SCiHRIA
Scientific Insights in Harm Reduction in Africa

Conference Updates 12th Global Forum on Nicotine Challenging Perceptions – effective communication for tobacco harm reduction Highlights

19-21 June 2025, Warsaw

This newsletter covers only a few highlights from the Conference, visit gfn.events for more information.

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SECTION 1

Tobacco Harm Reduction Approaches

Speaker Bios

Dr Mark Tyndall

Mark Tyndall MD, ScD, FRCPC is a Professor at the University of British Columbia, Canada. He was formerly the Executive Director of the BC Centre for Disease Control and the Deputy Provincial Health Officer. He received his medical degree from McMaster University, his infectious diseases training at the University of Manitoba, and his doctoral degree in public health from Harvard University. He has over three decades of community-based research and advocacy experience with a focus on global health, drug use, HIV, and harm reduction. He has authored over 250 peer-reviewed publications, presented a 2017 TEDMED talk on harm reduction, and is releasing a new book; "*Vaping: Behind the Smoke and Fears*" at this year's GFN. His current research and advocacy efforts are focused on innovative programs to reduce drug overdose/poisoning through safe drug supply programs and accelerating the global transition away from combustible cigarettes to vaping and other safer nicotine products.

Dr Carolyn Beaumont

Dr Beaumont is an Australian general practitioner. She founded the Australian 'SmokerHealth' national telehealth clinic (formerly MedicalNicotine) for vape prescriptions - a policy unique to Australia. Lung cancer and cardiac disease testing is also provided, for early diagnosis of the main diseases that kill smokers. Carolyn combines this with locum GP work in remote Australian communities, and understands firsthand the complex healthcare barriers that smokers from these regions face. In Australia's generally negative stance towards vaping, Carolyn plays an important role in THR. She is well known for her media engagement, presentations, publications and conference involvement. She is writing her first book titled 'Unfiltered', a collection of interviews with doctors from fields such as cardiology, vascular surgery, anaesthesia, neurosurgery and oncology. 'Unfiltered' aims to provide a compelling narrative across medical specialties, which focuses squarely on the harms caused by smoking and not by nicotine itself.

What's so scary about tobacco harm reduction?

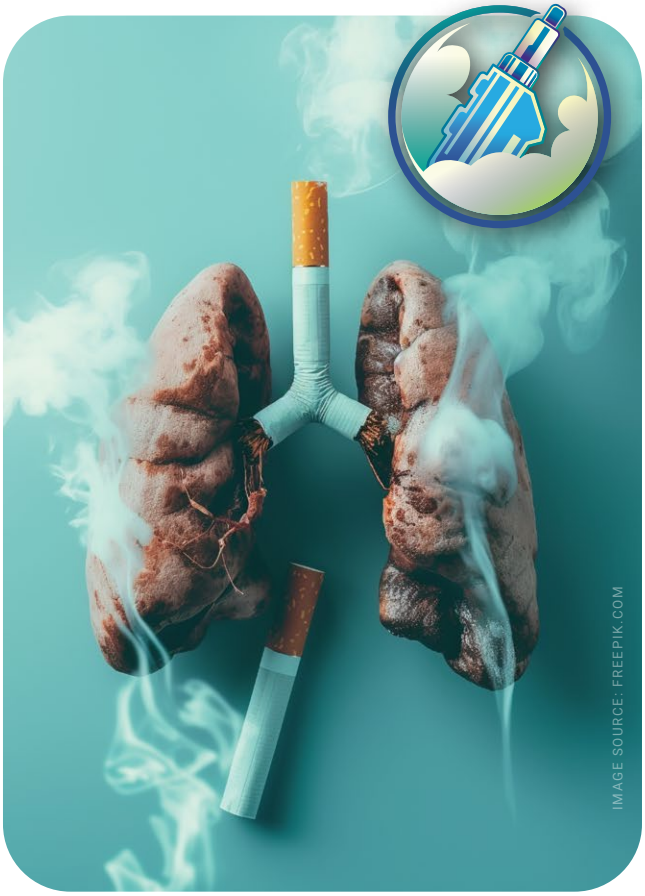
Dr Mark Tyndall

Mark shared the lessons he has learned from the drug harm reduction movement, not least the way stigma experienced by people who use drugs, and moral judgements about drug-taking affect policy and political decision making. Consumer advocates and tobacco harm reduction campaigners face significant challenges engaging lawmakers and public health organisations, including structural opposition to safer nicotine products. How can we convince those in power that this consumer-led public health revolution can lead to real-world change?

