Tobacco harm reduction and the right to health

GLOBAL STATE OF TOBACCO
HARM REDUCTION

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Key messages

Harm reduction is a range of pragmatic policies, regulations and actions that either reduce health risks by providing safer forms of products or substances, or encourage less risky behaviours. Harm reduction does not focus exclusively on the eradication of products or behaviours.

Tobacco harm reduction, using safer nicotine products, offers new choices to millions of people worldwide who want to switch away from smoking, but have been unable to with the options previously available.

There is substantial international, independent evidence that the safer nicotine products that are available today – including nicotine vaping devices (e-cigarettes), heated tobacco products and Swedish-style oral snus – are demonstrably and significantly safer than smoking tobacco.

Until now, official responses to tackle the death and disease caused by smoking have been led by tobacco control. While it has achieved much, it has not eradicated tobacco use. Millions of people worldwide are either unable or unwilling to give up nicotine and continue smoking tobacco to consume it.

In higher income countries, smoking levels remain highest among marginalised communities. In many low- and middle-income countries, smoking levels have plateaued and population increases look set to increase the number of people who smoke.

Millions of people should not be denied access to products that can help them avoid poor quality of life, disease, and premature death. Preventing access to these products denies people their right to health as enshrined in many international health conventions.

Where safer nicotine products are accessible and well regulated, the evidence is clear. People quit combustible tobacco in huge numbers and switch to these products – making the choice to improve their own health, at almost no cost to governments and taxpayers.

Yet bans on safer nicotine products are rising, including in those countries where the number of people who smoke is predicted to increase due to population growth. Government policies and regulation are being unduly influenced by flawed science and anti-harm reduction lobbying, leading to sensational media coverage. Flawed public health information in many countries is confusing and misleading people who want to switch away from smoking.

Similar problems accompanied the introduction of many previous drug or sex harm reduction strategies when they were still new. With tobacco use, the number of people directly affected is vast. Will the transformative public health potential of tobacco harm reduction be realised? Or will this opportunity to save millions of lives be squandered, as a decades-long war on tobacco turns into an all-out war on nicotine?

The global public health crisis caused by smoking tobacco

Death and disease

The facts are stark.

The World Health Organization (WHO) estimates that **one billion people will have died from tobacco-related diseases by the end of this century**.

That is roughly equivalent to the **entire population of North and South America, or 13 per cent of the current global population**.[1]

Each year, over **seven million people** die from diseases related to tobacco use – more than from malaria, HIV and tuberculosis combined.

Smoking is the **single biggest cause of non-communicable disease** (NCD) worldwide.

Half of all those who smoke will die prematurely and painfully due to diseases directly related to an extraordinary range of illnesses, from cancers of the lung, throat, pancreas, bladder, stomach, kidney, or cervix, to heart attack or stroke. Loved ones suffer these losses too.

Many millions of people worldwide also experience **years of disability and reduced quality of life** due to diseases such as chronic obstructive pulmonary disease (COPD), macular degeneration, cataracts, diabetes, fertility problems and rheumatoid arthritis, which are all caused by, linked to or exacerbated by smoking.

Smoking also directly impacts on bystanders. The WHO estimates that a third of all people around the world are regularly exposed to the effects of tobacco smoke. This exposure is estimated by the WHO to be responsible for about 600,000 deaths per year, and approximately 1% of the global burden of disease worldwide.[2]

Economic impact

Trying to establish the precise economic impact of smoking on the global economy is difficult. However, in 2017, the WHO and the US National Cancer Institute published a study which estimated that the worldwide healthcare cost of smoking in just one year (2012) was $422 billion, which would account for 5.7% of all global health expenditure. Estimated indirect costs totalled $357 billion for morbidity and $657 billion for mortality. The total annual economic cost of smoking was therefore estimated to be $1.4 trillion, or 1.8% of the world's annual GDP.[3]

Who smokes?

It's estimated that 1.1 billion people smoke tobacco every day, of whom it is thought 80% live in low-and middle-income countries (LMIC).[4]

In many higher income countries, levels of daily adult smoking have fallen since the early 1970s and are now 'low' as defined by international standards, meaning under 20% of the population smoke. This is largely due to greater public awareness of the importance of a healthier lifestyle and the introduction of tobacco control measures (including advertising bans, smoke-free environments, availability restrictions and higher taxation).

