unsafe sex: The socio-economic risk environment for HIV among street and off-street sex.' *J Acquired Immune Defic Syndr*, 63(4), pp.522-31; Tran, T. N., 2004. 'Drug use, sexual behaviours and practices among female sex workers in Hanoi, Viet Nam – a qualitative study.' *Int J Drug Policy*, 15(3), pp.189-95; UNAIDS, 2009. *Guidance note on HIV and sex work*. Geneva: Joint United Nations Programme on HIV/AIDS.

[8] Pinkham, S. & Malinowska-Sempruch, K., 2008. 'Women, harm reduction and HIV.' *Reprod Health Matters,* 16(31), pp.168–81.

[9] El-Bassel, N. & Strathdee, S. A., 1999. 'Women who use or inject drugs: an action agenda for women-specific, multilevel and combination HIV prevention and research.' *J Acquir Immune Defic Syndr,* 1(69, Suppl 2), pp.182–90.

By giving police licence to arrest and threaten women who use drugs, criminalisation pushes women into more hidden spaces in order to avoid such interaction.[10] Accordingly, research finds that women who use drugs, and particularly female sex workers who use drugs, face harassment and violence at the hands of police.[11] This also has a direct impact on their ability and willingness to access harm reduction services, or to be reached by outreach teams.[12]

1.2.b Violation of fundamental rights of women who use drugs in South Africa from law enforcement

Women who use drugs in Durban denounce abuse, discrimination, and physical and psychological violence by law enforcement. Among others, they report:

- Widespread stigma and dehumanisation: "We are used to being treated like animals," said one woman of the treatment she and her peers received at the hands of police.

- Lack of protection and discrimination: Police officers systematically refuse to investigate reports of violence and abuse received by women who use drugs ("You can't go to the police. They will never help you. Even if someone is hurting you. [...] They will shake hands with the person who is hurting you."). Women engaged in sex work are in a particular vulnerable position; insomuch that abuse by law enforcement is explained away as a natural consequence of their work, and they describe being ignored or prevented from denouncing abuses against them. Such entrenched stigma is not only a violation of the right to effective remedy, but it also dissuades them from reporting crimes, increasing their vulnerability to violence and ill-health.

- Arbitrary arrest and detention: Women who use drugs in Durban consistently reported being illegally searched, arrested, and detained without charge often for months, or following planting of illicit substances as evidence to justify arrests.

- Widespread physical and psychological violence: Violence experienced by women who use drugs is frequently sexual in nature, in some cases as part of an effort to humiliate and degrade them; this includes denigratory and unnecessary strip searches – including in private parts – sometimes in groups and in the presence of male officers. This goes in direct contrast with the Mandela Rules, according to which prisoners are entitled to be searched in private by properly trained, respectful staff of their own gender. Women also reported being threatened and exploited for sex, and being arrested and/or beaten if they refuse assaults (an officer told one woman, 'If you don't like to be arrested, let's go and book a place and have sex. Then I'll take you out.')

2. Discrimination in the field of health (Article 12 CEDAW)

Article 12 CEDAW requires all state parties to take all necessary measures to "eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services". General Recommendation no. 24 by this Committee stressed the need for particular attention to women belonging to vulnerable and

[10] Shannon, K. & Csete, J., 2010. 'Violence, condom negotiation, and HIV/STI risk among sex workers.' *JAMA,* 4(5), pp.573–4.
[11] El-Bassel, N. & Strathdee, S. A., 1999. 'Women who use or inject drugs: an action agenda for women-specific, multilevel and combination HIV prevention and research.' *J Acquir Immune Defic Syndr,* 1(69, Suppl 2), pp.182–90; Rusakova, M. et al., 2015. 'Why are sex workers who use substances at risk for HIV?' *The Lancet*. 385(9964), pp.211–2.
[12] Azim, T. et al., 2015. 'Women, drugs and HIV.' *Int J Drug Policy* 26(Suppl 1), pp.16-21; Davis, S. L. et al., 2009. 'Survey of abuses against injecting drug users in Indonesia.' Harm Reduct J, 24(1), pp.28.

marginalised groups; and clarified that from this right also descend an obligation to refrain from obstructing women's pursuit of their health goals.[13]

2.1. Background: Harm reduction as a fundamental component of the right to health

Harm reduction has been recognised as a fundamental component of the right to health, as well as of the right of everyone to enjoy the benefits of scientific progress.[14] Harm reduction has been explicitly endorsed as an essential measure for people who use drugs on numerous occasions by this Committee,[15] the Committee on Economic, Social and Cultural Rights,[16] the UN General Assembly,[17] the Human Rights Council,[18] the Committee on the Rights of the Child,[19] the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,[20] and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.[21]