Core Philosophy to Harm Reduction (HR)

1. Reduce Risk, Don't Demand Abstinence

- This started with Human-Immunodeficiency Virus (HIV) prevention — **you cannot eliminate risk, but you can reduce it effectively** (e.g., condoms, clean needles).
- **Applied the same principle to tobacco harm reduction (THR): if people will continue to use nicotine, provide them with safer alternatives.**



> We could not eliminate the risk, so we reduced it

Real-World Scenarios: Five Timepoints of Harm Reduction

1. Kenya: Condom Distribution-1989

- **Patients with suspected sexually transmitted infections** (STIs) were diagnosed after clinical examination and offered appropriate treatment. The same patients **were educated about the concern of HIV and offered testing** for HIV. Those testing negative were further offered condoms as a concrete prevention tool.
- **Emphasis of a clear, empowering message**, "If you use this every time, you will not get HIV"
- Set the tone for a **trust-based, solution-focused clinical approach**.

2. Vancouver: Clean Needle Exchange -1999

- **Dealt with people who injected drugs**, often homeless and struggling.
- Set in the context of an **estimated 20-30%** of active **intravenous (IV) drug users** who were **HIV positive**.
- **Offered treatment for drug-related illness** (i.e. abscesses and other infections) but also **advocated, educated and provided clean, sterile needles**, emphasising again, "Use a clean needle every time — and there is a **95% less chance of getting HIV with injecting**"
- **Provided care in non-judgemental, honest conversation**.

3. Vancouver: Supervised Injection Sites - 2003

- Chaotic social context of increased homelessness, crime, open drug use and mounting political pressure to clean up this act, resulting in more aggressive policing.
- **Offered education** and informed users/patients of a **supervised injection site**.
- **Advocated for safe spaces to use drugs**, not just to reduce harm but to restore dignity and safety. Offering **alternatives to unsafe, unclean and dangerous places** to inject drugs.
- This was in strong contrast to the social narrative of law enforcement crackdowns i.e. **help, not punishment**.

4. British Columbia: The Fentanyl Crisis, Safe Alternative Supply – 2019

- Noticed **increased drug overdoses from 2015** onwards.
- Toxicology reports identified **fentanyl** as the main culprit.
- **Drug cartels** were using a **cheaper opioid (fentanyl)** instead of heroin.
- Fentanyl was **20-100 times more potent than heroin**.
- **Biometric vending machines** were created dispensing a safe **pharmaceutical alternative i.e. hydromorphone**.
- **Rationale: people will use drugs regardless** of legality or purity, so **make them safe and regulated**.

5. Canada: Vaping as Harm Reduction – 2020

- Encountered a patient with a persistent cough caused by smoking.
- **Offered a vape starter kit**, explaining it was **95% safer than smoking**.
- Had developed the rapport through all the other projects i.e. clean needles, injection sites, safe opioid supply.
- The more common scenario: the physician 'down the road' discouraging vaping and ultimately leading patients to continue smoking instead - using traditional methods of encouraging smoking cessation.
- **Emphasised immediate quality-of-life** improvements and **long-term benefits**.

The Basis of Harm Reduction (HR) Strategies

Five defining features of effective harm reduction interventions:

1. Utilising the "**95% effective**" public health communication tool , often a ~ 95% risk reduction.
2. Simple **evidence-based and common sense** solutions – grounded in both data and practicality i.e. free condoms, clean needles, safe injection sites, opioid alternative pills, vapes (cigarette-nicotine alternative).
3. **Cost-effective** – prevention is cheaper than treatment.
4. Easily **scalable** - low-tech, high-impact.
5. **Patient-supported** – people want and need these solutions because they work for them . "driven largely by people that will benefit from it the most."

Despite the relative simplicity and effectiveness of these HR interventions, there remains significant controversy. This is not due to the interventions themselves, but rather due to ideology. There is fear that giving tools (e.g., vapes, needles) encourages 'bad' behaviour. In that anything you do, be it providing clean needles, creating safe injection sites, promoting condom use, and advocating vaping, will make things like drug use, sex, and vaping worse.

