Could International Human Rights Obligations Motivate Countries to Implement Tobacco Cessation Support?
Speakers

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FCTC Article 14 obligations to develop tobacco cessation support

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WHO Framework Convention on Tobacco Control (FCTC)

First ever and only UN treaty on health
Adopted by WHA in 2003
Entered into force 2005
Currently 181 Parties
91% of UN member states, 87% world’s population

Most widely embraced treaty in UN history
Article 14 guidelines

Three main sections

Developing an infrastructure to support cessation

Key components of a treatment system

A stepwise approach
Developing an infrastructure

Conduct national situation analysis (NSA)

Strengthen national coordination and funding

Develop official strategy and guidelines

Address tobacco use in healthcare workers

Make recording of tobacco use in medical notes mandatory

Ensure that all tobacco users are identified and provided with at least brief advice
Key components of a system

- Mass communication programmes to encourage cessation
- Brief advice integrated into all healthcare systems
  - Quitlines
- Specialised treatment services
- Medications
A stepwise approach 1: establish system components

First implement Articles that increase demand for cessation (eg. 6, 8, 11, 12)

Use existing infrastructure (eg. primary healthcare system, TB clinics)

Strengthen national coordination and identify funding

Develop and disseminate a national strategy and national guidelines
A stepwise approach 2: address issue in healthcare workers

Incorporate tobacco dependence and cessation into core curriculum of medical, dental, nursing, pharmacy and other relevant training

Train healthcare workers (and relevant others) to give brief advice

Help healthcare (and relevant others) workers quit
# Reducing tobacco use in health professionals

## Table 3.1: Selected studies of GP smoking prevalence

<table>
<thead>
<tr>
<th>Country</th>
<th>Method and sample details</th>
<th>Published</th>
<th>% who smoke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulgaria³</td>
<td>National survey (n=1194) in 8 of 28 regions</td>
<td>2005</td>
<td>44.2</td>
</tr>
<tr>
<td>Denmark⁶</td>
<td>Postal questionnaire with 313 GPs</td>
<td>1993</td>
<td>33</td>
</tr>
<tr>
<td>Greece¹⁰</td>
<td>National questionnaire of 1,284 physicians including 370 GPs</td>
<td>2007</td>
<td>38.6</td>
</tr>
<tr>
<td>Italy¹¹</td>
<td>Regional phone interview</td>
<td>2003</td>
<td>28.3</td>
</tr>
<tr>
<td>Netherlands¹²</td>
<td>Postal survey with GPs and other physicians.</td>
<td>1990/93</td>
<td>38</td>
</tr>
<tr>
<td>Romania¹⁴</td>
<td>Survey, details not given, n=1136, p=0.05</td>
<td>2000</td>
<td>43.2</td>
</tr>
<tr>
<td>Slovakia⁴</td>
<td>European postal survey of GPs</td>
<td>2005</td>
<td>48.5</td>
</tr>
<tr>
<td>Sweden⁴</td>
<td>European postal survey of GPs</td>
<td>2005</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Stead M, Angus K, Holme I, Tait G (2007) Review of the literature on factors that facilitate and hinder use of smoking cessation interventions by GPs, and of interventions to change GP behaviour. CRUK Centre for Tobacco Control Research
RESEARCH ARTICLE

Prevalence of tobacco use in healthcare workers: A systematic review and meta-analysis

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Abstract

Objectives

To estimate tobacco use prevalence in healthcare workers (HCW) by country income level, occupation, and sex, and compare the estimates with the prevalence in the general population.

Methods

We systematically searched five databases: Medline, EMBASE, CINHAL Plus, CAS Abstracts, and LILACS for original studies published between 2000 and March 2016 without language restriction. All primary studies that reported tobacco use in any category of HCW were included. Study extraction and quality assessment were conducted independently by three reviewers, using a standardised data extraction and quality appraisal form. We performed random-effect meta-analyses to obtain prevalence estimates by World Bank (WBI) country income level, sex, and occupation. Data on prevalence of tobacco use in the general population were obtained from the World Health Organisation (WHO) Global Health Observatory website. The review protocol registration number on PROSPERO is CRD42019041231.

Results

229 studies met our inclusion criteria, representing 457,415 HCW and 63 countries: 29 high-income countries (HIC), 21 upper-middle-income countries (UMIC), and 13 lower-middle- and low-income countries (LMIC). The overall pooled prevalence of tobacco use in HCW was 21%, 31% in males and 17% in females. Highest estimates were in male doctors in UMIC and LMIC, 36% and 45% and female nurses in HC and UMIC, 21% and 23%. Heterogeneity was high (I² = 90%). Country level comparison suggests that in HIC male-HCW tend to have lower prevalence compared with males in the general population while in
Our systematic review

229 studies from 2000 to 2016 representing 457,000 healthcare workers in 63 countries
(but still few up-to-date studies – a seriously neglected area)

Overall average – 21% used tobacco

Highest – 35% and 45%
(male doctors in upper and lower middle income countries)
## Basic infrastructure

<table>
<thead>
<tr>
<th>Does your country (% yes)</th>
<th>2012</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have an officially identified person responsible for treatment?</td>
<td>41</td>
<td>54</td>
</tr>
<tr>
<td>Have a clearly identified budget for treatment?</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Have national treatment strategy?</td>
<td>44</td>
<td>32 *</td>
</tr>
<tr>
<td>Have national treatment guidelines?</td>
<td>44</td>
<td>40 *</td>
</tr>
<tr>
<td>Offer to help healthcare workers to stop using tobacco?</td>
<td>46</td>
<td>44</td>
</tr>
<tr>
<td>Mandatory recording of tobacco use in medical notes</td>
<td>22</td>
<td>30</td>
</tr>
</tbody>
</table>

n = 121 and 142 (83% response rate)
So what should countries be doing now?

