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The right to health and the right to tobacco harm reduction

Introduction

Discussions about human rights have long been underdeveloped in tobacco control. Human rights considerations were neglected in the development of the international treaty – the Framework Convention on Tobacco Control (FCTC). Any subsequent advancement of human rights issues has focused mainly on the justification for demand and supply control strategies, prioritising the obligations of states to protect people from both tobacco products and the tobacco industry. Human rights discourse in tobacco control has neglected to address the issue of the right to health and an individual's freedom to take positive steps to protect their own health.

The International Covenant on Economic Social and Cultural Rights affirms that everyone has the right to the highest attainable standard of physical and mental health. This was elaborated by the Committee on Economic Social and Cultural Rights which determined 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".[i]

As a consequence, signatories to the FCTC have a responsibility to make sure they do not prevent smokers and users of hazardous oral tobacco products from having access to safer alternatives. They should also take positive steps to ensure that safer alternatives are available. The right to control one's health and body is at the core of tobacco harm reduction.

This Briefing Paper highlights the importance of developing a right to health and a right to harm reduction narrative and indicates the opportunities for human rights challenges. It argues that **international human rights law supports tobacco harm reduction**.

The United Nations system 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 the countries that agree to abide by them. This means that when a country signs an international convention, its government must do everything the treaty requires. Human rights are not just about sentiment, but practical action that can be used to improve people's lives.

In 1946, these principles were elaborated with respect to **health** with the establishment of the World Health Organization (WHO). The preamble to the Constitution of the WHO[ii] is recognised as the first statement of the right to health in international law. It 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.[…]"

and that

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

The principle of the right to health was included in the International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966.[iii] 171 countries have agreed to be bound by this treaty, listed here.[iv] Article 12 enshrines the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health". The Covenant says that States Parties (the countries that have signed up to it) must take steps regarding "the prevention, treatment and control of epidemic, endemic, occupational and other diseases". Article 15 paragraph 1(b) of the Covenant also states that everyone has the right "to enjoy the benefits of scientific progress".

Similar language is enshrined in many regional treaties and in national constitutions and human rights legislation. For example, the European Social Charter of 1965 states that "everyone has the right to benefit from any measures enabling them to enjoy the highest possible standard of health attainable".[v] 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**.[vi] Every state has ratified at least one international human rights treaty recognising the right to health.[vii]

The omission of a human rights framework in the FCTC

The Framework Convention on Tobacco Control (FCTC) of 2005 is the first health-based international treaty under the auspices of the WHO.[viii]

Article 1(d) of the FCTC 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 Preamble refers to Article 12 of the International Covenant on Economic, Social and Cultural Rights,[xi] and to the Preamble to the Constitution of the WHO previously mentioned. But, while it underscores the significance of human rights, it is not a human rights treaty, and a human rights framework was not incorporated into the text. There was little consideration of human rights issues during the negotiations and no delegate or NGO involved in the process raised the issue.[x] The treaty is, rather, based on the themes of interdependence of nation states and national and global economic and public health interests.[xi] Human rights interests had, at the time, been promulgated by the tobacco industry (arguing that tobacco control was an infringement on personal autonomy and human rights) though there was no equivalent discourse on human rights in tobacco control.

Human rights and tobacco control – freedom from and freedom to

While the issue has predominantly remained underdeveloped, when there have been discussions about human rights in tobacco control, the focus has been on the obligation of the state to protect people from the infringement of their rights by third parties, and hence the need for states to effectively regulate the tobacco industry to reduce the negative impacts of tobacco.[xii] In other words, this focus of tobacco control has been on measures to **discourage tobacco consumption**, to **protect people from** tobacco's harmful effects (including bystanders), to **protect people from** the tobacco industry, and to **protect children**. It therefore addresses the demand and supply components of tobacco control. This can be called a 'freedom from' position.

This would include the freedom to work in an environment unpolluted by other people's smoke, or the freedom from exposure to the advertising of combustible cigarettes. This is an example of **negative liberty**,[xiii] determined as the freedom from external constraints and influence. Neither Parties to the FCTC nor the FCTC Secretariat and few observers have elaborated the human rights principles that relate to the third element of tobacco control: harm reduction.[xiv]

The pursuit of the highest standard of health and protecting public health also includes **enabling people to protect themselves**. This can be called a 'freedom to' position. This includes the right to control one's health and body – for example, sexual and reproductive rights.[xv] In this context, for someone who uses tobacco, this would include the freedom to choose safer alternatives to combustible cigarettes or risky oral tobacco products. To date, the implementation of the FCTC has ignored what is known as **positive liberty**,[xvi] determined as the possession of the power and resources to fulfil one's own potential.

A rights-based approach that mixes both 'freedom to' and 'freedom from' elements is core to much public health thinking. The United Nations (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".[xvii] It is an approach that uses a language of empowerment and enablement, and recognises people as a key resource for health.

The preamble to the WHO Constitution states 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". 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.[xviii] "A right to health based upon empowerment" is also elaborated upon in the WHO analysis of the social determinants of health.[xix] These ideas were ignored in the FCTC and subsequently ignored by the WHO in its advice on tobacco control. The exclusive invocation of negative liberty in tobacco control discourse about human rights is extremely unusual in the public health sphere, making the FCTC an outlier in terms of its approach.

This limited approach fails to capitalise on significant opportunities for improved public health: those that arise by enabling people to take control of their own health, through choices they make for themselves.