Obstacles to Harm Reduction

There are three major barriers undermining progress in HR across drug use and tobacco products:

1. Overemphasis on Primary Prevention

While prevention is valuable, an exclusive focus on it ignores the reality: substance use and addiction are common and extremely complex. Telling people to "just quit" is unrealistic and unethical, especially when:

- **Addiction, for most, is not forever** – most people get over it.
- People **use drugs for reasons** that are often deeply **personal**.
- **Prohibition and access barriers** drives more **dangerous forms of acquisition**.
- **Moral panic** (e.g., giving out condoms or clean needles will 'encourage' risky behaviour) **has never been supported by evidence**. Fears of vaping turning kids into addicts, or giving out condoms promotes underage sex, are myths that have never materialised.

2. Stigma and Discrimination

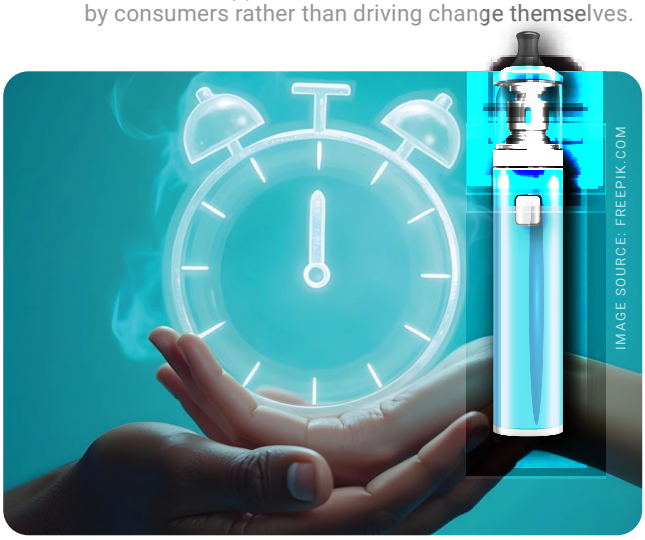
HR is controversial mainly because of who it is aimed at helping:

- **People engaging in "unacceptable" behaviours** (e.g., drug use and smoking) are **often blamed and excluded**, **not supported**.
- **People needing HR** are those in society who are **most vulnerable**.
- **Public health responses are shaped by moral judgement, not evidence**, i.e. if wealthy Westerners smoked at high rates and faced significant health risks, they would demand and receive safer options. Yet **poor or low-income nations are denied access** to harm reduction tools like vaping, largely **due to international bias and political interference and ideology**.

3. Apathy and Systemic Inertia

There exists a deep level of comfort with the status quo:

- **Healthcare systems** have **built** entire specialties **around treating smoking-related illness**, and there are no incentives to institute change.
- **HR would reduce chronic disease**, which ironically could threaten existing healthcare structures focused on treating its consequences.
- **Healthcare practitioners** (HCPs) focus on treating those afflicted by chronic illnesses but **neglect emphasis on prevention**.
- **Tobacco control organisations** have long backed **abstinence-only approaches**. In admitting HR holds significant value would mean **acknowledging** years of resistance and potential errors, **risking credibility**.
- **Tobacco companies**, while publicly supporting safer products, **show no urgency**, i.e. they do not fight legal restrictions that prevent them from stating that vaping is safer, and appear content with a slow transition led by consumers rather than driving change themselves.



Accelerating the Shift to Safer Tobacco: Three Urgent Strategies

The future of safer tobacco products is promising but unfolding too slowly. Despite the inevitability of this transition, actionable steps can be taken to hasten progress:

1. Empower Community Advocacy

Grassroots community activism is vital.

- Those who have switched to vaping and others affected by tobacco policy must be supported to advocate for themselves.
- Voices that speak truth to power especially **those with lived experience must be amplified** to counter discriminatory narratives and challenge harmful policies.

2. Combat Misinformation and Influence Policymakers

The anti-vaping landscape is filled with misinformation and opposition.

- It is **essential to build** co-ordinated, expert response **teams that can track, debunk, and respond to false claims** swiftly and effectively.
- Engaging policymakers directly and **placing sustained pressure on decision-makers** will be **critical to shifting** public health **narratives in support of harm reduction**.

3. Leverage Legal Action for Public Health

The legal system has historically supported harm reduction.

- e.g. Canadian courts have ruled **in favour of supervised injection sites** and needle exchanges.
- The same **legal approach** should now be **applied to THR**.
- **Ongoing legal challenges are needed** such as those cases against flavour bans as they could set powerful precedents affirming people's rights to access safer nicotine products.

A Cautionary Parallel: HIV Treatment and Access to Safer Nicotine Products

Based on decades of experience in HIV care, Dr Mark Tyndall, relates the dilemma of the delays in delivering life-saving antiretroviral therapy (ARTs) to low-income countries.

