How is the right to health relevant to tobacco harm reduction?

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> *While harm reduction as a social movement is relatively new, what affected communities have always been fighting for – the right to health, with nobody left behind – has long been enshrined in international conventions and continues to be so.*
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> *GSTHR – Tobacco Harm Reduction and the Right to Health*

'Promoting our rights' is a good sentiment. We all value human rights and freedoms, including the freedoms of thought and expression, the right to an education, the right to a private life, and the right not to be mistreated or wrongly punished by the state.

But what does it mean when we say that access to safer nicotine products is a human right? What does it mean when we say that tobacco harm reduction is justified under the right to health?

Is there a basis for this claim, and if so, how can it be realised in practice? And what are the implications for people who want to use safer alternatives to smoking?

The United Nations system is rights based

Let's start at the beginning. The United Nations (UN) system of international agreements between countries is rights-based. A series of human rights conventions and other instruments adopted since 1945 have developed into an influential body of international human rights law.

Obligations in international law are binding for countries which have agreed to abide by them. This means that when a country has signed an international convention, the country has a formal commitment and the Government must do everything the treaty requires. I will return to this, because human rights are not just about sentiment, but practical action that can be used to improve people's lives.

The UN Charter, signed in June 1945 towards the end of the Second World War, set out this international system of cooperation to maintain international peace and security. The opening statement of the UN Charter states the global determination:

> *To reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small.*

Human rights and the right to health

One year later these principles were elaborated with respect to health when the World Health Organization (WHO) was established in 1946.

The preamble to the Constitution of the WHO states that:

> *The enjoyment of the highest attainable state of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*

It continues:

> *The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.*

and

> *Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.*

I'll repeat this final phrase as we will come back to it:

> *Informed opinion and active cooperation on the part of the public are of the utmost importance.*

These principles of a right to health were included in the International Covenant on Economic, Social and Cultural Rights of 1966. 171 countries are signatories to this international covenant. Click here, and select the treaty to find whether your country is a signatory.

Article 12 enshrines the right of everyone to:

> *The enjoyment of the highest attainable standard of physical and mental health.*

and the Covenant says that States parties (that means countries that have signed up to it) must take steps regarding:

> *The prevention, treatment and control of epidemic, endemic, occupational and other diseases.*

And as for science – Article 15, paragraph 1 (b), of the Covenant also states that everyone has the right:

> *To enjoy the benefits of scientific progress.*

These principles are further enshrined in regional and national human rights legislation. For example the European Social Charter 1965 states that:

> *Everyone has the right to benefit from any measures enabling them to enjoy the highest possible standard of health attainable.*

In addition, Article 11 requires states to take measures to prevent disease and to encourage individual responsibility in matters of health.

Furthermore, the European Union (EU) Charter of Fundamental Rights of 2000, Article 35, stipulates that a high level of human health protection shall be ensured in the definition and implementation of all of the Union's policies and activities.

The right to health and tobacco

But how can the right to health inform smoking and tobacco policy?

That the right to health is relevant to smoking and tobacco rights is recognised in the first health-based international treaty, the Framework Convention on Tobacco Control (FCTC) of 2005 is a rights based convention. In the opening paragraph of the Forward it states that:

> *The WHO FCTC is an evidence-based treaty that reaffirms the right of all people to the highest standard of health.*

And the first point made in the Preamble to the FCTC is that the parties to the convention are:

> *Determined to give priority to the right to protect public health.*

The Preamble makes reference to Article 12 of the International Covenant on Economic, Social and Cultural Rights, and to the preamble to the constitution of the WHO that I have already mentioned.