> **1.1 billion people smoke tobacco every day; 80% live in low- and middle-income countries**

But in many higher income countries, smoking rates have now begun to level off: substantial numbers of people continue to smoke. In these countries, levels of smoking, and consequently smoking-related death and disease are disproportionately high among vulnerable and marginalised groups, including people living in poverty, from minority ethnic or indigenous communities, from the LGBTQ+ community, people living with mental health conditions or with substance use problems.

[1] Roser, M., Ritchie, H. and Ortiz-Ospina, E. (2019) – *World Population Growth*. Published online at OurWorldInData.org. Retrieved from: https://ourworldindata.org/world-population-growth

[2] World Health Organization (WHO), Global Health Observatory Data: Second-hand Smoke (publication date unknown). Retrieved from: https://www.who.int/gho/phe/secondhand_smoke/en/#targetText=Second%2Dhand%20smoke%20(SHS),asthma%2C%20have%20long%20been%20established.

[3] National Cancer Institute and WHO (2017), NCI Tobacco Control Monograph Series 21 – *The Economics of Tobacco and Tobacco Control*. Retrieved from: https://cancercontrol.cancer.gov/brp/tcrb/monographs/21/docs/m21_complete.pdf

[4] WHO (2019) *Tobacco: key facts*. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/tobacco

Image: Franck V. on Unsplash

Many low and middle-income countries (LMIC) are not sufficiently resourced to implement and enforce tobacco control policies. The situation is further complicated in countries where the economy is reliant on income from tobacco cultivation. Levels of smoking in many LMIC are plateauing (and may be under-reported). Numerous LMIC have large projected population increases, suggesting the number of smokers is likely to rise.

> **smoking-related death and disease are disproportionately high among vulnerable and marginalised groups**

One target of the overall UN Sustainable Development Agenda (SDA) is to reduce premature deaths from non-communicable disease by one third by 2030.[5] The top three causes of NCD mortality are cardiovascular disease, cancer and respiratory disease – all of which are closely associated with cigarette smoking. It is hard to see how this goal can possibly be achieved if dramatic reductions in smoking are not achieved.

"People smoke for nicotine but they die from the tar."

As pioneering tobacco researcher Professor Mike Russell identified in 1976, "Smokers cannot easily stop smoking because they are addicted to nicotine.... People smoke for nicotine but they die from the tar."[6]

People smoke tobacco because they feel they benefit from the effects of nicotine. People report that it helps concentration and can relieve anxiety or stress. Conversely, people who smoke say they crave cigarettes, feel agitated and irritable and find it hard to concentrate if they run out. From this point of view, some people are said to be dependent on nicotine. But given that nicotine as a substance is relatively benign and does not cause any of the illnesses associated with smoking, using nicotine is arguably not the physical or psychological problem usually conveyed by the public image of the word 'addiction'.

It has been clear for many years that the reason people die prematurely or develop life-threatening diseases from smoking cigarettes is exposure to the toxic chemicals released when a cigarette is lit and the fumes from burning are inhaled. The main toxins in cigarette smoke identified as potentially harmful include carbon monoxide, volatile organic compounds, carbonyls, aldehydes, tobacco-specific nitrosamines and metal particles.[7] Over 70 of the 7,000 – 8,000 chemicals released in the combustion of tobacco are carcinogenic.

Image: Obby RH on Unsplash

[5] UN Sustainable Development Goals (SDG) Knowledge Platform, SDG 3 Retrieved from: https://sustainabledevelopment.un.org/sdg3 (select 'Targets and indicators' tab).

[6] Russell, M. (1976) Low-tar medium-nicotine cigarettes: a new approach to safer smoking. *British Medical Journal* (BMJ 1: 1430-1433). Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1640397/pdf/brmedj00520-0014.pdf

[7] Knowledge-Action-Change (KAC) (2018). *No Fire, No Smoke: The Global State of Tobacco Harm Reduction 2018*, p63. https://gsthr.org/report/full-report

Nicotine, the drug for which people to continue to smoke, is not a carcinogen. Nor is it harmless – no substances are. But the clinical evidence suggests that at "commonly used dose levels, short-term nicotine use does not result in clinically significant harm."[8] Studies of nicotine replacement therapy (NRT) products, such as patches, gum, inhalators, tablets/lozenges or nasal/oral sprays containing nicotine, have demonstrated this. Long-term, it is more difficult to know, as studies to date have mainly relied on nicotine obtained through smoking tobacco. But, according to the UK Royal College of Physicians, "it is widely accepted that any long-term hazards of nicotine are likely to be of minimal consequence in relation to those associated with continued tobacco use."[9]

