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Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, in accordance with Human Rights Council resolution 51/21.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Harm reduction for sustainable peace and development

Summary

In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, focuses on harm reduction and explores this model as applicable to drug use and to other issues that are central to sustainable peace and development, spotlighting populations that are often stigmatized, criminalized and discriminated against to the detriment of their enjoyment of human rights. She focuses on the cases of drug use, HIV exposure, transmission and non-disclosure, abortion, same-sex relations, and sex work, arguing that States should divest from a punitive approach, moving away from criminalization while also employing regulatory tools to improve health outcomes. For the cases of tobacco, alcohol, food and nutrition, and environmental harms, she argues that harm reduction means adequately and effectively regulating corporate actors. The Special Rapporteur addresses how harm reduction can align with the right to health and related rights in the context of universal health coverage and with the rights of those in situations of vulnerability, including conflict, health emergencies and climate change. In her report, she focuses on good practices in different parts of the world and encourages States to integrate harm reduction as part of universal health coverage plans, incorporating comprehensive services that are accessible, affordable, acceptable and of quality.

I. Introduction

1. Preventing and redressing harm are aspirations that have long steered societies and their use of the law, including in the realm of health,[1] where "do no harm" has been a guiding principle for thousands of years.[2] Yet while the need for societies to steer away from harm has been straightforward, there has been less agreement on what constitutes and causes harm across time and space, as well as how to respond to it. Harm can present itself in numerous ways. Sometimes, it stems from certain behaviours or substances, other times, it stems not from the behaviours or substances themselves, but rather from how States address them (or not). In the cases of abortion, sex work, or same-sex relations, there is no actual or potential harm to start with; rather, harm is derived from State's responses, which often take the form of criminalization.[3] However, this approach undermines public health efforts, imposing barriers to health services and worsening related health outcomes.[4]

2. Colonialism has played a role in ingraining harmful norms and policies into legal systems across the world, including criminalization in circumstances such as the ones described above – one of the clearer manifestations of the looming power of States over individuals. The global dominance of corporations, largely headquartered in the global North while operating in the global South, resembles neocolonialism that contributes to spreading harm by manufacturing and commercializing harmful products, including tobacco, alcohol, unhealthy foods, and environmental harms. Against these interwoven complexities of power and resulting harms, a human rights-based approach to harm reduction is crucial to show the way forward.

3. The Special Rapporteur follows the definition of harm reduction established as relating to policies, programmes and practices that aim to minimize the negative health, social and legal impacts associated with drug use, drug policies and drug laws.[5] In the present report, she explores this model as applicable to drug use and to other issues that are central to sustainable peace and development, spotlighting populations that are often stigmatized, criminalized and discriminated against to the detriment of their enjoyment of human rights. In doing so, she explores what harm reduction looks like in the cases of drug use, HIV exposure, transmission, and non-disclosure, abortion, same-sex relations, and sex work, arguing that States should divest from a punitive approach, moving away from criminalization while also employing regulatory tools to improve health outcomes. For the cases of tobacco, alcohol, food and nutrition, and environmental harms, she argues that harm reduction means adequately and effectively regulating corporate actors.

4. The report builds on the well-established premise that health and human rights are mutually reinforcing frameworks,[6] meaning that a human rights approach can actively contribute to – and at the same time benefit from – public health tools such as harm reduction.

5. In harm reduction and all other realms, there is no path to sustainable peace and development without the meaningful participation of populations that face historic and ongoing forms of discrimination and marginalization, such as sex workers, women, LGBTIQA+ persons, Black people, Indigenous Peoples, migrant persons,

[1] Alice M. Miller and Mindy Jane Roseman, *Beyond Virtue and Vice: Rethinking Human Rights and Criminal Law* (University of Pennsylvania Press, 2019).

[2] World Health Organization (WHO), "Patient safety", 11 September 2023.

[3] A/HRC/14/20, para. 5; and A/66/254, para. 21.

[4] Ibid.

[5] See https://hri.global/what-is-harm-reduction/.

[6] Jonathan Mann and others, "Health and human rights", *Health and Human Rights Journal*, vol. 1, No. 1 (1994).

persons living with HIV or hepatitis, persons with disabilities, persons in situations of homelessness or poverty, persons deprived of their liberty, and persons living in rural areas.

6. The Special Rapporteur addresses how harm reduction can align with the right to health and related rights in the context of universal health coverage and the rights of those in situations of vulnerability, including conflict, health emergencies and climate change.

II. Methodology

7. The Special Rapporteur builds on her predecessors' work, in which they analysed the role of harm reduction to address the human rights impacts of international drug laws and policies as part of the "war on drugs", and how these legal frameworks have contributed to an environment of increased human rights risks and violations.[7]

8. She aims to illustrate the applicability of the harm reduction model beyond drug use across a wider realm. She does so by exploring various examples of public health issues, whose associated harms often derive not necessarily from a behaviour or substance itself, but from the legal frameworks surrounding them. She notes that the examples provided in the report are not exhaustive with respect to the potential applicability of the harm reduction model. She intends to continue exploring other applications going forward.

9. In preparing the present report, the Special Rapporteur issued a call for inputs inviting stakeholders to share their lived experiences and knowledge of relevant laws, policies and practices, with a particular focus on the persons and communities that have long been discriminated against and made most vulnerable.[8] The Special Rapporteur expresses her appreciation to all stakeholders who contributed to the report.

III. Legal framework

A. Human rights framework[9]

10. The social, political and commercial determinants of health frameworks, with the considerations on substantive equality, can inform the normative content of the underlying determinants of health. The 2030 Agenda for Sustainable Development provides a clear framework of the connection between the different Goals for achieving the right to health while leaving no one behind.

11. The right to health is tied to a number of other rights, such as the right to information, both as a component of the right to health[10] and as a stand-alone right.[11] The right to information requires the establishment of prevention and education programmes for behaviour-related health concerns.[12] Where many diseases are the result of preventable risk factors, access to clear, accessible and relevant information

[7] See A/65/255; and Office of the United Nations High Commissioner for Human Rights (OHCHR), "Statement by the UN expert on the right to health on the protection of people who use drugs during the COVID-19 pandemic", 16 April 2020.

[8] See www.ohchr.org/en/calls-for-input/2024/harm-reduction-sustainable-peace-and-development.

[9] A/HRC/56/52, paras. 15–25.

[10] E/C.12/2000/4, para. 12 (b).

[11] International Covenant on Civil and Political Rights, art. 19.2.

[12] E/C.12/2000/4, para. 16.

is key in enabling individuals to fully understand health-related risks and make informed decisions.[13] Health-related information is equally important in the context of sexual and reproductive health.[14]

12. The Special Rapporteur welcomes the resolution on human rights in the context of HIV and AIDS adopted by the Human Rights Council at its fifty-sixth session, in which the Council "urges States […] to review or repeal those restrictive, punitive or discriminatory legal and policy frameworks that adversely affect the successful, effective and equitable delivery of, and access to, HIV prevention, diagnosis, treatment, care and support programmes and services for all persons living with, presumed to be living with, at risk of or affected by HIV, including key populations".[15]

13. While information accessibility includes the right to seek, receive and impart information and ideas concerning health issues, the exercise of this right should not impair the confidentiality of personal health data.[16] The right to privacy, as a component of the right to health[17] and as the independent right to be free from arbitrary or unlawful interference with individual privacy,[18] is relevant especially in circumstances where medical records are shared with law enforcement agencies.[19]

14. Punitive provisions and legal restrictions to regulate people's control over their own body, the rights to bodily autonomy[20] including through regulations of same-sex consensual adult relations, termination of pregnancy, and sex work, is a severe and unjustified form of State control, generating stigma and discrimination, and constituting a human rights violation.[21]

15. Furthermore, denials of abortion can cause severe physical and mental pain or suffering for pregnant persons,[22] in certain circumstances meeting the threshold of torture or cruel, inhuman or degrading treatment, a right autonomously protected by the international legal framework.[23] The denial of post-abortion services, often as a result of criminalization or stigmatization, can have equally enduring negative consequences for pregnant persons.[24]

16. Significantly, the right to life entails a general obligation for States to take all necessary measures to prevent arbitrary deprivation of life, including by law enforcement officials[25] and in the context of incarceration.[26] The respect and insurance of the right to life extends to reasonably foreseeable threats and life-threatening situations.[27] States are equally required to take positive actions to protect

[13] WHO Framework Convention on Tobacco Control, arts. 10–12 and 14.c; A/71/282, para. 76; and OHCHR, "Statement by the UN Special Rapporteur on the right to health on the adoption of front-of-package warning labelling to tackle NCDs", 27 July 2020.

[14] E/C.12/2000/4, para. 11.

[15] See Human Rights Council resolution 56/20.

[16] E/C.12/2000/4, para. 12 (b).

[17] Ibid., para. 3.

[18] International Covenant on Civil and Political Rights, art. 17.

[19] A/64/272, para. 20; and Open Society Institute, "The effects of drug user registration laws on people's rights and health: key findings from Russia, Georgia, and Ukraine", October 2009, pp. 16–18.

[20] E/C.12/2000/4, para. 8.

[21] A/HRC/32/44, paras. 76–78; and A/HRC/WG.11/39/1, para. 19.