- ART became available in high-income countries by the late **1990s**, however, **millions of HIV patients in Africa died** unnecessarily **due to patent restrictions and lack of affordable access**. Only years later, with the launch of The US President's Emergency Plan for AIDS Relief (PEPFAR) and generic production, did treatment become more widely available.
- **The global failure to provide safer nicotine products to people who smoke, mirrors this earlier public health tragedy.** Both HIV and smoking involve slow-progressing harms, and both have known, effective interventions. Current tobacco control policies are actively obstructing access through flavour bans, restrictions on disposables, and general hostility to harm reduction products. This resistance can be viewed not just as a failure of policy but as moral one, comparable to withholding ARVs from those in need.

> **The urgency is clear:**
> **barriers must be removed to allow people who smoke to access safer alternatives now, before more lives are lost unnecessarily.**

Interested to read more:

"Vaping: Behind the Smoke and Fears", by Dr Mark Tyndall. ISBN-13978-1834182001. May 2025.

Tobacco Harm Reduction

Dr Carolyn Beaumont

> Society has normalised smoking-related death, and it's time to adopt bold, evidence-based interventions to change this trajectory.

1. Health Equity and Public Perception

Disadvantaged and remote populations often bear the greatest burden of tobacco-related harm.

- **There remains a deep stigma associated with smoking** (as well as those who use nicotine alternatives), leading to:
  - judgment from healthcare providers.
  - disengagement from care.
  - public apathy, hindering meaningful action.
- **There exists the need for clear, simplified public health messaging** to better inform communities, challenge stigma and encourage safer nicotine alternatives using non-judgemental, empathetic engagement.

2. A real-life example: a remote Australian mining community

- **In a remote mining town 1,500 km from Perth:**
  - Cardiovascular risk is extremely high.
  - Substance abuse and smoking rates are significantly elevated (compared to cities).
  - Legal access to nicotine alternatives (i.e. vapes) is limited to prescriptions.
- Despite challenges, **individuals showed openness to learning about harm-reduction** options and more importantly instituted behavioural change i.e. opting to try prescribed nicotine-alternatives e.g. vapes, when engaged by the clinician in a non-judgemental discussion.

3. Education – Public and Health Professionals

There is an urgent need to educate HCPs as well as the public on the evidence of nicotine alternatives.

- **The traditional clinician mindset is a major barrier**, where many HCPs are still trained to believe that 'just quit' is the gold standard, without exploring or supporting alternative strategies.
- Educating HCPs on a broader range of cessation tools, with a focus on regulated access to nicotine alternatives, would prompt real-world, patient-centric solutions.

4. Innovation, Education and Regulation

- **The future of new nicotine technologies and products must include a balance of innovation and openness**, coupled with regulation. Products like nicotine pouches and vapes offer opportunities but they must be controlled to prevent underage uptake.
- Teenage vaping is a multifactorial issue, often tied to undiagnosed Attention-Deficit/Hyperactivity Disorder (ADHD), mood disorders, increased school stress, or social anxiety.
- Teenagers rarely encounter compassionate and informed clinicians who explore these complexities in a holistic manner.
- **Vaping may well be a less harmful substitute** that deters initiation into traditional smoking.
- **Advocacy for open dialogue**, not scare tactics as well as integration of vaping into a broader adolescent mental health and lifestyle framework is needed.

5. Regulation and Environmental Changes

- There should be advocacy for **vaping-only spaces in public areas** (like airports), separating them from traditional smoking zones. This would change public perception and acknowledge an actual difference as well as contribute to a reduction in the risk of relapse for former smokers now using vapes.
- The **separation could promote social acceptance** and visibility of safer alternatives.

Final Thoughts

HCPs must be empowered and educated directly, bypassing political or media gatekeepers. Their daily contact with patients gives them immense power to influence positive outcomes.

Dr Beaumont urged the audience to reject complacency. Society has normalised smoking-related death, and it's time to adopt bold, evidence-based interventions to change this trajectory.

Children and young people need honest, age-appropriate conversations about nicotine, different from how alcohol or cannabis has traditionally been approached as fear tactics do not work, education and openness do.