The World Health Organization (WHO), UNAIDS and UNODC recognise Needle and Syringe Programs (NSPs) and Opioid Substitution Therapy (OST) as key components of an effective HIV and viral hepatitis response for injecting drug use.[22] These interventions have also been endorsed by the UN General Assembly,[23] the Economic and Social Council,[24] and the Commission on Narcotic Drugs (CND). The CND has highlighted the importance of these interventions to meet SDG targets to end AIDS and tuberculosis, and combat hepatitis by 2030.[25]

More broadly, harm reduction is linked not only to commodities to address HIV and other infectious diseases. It encompasses a range of social services and conditions, the most fundamental of which is respect for the human rights of people who use drugs. It seeks not only to reduce the harms of drug use itself, but also of drug laws and drug policy. As such, harm reduction also includes the provision of housing, psychosocial support and employment initiatives, as well as advocating for alternatives to criminal sanctions for people who use drugs.[26]

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[13] CEDAW (Twentieth Session:1999), General Recommendation no. 24: Article 12 of the Convention (women and health).

[14] Among others, see: Paul Hunt, 'Human rights, health, and harm reduction', 8; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover(2010) A/65/255, para. 55; CESCR, Concluding Observations on the combined initial and second periodic reports of Thailand, UN Doc. E//C.12/THA/CO/1-2; CEDAW, Concluding Observations on the combined fourth and fifth periodic reports of Georgia (2014), UN Doc. CEDAW/C/GEO/CO/4-5, para. 31(e); Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, Mission to Poland (2010) A/HRC/14/20/Add.3, para. 86; CESCR, 2016, Concluding Observations on the sixth periodic report of Sweden. UN Doc. E/C.12/SWE/CO/6.
For more information, see: International Centre on Human Rights and Drug Policy/UNDP, International Guidelines on Human Rights and Drug Policy

[15] In CEDAW/C/GEO/CO/4-5 and CEDAW/C/CAN/CO/8-9.

[16] In E/C.12/RUS/CO/5, E/C.12/LTU/CO/2, E/C.12/EST/CO/2 and E/C.12/UKR/CO/5.

[17] In its resolution 65/277.

[18] In its resolution 12/27.

[19] See the Committee's general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health.

[20] In A/65/255.

[21] In A/HRC/22/53.

[22] WHO, UNODC and UNAIDS, WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision (Geneva, WHO, 2012).

[23] Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS (General Assembly resolution 65/277, annex).

[24] Economic and Social Council resolution 2009/6.

[25] CND Resolution 60/8; Promoting measures to prevent HIV and other blood-borne diseases associated with the use of drugs, and increasing financing for the global HIV/AIDS response and for drug use prevention and other drug demand reduction measures (2017)

[26] *Women and harm reduction: Global State of Harm Reduction 2018 Briefing,* 2019 London: Harm Reduction International, https://www.hri.global/files/2019/03/06/women-harm-reduction-2018.pdf

2.1.a. Harm Reduction and Women

Research demonstrates that women face unique challenges in accessing health services in general, and harm reduction specifically.[27]

Women's access to harm reduction services is hindered by structural violence and stigma that result from patriarchal social norms and attitudes, and which can be compounded by other identities such as race, class and sexuality. With regard to barriers to harm reduction services for women, structural violence is apparent in the greater stigma faced by women who use drugs compared with men.

Qualitative studies have consistently found that women report facing greater stigma based on drug use than men, and that women fear disclosing drug use because of the risk of stigma and social sanctions.[28] This has direct consequences on the ability and willingness of women to access harm reduction services. Indeed, stigma discourages women from accessing services for fear of being identified as a drug user, which also means women who use drugs can be pushed into hidden and unsafe spaces in order to ensure that their drug use is not made public.

2.1.b. Harm reduction in South Africa

There are an estimated 76,000 people who inject drugs in South Africa. A recent systematic review has estimated that between 16% and 23% of these people are women.

HIV in South Africa is a generalised epidemic, with general adult population prevalence standing at 18.8%.[29] Prevalence among people who inject drugs is estimated to be more than double, at 46.4%.[30] This is also more than double the estimated global prevalence among people who inject drugs of 17.8%. Hepatitis C prevalence among people who inject drugs is slightly above the global figure at 54.7%, while hepatitis B prevalence is 5%.[31] No estimate is available for HIV prevalence among women who inject drugs.

South Africa is one of just four countries in sub-Saharan Africa in which both NSPs and OST are available.[32] However, the scale of implementation remains small, with just four NSPs and 11 sites providing OST. None of these services are tailored to the needs of women who inject drugs.[33] No services are available in prisons.