Many will be familiar with the definition of tobacco control in Article 1d the FCTC, which includes harm reduction:

> *"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;*

So, how does FCTC interpret the right to health? In practice parties to the FCTC as well as the FCTC secretariat have adopted a definition of human rights which focuses on demand and supply issues, in other words taking measures to discourage tobacco consumption and to protect people from the harmful effects of the tobacco industry (let's call this a 'freedom from' position). They have not elaborated the human rights principles that flow from including harm reduction in the definition of tobacco control, that pursuit of the highest standard of health and protecting public health also includes enabling people to people protect themselves (let's call this a 'freedom to' position). Tobacco control has focussed on negative liberty (freedom from external constraints and influence) and ignored positive liberty (the possession of the power and resources to fulfil one's own potential). Both are important.

A mix of a ‘freedom to’ and a ‘freedom from’ rights-based approach is a core of much public health thinking – one that uses both a language of empowerment, enablement, of people as a key resource for health. One of the key documents in understanding a public health model based on human rights is the WHO’s 1986 Ottawa Charter for Health Promotion.

This is not a binding document, but it sets out a firm vision of how international organisations and states can work to improve public health. Implicit in its approach is that statement that is in the founding Charter of the UN, of *dignity and worth of the human person,* and in the preamble to the WHO constitution that *Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.*

The Ottawa Charter for Health Promotion stressed the imperative to build public policies which support health, such that health promotion is an agenda item in all areas of government and organisational policymaking. It states that health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them.

It acknowledges people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being.

Sadly, this ethos about strengthening individuals and communities has been lost when it comes to international and national discussions on policy surrounding the use of substances such as illegal drugs, alcohol and tobacco. The human rights-based approach has assumed that the rights issues are about protecting people from hazardous substances and the activities of the industries that produce them – a demand and supply focus – rather than elaborating on how people may be enabled to take control of their health through the choices they make.

HIV/AIDS harm reduction in the right to health

There was an important exception to this with the arrival of HIV/AIDS in the mid-1980s. This was the beginning of a crisis for drug control, because clearly drug control measures had not prevented drug use, and states were faced with the problem that there were, within many countries, large numbers of people injecting drugs who might be at risk of HIV infection and who could not be punished or treated the way out of their habits.

Community AIDS activism amongst gay men and sex workers rapidly gained momentum with the idea of safer sex, and, so too the idea that safer drug use – or drugs harm reduction – might help curtail the spread of HIV among people who inject drugs.

Drug control at the time (and still today in many countries) was viewed through a prism of abstinence, prevention, treatment and regulation. The WHO and the UN Office on Drugs and Crime (UNODC) were opposed to the concept of drugs harm

reduction. The UNODC banned the use of the words harm reduction under pressure from the United States. In 1998 the UN declared *"A drug-free world: We can do it"*, and this has echoes in the FCTC of 2005 with the ambition of a tobacco free world built on the premise of enforcement and control.

But there were glimmers of resistance. Starting from the early 2000's, human rights organisations, including Human Rights Watch and the International Harm Reduction Association, campaigned to establish that harm reduction was a fundamental aspect of the right to health. They worked with the UN Special Rapporteurs on the Right to Health. In 2008 the then special rapporteur, Paul Hunt, set out the principles of *Human Rights, Health and Harm Reduction*, and then his successor Anand Grover, in a report to the UN General Assembly in August 2010, set out the principles for a health-based approach to drug control, including:

> *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 specifically included support for the idea that harm reduction was important, and that interventions such as methadone maintenance and needle exchange were fundamentally important for protecting the health of drug users. His primary recommendation to the UN General Assembly was that:

> *Member States should: Ensure that all harm-reduction measures […] are available to people who use drugs.*

One result of this campaigning work by NGOs is that drugs harm reduction is now an accepted and key part of the work of the WHO and UNODC.

The right to health and tobacco harm reduction

But what does this mean for tobacco harm reduction? Clearly the international system does not currently recognise tobacco harm reduction as being justified under the right to health.

As I indicated earlier the human rights thrust in tobacco control has focused on protecting people from tobacco, tobacco smoke, and from the tobacco industry. It has not developed a harm reduction approach to smoking, let alone a rights-based harm reduction approach.