[22] CCPR/C/85/D/1153/2003, para. 6.3.

[23] International Covenant on Civil and Political Rights, art. 7.

[24] A/66/254, paras. 31–33.

[25] Human Rights Committee, general comment No. 36 (2018), para. 13.

[26] Ibid., para. 25.

[27] Ibid., para. 7.

the right to life, particularly relating to those historically at risk or marginalized, including LGBTIQA+ persons.[28]

17. The right to live with dignity implies addressing conditions in society that threaten individuals' lives or prevent them from enjoying life with dignity.[29] Closely related to determinants of health, creating conditions adequate for dignified life entails, among others considerations, addressing environmental degradation, substance abuse and extreme poverty, as well as tackling stigmatization, violence and other harmful practices.[30] The right to live with dignity is also closely tied to the right to a clean, healthy and sustainable environment,[31] which entails substantive elements including: clean air; a safe climate; access to safe water and adequate sanitation; healthy and sustainably produced food; non-toxic environments in which to live; and healthy biodiversity and ecosystems.[32]

18. Furthermore, the right to benefit from scientific progress requires States to align their policies and programmes with the best available, generally accepted scientific evidence,[33] which applies to health law and policy, including harm reduction efforts in the context of drug use and drug use disorder[34] and other efforts for the prevention, control and treatment of diseases and their risk factors.[35] States must "take measures to avoid the risks associated with the existence of conflicts of interest by creating an environment in which actual or perceived conflicts of interest are adequately disclosed and regulated, especially those involving scientific researchers who give policy advice to policymakers and other public officials".[36]

19. The right to health is tied to the right to equality and non-discrimination, which proscribes any discrimination in both the access to health care and the underlying determinants of health, as well as in the means and entitlements for their procurement.[37] When it comes to harm reduction, States must eliminate formal discrimination by ensuring that their laws and policies do not discriminate based on prohibited grounds, and eliminate substantive discrimination through implementing measures to address the conditions and attitudes that cause or perpetuate discrimination.[38] In turn, this requires measures to dismantle systems of oppression in all its forms, particularly where law is instrumental to perpetuating such oppression.[39] For instance, States must take positive measures that prioritize individuals in the most marginalized groups, including by ensuring that health care workers in harm reduction programmes are trained to respond to the specific needs of sex workers, people who use drugs, trans and intersex persons, and other groups in situations of vulnerability.[40]

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[28] Ibid., paras. 21 and 23.

[29] Ibid., para. 26.

[30] Ibid.

[31] See General Assembly resolution 76/300.

[32] See A/HRC/43/53.

[33] Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), para. 52.

[34] A/HRC/56/52, para. 16.

[35] OHCHR, "Statement by the UN Special Rapporteur on the right to health on the adoption of front-of-package warning labelling to tackle NCDs", 27 July 2020.

[36] Committee on Economic, Social and Cultural Rights, general comment No. 25 (2020), para. 53; and A/HRC/48/61, para. 77, describes conflicts of interest as "pos[ing] direct threat to the right to science".

[37] E/C.12/2000/4, para. 18.

[38] Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), para. 8 (b).

[39] A/HRC/56/52, para. 30.

[40] E/C.12/2000/4, para. 37; and A/HRC/56/52, para. 28.

B. State obligations to respect, protect and fulfil human rights

20. The obligation to respect requires States to abstain from creating and enforcing discriminatory laws, policies and practices, that contribute to health disparities in the context of harm reduction.[41]

21. In the context of business activities, the State's obligation to protect entails an obligation to effectively prevent businesses from infringing human rights, including through direct intervention to protect public health.[42] Similarly, this obligation requires ensuring that third parties do not limit people's access to health-related information and services,[43] which is particularly relevant in the context of harm reduction, where misinformation can easily mislead individuals into thinking some alternatives are healthier or more sustainable than they really are.

22. Concomitantly, all businesses have a responsibility to respect human rights,[44] including the right to health.[45] This responsibility requires avoiding infringing human rights and addressing adverse impacts that businesses may be involved in, as well as conducting human rights due diligence to identify, prevent, mitigate and account for human rights impacts that they may cause or contribute to.[46] Equally, businesses should abstain from unduly influencing or interfering with right-promoting, evidence-based harm reduction efforts.

23. The obligation to fulfil requires States to give "sufficient recognition" to the right to health, preferably through domestic legislation and by addressing all the underlying determinants of health.[47] States must ensure that health-care providers are trained to recognize and respond to, with culturally acceptable services, the specific needs of marginalized groups.[48]

IV. Harm and substantive equality

24. Discrimination has multiple layers.[49] Individuals cannot be unjustifiably treated differently on the basis of a prohibited ground, nor can laws, policies or practices which appear neutral at face value have a disproportionate impact on individuals or groups protected by the anti-discrimination framework.[50] Prohibited grounds of discrimination include express ones, such as race and colour, sex, and national or social origin,[51] and others, as outlined by the Committee on Economic, Social and Cultural Rights in its general comment No. 20 (2009) on non-discrimination in economic, social and cultural rights, such as through the stigmatization and marginalization suffered by individuals in specific contexts, including in the context of disability status, health status, economic and social situation, and sexual orientation or gender identity.[52]

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[41] E/C.12/2000/4, para. 34.
[42] Committee on Economic, Social and Cultural Rights, general comment No. 24 (2017), paras. 14 and 19.
[43] E/C.12/2000/4, para. 35.
[44] Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework (A/HRC/17/31, annex).
[45] Committee on Economic, Social and Cultural Rights, general comment No. 24 (2017).
[46] Guiding Principles on Business and Human Rights, principles 11–24.
[47] E/C.12/2000/4, para. 36.
[48] Ibid., para. 37.
[49] A/HRC/56/52, para. 30.
[50] Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), para. 10.
[51] Ibid., paras. 18–24.
[52] Ibid., para. 27.

25. In the context of harm reduction, the stigma and marginalization associated with certain behaviours and/or substances may be linked with the legal framework surrounding them. For instance, a legal framework that is overreliant on criminal law has fuelled stigmatization and marginalization against individuals engaged in sex work and in the context of abortion, and same-sex relations, as well as in cases of HIV transmission, exposure and non-disclosure. At the same time, a legal framework that is overly lax with corporate actors can contribute to the disproportionate impact of their activities on certain individuals targeted by and/or exposed to marketing practices.

26. For example, in digital advertising, algorithms that are designed to optimize messaging according to previous individual behaviour, can lead persons with substance use disorders or eating disorders to be more exposed to the marketing strategies of the very products that are triggering for them. In this case, while disproportionate exposure occurs, in principle, on the basis of health status,[53] it can compound with other factors, which may also be prohibited grounds of discrimination, including race, gender or socioeconomic situation,[54] thereby increasing health disparities.

A. Criminalization of individual behaviours

27. Law and policy can themselves become a conduit to harm, by either enhancing or generating it. In particular, criminalization often disproportionately affects individuals who have historically been more vulnerable, as explored in the present report: in cases of drug use, HIV exposure, transmission and disclosure, abortion, same-sex relations and sex work.

1. Drug use

28. Criminalization is one extreme option and represents a barrier to people who use drugs from seeking health care,[55] both in accessing medicines and services and in establishing therapeutic relationships and continuing treatment regimens when needed, therefore leading to poorer health outcomes as, in addition to stigmatization, people who use drugs may fear legal consequences or judgment and harassment.[56]

29. The use of criminal sanctions, including the death penalty, results in more harm to people who use drugs and fails to reduce drug use and trafficking.[57] As of 2023, 34 countries retained the death penalty for drug-related offences.[58] In some countries, punitive and repressive drug policies have also led to extrajudicial killings.[59]

30. Despite the fact that opioid-based medicines are included on the Model List of Essential Medicines maintained by the World Health Organization (WHO), many countries do not ensure access for medical use to opioid agonist therapy medicines

[53] Discrimination on the basis of health status is prohibited as falling under article 2.2 of the International Covenant on Economic, Social and Cultural Rights' prohibition of discrimination based on "other status"; and Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), para. 33.

[54] Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), paras. 18–24.

[55] Submission from Switzerland.

[56] A/HRC/56/52, para. 31; and A/HRC/14/20, para. 47.

[57] A/65/255, paras. 14 and 16; and submission from Eleos Justice.

[58] Harm Reduction International, *The Death Penalty for Drug Offences: Global Overview 2023* (London, 2024), p. 14; and submission from Eleos Justice.

