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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 ☐ Other (please specify) Private sector public health agency
Name of State Name of Survey Respondent	United Kingdom Professor Gerry Stimson, on behalf of Knowledge•Action•Change
Email	c/o Ruth Goldsmith ruth@kachange.eu

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

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

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] 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

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

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**.

Introductory comments and context

Please note that this material replicates the letter from Professor Gerry Stimson to Ms Tlaleng Mofokeng that accompanies Knowledge•Action•Change's submission.

Knowledge•Action•Change is a UK-based agency focused on the promotion of harm reduction as a key public health strategy grounded in human rights.[3] We are experienced in many public health and social issues, including harm reduction for drug, alcohol and tobacco use, sexual health, HIV and prisons.

We would like to use this opportunity to discuss the role of harm reduction in tackling tobacco-related death and disease, and how it intersects with the right to health. Knowledge•Action•Change currently runs two projects in this area, the Global State of Tobacco Harm Reduction and the Tobacco Harm Reduction Scholarships Programme. Both are funded by the Foundation for a Smoke-Free World.[4,5]

Tobacco – primarily smoked – is one of the most popular psychoactive drugs globally used by one in five of the global population. Smoking is the leading cause of non-communicable diseases and premature death worldwide, with eight million smoking-related deaths annually, and tobacco use is a significant factor in global health inequity. Premature deaths related to smoking substantially exceed premature deaths from all psychoactive drugs. Yet tobacco smoking is a blind spot in drugs harm reduction.

Premature deaths from smoking are an issue of inequity - 80 per cent of people who smoke live in low- and middle-income countries, and disproportionately high rates of smoking are concentrated in disadvantaged and marginalised populations in higher income countries.

Tobacco control has in some countries reduced but not eradicated smoking, with 1.1 billion people worldwide continuing to smoke, a figure unchanged in the last 20 years. Hundreds of millions of people are either unable or unwilling to give up nicotine and continue smoking tobacco to consume it despite the known health risks.

Nicotine is not the cause of tobacco-related death and disease. As renowned UK psychiatrist Michael Russell noted in *The British Medical Journal* in 1976, "people smoke for [the] nicotine but die from the tar."[6] And as noted by the UK's Royal College of Physicians *Nicotine without smoke: tobacco harm reduction*, "it is widely accepted

[3] Knowledge•Action•Change (KAC): https://kachange.eu/
[4] The Global State of Tobacco Harm Reduction here: https://gsthr.org/
The Tobacco Harm Reduction Scholarships Programme here: https://thrsp.net/
[5] The Foundation for a Smoke-Free World: https://www.smokefreeworld.org/
[6] Russell, M.A. H. Low-tar medium nicotine cigarettes: a new approach to safer smoking. Br Med J: first published as 10.1136/bmj.1.6023.1430 on 12 June 1976. https://www.bmj.com/content/bmj/1/6023/1430.full.pdf

that any long-term hazards of nicotine are likely to be of minimal consequence in relation to those associated with continued tobacco use."[7]

Safer nicotine products (SNP), which include vaping devices (e-cigarettes), nicotine pouches, snus (an oral non-combustible tobacco) and heated tobacco products, enable people to continue using nicotine while eliminating the risks of tobacco combustion. None are risk-free, but all are proven to be significantly safer than continued smoking or use of high-risk oral tobaccos.

One of the founders of KAC – Professor Gerry Stimson – was formerly head of the International Harm Reduction Association (now Harm Reduction International).[8] Prof Stimson developed a programme of work at IHRA to highlight human rights abuses of drug users, and to argue that harm reduction was inherent in the right to health.

In 2008, Prof Stimson invited the then Special Rapporteur on the Right to Health, Paul Hunt, to deliver a keynote speech at the opening of Harm Reduction 2008: IHRA's 19th International Conference in Barcelona, Spain. The speech, which focused on human rights and drug policy, was later published as 'Human Rights, Health and Harm Reduction: States' Amnesia and Parallel Universes'.[9] It contained some of the strongest comments thus far expressed by a UN human rights expert both in favour of harm reduction and against drug policies at the international and national levels that violate the rights of people who use drugs.