SECTION 2

Reflections on the Framework Convention on Tobacco Harm Control

Jeannie Cameron (Host), Prof Tikki Pangestu, Dr Derek Yach, Prof David Khayat, Asa Saligupta

Despite its aim to reduce global consumption of cigarettes, the impact of the WHO's Framework Convention on Tobacco Control (FCTC) on tobacco use has been heavily contested, particularly in relation to low-income countries. The panel will assess the effectiveness of the convention as it reaches its 20th anniversary, and highlight areas that need drastic change, if it is to have any future relevance in reducing smoking.

Speaker Bios

Jeannie Cameron (host).
Jeannie is founder and managing director of JCIC International Consultancy, advocating for harm reduction policy since 2011. Recently elected to the States of Alderney parliament, she is a treaty law specialist with an LLM from King's College London and attended the negotiations establishing the FCTC. Jeannie is an active commentator on tobacco harm reduction, alternative nicotine products, and the therapeutic benefits of nicotine.

Doctor Derek Yach,
former head of the noncommunicable diseases and Mental Health at the World Health Organization (WHO), who worked on the beginnings of the Framework Convention on Tobacco Harm Control (FCTC) at the WHO. He's also a past president of the Foundation for a Smoke Free world. He's an epidemiologist and a swimmer.

Professor Tikki Pangestu,
who was an adviser on health policy at the World Health Organization (WHO), Director of research and policy. He's a biomedical and microbiologist specialist, and he is a graduate of the Australian National University and a Fellow of the Royal Academy of Medicine.

Professor David Khayat,
oncologist and Professor of Medicine. He is the past president of the French Cancer Institute and an adviser to the French president.

Asa Saligupta,
a consumer advocate from Thailand. He also works in the area of probiotics and herbals, and he is a member of the Thai Law and Regulatory Committee of the Thai Parliament.

Introduction

Jeannie Cameron

The FCTC was not originally an initiative conceived by the WHO. In fact, the idea emerged as a resolution from the World Conference on Tobacco or Health in 1994. This conference, which began in the 1960s and is held every three years, has often served as a catalyst for future global tobacco policy. If one maps the outcomes of each conference and follows developments over the next five years, it is evident that these resolutions frequently shape international policy in the field.

At the 1994 conference in Paris, it was proposed that the WHO pursue a multilateral treaty under Article 19 of the WHO Constitution, which provides for the adoption of conventions or agreements on matters within the Organisation's competence. Despite initial resistance, this idea gained traction.

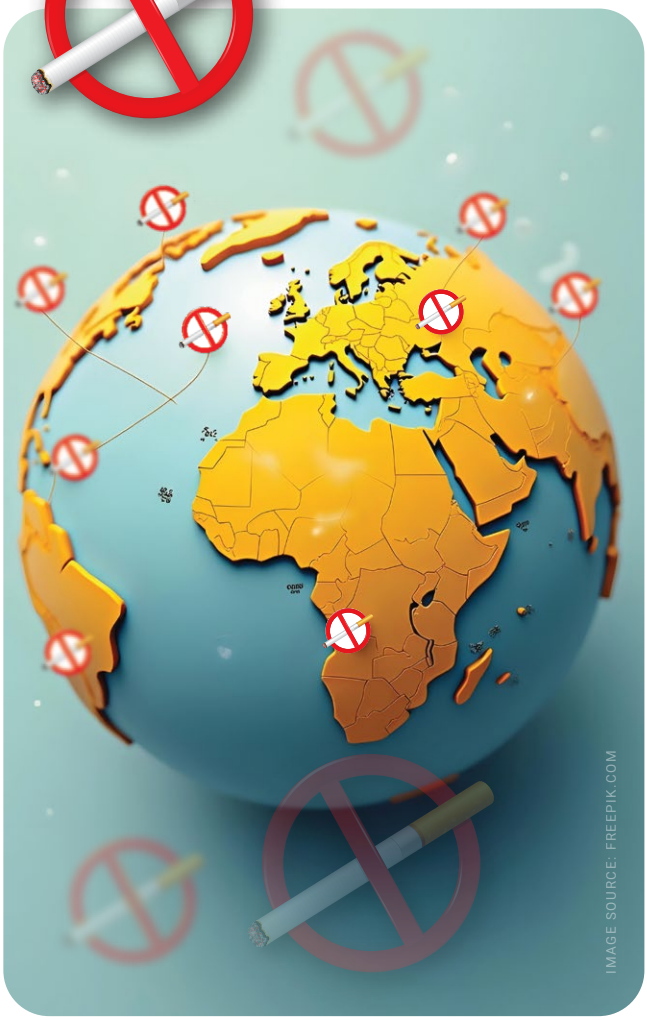
Between 2000 and 2005, I was involved in the negotiation and development of the FCTC, working alongside Derek Yach. From this experience, we identified several key indicators of a successful treaty:

1. **Legal effectiveness:** The FCTC achieved this quickly. In its first year, 168 countries signed and subsequently ratified the treaty.
2. **Political effectiveness:** Many of the core policy measures outlined in the treaty—such as bans on tobacco advertising, restrictions on public smoking, and requirements for packaging, labelling, and taxation—have been widely implemented. However, provisions related to harm reduction have not seen the same level of progress.
3. **Objective effectiveness:** The fundamental goal of the treaty was to reduce population-level exposure to tobacco smoke and the incidence of tobacco-related diseases. Unfortunately, this objective has not yet been fully realised.

FCTC's history and insights into the treaty itself

Dr Derek Yach

The origins of the FCTC can be traced back to the 1994 World Conference on Tobacco or Health in Paris. At the time, Ruth Roemer, a leading global health law scholar from UCLA (University of California, Los Angeles), delivered a pivotal address advocating for an international legal framework to tackle tobacco use. She argued that national governments, particularly in low-resource regions like Africa, lacked the legal capacity to effectively legislate on tobacco control, and thus required a multilateral treaty to guide and support them.



Roemer's vision was first presented in 1993 at a meeting in Harare, Zimbabwe, and attended by then-Minister of Health Dr Tim Stamps. The event received notable support, including a video message from former US President Jimmy Carter, urging African nations to lead in prevention while smoking rates remained relatively low on the continent.

Around the same time, the Canadian government, a global leader in tobacco control, began pushing for tobacco-related resolutions within the WHO, laying the groundwork for a treaty. The FCTC didn't emerge in a vacuum, it followed a progressive development of WHO resolutions from 1970 onwards, covering smoking risks, advertising restrictions, taxation, and public education. By the 1990s, countries like New Zealand, Sweden, the UK, Canada, and Singapore had already implemented strong national policies and were seeing declines in smoking prevalence. These frontrunner nations likely would have continued to succeed regardless of the treaty, but they supported the FCTC to help bring lagging countries along.

> **The Purpose of a Treaty: The FCTC was never intended to prescribe domestic policy in detail, but rather to address the transnational challenges of tobacco control – issues no single country could tackle alone. It aimed to establish international norms, capacity building, and cooperation in the face of globalised tobacco marketing and trade.**

Lessons from Implementation

- While the treaty was successfully adopted, implementation has been uneven. **Dr Yach noted a critical distinction between 'law on the books' in Geneva and actual enforcement on the ground** in countries such as India, Bangladesh, Nigeria, or across the Middle East. Many nations lacked the resources, political will, legal infrastructure, and organisational capacity needed to act on the treaty's commitments. **Although the FCTC was well-intentioned, no substantial funding was provided to support implementation.** At the time, pressing priorities like HIV/AIDS dominated the global health agenda, leaving **tobacco control underfunded**.
- **Philanthropic support**, notably from Bloomberg Philanthropies, **did contribute to some conventional measures such as advertising bans**. However, it had **minimal impact on tobacco taxation**, the **single most effective intervention**. Moreover, such funding actively opposed any measures relating to tobacco harm reduction.

Evaluating Impact 20 Years On

It has now been two decades since the FCTC came into force. Success can be assessed by two main outcomes:

- **Has tobacco use declined?**
  Despite global efforts, there are still 1.3 billion tobacco users worldwide. In some countries, smoking rates among men remain alarmingly high, i.e. 65% in Indonesia, over 50% in China, and 57–58% in Jordan.
- **Have tobacco-related deaths decreased?**
  When the treaty was being developed, **4–4.5 million people died annually from tobacco-related causes**. **That number has nearly doubled to 8.5 million per year and is expected to reach 10 million annually before it begins to fall.**

The Impact of WHO policy on Tobacco Harm Reduction

Prof Tikki Pangestu

The WHO has taken a very strong stance against tobacco harm reduction. This position not only persisted but was further reinforced during COP 10, the 10th Conference of the Parties to the WHO Framework Convention on Tobacco Control and is expected to continue through COP 11. This stance significantly influences tobacco control policies in many low- and lower-middle-income countries.

> One major challenge these countries face is their limited capacity to independently evaluate evidence and develop policies tailored to their unique circumstances.