[59] Submission from Eleos Justice.

like methadone, which are shown to be effective as a harm reduction measure[60] and for opioid dependence treatment.[61]

31. Punitive drug laws and policies have had a profoundly negative impact on minorities, women and girls, LGBTIQA+ persons, sex workers, migrants and people living with HIV/AIDS, among other population groups.[62]

2. HIV exposure, transmission and non-disclosure

32. Over 130 countries criminalize HIV to some degree.[63] Criminal laws in that regard include laws specifically proscribing HIV transmission (whereby HIV status is the only factor that transforms a legal act – consensual sex – into an illegal one), and the application of existing criminal law to cases involving HIV transmission (where HIV transmission is an aggravating factor for an existing crime such as sexual assault).[64]

33. Extensive evidence indicates that HIV-specific criminalization acts as a barrier to HIV prevention, diagnosis and treatment.[65]

34. Where countries have criminalized mother-to-child transmission of HIV, women are at heightened risk of prosecution.[66] Migrants and asylum-seekers have been disproportionately prosecuted for HIV transmission.[67] HIV-specific criminalization further stigmatizes people who are living with HIV by creating a presumption of criminality that is solely connected to their health status and signalling that they are a perpetual threat to their communities and partners.[68] Individuals convicted under these laws are sometimes added to sex offender registries, which subjects them to further stigmatization that exceeds the duration of their incarceration.[69]

3. Abortion

35. Abortion care is safe, effective and not inherently harmful.[70] However, as of 2023, 134 countries penalized those who seek an abortion, 181 penalized abortion providers, and 159 penalized people who assist with abortions.[71] Criminalization in the context of abortion involves the application of criminal law to any persons who seek, access, provide, aid, assist with, provide evidence-based information on, or are aware of someone having accessed abortion.[72] The threat of being prosecuted or imprisoned can have a "chilling effect" in the provision of health care, including post-abortion care.[73] The criminalization of abortion is associated with a lack of approved

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[60] WHO, *Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations* (Geneva, 2022); and submission from Global Commission on Drug Policy.

[61] WHO, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence* (Geneva, 2009); and submission from Global Commission on Drug Policy.

[62] A/HRC/56/52, para. 37.

[63] Edwin J. Bernard, Alison Symington and Sylvie Beaumont, "Punishing vulnerability through HIV criminalization", *American Journal of Public Health*, vol. 112, No. S4 (June 2022).

[64] A/HRC/14/20, para. 52.

[65] Zita Lazzarini and others, "Criminalization of HIV transmission and exposure: research and policy agenda", *American Journal of Public Health*, vol. 103, No. 8 (August 2013).

[66] A/HRC/14/20, para. 66.

[67] Amnesty International, *Body Politics: A Primer on Criminalization of Sexuality and Reproduction* (London, 2018), p. 48.

[68] Ibid.

[69] Ibid., p. 136.

[70] WHO, *Abortion Care Guideline* (Geneva, 2022).

[71] Sanhita Ambast, Hazal Atay and Antonella Lavelanet, "A global review of penalties for abortion-related offences in 182 countries", *BMJ Global Health*, vol. 8, No. 3 (2023).

[72] A/66/254, paras. 21–36.

[73] See CCPR/C/11/D/2425/2014.

essential abortion-related medicines, including mifepristone and misoprostol, a shortage of supplies and with obstructions in training for health workers to provide abortion care[74] and a reluctance of some health-care workers to offer such care.[75]

36. Women and children belonging to racial, ethnic and national minorities, for example, have a higher incidence of unintended pregnancies and greater abortion rates, particularly Black women,[76] and are also more often prosecuted in that regard.[77]

4. Sex work[78]

37. As of March 2023, over 150 countries criminalized some aspect of sex work.[79] Legal frameworks that criminalize sex work are based on the premise that the use of criminal law will successfully eradicate or diminish the sex industry. However, research consistently indicates that criminalising sex work fails to do so,[80] and negatively affects the health of sex workers.[81] Criminalization heightens their exclusion from accessing essential health services.[82] Equally, criminalization denies them basic labour protections, including occupational health and safety protections, that are afforded to workers in other industries.[83] Further, criminalization escalates health risks for sex workers, as the fear of arrest leads to rushed transactions, riskier sexual practices, or encounters in secluded venues where they have less control.[84]

38. Criminalization increases rates of harassment, violence and crime against sex workers, besides making them less likely to report these abuses to the authorities out of fear of arrest.[85] Likewise, punitive approaches can perpetuate stigma, thereby hampering access to health care, including regular screening and medical care, adequate prevention, as well as access to other necessary health services and information.[86]

39. Sex work is a largely feminized industry that follows pre-existing patriarchal, racial and class-based hierarchies.[87] In a recent study with sex workers, researchers found that 74 per cent of participants lived below the poverty line, 70 per cent had experienced unstable housing and almost 60 per cent had low levels of formal education, which limited their employment options.[88] Sex workers are also often indirectly criminalized through the criminalization of other behaviours adopted by marginalized and disadvantaged communities, including the criminalization of drug use and possession, same sex-relations, or certain sexual orientations or gender identities, and homelessness.[89]

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[74] A/66/254, paras. 21–36.
[75] WHO, *Abortion Care Guideline*, pp. 12–13.
[76] CERD/C/USA/CO/6, para. 33.
[77] Colombia, Penal Code, Law No. 599 of 24 July 2000, *Official Gazette*, No. 44,097 (24 July 2004), para. 363.
[78] OHCHR, “A guide on the human rights of sex workers”, 14 March 2024.
[79] Joint United Nations Programme on HIV/AIDS (UNAIDS), “New legal principles launched on International Women’s Day to advance decriminalization efforts”, 8 March 2023.
[80] Sean Bland and Benjamin Brooks, “Improving laws and policies to protect sex workers and promote health and well-being: a report on the criminalization of sex work in the District of Columbia” (2020).
[81] A/HRC/14/20, para. 34.
[82] OHCHR, “A guide on the human rights of sex workers”.
[83] A/HRC/14/20, para. 27.
[84] Ibid., paras. 36–37.
[85] WHO, *Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention*.
[86] Bland and Brooks, *Improving Laws and Policies to Protect Sex Workers*.
[87] A/HRC/WG.11/39/1, para. 3.
[88] Bland and Brooks, *Improving Laws and Policies to Protect Sex Workers*, p. 13.
[89] A/HRC/WG.11/39/1, para. 12.

5. Same-sex relations

40. Despite increased recognition of the human rights of LGBTIQA+ persons, around 77 countries still have discriminatory laws that criminalize private, consensual same-sex relationships.[90] Many of these laws were first implemented under British, French and Spanish colonial rule, and continue to serve as post-colonial legacies through “anti-sodomy” laws.[91]

41. This criminalization exposes the LGBTIQA+ community to risks of arrest and deprivation of liberty, and contributes to hate-motivated violence, torture and ill treatment, across various settings, including those that are vital to health and the social determinants of health, such as hospitals and clinics, schools and places of employment.[92] The fear of existing in unsafe spaces, in and of itself, can cause severe mental distress and can lead LGBTIQA+ persons to forgo health care or other services. Furthermore, rates of HIV testing are far higher in countries that maintain the least severe anti-LGBTIQA+ policies.[93]

6. Harm derived from corporate activities and the co-opting of harm reduction narratives

42. Power asymmetries manifest largely because of inadequate or ineffective regulation on the part of Governments. Such is the case of corporate activities to manufacture and commercialize inherently harmful products, including tobacco, alcohol, and, in the food and nutrition realm, those with an excess of sugar, salt or fats, often found in ultra-processed products.[94] This is also the case of products that may be harmful when improperly used, including prescription drugs.[95] In some instances, in their effort to commercialize these products, corporations have been documented as having targeted specific groups that are protected under international law.[96]

43. Furthermore, corporations exert their power by co-opting the harm reduction narrative or by seeking to position themselves as part of the solution to problems they have largely created,[97] including through alleged harm reduction efforts.[98]

7. Tobacco

44. Tobacco use is one of the leading risk factors for several non-communicable diseases, including cardiovascular and respiratory diseases and over 20 types of cancer, among other diseases.[99] While the world has made much progress in taking effective measures to address the tobacco crisis since the adoption of the WHO Framework Convention on Tobacco Control in 2003, tobacco use continues to be

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[90] See www.un.org/en/fight-racism/vulnerable-groups/lgbtqi-plus.

[91] International Lesbian, Gay, Bisexual, Trans and Intersex Association, “The impact of colonial legacies in the lives of LGBTI+ and other ancestral sexual and gender diverse persons”, 26 May 2023.

[92] See www.un.org/en/fight-racism/vulnerable-groups/lgbtqi-plus.

[93] HIV Policy Lab and others, *Progress and the Peril: HIV and the Global De/criminalization of Same-Sex Sex* (2023).

[94] WHO, “Noncommunicable diseases”, 16 September 2023; and A/77/197, para. 30.

[95] WHO, “Opioid overdose”, 29 August 2023.

[96] A/77/197, paras. 45–46.

[97] A/78/185, para. 58.

[98] WHO, *Reducing the Harm from Alcohol by Regulating Cross-Border Alcohol Marketing, Advertising and Promotion: A Technical Report* (Geneva, 2022), p. 24.

