UNITED NATIONS
HUMAN RIGHTS
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 ☐ **Other (please specify)**
Name of State Name of Survey Respondent	**World Vapers' Alliance**
Email	**info@worldvapersalliance.com**

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 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.

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

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.

The purpose of this consultation is to expand the understanding and application of harm reduction strategies, particularly focusing on tobacco use. Our contribution will center on how harm reduction strategies, especially through safer smoking alternatives, can effectively decrease smoking prevalence.

This approach aligns with the principles outlined in the WHO Framework Convention on Tobacco Control (FCTC). Specifically, Article 1(d) of the FCTC highlights the importance of incorporating harm reduction strategies into broader tobacco control measures, encompassing supply and demand aspects.

Evidence from various countries, such as Sweden, the United Kingdom, New Zealand and Japan, supports the effectiveness of safer smoking alternatives. These countries have witnessed significant reductions in smoking rates attributed to the adoption of less harmful smoking options.

Despite global efforts, smoking continues to be a major public health challenge. With over a billion people worldwide still engaged in smoking, particularly in less affluent nations, the consequences are substantial, including approximately 8 million deaths annually. Therefore, it is crucial for entities like the UN and WHO to integrate smoking-related harm reduction into their future initiatives to curb smoking rates effectively.

For a detailed analysis of how integrating safer alternatives into smoking harm reduction strategies is vital for upholding the right to health, further insights can be found in the letter.

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.

    a) **Vaping in the United Kingdom: The UK has progressively endorsed vaping as a harm reduction tool. Smoking rates in the UK have fallen by over 29% in the past decade, a period coinciding with the rise of vaping. This rate of decline is twice as fast compared to the EU average. In 2023, the UK Government launched a program aimed at motivating smokers to switch from cigarettes to vaping (swap to stop) to enhance public health and further reduce smoking prevalence. This is a great example of how the government and public health endorse vaping as a less harmful alternative for smokers.**

    b) **Snus Use in Sweden: Snus, a type of oral smokeless tobacco, has been instrumental in Sweden's tobacco harm reduction strategy. Sweden's smoking rate has decreased to 5.6%, and the country is on track to become the first to reach a "smoke-free" goal. This reduction in smoking rates has been accompanied by much lower smoking-related mortality compared to other European countries. Its cancer rate is 41% less than the European average, and it has a**

tobacco-related mortality rate less than half that of 24 out of the 27 EU countries relative to population size. Furthermore, Sweden reports a 39.6% lower death rate from all tobacco-related diseases compared to the EU average.

c) **New Zealand's 'Quit Strong' Initiative: The Ministry of Health in New Zealand has promoted vaping through the 'Quit Strong' initiative, which aims to provide smokers with information about vaping and support them in quitting cigarettes.**

d) **Heat-not-burn products in Japan: Within only five years (2016-2021), cigarette sales in Japan plummeted by 43% due to the introduction of heat-not-burn products. More and more people in Japan are rejecting cigarettes and choosing less harmful alternative products such as heat-not-burn.**

Each of these examples demonstrates a successful implementation of harm reduction strategies in tobacco use, showing notable reductions in smoking rates and associated health risks. These cases illustrate the effectiveness of providing safer alternatives and supportive policies to reduce the harm associated with 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, programmes, and practices? Aside from legal and regulatory barriers, are there other obstacles in place? Please provide specific examples.

Legal frameworks significantly impact harm reduction policies, programs, and practices related to smoking. Central to these frameworks is the principle of the right to health, which includes the right of adults who smoke to access safer alternatives. This principle is intertwined with the right to information, ensuring individuals can make informed choices about their health.

However, legal and regulatory barriers often hinder the implementation of harm-reduction strategies. For example, bans and flavor restrictions on vaping products have been shown to lead to increased smoking rates.

a) **Restrictions on Vaping Products: In some regions, legal restrictions, such as bans or flavor restrictions on vaping products, have led to unintended consequences, including higher smoking rates. For instance, a flavor ban in San Francisco resulted in rising smoking rates among teenagers for the first time in decades.**

b) **Impact of Flavor Bans and Taxation: For example, in Estonia, a ban on flavors led to 60% of vapers continuing to use them by mixing their liquids or obtaining them from the black market, compromising safety and quality control.**

c) **A comprehensive flavor ban in Massachusetts resulted in higher sales of cigarettes.**

d) **Generally, Countries with relatively high adoption of alternative nicotine products, such as vaping, heated tobacco, nicotine pouches, and Snus, lower smoking rates faster than other more hostile countries such as Australia.**

There is evidence suggesting that lower prices and greater availability of alternative products can reduce tobacco consumption, but there is a disparity in the acceptance of tobacco harm reduction strategies. Countries like Sweden and the United Kingdom have embraced these approaches the most, leading to significant reductions in smoking rates. In contrast, low- and middle-income countries often face more restrictive policies, hampering harm reduction efforts. This disparity suggests that policies preventing access to safer smoking alternatives are not only violating the right to health but also contributing to global public health inequity.

3. 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.

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.

Providing accurate information about safer alternatives like vaping is critical to the harm reduction approach. Sweden's comprehensive strategy, which includes regulatory frameworks, education programs, and accessible, safer alternatives to smoking, is on track to make it the first "smoke-free" country.

The 2022 Cochrane Review on vaping for smoking cessation presents compelling evidence that nicotine vaping aids more effectively in quitting smoking than traditional nicotine replacement therapies, such as patches and gums. Vaping is twice as effective for quitting smoking as nicotine replacement therapies, according to a Queen Mary University clinical trial. Additionally, research from the University of Geneva and Virginia Commonwealth University indicates that former smokers who switch to vaping show less dependence on e-cigarettes than long-term nicotine gum users do.

These examples underscore the right of individuals to access safer and more effective alternatives for smoking cessation, reflecting a broader commitment to public health and individual rights within the harm reduction framework.

Vaping is a recommended means of quitting for smokers in France. Outside the EU, the United Kingdom, Health Canada, and New Zealand's Ministry of Health also recommend vaping to smokers looking to quit. Not only in those countries but everywhere, individuals have the right to pursue the highest attainable standard of health, which includes making informed choices about harm reduction strategies.

Access to safer and more effective alternative nicotine products, such as vaping, heated tobacco, nicotine pouches, and Snus, aligns with the human right to health.

By providing access to these alternatives, individuals who wish to quit or reduce smoking have the opportunity to do so in a less harmful and more effective way.

By offering safer alternatives, public health policies can effectively support individuals to reduce or quit smoking, improving overall health outcomes.

The right to health encompasses not only access to healthcare services but also accurate information and education about health, including the risks and benefits of different products. Therefore, ensuring access to these alternatives, alongside reliable information about their relative risks and benefits, is a fundamental aspect of respecting and fulfilling individuals' right to health.

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.).

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)?

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.).

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.

a) **Cohrance Library, Electronic cigarettes for smoking cessation**
https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010216.pub7/full

b) **American Public Health Association, Balancing Consideration of the Risks and Benefits of E-Cigarettes,**
https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2021.306416

c) **Action on Smoking and Health (ASH), Addressing Common Myths About Vaping**
https://ash.org.uk/uploads/Addressing-common-myths-about-vaping-ASH-brief.pdf?v=1691052025

d) **Tobacco-related mortality Sweden & EU**
https://www.researchgate.net/publication/345643346_Tobacco-related_mortality_SwedenEU_easier_readable_charts