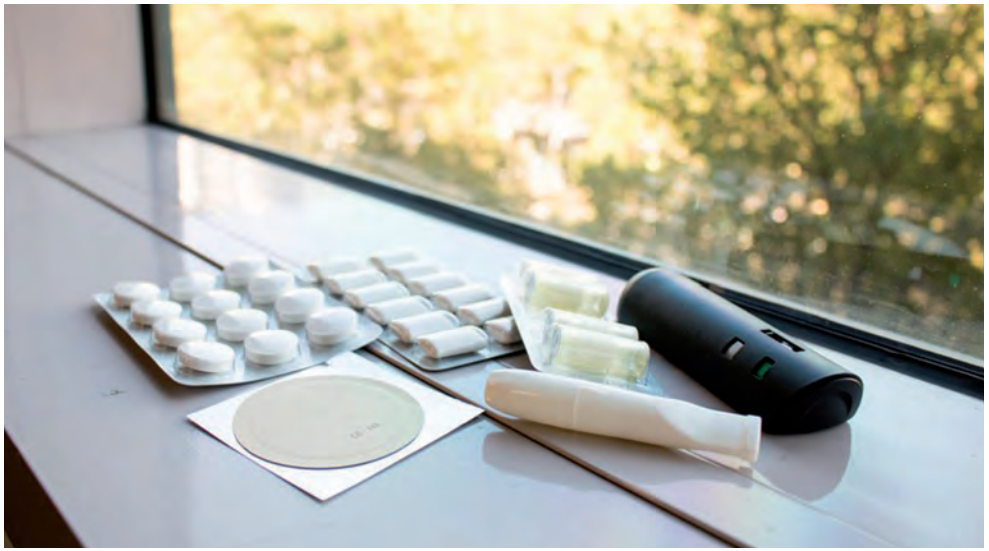

Image: Google

The risks nicotine poses to human health are minute compared to those posed by its most commonly used delivery system, the tobacco cigarette.

The majority of smokers want to quit smoking and many thousands do so successfully every year. Some manage to quit by themselves. In countries where they are accessible and affordable, some people use NRT products, or medications such as varenicline or bupropion. Many smokers have very many unsuccessful quit attempts before finally managing to quit indefinitely.

For many, using NRT or medicines does not work. The reasons for this will be as individual as the person who wants to quit, but may include the failure of these products to replicate the ritual aspect of smoking and the lack of a sufficient nicotine experience.

Tobacco control

The primary piece of international legislation concerned with tobacco control is the Framework Convention on Tobacco Control administered by the WHO, which encourages FCTC delegate countries to adopt the following strategy:

Monitor tobacco use and prevention policies
Protect people from tobacco smoke
Offer help to quit tobacco use
Warn about the dangers of tobacco
Enforce bans on tobacco advertising, promotion and sponsorship
Raise taxes on tobacco

In higher income countries, the so-called MPOWER model has been in place for years. Most recently, these have included increasing numbers of public smoking bans. These measures have helped to bring down adult daily smoking rates. But rates among people who are vulnerable or marginalised due to poverty, sexuality, ethnic minority or indigenous background, mental health diagnosis, involvement with the criminal justice system or use of illicit drugs or alcohol remain consistently high.

Raising cigarette prices has helped to reduce smoking rates. However, the strategy has a regressive effect, namely, increasing economic inequality, given that both smoking rates and the number of cigarettes smoked each day are higher among people from lower socioeconomic groups.

Moreover, public anti-smoking campaigns have embedded feelings of guilt and shame in people who, for whatever reason, continue to smoke. Research has shown that the stigma attached to smoking can prevent people from seeking help if they

[8] Royal College of Physicians (RCP) (2016). *Nicotine without smoke; tobacco harm reduction. A report by the Tobacco Advisory Group of the Royal College of Physicians*. https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction

[9] Royal College of Physicians (RCP) (2016). *Nicotine without smoke; tobacco harm reduction. A report by the Tobacco Advisory Group of the Royal College of Physicians.* https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction

Image: Patrick Hendry on Unsplash

are unwell. For lung cancer patients, for example, this can lead to delayed diagnosis and poorer prognosis, lower quality of life, negative impacts on relationships and interactions with health workers.[10]

> **public anti-smoking campaigns have embedded feelings of guilt and shame in people who, for whatever reason, continue to smoke**

Stigma creates additional suffering on an individual level. However, it can also reinforce population health disparities, impacting most significantly on those who are already the most vulnerable. Some argue it should not be used as a strategy in global health at all.[11]

> *"People think you're dirty because you smoked. People automatically think you've brought it on yourself."*
>
> 56-year-old living with lung cancer[12]

The war on tobacco becomes a war on nicotine

Many advocates for tobacco control see worldwide abstinence from tobacco use and the dismantling of the tobacco industry as the only viable measure of success. Tobacco control has become a war on tobacco.