[99] See www.who.int/health-topics/tobacco#tab=tab_1.

prevalent, particularly in low- and middle-income countries, which are home to over 80 per cent of global tobacco users.[100]

45. The scepticism towards the tobacco industry's harm reduction initiatives stems from their long and well-documented history of duplicitous behaviour, concealing and downplaying the health risks of their products, while deceptively marketing alternatives as harm reduction or quitting alternatives[101] as ascertained in judicial proceedings.[102]

46. Tobacco use contributes to deepening cycles of poverty; while increasing health-related costs, tobacco consumption leads to premature disability that hampers economic productivity, further contributing to economic hardships.[103]

47. The tobacco industry has a history of targeting Black populations with more addictive products, making it harder to quit smoking.[104] Decades after the adoption of the Framework Convention on Tobacco Control and the scientific evidence of the risks to health caused by tobacco use became public knowledge, the same industry allegedly intends to mend the damage by spreading new products whose health risks are uncertain and which are marketed broadly beyond people who are already addicted to traditional tobacco.[105]

8. Alcohol

48. While alcohol consumption has been historically accepted in many cultures for centuries,[106] it is associated with a range of health risks, including alcohol use disorders, injuries, liver disease, cardiovascular diseases and some cancers.[107] Causing over 3 million deaths every year,[108] alcohol can be dangerous and result in harm for non-consumers, including family members and strangers who can be the subject of injuries, violence or other alcohol-related harm.[109]

49. Furthermore, zero- or low-alcohol products[110] are sometimes targeted at children, creating risks and vulnerability due to alcohol harm.

9. Ultra-processed products[111]

50. Unhealthy diets are responsible for 11 million preventable global deaths every year[112] and are a major risk factor for preventable non-communicable diseases, including cardiovascular diseases, cancer, diabetes and other conditions.[113] Ultra-processed

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[100] Ibid.

[101] WHO, "Tobacco", 31 July 2023.

[102] A court in the United States of America found this scheme to be deceptive and intended to further tobacco's economic goals: "to keep smokers smoking; to stop smokers from quitting; to encourage people, especially young people, to start smoking; and to maintain or increase corporate profits". See United States District Court, District of Columbia, *United States v. Philip Morris USA, Inc.*, 449 F. Supp. 2d 1 (D.D.C. 2006); and Edward L. Sweda, Jr., Mark Gottlieb and Christopher N. Banthin, "Light cigarette lawsuits in the United States: 2007", Tobacco Control Legal Consortium, November 2007.

[103] See www.who.int/health-topics/tobacco#tab=tab_2.

[104] Centres for Disease Control and Prevention, "Menthol tobacco products", 15 May 2024.

[105] WHO, "Tobacco", 31 July 2023.

[106] WHO, "Alcohol", 28 June 2024.

[107] Ibid.

[108] See www.who.int/health-topics/noncommunicable-diseases.

[109] WHO, "Alcohol".

[110] WHO, *Reducing the Harm from Alcohol*.

[111] A/78/185, paras. 24–31, 38 and 58.

[112] NCD Alliance, "Bad diets responsible for 11 million premature deaths globally per year", 8 April 2019.

[113] See www.who.int/health-topics/noncommunicable-diseases.

products also pose significant health risks owing to their low nutritional value and hyper-palatable nature, while being heavily advertised and marketed.[114]

51. Marginalized groups are often driven to rely on these unhealthy products as their only real economically or physically available food option,[115] in a shift that replicates colonial power structures and affects communities and individuals in the most disadvantaged positions.

52. In response to mandatory front-of-package warning labelling, the food and beverage industry has been shown to reformulate its products not only to avoid labelling requirements, but also to add micronutrients to promote products through nutrition or health claims.[116]

10. Prescription drugs

53. Pharmaceutical companies play a major role in the research and development of life-saving and life-improving medicines.[117] Left unchecked, however, pharmaceutical companies have been shown to seek profit maximization at all costs, often to the expense of individual or public health.[118]

54. The number of opioid-related deaths has increased dramatically over recent years, now causing around 80 per cent of deaths attributable to drug use worldwide.[119] This surge is at least partially attributable to reckless and sometimes illegal behaviour by pharmaceutical companies, who purposely flooded the market with prescription opioids and marketed them aggressively and misleadingly, without proper warnings about associated health risks, which has resulted in criminal and civil liability cases.[120] Paired with a lack of adequate regulation and oversight, those practices led to a public health crisis that persists to date.[121]

11. Environmental harm and greenwashing

55. Emerging tobacco products pose environmental threats, as the production of batteries and electronic components generates waste that is hard to dispose of or recycle.[122] In food and nutrition, the environmental impact of ultra-processed products is well documented, as they have a high carbon and water footprint[123] and produce large amounts of waste.[124]

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[114] Pan American Health Organization, *Ultra-Processed Food and Drink Products in Latin America: Trends, Impact on Obesity Policy Implications* (Washington, D.C., 2015), p. 6.

[115] A/78/185, paras. 21 and 28.

[116] Submission from Global Health Advocacy Incubators.

[117] WHO, Regional Office for Europe, *Commercial Determinants of Noncommunicable Diseases in the WHO European Region* (Copenhagen, 2024).

[118] Ibid.

[119] WHO, “Opioid overdose”.

[120] United States, Department of Justice, “Justice Department announces global resolution of criminal and civil investigations with opioid manufacturer Purdue Pharma and civil settlement with members of the Sackler family”, press release, 21 October 2020.

[121] Andrew Kolodny, “How FDA failures contributed to the opioid crisis”, *AMA Journal of Ethics*, vol. 22, No. 8 (August 2020).

[122] Expose Tobacco and WHO, “Talking trash: behind the tobacco industry’s ‘green’ public relations”, May 2022; and submission from Corporate Accountability.

[123] Paraskevi Seferidi and others, “The neglected environmental impacts of ultra-processed foods”, *The Lancet: Planetary Health*, vol. 4, No. 10 (October 2020); and Josefa Maria Fellegger Garzillo and others, “Ultra-processed food intake and diet carbon and water footprints: a national study in Brazil”, *Revista de Saúde Pública*, vol. 56 (2022).

[124] Seferidi and others, “The neglected environmental impacts”.

56. Fossil fuel combustion, a major contributor to climate change,[125] is harmful to health on account of air pollution being a risk factor for numerous diseases, including stroke, heart disease, lung cancer, and both chronic and acute respiratory diseases.[126] Similarly, plastic waste is increasingly concerning on account of the uncertain effects of plastic by-products, particularly nano- and microplastic particles, on human health.[127]

57. Greenwashing practices mislead the public into believing that companies are doing more to protect the environment than they are, promoting false remedies to the environmental crisis while promoting unsustainable consumption patterns and stalling progress towards genuine solutions,[128] thereby causing harm.

58. Given the nature of environmental harm and greenwashing, evidence-based regulation has emerged as a tool to prevent harm caused by the production and commercialization of these products, as well as by the appropriation of harm reduction narratives.

V. Governance

59. Harm reduction is a multisectoral and multilevel issue, requiring contributions from many sectors.[129] Governance refers to the processes, structures and institutions that are in place to oversee and manage systems. It is concerned with the relationships between the State, private sector entities, civil society organizations, communities and individuals,[130] and the making, monitoring and enforcing of formal and informal rules in those systems.[131]

60. Using a human rights lens and understanding the intersections of harm, harm reduction should be guided by the principles of good governance: participation, transparency and accountability.[132]

A. Meaningful participation

61. The meaningful involvement of the persons most affected by specific harms and harm reduction efforts is essential for the development and implementation of harm reduction programmes.[133] Sex workers, persons living with HIV, persons who use

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[125] WHO, "Climate change", 12 October 2023.

[126] WHO, "Ambient (outdoor) air pollution", 19 December 2022.

[127] WHO, *Dietary and Inhalation Exposure to Nano- and Microplastic Particles and Potential Implications for Human Health* (Geneva, 2022).

[128] See www.un.org/en/climatechange/science/climate-issues/greenwashing.

[129] Nicola Singleton and Jennifer Rubin, "What is good governance in the context of drug policy?", *International Journal of Drug Policy*, vol. 25, No. 5 (September 2014).

[130] Lawrence O. Gostin and others, "The legal determinants of health: harnessing the power of law for global health and sustainable development", *The Lancet*, vol. 393, No. 10183 (May 2019).

[131] Seye Abimbola and others, "Institutional analysis of health system governance", *Health and Policy Planning*, vol. 32, No. 9 (November 2017).

[132] See Human Rights Council resolution 7/11; and E/CN.4/2006/48, para. 25.

[133] See https://harmreduction.org/about-us/principles-of-harm-reduction; UNAIDS, *Ending Overly Broad Criminalization of HIV Non-Disclosure, Exposure and Transmission: Critical Scientific, Medical and Legal Considerations* (Geneva, 2013); and Shira M. Goldenberg and others, eds., *Sex Work, Health and Human Rights: Global Inequalities, Challenges, and Opportunities* (Cham, Switzerland, Springer, 2021).

drugs and other marginalized groups are intimately familiar with their communities' needs and cultures, as well as the barriers to services and health.[134]

62. Criminalization hampers participation, which further deepens the stigmatization, marginalization and discrimination that the most affected communities face.[135] Criminalization becomes a literal physical barrier to participation if people are incarcerated and/or excluded because of a criminal record.[136]

63. As the main duty bearers for the realization of the right to health and related rights, States have an obligation to establish structures and mechanisms to facilitate the meaningful participation of people affected by policies.[137]

B. Transparency and accountability

64. Accountability means that any person or group whose health and related rights have been violated should have access to effective judicial or other appropriate remedies and be entitled to reparation.[138] It includes having measures in place to help prevent violations of rights in the first place, through regulation, monitoring and potential sanctions.[139]

65. Rights-based approaches to health and harm reduction programmes demand that clear accountability mechanisms are in place for decisions, review, complaints and redress.[140] Ensuring access to information about health and harm reduction policies ensures greater accountability. Transparency "acts as a check against arbitrary decisions that may be taken by States and pre-empts violations of the right to health".[141]

66. Some industries have used stakeholder consultation processes to block, weaken and challenge policies, directly or through front groups, and have also used industry-funded misleading evidence,[142] all of which makes it challenging for lawmakers to adopt evidence-based public health and environmental protection policies without the direct influence of industries.