Prof Stimson wrote the definition of harm reduction that was referenced by Anand Grover in his UN General Assembly *'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'* (see also below).

Since co-founding KAC, Prof Stimson has argued that argued that tobacco harm reduction is also supported by the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights.[10] Under a harm reduction approach, where nicotine abstinence is unachievable, the use of SNP in place of smoking represents a net benefit both to individuals and to public health.

The read across from drugs harm reduction to tobacco harm reduction is clear: in the same way that the shared syringe is a dirty delivery system for drugs, so the combustible cigarette is a dirty delivery system for nicotine. Safer alternatives to smoking enable people who are dependent on nicotine and/or who use it functionally to

[7] Nicotine without smoke: tobacco harm reduction. Royal College of Physicians, UK. April 2016. Accessible at: https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction

[8] Harm Reduction International (formerly the International Harm Reduction Association): https://hri.global/

[9] 'Human rights, Health and Harm Reduction: States' Amnesia and Parallel Universes'. Professor Paul Hunt. Published by Harm Reduction International. https://hri.global/publications/un-special-rapporteur-speech-from-harm-reduction-2008/

[10] Stimson, G. GSTHR Briefing Paper: The right to health and the right to tobacco harm reduction. Global State of Tobacco Harm Reduction, June 2022. https://gsthr.org/resources/briefing-papers/the-right-to-health-and-the-right-to-tobacco-harm-reduction/

moderate mood, stress and mental health issues to use nicotine, without the disastrous health effects due to smoking.

The UN Committee on Economic, Social and Cultural Rights affirms the obligation, under the ICESCR, of States to support people in making informed choices about their health, adding that a right to control one's health and body requires "a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health". It is an approach that uses a language of empowerment and enablement, and recognises people as a key resource for health.

Smokers have the right to choose to use safer alternatives to smoking. Our estimates suggest that 112 million people already use SNP.[11]

Our submission is a request to the Special Rapporteur to include smoking and nicotine use in considerations of harm reduction and the right to health. Our responses below to the Special Rapporteur's questions discuss some of the policies, programmes, and practices that aim to minimise the negative health, social, and legal impacts associated with smoking and high-risk tobacco use.

Please contact us for further clarification or discussion on any of the information supplied.

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.**

Countries that have enabled or accepted SNP and tobacco harm reduction have seen major reductions in smoking and tobacco-related disease. Sweden, where snus has largely displaced smoking, has smoking rates of under 5%, a level at which the WHO considers a country 'smokefree'. Sweden has the lowest level of tobacco-related disease in Europe. In Japan, there was a massive 38% drop in overall cigarette sales between 2011 – 2019, largely attributed to the introduction of heated tobacco products in 2016.[12] This is a reduction at a pace and scale never before seen in the field of tobacco control.

By supporting of nicotine vaping for smoking cessation, the UK Government has embraced a tobacco harm reduction approach, and the decline in smoking has

[11] Jerzyński, T., Stimson, G.V., Shapiro, H. *et al.* Estimation of the global number of e-cigarette users in 2020. *Harm Reduct J* 18, 109 (2021). https://doi.org/10.1186/s12954-021-00556-7
GSTHR Briefing Paper: 82 million vapers worldwide in 2021. K●A●C, 2021.
https://gsthr.org/resources/briefing-papers/82-million-vapers-worldwide-in-2021-the-gsthr-estimate/

[12] Cummings KM, Nahhas GJ, Sweanor DT. What Is Accounting for the Rapid Decline in Cigarette Sales in Japan? Int J Environ Res Public Health. 2020 May 20;17(10):3570. doi: 10.3390/ijerph17103570. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7277739/

accelerated. In 2011, 20.2% of the population smoked; in 2022 it had fallen to 12.9%, an all-time low.[13]

The use of safer forms of nicotine as alternatives to smoking was endorsed by the UK Royal College of Physicians (RCP) in 2007 before vaping was well known and reiterated in 2016 and 2021. Multiple evidence reviews conducted by the Office for Health Inequalities and Disparities (OHID, formerly Public Health England) concluded that "e-cigarettes are at least 95% less harmful than smoking".[14] These findings have been influential both domestically and globally.