In taking a total prohibitionist stance on tobacco, tobacco control advocates are also waging war on nicotine. In doing so, they may be missing the most significant public health opportunity the world has ever seen.

[10] Riley, K. E., Ulrich, M. R., Hamann, H. A., and Ostroff, J. S. (2017). Decreasing Smoking but Increasing Stigma? Anti-tobacco Campaigns, Public Health, and Cancer Care. *AMA journal of ethics*, 19(5), 475–485. (doi:10.1001/journalofethics.2017.19.5.msoc1-1705). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5679230/

[11] Brewis A, Wutich A. (2019) Why we should never do it: stigma as a behaviour change tool in global health. *BMJ Global Health* (doi:10.1136/ bmjgh-2019-001911). https://gh.bmj.com/content/4/5/e001911

[12] Chapple A, Ziebland S, McPherson A. (2004) Stigma, shame, and blame experienced by patients with lung cancer: qualitative study. *British Medical Journal* (BMJ 2004; 328 :1470). https://www.bmj.com/content/328/7454/1470

Harm reduction, health and human rights

The everyday world of harm reduction

Harm reduction is a range of pragmatic policies, regulations and actions that either reduce health risks by providing safer forms of products or substances, or encourage less risky behaviours. Harm reduction does not focus exclusively on the eradication of products or behaviours.

In the course of everyday life, we all use or do things which could be dangerous. Many products or activities have been modified to reduce that risk. Modifications may come from manufacturers, regulators or be led by consumers.

Consider road safety. Many countries now have rules about wearing seat belts. Modern cars are designed with airbags which protect us in the event of a crash. Many riders wear cycle and motorbike helmets. Roads have speed limits. We don't ban cars and bikes in case they cause harm to us or others. We adopt these measures to reduce harm, although they are called 'health and safety' rather than 'harm reduction'.

Harm reduction as social justice

Harm reduction has another important aspect: a role in championing social justice and human rights for people who are often among the most marginalised in society.

Proponents of harm reduction argue that people should not forfeit their right to health if they are undertaking potentially risky activities, like drug or alcohol use, sexual activity or smoking.

The more political dimension to harm reduction grew out of the HIV/AIDs epidemic of the 1980s. At-risk and marginalised members of the gay and drug using communities in the USA and Europe acted in support of their own right to health, providing condoms and clean injecting equipment to their communities.

> **harm reduction champions social justice and human rights for the most marginalised**

Over time, the benefits to public health were evidenced and more interventions of this kind were officially introduced by some governments. Eventually, they were endorsed by international health agencies. And it worked; those countries which embraced harm reduction as an important health strategy saw significant falls in HIV rates among affected communities. High risk populations benefitted, but so too did the general population.

When applied to these areas of human activity, there are several key principles in play. Harm reduction responses should:

- Be **pragmatic**, accepting that substance use and sexual behaviour are part of our world and choosing to work to **minimise harmful outcomes** rather than simply ignore or condemn them;
- Focus on and **target potential harms** rather than trying to eradicate the product or the behaviour;
- Be **non-judgmental**, **non-coercive** and **non-stigmatising**;
- Acknowledge that some behaviours are safer than others and **offer healthier alternatives**;
- **Facilitate changes in behaviour** by provision of information, services and resources;
- Ensure that **affected individuals and communities have a voice** in the creation of programmes and policies designed to serve them – encapsulated in the slogan 'nothing about us without us';
- Recognise that the realities of poverty, class, racism, social isolation and other **social inequalities affect people's vulnerability to and capacity for dealing with health-related harms**.

The intersection of harm reduction and human rights

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

Harm reduction sits at the intersection between public health and human rights.