HIV/AIDS harm reduction in the right to health

The important and highly relevant exception to this came with the arrival of HIV/AIDS in the mid-1980s. In this period, drug control was viewed through a prism of bans, prevention and abstinence; in many countries, this remains the case today.

But community-led AIDS activism among gay men and sex workers rapidly gained momentum, as calls for abstinence from all sexual activity were recognised as neither ethical, realistic nor appropriate. Instead, by focusing on encouraging safer sex through the use of condoms, the movement empowered people to significantly reduce their own risk of HIV infection. It was around the same time that the idea of safer drug use, or drug harm reduction, emerged as people took action to limit the spread of HIV among those who injected drugs.

At first, the WHO and the UN Office on Drugs and Crime (UNODC) actively opposed drug harm reduction. Indeed, 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". This has echoes in the FCTC of 2005, with the ambition of a tobacco-free world built on the premise of enforcement and control.

From the early 2000s, human rights organisations, including Human Rights Watch and the International Harm Reduction Association (now Harm Reduction International), 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.[xx] His successor, Anand Grover, set out the principles for a health-based approach to drug control in a report to the UN General Assembly in August 2010.[xxi] It stated 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".

Grover's report argued that interventions such as opiate substitution treatment 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".

Court challenge

Just as for people who use drugs, the enjoyment of the right to health of all people who use tobacco and nicotine is applicable, irrespective of the fact of their tobacco and nicotine use. The availability of, and access to, safer nicotine products – or tobacco harm reduction – is fundamentally important for protecting the health of tobacco and nicotine users.

This argument was used by the UK-based advocacy organisation, the New Nicotine Alliance (NNA). In the EU it is illegal to sell snus, except in Sweden, despite extensive scientific research demonstrating it is much safer than combustible tobacco. The evidence from Sweden and Norway indicates that using 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.[xxii] The NNA's legal case at the ECJ was rights-based.[xxiii] It argued that the ban on the sale of snus contravenes the EU Charter of Fundamental Rights,[xxiv] 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, the NNA argued that the EU requirement regarding health protection should be interpreted not only as 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 was based on the premise that people needed to be protected from this substance. The evidence from Sweden and Norway showed that snus enabled people to protect themselves from smoking, so the NNA argued that people across Europe had a right to access it.

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

UN system of periodic review of countries' progress on human rights

Civil society organisations can use the UN system of Universal Periodic Review, which analyses the human rights record of all UN member states.[xxv] Under the auspices of the UN Human Rights Council, the human rights situations in countries are reviewed every five years. This mechanism is designed to improve the human rights status in every country, and the process involves assessing states' human rights records and addressing human rights violations.

The Universal Periodic Review (UPR) system permits all stakeholders, including NGOs and civil society organisations, to make submissions. 'Shadow reporting' is a parallel process to the UPR which sees non-governmental organisations present the perspectives of civil society to either add to, or offer alternative information from, the submissions that governments must present under the UPR system. Both the O'Neill Institute for National and Global Health Law and the Campaign for Tobacco Free Kids used this process during the Universal Periodic Review undertaken in 2008 in Brazil to argue that the Brazilian government's failure to ban smoking in public places and to ban advertising, promotion and sponsorship violated its obligations under ICESCR to respect, protect and fulfil the right to health.[xxvi] The O'Neill Institute has a guide to tobacco-related shadow reporting on its website.[xxvii]

The UPR process has been used to challenge a lack of progress in the adoption of drug harm reduction and human rights abuses against drug users. Examples of the submissions from Harm Reduction International to the Universal Periodic Reviews on drug policy are available to view at their website.[xxviii] The International Drug Policy Consortium, Harm Reduction International, Bridging the Gaps and PITCH (Partnership to Inspire, Transform and Connect The HIV response) published a guide, Making the Universal Periodic Review work for people who use drugs, based on what these organisations learned from participating in UPRs between 2008–2017.[xxix] But the process has yet to be used to argue for access to safer nicotine products.

Conclusion

There was a lack of consideration of human rights issues in the drafting of the FCTC, and subsequent underdevelopment of discussion of human rights and the use of nicotine. The discourse on human rights and tobacco that followed has mainly focused on protection. This is unbalanced as it concentrates mainly on human rights issues as a justification for demand and supply measures to protect people from tobacco use and the tobacco industry.

The neglect of the right to health being a basis of tobacco control is paralleled in the neglect of harm reduction. Hence, a huge resource for change – the opportunities for people to take charge of their health by switching to safer nicotine products – has been systematically undermined.

The right to health underpins the right to tobacco harm reduction.

Putting harm reduction on the tobacco control agenda and promoting it as a health rights issue needs to be carried forward by advocacy organisations that represent the people who are directly affected by its absence – those who use nicotine.

Within countries, there is a need to explore the possibilities for challenges under international, regional and national legislation, as well as national constitutions, to establish tobacco harm reduction as being justified under the right to health. At an international level, the neglect of tobacco harm reduction, and of a positive rights approach in the implementation of the FCTC, needs to be challenged by the States Parties that attend the biennial Conference of the Parties.

For further information about the Global State of Tobacco Harm Reduction's work, or the points raised in this GSTHR Briefing Paper, please contact info@gsthr.org

Knowledge•Action•Change (K•A•C) is a private sector public health agency that promotes harm reduction as a key public health strategy grounded in human rights. The team has over forty years of experience of harm reduction work in drug use, HIV, smoking, sexual health, and prisons. KAC runs the Global State of Tobacco Harm Reduction (GSTHR) which maps the development of tobacco harm reduction and the use, availability and regulatory responses to safer nicotine products around the world.

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