Nicotine vapes are regulated as consumer products under the UK's Tobacco and Related Products Regulations 2016 and must comply with product standards, ensuring consumer safety. The National Health Service, most anti-smoking and health NGOs and many medical bodies endorse the use of e-cigarettes for smoking cessation, and they have become the most popular quit aid.[15] In April 2023, the UK Government announced its 'Swap to Stop' programme, under which a million vaping kits will be given to people who smoke along with behavioural support.[16]

There are challenges. Youth uptake of vaping products has been rising, with daily or occasional use among UK 16 – 24-year-olds increasing from 11.1% in 2021 to 15.5% in 2022.[17] However, this should be seen in the context of the dramatic decline in smoking rates in young people. In 2011, 25.7% of 18- to 24-year-olds smoked, compared to 11.6% in 2022.[18] Vaping may be diverting younger people from combustible cigarettes, as they choose to use nicotine in ways that are less risky to health.

A regulatory and policy environment supporting vaping for smoking cessation, plus endorsement from trusted sources, has helped millions of people quit combustible tobacco in the UK. A tobacco harm reduction approach has furthered the right to health for people who use nicotine, giving them the freedom to choose safer alternatives to smoking.

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,

[13] Adult smoking habits in Great Britain 2022. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2022
[14] Nicotine vaping in England: an evidence update including health risks and perceptions, September 2023, Office for Health Inequalities and Disparities. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107701/Nicotine-vaping-in-England-2022-report.pdf
[15] Vaping in England evidence update including vaping for smoking cessation, February 2021. Office for Health Inequalities and Disparities. https://assets.publishing.service.gov.uk/media/602d076fe90e0709de875362/Vaping_in_England_evidence_update_February_2021.pdf
[16] Smokers urged to swap cigarettes for vapes in world first scheme. Department of Health and Social Care. April 2023. https://www.gov.uk/government/news/smokers-urged-to-swap-cigarettes-for-vapes-in-world-first-scheme
[17] ONS
[18] ONS

programmes, and practices? Aside from legal and regulatory barriers, are there other obstacles in place? Please provide specific examples.

Rather than focusing on a single country or region, we will briefly discuss how legal frameworks can facilitate or serve as a barrier to harm reduction for tobacco, with reference to the global picture.

No country currently bans the sale of combustible cigarettes. Yet SNP are banned in many countries – for example, the sale of nicotine vaping devices is prohibited in 37 countries, snus in 38, and heated tobacco in 15; regulation for these products simply does not exist in most countries.[19]

Prohibition or regulatory vacuums do not mean that consumers cannot purchase SNP, as black or grey markets meet demand, similar to the case with drug prohibition. It does mean, however, that people are put at risk from unregulated and illicit goods. Highly regulating or banning SNP perversely means that the highly dangerous combustible cigarette remains available when safer alternatives are not.

Evidence-based tobacco control policies should continue to discourage smoking, encourage smoking cessation, and prevent initiation. In addition, however, governments should make it as easy as possible for people who smoke – and who cannot quit or want to continue using nicotine – to switch away from combustibles to products that the evidence base shows are significantly less risky to health.

To facilitate this, SNP need to be treated as consumer products with proper consumer safety regulations in place (such as in the UK/EU). Products should not be banned outright (as in India). Nor should they be subject to *de facto* bans, such as those that result when they are categorised as medical devices or products available on prescription (as in Australia), or when specific elements of their use are prohibited or restricted, such as with flavour bans for vaping liquids (as in some states in the US). Banning SNP has the unintended consequence of privileging cigarettes in the nicotine marketplace.