Image: Google

People have to be at the centre of decisions about their health; they need choice and to exert control over their own wellbeing. Behaviour changes will originate in, and be sustained, only if they fit with what people both want and are able to do.[13]

World Health Organization Constitution 1946:
"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

European Social Charter 1965:
"Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable".
Article 11 requires states to take measures to prevent disease and to encourage individual responsibility in matters of health.

The International Covenant on Economic, Social and Cultural Rights, 1966:
Article 12 recognizes "*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"* and that States Parties must take steps regarding *"the prevention, treatment and control of epidemic, endemic, occupational and other diseases."*

Ottawa Charter for Health Promotion, 1986:
Aims to build public policies which support health such that health promotion is an agenda item in all areas of government and organisational policy-making. *'Any obstacles to health promotion should be removed with the aim of making healthy choices the easiest choice'.*

Millions of people smoke tobacco cigarettes every day in order to consume nicotine. There is now a range of ways to consume nicotine that are significantly safer.

People who smoke tobacco have the same fundamental right to enjoy the highest attainable standard of health as non-smokers. People who smoke therefore have the right to access accurate information and products that help them achieve this.

[13] Knowledge-Action-Change (KAC) (2018). *No Fire, No Smoke: The Global State of Tobacco Harm Reduction 2018*, p14. https://gsthr.org/report/full-report

Tobacco harm reduction: the potential

No longer just ‘quit or die’, but ‘quit and try’

From the 1980s onwards, the main tobacco harm reduction product was nicotine replacement therapy (NRT) – products including patches, gum and inhalators. NRT is now the medically approved way to consume nicotine without tobacco and is on the WHO’s List of Essential Medicines. Given this, it is easy to refute any claims that the harmful chemical in a cigarette is the nicotine. Though still banned or tightly regulated in some countries, in others NRT is widely available, and in many places, it can be obtained without prescription, including by young people.

Since the mid-2000s, however, an entirely new harm reduction front for tobacco has opened up. There has been widespread uptake of nicotine vaping products among consumers in many countries, together with the realisation of significant public health gains from the switch from combustible tobacco to smokeless tobacco (snus) in Sweden, and a proliferation in the range of newer products, such as heated tobacco products and oral nicotine pouches (containing no tobacco).[14]

Image: Wikimedia Commons

In comparison to conventional tobacco control initiatives, uptake of safer nicotine products has largely occurred without any overall public health input – without encouragement or investment from governments, tobacco control experts or tobacco control NGOs. However, following consumer uptake, the UK and New Zealand gave strong policy support to this development. A few other governments are beginning to be supportive, but again, this has come after initial consumer interest.

Safer nicotine products

There is substantial international, independent evidence that the new products are demonstrably and significantly safer than traditional cigarettes.

There is no more dangerous way to consume nicotine than by smoking a tobacco cigarette.

Nicotine vaping products (also known as e-cigarettes)

These products allow the user to inhale nicotine in a vapour which contains no tar or carbon monoxide. All vaping products have three basic elements: the battery, which heats up the coil or atomiser, which turns the flavoured liquid into a vapour to be inhaled.

Most e-liquids contain four ingredients: vegetable glycerine (VG) which provides the vapour, propylene glycol (PG) which carries the flavour (although PG-free liquids are available as some people are allergic to this ingredient), nicotine, and flavouring.

> *“With vaping, you get [...] the action of smoking, you get the inhalation, the exhalation, you can choose what nicotine level you want, you can choose what flavours you want.”*
>
> Catherine [15]

[14] Foulds J. et al. (2003). Effect of smokeless tobacco (snus) on smoking and public health in Sweden. *Tobacco Control*, 12:349-359

[15] Catherine is a UK vaper interviewed for The Switch, a video made by the New Nicotine Alliance (NNA) and the National Centre for Smoking Cessation Training (NCSCT). All videos accessible at the NNA website: https://nnalliance.org/nnaresources/switch-videos

The first modern e-cigarette came onto the market in 2003. Since then, there have been numerous product developments. Vaping products range from very simple disposable or partially disposable devices through to more complicated devices which consumers can customise for themselves using different component parts or settings.