For example:

- Indonesia has the highest smoking prevalence among males globally, with about 70% of men smoking cigarettes. Beyond this, **several factors hinder progress:**

  1. **Lack of capacity to critically assess the scientific evidence.**
  2. **Insufficient local research relevant to their specific context, which policymakers need to inform effective decisions.**
  3. **Apathy within governments, who often take the easier path of simply following WHO's lead without critical examination.**

- **Effective communication is crucial** to overcome misinformation and advocate for sensible regulation. These challenges are key battlegrounds in our efforts to promote harm reduction.

- **However, the 'elephant in the room' remains the WHO.** Until the organisation's position shifts, many countries will continue to exhibit apathy and default to WHO guidance. This dynamic profoundly impacts tobacco policies in low- and middle-income countries.

- Despite the important progress happening within global forums such as the Global Forum on Nicotine (GFN), I firmly believe **we all must play our part in advocating for our governments to take leadership, build movements, and push for change at the WHO**. The reality is that only sovereign member states, the countries themselves, can influence the WHO's policies. No amount of expert opinions, Nobel laureates, or civil society voices will make a difference unless the ministers of health from member states demand change by engaging directly with the WHO Director-General.

- **It is important to remember that the WHO is a politically driven organisation** governed solely by its member states. There are no industry representatives, no civil society groups, and no consumer organisations involved in its board of directors.

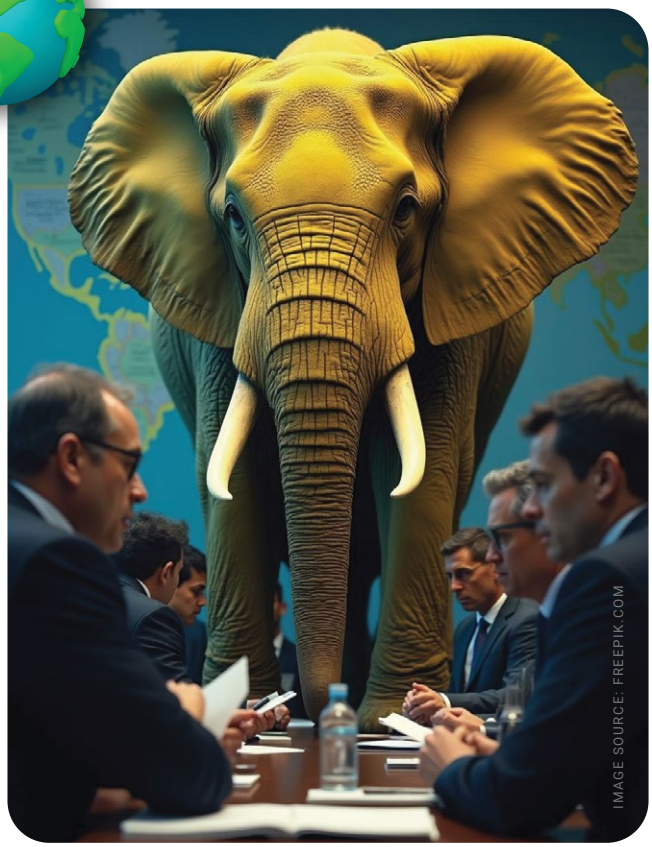


IMAGE SOURCE: FREEPIK.COM

> Our aim must be to change the WHO's "evidence-blind" policy. The WHO's mission is to ensure the highest possible level of health for all people—a mission rooted in social justice and human rights. Sadly, this mission seems to have been overlooked in the current tobacco control approach. Despite my critique, I remain deeply committed to the value and importance of the WHO. No other organisation can replace its role in global health leadership.

The comparison of the FCTC with the Charter of Paris Convention against Cancer

Prof David Khayat

World Cancer Day is observed on 4 February each year to raise awareness about cancer and encourage its prevention, detection, and treatment. It originated from the **signing of the Paris Charter Against Cancer on 4 February 2000 during the World Summit Against Cancer in Paris**. The charter was co-signed by United Nations Educational, Scientific and Cultural Organization (UNESCO) and French President Jacques Chirac, along with representatives from 27 countries.

The charter addressed key issues such as:

- Freedom of cancer research
- Patient rights and access to information
- Equity in access to care and innovation
- Reducing stigma around cancer

> A major motivation for the initiative was the fact that 80% of cancers are linked to lifestyle factors, making education and prevention critical.
>
> The signing was broadcast worldwide, seen by over 400 million people, solidifying 4 February as World Cancer Day.

