**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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| --- | --- |
|  | [ ]  Member State [ ]  Observer StateX Other (please specify) Consumer Organisation |
| Name of StateName of Survey Respondent | Nancy E Loucas |
| Email | Nancy@caphraorg.net |

**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 |
| **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.

Tobacco Harm Reduction is something that has been accepted and implemented in countries throughout the world. Tobacco Harm Reduction follows the same precepts as Drugs Harm Reduction – substitution of the known harmful product with a less harmful alternative.

In New Zealand, the United Kingdom, Japan, Korea and the Philippines, the application of Tobacco Harm Reduction to eradicate combustible tobacco use has assisted in reducing the rates of combustible tobacco to the point where these countries will meet, or come very close to meeting, the 2030 global goal of less than 5% of the population using combustible tobacco.

The use of combustible tobacco in these countries have fallen to record lows as you will see outlined below:

 **2010 Smoking Rates 2022 Smoking Rates**

 *amongst adults over the age of 18.*

New Zealand[[3]](#endnote-1) 20.1% 8%

Korea[[4]](#endnote-2) 26.9% 19.2%

Japan[[5]](#endnote-3) 25.8% 11%

Philippines[[6]](#endnote-4) 28.3% 19.5%

United Kingdom[[7]](#endnote-5) 24.1% 12.9%

The relative newcomers to a legalised consumer models have shown the most dramatic decreases within two years of legalisation. New Zealand regulated its market and made safer nicotine products (sans snus) legal as of 2020. Philippines regulated its market and made safer nicotine products (sans snus) legal in 2021, it will be interesting to see the decline in the statistics for 2023.

One must also take into consideration the economies of scale – New Zealand currently has a population of 5.1 million, whereas the Philippines current population is 113.9 million; Japan’s population is 125.7 million; Korea’s population is 51.74 million and the population of the United Kingdom is 67.33 million.[[8]](#endnote-6)

When taking an anti-coloniality and anti-racism approach, the Special Rapporteur needs to review the behaviour of the WHO FCTC and the Global Ambassador for Non-Communicable Diseases with regards to the stigmatisation of Tobacco Harm Reduction as a concept and the supporters of safer nicotine products. Consumers of these products are criminalised in countries where there are outright bans on Safer Nicotine Products (India, Thailand) and stigmatised globally by public health officials, tobacco controllers and NGO’s as their voices are silenced and disenfranchised under the guise of Article 5.3 of the Framework Convention on Tobacco Control. This has been going on for years and has been termed “Philanthropic Colonialism” by those in the wider Harm Reduction field due to its significant impacts on LMIC countries as well as disadvantaged communities.

The highest burden of smoking related harm is amongst disadvantaged populations that includes those who are living in poverty, members of the LGTBQI community, those who have mental health struggles and challenges and those who live in Low and Middle Income Countries (LMICs).

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.

There is a disconnect between the application of stated UN policies on the Right to Health and those of the WHO FCTC article 1D to promote harm reduction. The WHO FCTCs refusal to acknowledge Tobacco Harm Reduction is diametrically opposed to the acceptance of Harm Reduction in every other area of Public Health except for Tobacco.

As the goal of 5% or less of the population using combustible tobacco is almost reached, the WHO FCTC has now decided to take aim at Nicotine, which includes the safer products that millions of adults have utilised to switch off of combustion and unsafe oral tobacco. Instead, countries are banning safer nicotine products justified by WHO FCTC guidelines which are not based on the entire body of scientific evidence available.

In 2022, CAPHRA (The Coalition of Asia Pacific Harm Reduction Advocates) issued a [white paper](https://caphraorg.net/wp-content/uploads/pdfs/white-paper-subversion_of_public_health.pdf) entitled *“The Subversion of Public Health: Consumer Perspectives”* that details the failures of the World Health Organisation FCTC with regards to Tobacco Harm Reduction. Esteemed former WHO employees have come forth to express their reactions to advice and information issued by FCTC with regards to Electronic Nicotine Delivery Devices (ENDS).

In the lead up to the COP10 in November 2023, CAPHRA also issued a [report](https://caphraorg.net/wp-content/pdf/FCTC_Shadow_Report.pdf) entitled *“Shadow Report on the (NON)-Implementation of the Framework Convention on Tobacco Control Article 1 (d) on Harm Reduction Strategies”.* In it, we demand that the WHO FCTC should prioritize ending the premature deaths caused by cigarettes by also looking at promoting harm reduction strategies that can help reduce the harm caused by smoking.

We believe the FCTC should focus on reducing smoking prevalence as this the primary objective of their mandate. This can be done by providing honest, risk-proportionate communication and regulatory recommendations and opposing treating safer nicotine products as tobacco products and regulating and taxing vaping the same way as smoking; opposing the treatment of vaping aerosols as smoke and opposing any radical progressive tobacco measures that will be extended to novel and emerging tobacco products.

The WHO FCTC needs to prioritise science-based, inclusive policy making based on the best available evidence and ensure that all stakeholders are included in the decision-making process. By including harm reduction strategies and focusing on reducing smoking prevalence, we believe that the WHO FCTC can make progress towards its goal of reducing the global burden of tobacco related diseases and deaths.

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.
3. 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.).
4. 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)?
5. 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.).
6. 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.
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)
3. https://www.macrotrends.net/countries/NZL/new-zealand/smoking-rate-statistics [↑](#endnote-ref-1)
4. https://www.statista.com/statistics/645282/south-korea-smoking-rate-by-gender/ [↑](#endnote-ref-2)
5. https://www.statista.com/statistics/1019102/japan-share-smoking-adults/ [↑](#endnote-ref-3)
6. https://www.macrotrends.net/countries/PHL/philippines/smoking-rate-statistics [↑](#endnote-ref-4)
7. https://www.macrotrends.net/countries/GBR/united-kingdom/smoking-rate-statistics [↑](#endnote-ref-5)
8. https://www.worldometers.info/world-population/population-by-country/ [↑](#endnote-ref-6)