67. Legitimate engagement with industry does not require that corporations be given such a prominent seat at the policymaking table, but instead requires that conflicts of interest are actively prevented and managed within health policy.[143]

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[134] Ann Fordham, "The meaningful participation of 'stakeholders' in global drug policy debates: a policy comment", *Drug Policies and Development*, vol. 12 (2020), para. 21; and WHO and others, *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions* (Geneva, WHO, 2013).

[135] Fordham, "The meaningful participation of 'stakeholders'", para. 21.

[136] Ibid., paras. 20–23.

[137] E/C.12/2000/4, para. 54; and A/65/255, para. 70.

[138] E/C.12/2000/4, para. 59.

[139] Ibid., para. 56.

[140] Sofia Gruskin, Dina Bogecho and Laura Ferguson, "'Rights-based approaches' to health policies and programmes: articulations, ambiguities, and assessment", *Journal of Public Health Policy*, vol. 31 (2010).

[141] A/HRC/26/31, para. 52.

[142] Anna B. Gilmore and others, "Defining and conceptualizing the commercial determinants of health", *The Lancet*, vol. 401, No. 10383 (April 2023).

[143] Anna B. Gilmore and others, "Public health, corporations and the New Responsibility Deal: promoting partnerships with vectors of disease?", *Journal of Public Health*, vol. 33, No. 1 (2011).

VI. Harm reduction: legislation, policies and programmes for sustainable peace and development

68. In her report to the Human Rights Council on drug use, harm reduction and the right to health, the Special Rapporteur described regulatory tools as existing on a spectrum.[144] On one end, States proscribe certain conducts and impose sanctions for non-compliance, including criminal penalties.[145] On the other end is liberalization, whereby States pull back and allow different actors in society to self-regulate, including through voluntary corporation-led initiatives[146] that are often adopted to stave off Government regulation.[147]

A. Decriminalization

69. In the context of health and human rights, criminalization is multifaceted. While there are instances in which international human rights law mandates the use of criminal law (e.g. torture, forced disappearance),[148] in other instances it prohibits it (e.g., same-sex relations, blanket bans on abortion)[149] or cautions against an overreliance on it (e.g. drug use).[150] Human rights mechanisms have indicated that the use of criminal law, particularly when it targets people seeking health services, can negatively affect public health.[151]

70. The use of criminal law can itself give rise to harm, either by exacerbating harm or causing harm, with decriminalization emerging as the self-evident harm reduction approach and a regulatory option to mitigate harm and promote health.

1. Drug use

71. WHO,[152] the Global Commission on HIV and the Law[153] and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommend the full decriminalization of drug use and possession for personal use in order to respond effectively to HIV.[154] The provision of, and access to, harm reduction care is critical to ending AIDS as a public health threat by 2030.[155] However in 2019, fewer than 1 per cent of people who inject drugs lived in countries that reported providing the recommended level of opioid agonist therapy and needle/syringe provision services.

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[144] A/HRC/56/52, para. 56.

[145] Darren Sinclair, "Self-regulation versus command and control? Beyond false dichotomies", *Law and Policy*, vol. 19, No. 4 (October 1997).

[146] A/HRC/56/52, para. 56.

[147] Alexandra Finch, "Sweet and sour: a responsive strategy to strengthen sugar-sweetened beverage regulation in Australia", *Journal of Law and Medicine*, vol. 29, No. 1 (March 2022).

[148] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, art. 4; and Mattia Pinto, "Awakening the leviathan through human rights law: how human rights bodies trigger the application of criminal law", *Utrecht Journal of International and European Law*, vol. 34, No. 2 (2018), p. 161.

[149] A/72/172, para. 32; Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016); and Committee on the Elimination of Discrimination against Women, general comment No. 35 (2017), paras. 29 (c)–(i).

[150] A/HRC/14/20, para. 47.

[151] See A/HRC/14/20; A/66/254; and OHCHR, "Statement by the UN expert on the right to health on the protection of people who use drugs during the COVID-19 pandemic".

[152] WHO, *Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention*.

[153] Secretariat of the Global Commission on HIV and the Law, *Global Commission on the HIV and the Law: Risks, Rights and Health – Supplement* (New York, UNDP, 2018).

[154] Submission from UNAIDS.

[155] Ibid.; and UNAIDS, "Political declaration on HIV and AIDS: ending inequalities and getting on track to end aids by 2030", June 2021.

72. States are required to respect the right to health by refraining from denying or limiting equal access for all persons to curative and palliative health services, which also applies in crisis, conflict and humanitarian settings.[156] This obligation includes providing persons deprived of their liberty with necessary medical care and with equal access to preventive, curative and palliative health-care services.[157]

2. HIV transmission, exposure and non-disclosure

73. HIV-specific criminal laws, which criminalize HIV exposure, transmission and non-disclosure, infringe on the right to health and related rights, including the rights to privacy and to equality and non-discrimination.[158] Especially in the absence of factual transmission, the harms of HIV non-disclosure and exposure do not warrant criminalization.[159]

3. Abortion

74. States must ensure access to affordable, acceptable and quality sexual and reproductive health information, goods and services, including abortion and post-abortion care, without discrimination. The human rights framework supports the elimination of all laws and policies that criminalize or otherwise punish abortion. States must eliminate formal and substantive barriers to guarantee that abortion is accessible in practice. Such barriers include policy and programmatic barriers, as well as barriers in practice.[160]

4. Sex work

75. States have an obligation to respect, protect and fulfil the rights of sex workers. Echoing recommendations of a former Special Rapporteur on the right to health,[161] the Committee on Economic, Social and Cultural Rights,[162] the Committee on the Elimination of Discrimination against Women[163] and multiple States[164] have urged that States remove all laws, policies and practices that criminalize sex work.[165] Decriminalizing sex work would reduce the levels of discrimination, harassment, violence and injury that sex workers currently experience, while making it possible for them to seek justice for the violation of their rights in legal forums without fear of punishment, violence and further stigmatization.[166]

76. Various laws and policies can help to mitigate harm and promote health. Such measures may include, for example: reducing policing; enacting measures to prevent and address violence against sex workers, including confidential reporting and redress

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[156] E/C.12/2000/4, para. 34; and A/HRC/56/52, para. 34.

[157] A/HRC/56/52, para. 34; Human Rights Committee, general comment No. 36 (2018), para. 25; and United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), rule 24 (see General Assembly resolution 70/175, annex).

[158] A/HRC/14/20, para. 56.

[159] UNAIDS, *Ending Overly Broad Criminalization of HIV*.

[160] Human Rights Committee, general comment No. 36 (2018), para. 8; and CCPR/CO/70/ARG, para. 14.

[161] A/HRC/14/20, paras. 46–50; and written submission by the Special Rapporteur regarding European Court of Human Rights, *M.A and Others v. France*, Case Nos. 63664/16, 64450/19, 24387/20, 24391/20 and 24393/20, 30 September 2021, available at www.ohchr.org/sites/default/files/documents/issues/health/sr/Fax-AC-MA-et-autres-c-France.pdf.

[162] E/C.12/ZAF/CO/1, paras. 32–33; and E/C.12/RUS/CO/6, para. 53.

[163] CEDAW/C/FJI/CO/4; CEDAW/C/TGO/CO/6-7, para. 25; and CEDAW/C/KAZ/CO/5, para. 27 (e).

[164] A/HRC/46/12; A/HRC/33/16; and A/HRC/19/8.

[165] A/70/811, paras. 53 and 75 (f).

[166] A/HRC/50/28, para. 71; International Commission of Jurists, “The 8 March principles for a human rights-based approach to criminal law proscribing conduct associated with sex, reproduction, drug use, HIV, homelessness and poverty” (Geneva, March 2023), principle 15.

mechanisms; and enacting measures that support access to comprehensive sexual education, contraception, services to address sexually transmitted infections, including prevention, screening and treatment, and wider access to health services.[167]

5. Same-sex relations

77. Sexual orientation is recognized as prohibited grounds of discrimination.[168] Furthermore, "[t]he criminalization of private, consensual same-sex conduct creates an environment that is not conducive to affected individuals achieving the full realization of their right to health".[169] In this case, harm reduction grounded on a rights-based approach therefore requires the decriminalization of same-sex relations.[170]

78. Decriminalizing same-sex relations is essential to health and human rights. Yet it is important to highlight certain measures that can be adopted or implemented to reduce the health harms associated with criminalization while the fight for decriminalization persists. These include measures to reduce the discriminatory policing of LGBTIQA+ persons, and measures to prevent violence – including sexual violence – against LGBTIQA+ persons, such as in settings of incarceration.[171] Furthermore, policies can prohibit discrimination based on sexual orientation in various contexts surrounding the social determinants of health, such as with housing, employment, education and health care.[172]

B. Regulation of corporate actors

79. Harm reduction for peace and sustainable development requires regulation that is cohesively developed by States in a way that is more or less restrictive depending on scientific evidence and considering power asymmetries, alongside the disparate impacts of both harm and harm reduction.[173]

80. While commercial actors have long shown a preference for self-regulatory and co-regulatory approaches over direct Government regulation,[174] such measures have been shown to lead to legal gaps and inconsistencies, making them less transparent[175] and less effective, and there is a lack of mechanisms for adequate industry accountability.[176]

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[167] Shree Schwartz, Nikita Viswasam and Phelister Abdalla, "Integrated interventions to address sex workers' needs and realities: academic and community insights on incorporating structural, behavioural, and biomedical approaches", in *Sex Work, Health, and Human Rights*, Goldenberg and others, eds.