In pursuit of public health gains, safer nicotine products should not be treated the same as combustible tobacco products. If they are taxed, this should be at substantially lower levels than cigarettes. Governments should ensure that safer products are both available and affordable to people who want to switch to them. This creates an environment conducive to switching away from combustible cigarettes to safer products.

People who cannot quit smoking, or who do not want to stop using nicotine, should be empowered to make decisions about their own health, with access to evidence-based information from trusted sources on the benefits of switching to SNP. As well as legal and regulatory frameworks, a significant additional barrier to harm reduction for tobacco is growing misinformation among the general public about the risks associated with SNP.

3. How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use? Please provide disaggregated

[19] Source: The Global State of Tobacco Harm Reduction - https://gsthr.org/

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.

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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.

Harm reduction for tobacco would further the attainment of the right to health for people who use nicotine – both the 1.1 billion people who smoke and the 112 million who use SNP.

The Special Rapporteur will be aware of the words of her predecessor Anand Grover in 2010, that "the enjoyment of the right to health of all people who use drugs – and are dependent on drugs – is applicable irrespective of the fact of their drug use". His report endorsed the right to drugs harm reduction.

Nicotine is one of the world's most widely consumed drugs. In practice, the attainment of the right to health for people who smoke and use SNP is frequently obstructed. The consequences are borne out in the ever-increasing toll of smoking-related deaths.

None of the international drug control conventions mention harm reduction. This has been an ongoing obstacle for those advocating for drugs harm reduction within the UN system – for example at the Commission on Narcotic Drugs and the United Nations Office of Drugs and Crime, where the words harm reduction were banned from decisions and documents for many years, often under pressure from significant States Parties.

The international response to smoking-related death and disease is driven by the WHO Framework Convention on Tobacco Control (FCTC), which differs from the drugs conventions by explicitly mentioning harm reduction. Article 1d states that "'Tobacco control' means a range of supply, demand and **harm reduction** strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke." [emphasis added].

The harm reduction component of 'tobacco control' as defined by the FCTC has been largely ignored, along with the fundamental human rights principles that relate to it. Discussions about human rights in tobacco control have focused on the state's obligation to protect people from the infringement of their rights by third parties, hence to regulate the tobacco industry to reduce the negative impacts of tobacco, addressing supply and demand reduction.

FCTC implementation has failed to recognise that the pursuit of the highest standard of health and protecting public health *also* includes enabling affected populations to protect themselves. For people who smoke tobacco, this includes the freedom to choose safer alternatives to combustible or risky oral tobacco products.

Concerningly, ahead of the 10th Conference of the Parties to the FCTC, now postponed until 2024, meeting papers indicate that the WHO and the FCTC Secretariat are seeking to conflate all tobacco and nicotine-containing products into a single category, failing to distinguish between high-risk tobacco products and SNP, with the likely aim being to encourage Parties to ban or strictly regulate the use of SNP.[20] This would be consistent with the WHO's public negative stance on SNP to date – in 2021, the Director-General's Special Recognition Award was given to India's Health and Welfare Minister "for spearheading the Government of India's legislation to ban e-cigarettes and heated tobacco products in 2019".[21]

Many meetings of UN bodies encourage the participation of civil society organisations and ensure that the voices of affected people are heard. However, FCTC COP meetings exclude participation of nicotine advocacy groups, meaning affected populations have no avenue to contribute.[22]

5. 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.).

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6. 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)?

