**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 | Sweden, Stockholm  Bengt Wiberg |
| Email | euforsnus@gmail.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]](#footnote-1) determinants of health, the Special Rapporteur will examine the laws, policies, and practices that give rise to the need for harm reduction, as well as the laws, policies, and practices that take a harm reduction approach, aiming to address the negative health, social, and legal outcomes in various contexts.

Harm reduction has been primarily developed in the context of drug use, including needle and syringe programs, supervised injection and drug use facilities, opioid substitution therapy, overdose prevention, and community outreach programs, as well as access to legal assistance, social services, housing, and adequate food. However, in this report, the Special Rapporteur will take a broadened view of harm reduction to examine how this approach can intersect with the right to health and related human rights in other realms, including but not limited to sex work, abortion, and safe sex.

The Special Rapporteur also intends consider harm reduction as key public health interventions for populations that are often stigmatised and discriminated against. She will explore how the laws, policies, and practices that give rise to the need for harm reduction can disproportionately impact certain people, such as those in situations of homelessness or poverty, persons who use drugs, sex workers, women, children, LGBTIQ+ persons, persons with disabilities, persons who are incarcerated or detained, migrants, Indigenous Peoples, Black persons, persons living with HIV or hepatitis, and persons living in rural areas. Taking an anti-coloniality and anti-racism approach, the Special Rapporteur will explore how in some contexts criminalisation and stigmatisation can serve as a legacy of colonialism and slavery.

**Definitions**

Most commonly, harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.[[2]](#footnote-2) For the purposes of this report, the Special Rapporteur defines harm reduction in a broader sense, including the policies, programmes, and practices that aim to minimise the negative health, social, and legal impacts associated with various behaviours and related policies and laws, as exemplified above.

**Questionnaire**

The questionnaire can be downloaded below in English (original language), French and Spanish (unofficial translations). Responses can address some of the questions or all of them, as feasible or preferred.

* Download the questionnaire (WORD): English | Français | Español

# How and where to submit inputs

Inputs may be sent by e-mail by 15 November 2023.

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| --- | --- |
| **E-mail address** | ohchr-[srhealth@un.org](mailto:srhealth@un.org) |
| **E-mail subject line** | Contribution to HRC report - SR right to health |
| **Word limit** | 500 words per question |
| **File formats** | Word and PDF |
| **Accepted languages** | English, French, Spanish |

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# Treatment of inputs/comments received

# Please note that all responses will be published on the official webpage of the mandate of the Special Rapporteur by default.

# Key Questions

*You can choose to answer all or some of the questions below. (500 words limit per question).*

Inputs may be sent by e-mail **by 15 November 2023**.

1. While the concept of harm reduction has traditionally been applied to drug use, the Special Rapporteur is taking a broadened approach to harm reduction. What types of harm reduction policies, programmes, and practices are in place in your community, and what is their purpose or aim? How successful have they been at achieving that aim? Please provide data, as possible.

In Sweden, soon to be the first country in the world to reach WHO goal of a smoke-free country the most successful harm reduction approach has been sound tobacco control combined by intelligent regulations and the availability of 97-99,8% less harmful alternatives to deadly smoking like snus, nicotine pouches and ecigs. Sweden has the by far the lowest rate of all tobacco caused cancers as well as cardiovascular diseases and tobacco mortality in all Europe thanks to this combination. The phenomenon is internationally called The Swedish Experience. Daily smoking in Sweden is now down to 5,6% and already we have two smokefree generations 16-29 year olds and 30-44 years old with <5% daily smoking. Source: EU Eurostat & <https://snusforumet.se/en/the-year-in-snus-2022-the-best-one-in-a-long-time/>

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.

The Swedish government and a huge majority of the Swedish parliament are pro harm reduction, including tobacco harm reduction. The evidence of its success is massive since nationwide epidemiological evidence as to the success of making immensely less harmful, non-combustible, nicotine products available for adults in combination with an age limit and a ban of advertising targeting people under 25 years old. The Swedish regulations should be copy & pasted by WHO and any country in the world that has a goal of reducing deadly smoking. The Swedish regulations of reduced risk tobacco-free nicotine products are available from the State Department of Health here: <https://www-riksdagen-se.translate.goog/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-20221257-om-tobaksfria-nikotinprodukter_sfs-2022-1257/?_x_tr_sl=sv&_x_tr_tl=en&_x_tr_hl=en&_x_tr_pto=wapp&_x_tr_hist=true>

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.

See above replies. Smoking of combustible cigarettes is the world’s biggest preventable cause of early death. According to WHO some 8 million people die prematurely each year mainly due to smoking. Tobacco harm reduction, is therefore the most important measure and example of harm reduction.

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

Sweden is on the brink of reaching a smoke-free nations, with today only 5.6% daily smoking prevalence in the adult population. Whilst smoking among people under 29 years old is almost extinct already (3% daily smokers only) the daily smoking rate of men not born in Sweden is 220% higher than for men born in Sweden. Sweden has since 2015 had an immigration of refugees amounting to approx. 350 000 persons, mainly men and coming from the Middle East where smoking in the male population is extremely high. As immigrants assimilate in Sweden, these foreign born men learn about the availability of considerably safer forms of nicotine products like snus, nicotine pouches and e-cigs. That is why Sweden as a whole will probably reach WHO & EU smokefree status of <5% smokers already 2023-2026, i.e. 16-17 years ahead of the WHO & EU goal.

1. Are there alternative measures to institutionalisation or detention? For example, are there outpatient or inpatient facilities available in your country for people using drugs? Please provide additional details (are they compulsory, voluntary; number available in urban and rural areas; entity in charge; type of support provided and type of staff working in these facilities/centres)?
2. 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.).

See above replies. <https://www-riksdagen-se.translate.goog/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-20221257-om-tobaksfria-nikotinprodukter_sfs-2022-1257/?_x_tr_sl=sv&_x_tr_tl=en&_x_tr_hl=en&_x_tr_pto=wapp&_x_tr_hist=true>

1. 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.

Yes, the Swedish state provide all the above mentioned practices mentioned in your question.

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)