In Durban, the Step Up project has operated since 2015 with the support of the TB/HIV Care Association. It currently provides people who use drugs in the city with information on harm

[27] Ibid.
[28] Zamudio-Haas, S., 2016. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania.' *Int J Drug Policy,* 30, pp.43–51; Myers, B. et al., 2016. '"Not on the agenda": A qualitative study of influences on health services use among poor young women who use drugs in Cape Town, South Africa.' *Int J Drug Policy,* 30, pp.52–8; Otiashvili, D. et al., 2013. 'Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers.' *Int J Drug Policy,* 24(6), pp.566–72.
[29] UNAIDS, 2019. *UNAIDS Data 2019.* Geneva: Joint United Nations Programme on HIV/AIDS.
[30] UNAIDS, 2019. *UNAIDS Data 2019.* Geneva: Joint United Nations Programme on HIV/AIDS.
[31] Scheibe, A. et al., 2017. *Programmatic surveillance of viral hepatitis and HIV co-infection among key populations from seven South African cities: Data to inform unmet need.* South Africa.; TB/HIV Care, 2018. *Viral hepatitis C initiative for key populations in South Africa: Summary Sheet.* Cape Town: TB/HIV Care Association
[32] Stone, K. & Shirley-Beavan, S., 2018. *The Global State of Harm Reduction 2018*. London: Harm Reduction International.
[33] Stone, K. & Shirley-Beavan, S., 2018. *The Global State of Harm Reduction 2018*. London: Harm Reduction International.

reduction interventions and practices, and linkage to health services. Until 2018, Step Up also provided a needle and syringe programme. However, the local government forced the closure of the programme citing discarded needles and syringes in public spaces. Since then, Step Up, TB/HIV Care and local organisations of people who use drugs have been advocating for the re-opening of this essential service.

2.2. Discrimination in accessing essential health services in South Africa

Women in Durban report a reluctance to access any health service due to experienced stigma, and due to interference by the part of law enforcement officers.

With regards to the former, women reported being arbitrarily deprived of essential commodities (such as clothes and blankets), health and harm reduction equipment (such as sterile syringes), and medication such as HIV treatment. This directly impinges on these women's ability to obtain and maintain good health.

Concerning stigma, women who use drugs reported not only experience generalised social stigma, but also direct stigma and discrimination from health professionals, including those involved in providing harm reduction services. As in the wider public, this stigma is more acute for women than men because of wider social expectations about womanhood and the role of women. Women have reported pervasive stigma across the health system in studies conducted around the world, including in South Africa.[34]

A systematic review of stigma towards people who use drugs from health professionals found that negative attitudes are pervasive and that they lead people who use drugs avoiding health and harm reduction services.[35] Experienced stigma leads to the anticipation of stigma, which discourages people who use drugs – and particularly women who use drugs who face greater stigma – from accessing services.

2.3. Barriers to healthcare in detention

States have a heightened obligation to protect the fundamental rights of people in detention:[36] by arresting and depriving individuals of their liberty, states assume the responsibility to care for their life and bodily integrity, and to take appropriate measures to protect their right to life. Furthermore, under the principle of equivalence of care, detainees should have access to healthcare in custody that is at least equivalent to that available in the community.[37]

Access to harm reduction in prisons is severely limited worldwide, and there is a grave dearth of data on prisoner health.[38] HIV, viral hepatitis and tuberculosis treatment and prevention, including needle and syringe programmes and opioid substitution therapy, are near universally less

[34] Myers, B. et al., 2016. '"Not on the agenda": A qualitative study of influences on health services use among poor young women who use drugs in Cape Town, South Africa.' Int J Drug Policy, 30, pp.52–8.
[35] Van Boekal, L. C., 2013. 'Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: A systematic review.' *Drug Alcohol Depend*, 131(1-2), pp.23-35.
[36] Communication No. 763/1997
[37] UNHCHR, report on the human rights in the administration of justice, para. 34. https://www.ohchr.org/Documents/Issues/RuleOfLaw/Violence/A_HRC_42_20_AUV_EN.pdf
[38] Sander, G. et al., 2019. 'The Global State of Harm Reduction in Prisons.' *J Correct Health Care* 25(2), pp.105–20.

accessible in prison that outside.[39] This translates in a violation of the right to health of people who use drugs in prison, and in some cases reaches the threshold of ill-treatment.

The situation is particularly dire for women in prison. The female prison population is increasing, with (often minor) drug offences driving this trend. Increasing numbers of women are incarcerated worldwide, including large proportions of those for drug offences, and substance use is clearly present in women's prisons.[40] Indeed, a higher proportion of women than men are incarcerated for drug-related offences.[41] Sex workers who use drugs are particularly vulnerable, with the dual criminalisation of sex work and drug possession putting them at particularly high risk of incarceration.[42] Despite the growing population of incarcerated women, antiretroviral therapy for HIV treatment, opioid substitution therapy and needle and syringe programmes are all more widely available in male prisons than in female prisons.[43] Men are consistently prioritised for prison health services, due to the larger number of men incarcerated and therefore the greater urgency and cost-effectiveness of providing services to male prisoners.[44] Women consistently report unsafe injection behaviour in prison in the absence of accessible sterile injecting equipment.[45]

When women who use drugs are held in prison or police detention, access to health and harm reduction services is frequently made impossible. This relates in part to the total absence of harm reduction services in South African prisons: HRI's research indicates no NSP or OST is available in any detention centre in the country.[46] This is exacerbated by the discriminatory and stigmatising attitudes of police and prison staff when dealing with women who use drugs with medical concerns.