Using vaping products instead of combustible tobacco cigarettes reduces the users' exposure to multiple toxicants and carcinogens present in tobacco smoke. This means that vaping products are at least 95 per cent safer than cigarettes.[16] There is no evidence so far that second-hand vapour causes harm to bystanders.[17]

Case study: e-cigarettes in the UK – official endorsement, rapid consumer uptake, smoking in continued decline

The UK has taken many steps to embrace tobacco harm reduction. As early as 2007, use of safer forms of nicotine was endorsed by the Royal College of Physicians,[18] an endorsement that was repeated in 2016.[19] The evidence reviews by Public Health England that conclude 'e-cigarettes are 95% less harmful to your health than normal cigarettes' have been very influential. [20,21]

In the UK, e-cigarettes are tightly regulated for quality and safety. Most of the anti-smoking and health NGOs and many trusted medical bodies endorse the use of e-cigarettes as a way to help people stop smoking tobacco. These include ASH (Action on Smoking and Health),[22] Cancer Research UK,[23] the British Heart Foundation,[24] the Royal College of General Practitioners,[25] and the Royal College of Psychiatrists.[26] The importance of innovation and less harmful alternatives has been adopted within government,[27] with the Department of Health (in England) setting the ambition to go 'smoke-free' by 2030 "with smokers quitting or moving to reduced risk products like e-cigarettes."[28] **A recent randomised controlled trial in a UK NHS smoking cessation service showed that vaping was almost twice as effective as NRT in supporting smokers to quit smoking.**[29]

As of 2019, an estimated 7.1% of the total UK adult population – 3.6 million people – use e-cigarettes. Over half (54.1%) of current e-cigarette users are ex-smokers, a proportion which has grown year on year, while the proportion of dual users (people who vape who also smoke) has declined to 39.8%.

Ex-smokers report using e-cigarettes to help them quit (31%), to prevent relapse (20%), because they enjoy it (14%) and to save money (13%). Dual users report using e-cigarettes to cut down on tobacco (21%), to save money compared to smoking (16%) and to help them stop smoking (14%).[31]

[16] McNeill, A. et al. *Evidence review of e-cigarettes and heated tobacco products 2018. A report commissioned by Public Health England*. PHE, 2018 https://www.gov.uk/government/publications/e-cigarettes-and-heated-tobacco-products-evidence-review

[17] McNeill, A. et al. *Evidence review of e-cigarettes and heated tobacco products 2018. A report commissioned by Public Health England*. PHE, 2018 https://www.gov.uk/government/publications/e-cigarettes-and-heated-tobacco-products-evidence-review

[18] Royal College of Physicians, Tobacco Advisory Group. *Harm reduction in nicotine addiction: helping people who can't quit*. RCP, 2007

[19] Royal College of Physicians, Tobacco Advisory Group. *Nicotine without smoke; tobacco harm reduction*. RCP, 2016

[20] McNeill, A. et al. *E-cigarettes: an evidence update: a report commissioned by Public Health England*. PHE, 2015. https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

[21] McNeill A. et al (2018). *Evidence review of e-cigarettes and heated tobacco products 2018. A report commissioned by Public Health England.* PHE, 2018

[22] Action on Smoking and Health (ASH) website (accessed December 2019) *Harm reduction* https://ash.org.uk/category/information-and-resources/product-regulation/harm-reduction/

[23] Cancer Research UK website. *Our policy on e-cigarettes* (2019) https://www.cancerresearchuk.org/about-us/we-develop-policy/our-policy-on-preventing-cancer/our-policy-on-tobacco-control-and-cancer/our-policy-on-e-cigarettes

[24] British Heart Foundation *Smokers who switch to vaping see improvements in their blood vessel health* – a press release about the VESUVIUS study, funded by the British Heart Foundation (November 2019) https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2019/november/smokers-who-switch-to-vaping-see-improvements-in-their-blood-vessel-health

[25] Royal College of General Practitioners (RCGP) website (accessed December 2019): https://www.rcgp.org.uk/policy/rcgp-policy-areas/e-cigarettes-non-combustible-inhaled-tobacco-products.aspx

[26] Royal College of Psychiatrists Position statement: *The prescribing of varenicline and vaping (electronic cigarettes) to patients with severe mental illness* (2018) https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps05_18.pdf?sfvrsn=2bb7fdfe_4

[27] UK Department of Health (2019) *Towards a smoke-free generation: the tobacco control plan for England* p. 15, p. 27. https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

[28] UK Department of Health (2019), *Advancing our health: prevention in the 2020s – consultation document*. https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document

[29] Hajek, P., Phillips Waller A., Przulj, D. et al. (2019) A Randomized Trial of E-Cigarettes versus Nicotine-Replacement Therapy *New England Journal of Medicine* (DOI: 10.1056/NEJMoa1808779). https://www.nejm.org/doi/pdf/10.1056/NEJMoa1808779?articleTools=true