[168] Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), para. 32.

[169] A/HRC/14/20, para. 24.

[170] Ibid., para. 26.

[171] Independent Expert on sexual orientation and gender identity, "The impact of colonialism in violence and discrimination based on SOGI (sexual orientation and gender identity)", October 2023.

[172] *Living Free and Equal: What States are Doing to Tackle Violence and Discrimination against Lesbian, Gay, Bisexual, Transgender and Intersex People* (United Nations publication, 2016).

[173] A/HRC/56/52, para. 56.

[174] Gilmore and others, "Defining and conceptualizing".

[175] A/69/286, paras. 20–21 and 101.

[176] CRC/C/CHE/CO/5-6, para. 16.

81. "Surrogate marketing"[177] is frequently an avenue to circumvent legally mandated advertising bans or restrictions.[178] Such tactics are often combined with sponsorship or other corporate social responsibility programmes,[179] with dubious health benefits that increase brand reputation,[180] and these must stop.

82. In the action plan 2022–2030 to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority, WHO provides steps for both the prevention and the treatment of alcohol use disorders.[181] In 2023, for the first time, WHO included two medications for the treatment of alcohol use disorders on the Model List of Essential Medicines.[182] The action plan further emphasizes the need to reduce the harms of alcohol for people with alcohol use disorders, as well as for their families, friends and communities.[183]

83. States have obligations under the Framework Convention on Tobacco Control[184] to use revenue from tobacco taxes to build robust cessation programmes.[185]

84. Action that States can take to reduce harm stemming from diet-related non-communicable diseases includes: measures to protect biodiversity and the enjoyment of the right to land; requiring the food industry to provide accurate and easy-to-read information through front-of-package nutrition labelling; and healthy food procurement policies. Fiscal policies, including taxation and subsidy strategies, can redistribute the relative cost of food, thereby promoting equity and empowering decision-making.[186]

85. Likewise, action is needed by States with respect to breast-milk substitutes, which are indirectly cross-promoted through the marketing of toddler milks that use similar colour schemes, designs, names, slogans or mascots, in an attempt to circumvent the provisions of the International Code of Marketing of Breast-milk Substitutes. Such practices create confusion and may pose risks for infants' health.[187]

86. Children, particularly those who are of lower socioeconomic status within high-income countries, are vulnerable to the advertising of unhealthy food and drinks. States are required to reduce children's exposure to food and beverage advertising.[188]

VII. Harm reduction in humanitarian and emergency settings

87. Humanitarian and emergency settings, including conflicts, pandemics, natural disasters and other crises pose distinct threats and harms to health. Each individual's

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[177] WHO, *Reducing the Harm from Alcohol*, p. xv (Glossary). There is discussion in the literature regarding the use of the terminology to refer to these practices, using other terms including "alibi marketing" and "brand marketing" to refer to similar, albeit not identical, tactics. See Nathan Critchlow, John Holmes and Niamh Fitzgerald, "Alibi marketing? Surrogate marketing? Brand sharing? What is the correct terminology to discuss marketing for alcohol-free and low-alcohol products which share branding with regular strength alcohol products?", *Addiction* (2024).

[178] WHO, *A Public Health Perspective on Zero- and Low-Alcohol Beverages*, Snapshot Series on Alcohol Control Policies and Practice, Brief No. 10 (Geneva, 2023).

[179] WHO, *Reducing the Harm from Alcohol*, p. 23.

[180] Submission from Global Health Advocacy Incubator.

[181] WHO, *Global Alcohol Action Plan 2022–2030* (Geneva, 2024).

[182] WHO, "Landmark public health decision by WHO on essential medicines for alcohol use disorders", 8 August 2023.

[183] WHO, *Global Alcohol Action Plan 2022–2030*.

[184] See www.who.int/teams/health-promotion/tobacco-control/quitting/offer-help-to-quit-tobacco-use.

[185] Ibid.

[186] A/78/185, paras. 78 and 80.

[187] WHO and UNICEF, "WHO/UNICEF information note: cross-promotion of infant formula and toddler milk", 2019.

[188] A/HRC/26/31, para. 22; and A/78/185, para. 78.

experience of crises depends heavily on such intersecting factors as: age; sex or gender; migration or displacement status; race, ethnicity or national origin; sexual orientation; disability status; and social and economic status. During a crisis, as resources become more limited and controlled by those with power, mental and physical health risks increase along with the prevalence of violence, and access to health, education and social services becomes diminished. Further, crises are often used as a pretext to increase the policing or criminalization of already vulnerable or marginalized populations, often adding to, rather than mitigating, the harms of the crisis itself. Given the risks associated with climate change, technological advancements, and humanitarian settings, the intersection between crises and harm reduction is critically important.

88. In the context of people who use drugs, the COVID-19 pandemic meant that people often lost access to harm reduction services that were not considered "essential", or were in situations in which lockdowns and other restrictive measures prevented them from accessing services.[189] Supply chain disruptions of medicines, including antiretroviral treatment for people living with HIV/AIDS, anti-tuberculosis drugs, antiviral and interferon drugs for hepatitis, and naloxone, caused shortages, leading to access issues and higher prices.[190] Meanwhile, lockdowns and isolation exacerbated situations of stress, trauma and abuse that are associated with drug use and drug use disorder.[191]

89. At the same time, some Governments and service providers – especially peer-led services – demonstrated an incredible resolve and agility. For example, 47 of the 84 countries that provide opioid substitution therapy provided expanded take-home supplies in 2020, and 23 countries provided home delivery or dosing through pharmacies or outreach programmes, so as to ensure continued access.[192] Switzerland has continued the harm reduction policy of permitting take-home distribution of diacetylmorphine for the treatment of opioid use disorder, following a relaxation of rules during the COVID-19 pandemic, because the approach proved effective.[193]

90. Realizing sexual and reproductive rights is challenged during crises and emergencies, especially where criminalization or stigmatization is pre-existing. During the COVID-19 pandemic, some countries restricted access to abortion care, including by designating abortion as "non-essential" in order to delay or cease procedures, requiring abortion clinics to close, or banning the use of telemedicine for abortion.[194] Meanwhile, abortion restrictions were eased in at least 11 countries during the pandemic, including by raising gestational limits, omitting waiting periods and enabling the use of telemedicine for abortion.

91. Crises and humanitarian settings bring increased risks with respect to maternal mortality and morbidity; child, early and forced marriage; sexual and gender-based violence; and human trafficking. Importantly, States' human rights obligations to respect, protect and fulfil sexual and reproductive health rights extend to conflict and emergency settings,[195] including, for example, obligations to ensure access to services

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[189] Laura Grau-López and others, "COVID-19 lockdown and consumption patterns among substance use disorder outpatients: a multicentre study", *European Addiction Research*, vol. 28, No. 4 (June 2022).

[190] Harm Reduction International, *The Global State of Harm Reduction 2022*, 8th ed. (London, 2022).

[191] Grau-López and others, "COVID-19 lockdown and consumption patterns".

[192] Harm Reduction International, *The Global State of Harm Reduction 2020* (London, 2020); and submission from UNAIDS.

[193] Submission from Switzerland.

[194] Isabella Ong and others, "The global impact of COVID-19 on abortion care", *Heliyon*, vol. 9, No. 5 (May 2023).

[195] Committee on the Elimination of Discrimination against Women, general recommendation, No. 30 (2013).

for survivors of gender-based violence; to prioritize access to safe abortion;[196] and to take additional steps to ensure that refugees, stateless persons asylum-seekers and undocumented migrants, given their vulnerable legal status, have access to affordable and quality sexual and reproductive information, goods and health services.[197]

92. Humanitarian and human rights law entitles sex workers to receive humanitarian assistance free from discrimination. Yet all too often, criminalization, stigmatization, and policies that conflate consensual sex work with trafficking, exploitation and abuse, only reinforce harmful stereotypes and narratives that impede sex workers' access to health goods and services. Conflict and emergency implications combined with the systemic exclusion of sex workers thus reinforce the need for the decriminalization and destigmatization of sex work, along with the need to provide support for sex work organizations, in order to address trafficking, exploitation and abuse.[198]

93. Climate change is the greatest health threat confronting humanity.[199] Along with pollution and the loss of biodiversity, climate change constitutes an existential threat to the health of the planet and all life on earth, often referred to as the triple planetary crisis.[200] While some of the effects of climate change are already tangible, more profound and potentially devastating impacts are foreseeable unless urgent coordinated action is taken on a global scale. While the disruptions of climate change may be related to extreme weather events, for instance extreme drought or flooding causing displacement or malnutrition;[201] climate change also drives slow-onset events, such as desertification, rising temperatures, the loss of biodiversity, land and forest degradation, glacial retreat and related impacts, ocean acidification, sea-level rise and salinization.[202] Climate change will have effects on physical and mental health, increasing morbidity and mortality as a result of a surge in the number of communicable and non-communicable diseases[203] in communities and regions that are already disadvantaged, thereby deepening pre-existing inequalities and marginalization.[204] In this context, mitigation and adaptation measures that prioritize those more at risk through using an intersectional and decolonial approach are fundamental to building substantive equality.