Comparison between the Paris Chrater and FCTC

Major differences in tone and attitude toward humans

Paris Charter – humanitarian approach	FCTC
Article 1: Cancer patients are humans with rights - we respect their life, we respect their hope, we will respect their chance to be tested, to be diagnosed as early as possible. Raise awareness about evidence of cancer so that they can do something to try to prevent it themselves	Control of people
Article 2: Trying to work against the stigmas (i.e. mammogram gives cancer) as these are barriers to health	Stigma is part of the plan – threatening awareness, instead of removing stigma
We work together, we will defeat cancer	**Quit smoking or die as tobacco is the main driver**
Measurement of success: raising the awareness of the disease in the world, raising the respect of dignity, raising the aspect of the end of life, and give some hope to affected people	**Measurement of success:** don't count on people, they just look at the number of countries who ban tobacco smoking
Takes into account innovation, controlled studies and provides people with the best and the latest improvement in the diagnoses, the treatment and the prevention of cancer	More than just control tobacco smoking but also all the alternatives that would give a better outcome for the smokers
Risk is more complex i.e. personal, addiction not just pleasure (64% will continue to smoke)	Risk is binary and hence results are not achieved i.e., lower number of smokers and lower death rates

FCTC and human rights

Jeannie Cameron

The FCTC includes several references to human rights in its preamble, notably drawing on Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted in 1966, which recognises the right to the highest attainable standard of health. Both the ICESCR and the International Covenant on Civil and Political Rights (ICCPR), also from 1966, incorporate significant human rights provisions relevant to this context. These treaties include 'optional protocols', which are additional agreements in international law that allow individuals or groups affected by national policies to bring complaints against their governments to the respective treaty bodies.

Most countries are parties to these 1966 human rights treaties. Under the optional protocols, individuals, such as those prevented from vaping by government regulations, can file cases with the relevant human rights bodies. For example, in 1997, while working in Australia's Department of the Prime Minister and Cabinet on international treaty issues, I witnessed a case where two homosexual men successfully challenged a state law criminalising homosexuality. They invoked the human rights provisions of these treaties, winning their case and compelling the government to amend the law.

> Article 12 of the ICESCR, which emphasises the right to health, provides a strong basis for individuals to challenge national policies under their country's treaty obligations.
>
> This mechanism allows individuals to seek redress when national policies infringe upon their rights as outlined in these international agreements.

Bloomberg, anti-tobacco control and anti-harm reduction areas

Asa Saligupta

> Bloomberg Philanthropies has been funding anti-tobacco campaigns with the goal of reducing smoking rates. However, their efforts have not been entirely effective, and in many cases, they are also working to restrict access to safer alternatives like vaping or nicotine pouches.

In some countries, such as Thailand, the laws are inconsistent and confusing, i.e. it is illegal to import or sell vaping products, but it's not illegal to possess or use them. This creates a lot of misunderstanding among the public.

There is also **widespread misinformation**, especially amplified by social media. Many people, particularly the older generation, tend to believe whatever they see online or on traditional news channels without questioning it. They trust that if it is on Facebook, Instagram, or the news, it must be true. But much of this information is either misleading or one-sided.

In my country, although **Bloomberg's influence is significant**, there are also **several local NGOs pushing similar anti-harm-reduction narratives**. These groups often ignore scientific evidence and instead rely on ideology to support prohibition-based policies. This approach ultimately harms public health by limiting access to safer alternatives that could help people quit smoking.

Big Tobacco has long been seen as the enemy in the fight against smoking, but it is not just them, Big Pharma has also played a role. They have introduced nicotine patches, gums, and medications to help people quit smoking. Among these, **Varenicline** (known as Chantix or Champix) was **considered the most effective method**. The **second most effective method**, according to growing evidence, is **vaping**.

However, **Varenicline was removed from the market due to concerns about side effects** and contamination, which left a gap in effective cessation tools. Despite this, **Big Pharma continues to fund selective research and lobbies heavily for regulations** often in ways that disadvantage alternatives like vaping.

I currently serve on a government committee in **Thailand**, and we are now **very close to legalising vaping as a safer alternative for smokers**.

Globally, regulations on vaping vary widely. In Ireland, for example, there's a push for plain packaging and possibly limiting flavours. In contrast, Thailand still has strict bans, even though more than 70,000 people die each year from tobacco-related illnesses and we have yet to see confirmed deaths linked to vaping. This inconsistency **highlights the need for evidence-based policies**—not ones driven by ideology or industry influence.

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