1. Review where treatment fits into their tobacco control programme and what resources they have - do the National Situation Analysis (NSA)

2. Starting with core infrastructure measures
   (budget, official in charge, official policy, official guidelines, mandatory recording)

3. Then broad reach low cost approaches
   (brief advice, text messaging (quitlines?), access to affordable medications)

4. Then more specialised support
   (face-to-face support including in clinics, providing all meds)
So what should countries be doing now?

1. This could be expressed more succinctly – they should be implementing the FCTC Article 14 Guidelines
2. But they are not
3. At least not adequately or quickly
4. There are various reasons why not but perhaps more important – what can be done to improve implementation?
Thank you

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Tobacco Undermines the Right to Health
State Cessation Obligations & International Accountability Mechanisms

Benjamin Mason Meier, JD, LLM, PhD
ASH Webinar Series
March 16, 2023
Birth of the Right to Health

CONSTITUTION
OF THE
WORLD HEALTH ORGANIZATION

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.
Human Rights in Global Health

- Health & Human Rights Movement
  - Human Rights Law Matters
  - Human Rights Evolve
  - Human Rights Frame Policy
- Human Right Can Frame Cessation
Right to Health – Addiction Undermines Autonomy

Tobacco Cessation – Cessation as a Human Rights Obligation

Human Rights Accountability – Monitoring to Support FCTC Implementation
Addiction Undermines Autonomy

Nicotine Addiction Limits Individual Autonomy

Right to Health Upholds Healthy Decision Making

Industry Manipulates Addiction to Undermine Individual Decision Making
Article 14 as a Human Rights Obligation

- Cessation
  - Helps overcome influence of nicotine addiction
  - Supports restoration of individual autonomy over health

Article 14

Each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence.
Accountability through Monitoring

– FCTC Monitoring
  • State Party Reporting
  • WHO Reporting

– Human Rights Monitoring
  • Human Rights Treaty Bodies
  • Universal Periodic Review
  • UN Special Rapporteurs

Human Rights Monitoring & Review

Implementation & Follow-Up

Review of State Reports

Concluding Observations

Constructive Dialogue
Could International Human Rights Obligations Motivate Countries to Implement Tobacco Cessation Support?

Benjamin Mason Meier, JD, LLM, PhD
Professor of Global Health Policy
University of North Carolina at Chapel Hill
Utilizing human rights mechanisms to influence local tobacco control regulations

March 16, 2023

Kelsey Romeo-Stuppy, Managing Attorney
Chris Bostic, Policy Director
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RUGGIE PRINCIPLES

Protect = Protect citizens from tobacco industry

Respect = Industry should respect human rights norms

Remedy = Mechanisms and processes to request reparation when industry infringes on human rights
HUMAN RIGHTS: THE ARGUMENT

Everyone has a right to life and to health

Governments therefore have a duty to protect their citizens from the tobacco industry and harms from tobacco

Governments have a duty to enforce those rights

Legal remedies are available at the international, regional, and national levels.
Everyone has a right to health (aided by quitting smoking)

Governments therefore have a duty to protect their citizens from the tobacco industry and harms from tobacco (by providing cessation support)

Governments have a duty to enforce those rights (by helping citizens quit smoking)

(if governments don’t provide cessation support) Legal remedies are available at the international, regional, and national levels.
The U.S. **has not ratified:**

- The Framework Convention on Tobacco Control (the FCTC) (Signed)
- International Covenant on Economic, Social and Cultural Rights (ECOSOC) (signed)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (signed)
- Convention on the Rights of the Child (CRC) (signed)
The U.S. has ratified:

- International Covenant on Civil and Political Rights (ICCPR)
- International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
How it comes together: a real life example
The National Component
How it comes together: a real life example

The National Component
International Convention on the Elimination of All Forms of Racial Discrimination

Adopted and opened for signature and ratification by General Assembly resolution 2106 (XX) of 21 December 1965

entry into force 4 January 1969, in accordance with Article 19

The States Parties to this Convention,

Considering that the Charter of the United Nations is based on the principles of the dignity and equality inherent in all human beings, and that all Member States have pledged themselves to take joint and separate action, in co-operation with the Organization, for the achievement of one of the purposes of the United Nations which is to promote and encourage universal respect for and observance of human rights and fundamental freedoms for all, without distinction as to race, sex, language or religion,

Considering that the Universal Declaration of Human Rights proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set out therein, without distinction of any kind, in particular as to race, colour or national origin,

Considering that all human beings are equal before the law and are entitled to equal protection of the law against any discrimination and against any incitement to discrimination,
How it comes together: a real life example

The Local Component

Tobacco violates every person’s right to live healthy.
Upcoming opportunities

• COP 10

• CERD General Recommendation

• Reports from civil society when countries report to various treaty bodies

• Engaging with Special Rapporteurs, etc.
TOBACCO AND HUMAN RIGHTS HUB

Visit: ash.org/hrhub
Thank you!

Kelsey Romeo-Stuppy  
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Have you seen tobacco industry interference in public health policymaking? Email us the details at info@ash.org!

Read More:

Tobacco & Human Rights Hub

ash.org/hrhub

U.S. Tobacco Lobbyist & Lobbying Firm Registration Tracker

ash.org/tobacco-money

NEXT WEBINAR:
April 13, 2023
STPA on UN Plastic Pollution Treaty

Tools for Advocates

Could international human rights obligations motivate countries to implement tobacco cessation support?

Benjamin Mason Meier | Martin Rave | Donna Shalala | Chris Smith
Ashita Gupta | Kelley Romeo-Stuppy | Laurent Huber

“Governments must protect their citizens from the tobacco industry.”
— David Kambala, Programme Coordinator, CEPHD