VIII. Harm reduction and universal health coverage

94. Sustainable Development Goal target 3.8 contains a call for Member States to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and

[196] Ibid.

[197] See E/C.12/CZE/CO/2; E/C.12/SVK/CO/3; and CEDAW/C/LTU/CO/4.

[198] Global Network of Sex Work Projects, "Sex workers in conflict zones and humanitarian crises", March 2024.

[199] WHO, *COP26 Special Report on Climate Change and Health: The Health Argument for Climate Action* (Geneva, 2021), p. 2.

[200] United Nations Framework Convention on Climate Change, "What is the triple planetary crisis?", blog, 13 April 2022.

[201] Intergovernmental Panel on Climate Change, *Climate Change 2022: Impacts, Adaptation and Vulnerability – Working Group II Contribution to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change* (Cambridge, Cambridge University Press, 2022), pp. 1074 and 1076.

[202] See https://unfccc.int/process/bodies/constituted-bodies/WIMExCom/SOEs.

[203] Intergovernmental Panel on Climate Change, *Climate Change 2022*, p. 1048.

[204] WHO, "Climate change"; and Céline Guivarch, Nicolas Taconet and Aurélie Méjean, "Linking climate and inequality", International Monetary Fund: Finance and Development Magazine, September 2021.

affordable essential medicines and vaccines for all.[205] Models for universal health coverage must ensure that all people and communities have access to the health services that they need, that care is of sufficient quality to be effective, and that the use of services does not expose the user to financial hardship.[206] In line with the principle of leaving no one behind, harm reduction services within models for universal health coverage are a key way to help ensure that many groups who are pushed to the fringes of society are not left behind.

95. Comprehensive harm reduction programmes and services within models for universal health coverage occur in primary care settings where people receive other health-care services. For people who use drugs, this would include services such as needle and syringe programmes, opioid agonist therapy, drug consumption rooms and supervised injection facilities, drug checking, and overdose prevention and reversal.[207] Currently, only 23 countries provide comprehensive tobacco cessation services that are fully or partially covered under public health services, representing less than a third of the world's population.[208]

96. Criminalization can pose several barriers to universal health coverage. Where such coverage is employment-based or provided through the private sector, a number of challenges arise for marginalized communities such as sex workers, who are kept outside the formal economy.[209] Where enrolment in health coverage, or receiving services, requires providing information such as a permanent address, personal information and other disclosures, confidentiality concerns can drive a person to forgo care for fear of repercussions.[210]

97. The Special Rapporteur supports models for universal health coverage that extend beyond health care programmes and services to encompass the social determinants of health, such as housing, employment and education – basic needs that should be accessible and of quality without driving people to financial hardship. Legal and political environments that allow for a criminal record, serve as a barrier to accessing the social determinants of health and are antagonistic to comprehensive coverage.

98. The world remains off track for achieving the universal health coverage envisioned in target 3.8 by 2030.[211] A lack of dedicated domestic financing, along with reluctance to direct funds towards criminalized and stigmatized groups, leaves a large gap in financing for harm reduction services that is often filled only through international assistance.[212] States need to scale up efforts to set appropriate spending targets on health services, including for harm reduction.[213]

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[205] See www.who.int/data/gho/data/themes/theme-details/GHO/universal-health-coverage.
[206] Ibid.
[207] See A/HRC/56/52.
[208] See www.who.int/activities/quitting-tobacco.
[209] International Network of People Who Use Drugs, "What does universal health coverage mean for people who use drugs: a technical brief", 2019.
[210] Ibid.
[211] WHO, "Universal health coverage (UHC)", 5 October 2023.
[212] Submission from Drug Free America Foundation.
[213] Ibid.

IX. Good practices

99. In Estonia, greater access to harm reduction services led to a 97 per cent reduction in new HIV diagnoses among people who inject drugs between 2007 and 2016.[214]

100. The provision of scientific information on psychoactive substances and on their side effects (including risks and potential after-effects) are effective harm reduction measures, such as in Switzerland, with the "Just Say Know" campaign. The country conducts annual training of professionals in the field, including medical and non-medical professionals, regarding the risk of communicable disease transmission associated with drug use, including in prisons, which is an effective harm reduction measure.[215]

101. The decriminalization of sex work has been shown to have positive impacts on the health of sex workers, among others.[216] New Zealand decriminalized sex work in 2003, with the explicit goal of protecting the human rights of sex workers. Prior to that change, sex workers were often reluctant to reveal their occupation to health professionals or carry condoms.[217] They are also increasingly able to reject certain practices and negotiate safer sex.[218]

102. In Australia, successful harm reduction programmes, coupled with services provided by peer-based drug user organizations, have sustained the virtual elimination of HIV transmission among people who inject drugs and form part of the country's national hepatitis C strategy, which also includes outreach services, including to remote and Indigenous populations, as well as integrated care models. Opioid dependence treatment medicines are available at a significantly reduced cost to patients under the country's Pharmaceutical Benefits Scheme, which subsidizes most cost-effective medications. The "Rethink Addiction" national convention was launched, with the participation of people with lived experience, so as to reduce the stigma associated with alcohol, drugs, gambling and addiction.[219]

103. In Mali, in the country's northern regions, it is difficult for health services and health-care workers to carry out their routine activities. In response, the Government has collaborated with non-governmental humanitarian organizations to ensure the continuation of health services.[220]

104. In 2022 in Argentina, a programme that aims to establish integrated and comprehensive access to health care among people who use or are dependent on drugs was implemented, by strengthening the network among health and mental health-care providers, Government and non-government actors, in order to achieve access, quality care and equity. The programme aims to create interjurisdictional, multidisciplinary spaces for consultation so as to collaboratively design strategies to integrate policies on drugs and mental health, with an emphasis on the care system. Furthermore, the

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[214] Marty Lise and others, "Revealing HIV epidemic dynamics and contrasting responses in two WHO Eastern European countries: insights from modeling and data triangulation", *AIDS*, vol. 35, No. 4 (March 2015); and submission from UNAIDS.

[215] Submission from Switzerland.

[216] A/HRC/14/20, para. 35.

[217] Jan Jordan, *The Sex Industry in New Zealand: A Literature Review* (Wellington, New Zealand Ministry of Justice, 2005), p. 65, cited in A/HRC/14/20, para. 35.

[218] New Zealand, Ministry of Justice, *Report of the Prostitution Law Reform Committee on the Operation of the Prostitution Reform Act of 2003* (Wellington, 2008), pp. 46–47 and 50, cited A/HRC/14/20, para. 35.

[219] Submission from Australia.

[220] Submission from Mali.

Mental Health Law No. 26,657 specifies that addiction must be addressed as an integral part of mental health policies.

105. In Ukraine, the Ministry of Justice and prison authorities have developed and are in the process of piloting a rehabilitation programme to support prisoners in developing skills that will allow them to manage the use of psychoactive substances, both during their stay in prison and after release.[221] In Kosovo,[222] the treatment of people who use drugs is included as part of health-care provisions.[223] In Slovenia, the Council of Europe supported the development and adoption of a new risk and needs assessment tool that addresses, among other things, the use of drugs as part of the overall assessment in view of individual sentence planning.[224]

106. In El Salvador, the addiction prevention and treatment clinics of the Solidarity Fund for Health have emerged as fundamental pillars to address drug dependency. The approach taken involves a combination of medical consultations, specialized psychiatric and psychological care, and social and therapeutic interventions, including individual, group, family and couple sessions, as well as psychoeducational activities aimed at raising awareness and preventing the development of addiction. Regarding professional training, the technical support provided by the Inter-American Drug Abuse Control Commission through the Colombo Plan, with the Universal Treatment Curriculum, in both virtual and in-person modalities, has facilitated the training and development of multidisciplinary health personnel. The process has been aimed at developing the capacities, skills, abilities, values and essential competencies to improve the work efficiency of staff, promote their professional development and incorporate quality standards into the health services offered to the country's population.