Women report being denied medical care because of their status as women who use drugs, for pre-existing conditions, illnesses, and when experiencing withdrawal symptoms. In recent research conducted by HRI and SANPUD, women reported symptoms are so grave that at least one woman ended up committing suicide while in detention.

[39] Sander, G. et al., 2019. 'The Global State of Harm Reduction in Prisons.' J Correct Health Care 25(2), pp.105–20; Strathdee, S. A. et al., 1999. 'Substance Use and HIV Among Female Sex Workers and Female Prisoners: Risk Environments and Implications for Prevention, Treatment, and Policies.' *J Acquir Immune Defic Syndr*, 1(69, Suppl 2), pp.110-117.
[40] Pinkham, S. et al., 2012. 'Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy.' *Adv Prev Med*.
[41] UNODC, 2018. *World Drug Report 2018*. Vienna: United Nations Office on Drugs and Crime.
[42] Pinkham, S. et al., 2012. 'Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy.' *Adv Prev Med*.
[43] El-Bassel, N. & Strathdee, S. A., 1999. 'Women who use or inject drugs: an action agenda for women-specific, multilevel and combination HIV prevention and research.' J Acquir Immune Defic Syndr, 1(69, Suppl 2), pp.182–90; Sander, G. et al., 2019. 'The Global State of Harm Reduction in Prisons.' J Correct Health Care 25(2), pp.105–20.
[44] Fair, H., 2009. *International review of women's prisons*. London: International Centre for Prison Studies, Kings College London.; Burns, K., 2009. *Women, Harm Reduction and HIV: Key findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*. New York: Open Society Foundations; van der Meulen, E. et al., 2018. 'A legacy of harm: Punitive drug policies and women's carceral experiences in Canada.' *Women Crim Justice*, 28(2), pp.81-99.
[45] Strathdee, S. A., 1999. 'Substance Use and HIV Among Female Sex Workers and Female Prisoners: Risk Environments and Implications for Prevention, Treatment, and Policies.' *J Acquir Immune Defic Syndr,* 1(69, Suppl 2), pp.110-117; Dolan, K. et al., 1996. 'HIV risk behaviour of IDUs before, during and after imprisonment in New South Wales.' *Addict Res*, 4(2), pp.151-60; Rehman, L. et al., 2004. 'Harm reduction and women in the Canadian national prison system: Policy or practice?' *Women Health*, 40(4), pp.57-73; Dolan, K. et al., 2009. 'Presence of hepatitis C virus in syringes confiscated in prisons in Australia.' *J Gastroenterol Hepatol*, 24(10), pp.1655-7.
[46] Stone, K. & Shirley-Beavan, S., 2018. *The Global State of Harm Reduction 2018*. London: Harm Reduction International.

SUGGESTIONS FOR LIST OF ISSUES

We respectfully recommend this Committee to raise the above-described issues with the Government of South Africa, including by submitting the following questions:

- Elaborate on the compatibility of the criminalization of drug use and possession for personal use with its obligations under Article 2 CEDAW, and on how criminalization impacts upon the realization of other fundamental rights of women who use drugs;

- Which measures has the government adopted to prevent violence (including sexual violence), arbitrary arrest, and discriminatory action by law enforcement against women who use drugs and women sex workers specifically? How was the effectiveness of these measures assessed?

- How many claims of arbitrary arrest and detention, physical and sexual violence have been submitted by women who use drugs and sex workers against law enforcement in the reporting period? How many of these have been investigated, how many individuals prosecuted, and what was the outcome of these proceedings?

- What measures have been adopted at the legislative, policy, and practical level to ensure women who use drugs have access to quality harm reduction services on a non-discriminatory basis?

- Elaborate on the compatibility of the closure of the Needle and Syringe Programme in Durban with the prohibition of retrogressive measures enshrined in the Covenant on Economic, Social and Cultural Rights;

- What measures has the government undertaken to ensure and monitor the implementation of the Mandela Rules, including with specific regard to the provisions on strip searches?

- Elaborate on the compatibility of the lack of harm reduction services in prison with the right to health;

- Which measures have been adopted at the legislative, policy and practical level to prevent and redress discrimination against women who use drugs in healthcare services?