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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

[20] For an analysis of the FCTC COP10 published papers through a tobacco harm reduction lens, see the GSTHR Briefing Paper 'The FCTC COP10 Agenda and supporting documents - implications for the future of tobacco harm reduction'. The Global State of Tobacco Harm Reduction, October 2023. https://gsthr.org/resources/briefing-papers/the-fctc-cop10-agenda-and-supporting-documents/

[21] WHO News release: 'Dr Harsh Vardhan conferred WHO award for leadership in tobacco control', 2 June 2021. https://www.who.int/india/news/detail/02-06-2021-dr-harsh-vardhan-conferred-who-award-for-leadership-in-tobacco-control

[22] For further information on the lack of access for consumer advocacy groups to the FCTC COP meetings, see the GSTHR Briefing Paper 'The Framework Convention on Tobacco Control – an explainer'. The Global State of Tobacco Harm Reduction, April 2023. https://gsthr.org/resources/briefing-papers/the-framework-convention-on-tobacco-control-fctc-and-the-conference-of-the-parties-cop-an-explainer-updated-april-2023/

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.).

Tobacco smoking is the leading cause of premature death worldwide, with eight million smoking-related deaths annually. It is also a significant factor in global health inequity. This is true for inequities between the health of people living in low- and middle-income countries and people living in higher income countries, and for inequities between vulnerable groups and the populations of all countries.

The WHO reports that the share of deaths caused annually by NCDs has grown consistently and is now responsible for nearly three quarters of all lives lost each year.[23] Eighty per cent of people who smoke live in low- and middle-income countries (LMIC).[24] The majority of tobacco-related disease and disability therefore occurs among people living in countries with healthcare systems that are least able to cope.

The number of smokers has remained broadly stable for two decades, and in many LMIC, rates have plateaued, but population increases are likely to increase the number of people who smoke. Many of the tobacco control interventions that discourage smoking and encourage cessation are costly for governments to implement, for example, the establishment of national cessation support programmes. Integrating a tobacco harm reduction approach alongside tobacco control, by ensuring the availability of affordable and acceptable safer alternatives to smoking or high-risk oral tobacco products, could help lower the significant burden of tobacco-related disease in LMIC at minimal cost to the state.

Globally, tobacco smoking intersects with deprivations and marginality, including among drug-using populations, mental illness populations, LGBTQI+, incarcerated populations and minorities, all of whom have much higher levels of smoking than the wider population.

Using the UK as an example, the impact of smoking on health inequalities is stark. The general population smoking rate is 12.9%. People living in more deprived areas are 2.5 times more likely to smoke than those in least deprived and find it harder to quit, with smoking responsible for twice as many cancer cases in lower income groups compared to higher income groups.[25] Smoking rates among people who are homeless are estimated to be 76 – 85%, and their life expectancy is roughly half that of the general

[23] Urgent action needed to tackle stalled progress on health-related sustainable development goals. WHO, May 2023.
https://www.who.int/news/item/19-05-2023-urgent-action-needed-to-tackle-stalled-progress-on-health-related-sustainable-development-goals
[24] Tobacco factsheet. WHO.
https://www.who.int/news-room/fact-sheets/detail/tobacco
[25] Smoking responsible for twice as many cancers in most deprived groups. Cancer Research UK, August 2021.
https://news.cancerresearchuk.org/2021/08/03/england-smoking-responsible-for-twice-as-many-cancers-in-most-deprived-groups/

population.[26] 30% of people who smoke in the UK has a mental health condition and over 40% of people with a serious mental illness smoke; smoking is the single largest contributor to their 10 – 20 year reduced life expectancy.[27]

Harm reduction has the capacity to empower the most vulnerable communities to improve their own health.

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.

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[26] Hertzberg, D., Boobis, S. (2022). Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit. Homeless Link. https://homeless.org.uk/knowledge-hub/unhealthy-state-of-homelessness-2022-findings-from-the-homeless-health-needs-audit/
Burrows, M. (2016). Room to Breathe. A Peer-led health audit on the respiratory health of people experiencing homelessness. Groundswell and Trust for London. https://groundswell.org.uk/our-approach-to-research/peer-research/room-to-breathe/
Public Health England. (2020, February 11). Health matters: Rough sleeping [Guidance]. https://www.gov.uk/government/publications/health-matters-rough-sleeping/health-matters-rough-sleeping.

[27] Smoking and mental health. ASH UK Briefing. https://ash.org.uk/resources/view/smoking-and-mental-health