107. In Ecuador, the Constitution recognizes addiction as a public health problem, requiring information, prevention and treatment programmes without criminalization. The law guarantees that every person at risk of drug use, who uses, consumes or has consumed drugs, has the right to health, through prevention, diagnosis, treatment, rehabilitation and social inclusion, in order to improve their quality of life, with a biopsychosocial approach. Furthermore, in recognizing the influence of the food industry in people's nutritional decisions, the country's Ministry of Public Health has developed several actions to create a framework of truthful information and consumer protection, such as with food labelling regulations, food-based dietary guidelines and the adoption of the NOVA food classification system.[225]

108. In Qatar, the Malaz Project seeks to create a safe and positive community environment through various activities including preventive and awareness campaigns on drugs and drug-related disorders, workshops and lectures, rehabilitation programmes and by conducting relevant research and participating in local and international conferences to increase knowledge and awareness.[226]

109. In the United States of America, harm reduction interventions were discussed for the first time in the National Drug Control Strategy in 2022. The Strategy emphasizes actions that can reduce drug overdoses and increase engagement in treatment and the health-care system. Harm reduction is also a key pillar of the United States Department of Health and Human Services Overdose Prevention Strategy, which was launched in October 2021. In addition, the National Institute on Drug

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[221] Submission from the Council of Europe.

[222] References to Kosovo shall be understood to be in the context of Security Council resolution 1244 (1999).

[223] Submission from the Council of Europe.

[224] Ibid.

[225] Submission from Ecuador.

[226] Submission from Qatar.

Abuse launched a harm reduction research network to generate and disseminate data on novel harm reduction approaches, settings and strategies to address barriers. The United States does not have universal health coverage, however, the percentage of people who do not have health insurance is at an all-time low in the country. Most public insurance programmes, such as Medicaid, and some private insurance programmes do cover certain harm reduction services such as naloxone and other opioid overdose reversal medications. These advancements in coverage for harm reduction services are a critical way to support expanded access to life-saving interventions in the country.[227]

110. In Azerbaijan, the implementation of the harm reduction programme ensures the access of high-risk population groups to medical services. The programme provides social adaptation and integration of people who inject drugs into society, prevention of HIV/AIDS, hepatitis B and C, sexually transmitted infections and infections transmitted by skin-to-skin contact, and treating co-morbidities (such as tuberculosis, diabetes or mental disorders), thereby reducing complications related to injection drug use and increasing the efficiency of medical services provided to women who take drugs before and after childbirth. During the strict quarantine regime during the COVID-19 pandemic, along with medical therapy, individual and group psychological assistance were provided in a virtual format.[228]

111. In Lebanon, for example, where the financial crisis led to a shortage of opioid agonist therapy, drug harm reduction organizations coordinated the rationing of existing stock. They sought cheaper medication alternatives, secured funding and donations from international donors and worked with United Nations entities, including WHO, to facilitate the reception and handover of medications to the Ministry of Public Health. In addition, local civil society organizations mobilized resources to procure and provide naloxone for those most at risk and covered hospitalization costs for detoxification of individuals adversely affected by the sudden decrease in opioid agonist therapy medication dosages.[229]

112. In countries in the Eastern European region, civil society organizations have supported several projects aimed at increasing access to comprehensive care for women, as well as specific training sessions for police, harm reduction professionals and social care workers.[230]

113. In Colombia, the new drug policy aims to achieve a change in the narratives about people who use drugs and within its strategic actions it aims to work with health personnel to eliminate stigma and discrimination and promote care based on public health and human rights. In different territories, the following services are provided: prevention and psychoeducational interventions; early detection, including screening for sexually transmitted infections and for mental health; the delivery of material, including for injection; education for the prevention of sexual risks among others; prevention of and care for overdose through naloxone; and the activation of differentiated channels for persons with specific needs, including mothers, minors, older persons or populations with comorbidities.[231] To address underlying stigma and promote social and cultural transformation, the “Detoxifying Narratives” project led by Elementa seeks to make visible the role that the media, decision makers and opinion leaders have played in replicating the language of prohibition, thereby leading to human rights violations. The project has helped to shift narratives around drug use, informing the national drug policy in Colombia and raising awareness of

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[227] Submission from the United States.
[228] Submission from Azerbaijan.
[229] Submission from Skoun.
[230] Submission from Eurasian Harm Reduction Association.
[231] Submission from Colombia.

the disparate impact that the framework of prohibition has on women, through direct interactions with the patriarchal system.[232]

114. Youth and youth-led organizations in the global South are developing innovative harm reduction programmes tailored to their needs and those of their communities.[233] In South Africa, where young people who use drugs face severe health and social challenges, including the risks associated with HIV, hepatitis C, infections, poverty, unstable housing, violence the and risk of overdose, the South African Network of People Who Use Drugs launched the country's first take-home naloxone programme in 2021. The initiative was piloted in three cities; however, it was discontinued on account of a lack of funding and political support.[234]

X. Conclusions and recommendations

115. **The Special Rapporteur recommends that States and other stakeholders:**

(a) **Integrate harm reduction as part of universal health coverage plans, incorporating comprehensive services that are accessible, affordable, acceptable and of quality. Universal health coverage should make essential medicines accessible and affordable; and should extend beyond health care programmes and services to encompass the social determinants of health;**

(b) **Examine the power asymmetries of States and non-State actors that have become woven into the fabric of societies, the dismantling of which is fundamental in working toward sustainable peace and development. In this regard, the meaningful participation of rights holders is key;**

(c) **Adopt, implement and monitor effective and evidence-based regulations to prevent health or environmental harms stemming from the use of products such as tobacco, alcohol and products with excess of sugar, salt or fats, which are often ultra-processed products. Enforce, through regulation, the expectation that all businesses must respect human rights throughout their operations;**

(d) **Strengthen existing regulations on the advertising, promotion and sponsorship of harmful products, including by developing new regulations on "surrogate marketing";**

(e) **Decriminalize abortion and guarantee access to quality care; in all cases, eliminate formal and substantive barriers;**

(f) **Repeal all laws, policies and practices that criminalize sex work and take measures to ensure that sex workers' rights, including the right to health, are guaranteed;**

(g) **Repeal laws that criminalize HIV exposure, transmission and non-disclosure;**

(h) **Decriminalize the use, possession, purchase and cultivation of drugs for personal use.**[235] **Adopt cohesive regulatory frameworks on drugs informed by scientific evidence, considering power asymmetries, pre-existing disparities and the impacts of law and policy in practice;**[236]

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[232] Submission from Elementa.

[233] Submission from Ágora and the Mexican chapter in the Latin American Network of People Who Use Drugs.

[234] Ibid.

[235] Submission from UNAIDS; and A/HRC/56/52, para. 85 (f).

[236] A/HRC/56/52, para. 85 (f).

(i) **Implement the full measures of drug harm reduction policies, including needle and syringe programmes, drug dependence treatment, HIV testing and counselling, antiretroviral therapy, prevention and treatment of sexually transmitted infections, condom programmes, information, education, prevention, diagnosis, treatment and vaccination measures, and opioid overdose management with naloxone, including in crisis, humanitarian and conflict settings and by removing financial barriers;**[237]

(j) **Tackle harm reduction as a continuum of care that supports individuals as they transition from active addiction to treatment, sustained recovery and social integration.**[238] **Include community care measures for the user population that allow for the reconstruction of social fabrics fractured by intersectionality between systems of oppression such as patriarchy, capitalism, racism and prohibition;**[239]

(k) **Fully implement the WHO Framework Convention on Tobacco Control, including measures and best practices outlined in article 14 thereof and in the related Guidelines for implementation;**[240]

(l) **Ensure that harm reduction services are applied widely and are non-discriminatory, evidence-based, trauma-informed, gender- and culturally sensitive, and age-appropriate,**[241] **focusing on the individual and steering away from "one-size-fits-all" approaches that are ineffective and often reproduce pre-existing power dynamics;**

(m) **Adopt robust information campaigns on genuine harm reduction options that are targeted specifically to individuals who suffer substance use disorders. Adopt robust education, public awareness and information campaigns to offer relevant, clear and easy-to-access evidence on the risks of substance use;**[242]

(n) **Ensure adequate and sustainable resources to support evidence-based harm reduction programmes, through sustainable and unconditional funding and steering away from less sustainable conditional or international funding,**[243] **where possible. Consider reallocating resources that are currently devoted to law enforcement and criminal approaches to prevention and harm reduction efforts, which, in addition to enhancing equity, can reduce health-related harms and costs;**[244]

(o) **Train health-care personnel to deliver quality services, in line with universal health coverage and harm reduction, that respect and promote autonomy and self-determination;**

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[237] WHO, *Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention*; General Assembly resolution 75/284; and submission from UNAIDS.

[238] Submissions from Drug Free America Foundation; and Ágora and the Mexican chapter in the Latin American Network of People Who Use Drugs.

[239] Submission from Elementa.

[240] "Guidelines for implementation of article 14 of the WHO Framework Convention on Tobacco Control", in *WHO Framework Convention on Tobacco Control, Guidelines for Implementation – Article 5.3; Article 8; Articles 9 and 10; Article 11; Article 12; Article 13; Article 14* (Geneva, World Health Organization, 2013).

[241] Submission from World Federation against Drugs and Drug Free America Foundation.

[242] Submission from Corporate Accountability.

[243] Submissions from Conectas Direitos Humanos; and Centro de Convivência É de Lei.

[244] Submission from Eastern and Southern Africa Commission on Drugs.

(p) **Ensure the collection of comprehensive disaggregated data in partnership with affected communities;**[245]

(q) **In working toward sustainable peace and development, all stakeholders must incorporate human rights and harm reduction approaches through evidence-based, stigma-free legislations, policies, programmes and practices linked with universal health coverage.**

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[245] Submission from UNAIDS.