This is clearly wrong and needs to be challenged by civil society organisations and others.

The International Covenant on Economic, Social and Cultural Rights states that everyone has the right to benefit from scientific progress. Since it is clear that a significant body of evidence exists regarding the effectiveness of harm reduction programmes and policies and of the safety of safer nicotine products, it follows that States parties should be obliged to support such interventions.

There needs to be a shift in health-rights thinking, from protecting people from substances and industries, to enabling people to have access to resources that help them reduce or avoid unnecessary suffering, and premature death.

Rights-based legal challenge

This in fact was the argument used by the UK based New Nicotine Alliance (NNA).

In the EU it is illegal to sell snus, except in Sweden, despite the extensive scientific evidence that snus is much safer than combustible tobacco. The evidence from Sweden and Norway indicates that the use of snus helps protect individuals and populations against the risks from smoking tobacco.

In 2017, Swedish Match – a snus manufacturer – initiated a case against the ban that was heard in the European Court of Justice (ECJ). The UK High Court allowed the NNA to join the case as an independent intervener, in that it had additional arguments to present to the ECJ from a consumer perspective.

The NNA's legal case at the ECJ was rights-based – it argued that the ban on the sale of snus contravenes the EU Charter of Fundamental Rights, in particular that it violated:

> Article 1, *Human dignity*, as the ban on snus causes needless suffering and debilitating illness;
>
> Article 7, *Respect for private and family life*, because the ban represents unwarranted interference in personal choices; and
>
> Article 35, *Health care*, which stipulates that a high level of health protection shall be ensured in EU policies and activities.

In its submission to the ECJ the NNA argued that the EU requirement regarding health protection should be interpreted not only about protection from potentially hazardous products and activities, but should also include enabling people to protect themselves by helping them make healthier choices – choices that help them avoid ill-health. The EU ban on snus, the NNA argued, was based on the premise that people needed to be protected from this substance, whereas the evidence from Sweden and Norway showed showed that snus enabled people to protect themselves from smoking.

The Swedish Match case was unsuccessful, but I see the NNA case as a forerunner of health rights challenges that might be engaged elsewhere.

Ways forward

What else can civil society organisations do? One measure that civil society organisations can use is the UN system of Universal Periodic Review, which analyses the human rights record of all UN member states. Under the auspices of the UN Human Rights Council, the human rights situations in countries are

periodically assessed. This mechanism is designed to improve the human rights situation in every country, and the process involves assessing states' human rights records and addressing human rights violations.

The periodic review process provides for the participation of all stakeholders, including NGOs and civil society organisations who can make submissions. States are reviewed every five years. The review process has been used to challenge a lack of progress in the adoption of drugs harm reduction and human rights abuses against drug users. It has yet to be used to argue for access to safer nicotine products.

The method by which civil society organisations can engage in this process is explained in this International Drug Policy Consortium briefing.

Conclusion

We are still only in the early days of developing a health rights case for tobacco harm reduction, let alone seeing this debate occurring within international organisations. There is a long way to go to reformulate the idea of health rights and tobacco harm reduction at an international and national level.

At an international level we have to keep up pressure to include harm reduction in the policies developed under the FCTC, including pressure on states which attend the two-yearly Conference of the Parties of the FCTC. Putting harm reduction on the agenda and promoting harm reduction as a health rights issue is clearly something that needs to be carried forward by advocacy organisations.

Second, within countries, there is a need explore the possibilities under international, regional and national legislation, and national constitutions, to establish tobacco harm reduction as justified under the right to health. Tobacco harm reduction advocacy organisations are small, underfunded, and under-resourced – so it is a matter of building alliances with human rights organisations, and other harm reduction organisations, in order to explore these possibilities. In getting tobacco harm reduction on the agenda, we have to learn what others have done in providing a health rights argument to back up harm reduction in general, and to extend that to a health rights basis for tobacco harm reduction.