[30] Action on Smoking and Health (ASH) (2019) *Use of e-cigarettes among adults in Great Britain* https://ash.org.uk/wp-content/uploads/2019/09/Use-of-e-cigarettes-among-adults-2019.pdf

[31] Action on Smoking and Health (ASH) (2019) *Use of e-cigarettes among adults in Great Britain*. https://ash.org.uk/wp-content/uploads/2019/09/Use-of-e-cigarettes-among-adults-2019.pdf

Image: Sven Kucinic on Unsplash

Image: Antonin FELS on Unsplash

Concerns that young people would take up vaping in large numbers have not been borne out in Great Britain. Anti-smoking charity ASH's Smokefree Great Britain Youth Survey found that among 11 – 18 year olds who had never smoked, 5.5% have tried e-cigarettes at some time, 0.8% are current vapers, only 0.1% vape more than once a week. Not a single 'never smoker' reported vaping daily.[33]

> *"I had an e-cig that the Stop Smoking Nurse gave me. I tried it a couple of times and thought, yeah, this is all right – because I think it was more the habit of the smoke that I needed – so I thought, I'm gonna give it a real good go. E-cigs are the best thing that I've ever discovered. They've changed my life."*
>
> Glen[32]

Heated tobacco products

A new generation of devices called heated tobacco products has reached the market recently in many countries. These devices heat tobacco below the level of combustion to a temperature of no more than 350°C, which is sufficient to release nicotine in a vapour containing significantly reduced levels of toxins compared to combustible cigarettes.[34] Tobacco for use in heated tobacco devices is powdered and mixed with glycerine, guar gum, and other ingredients.

Heated tobacco products generate significantly lower levels of harmful constituents compared to cigarettes; in terms of cancer potency, a review of extant studies of toxicological risk and likely daily exposure indicated that cancer risk from heated tobacco products is between one and 10% that of cigarettes.[35]

[32] Glen is a UK vaper interviewed for The Switch, a video made by the New Nicotine Alliance (NNA) and the National Centre for Smoking Cessation Training (NCSCT). All videos accessible at the NNA website: https://nnalliance.org/nnaresources/switch-videos

[33] Action on Smoking and Health (ASH) (2019) *Use of e-cigarettes among young people in Great Britain*. https://ash.org.uk/wp-content/uploads/2019/06/ASH-Factsheet-Youth-E-cigarette-Use-2019.pdf

[34] Committee on Toxicity (2017). *COT Meeting: 4 July 2017*. https://cot.food.gov.uk/cot-meetings/cotmeets/cot-meeting-4-july-2017

[35] Stephens E (2018) *The role of emissions in the debate on health effects across the spectrum of nicotine delivery*. Global Forum on Nicotine, June 2018, Warsaw. https://gfn.net.co/downloads/2018/PRESENTATIONS/SATURDAY/Plenary%202/EdStephens.pdf

Case study: Japan – rapid rise in sales of heated tobacco products, rapid fall in cigarette sales

According to the WHO, 19% of Japan's adult population were daily smokers in 2015, with smoking higher among men (30%) than women (9%). These levels are much lower than the extraordinarily high percentage of male smokers in Japan back in 1968, at 78%. But the decline had, until recently, abated.

Japan does not have an overtly hostile approach to tobacco. Until 1985, the tobacco industry was a state monopoly and it still owns one-third of Japan Tobacco, Inc. (JTI), remaining the largest shareholder. Recently voluntary bans have been introduced by some companies and a street smoking ban introduced by some cities.[36] For the 2020 Tokyo Olympics there will be smoking bans in all indoor and outdoor venues and in the perimeter areas of venues.[37]

Since the tobacco industry introduced heated tobacco products to the Japanese market, in pilot areas from 2014, before a nationwide rollout in 2016, cigarette sales have dropped by an astonishing 33%.[38] Such spectacular results have never been seen as a result of the implementation of any tobacco control measure, anywhere in the world.

This dramatic transformation in cigarette sales has been brought about simply by selling a safer alternative to smoking, the use of smart marketing, and consumers deciding to switch from smoking to heated tobacco. No action was required on the part of public health and tobacco control, except perhaps to help create a climate where smokers wish to quit; it has been at no direct cost to the Japanese taxpayer.

Snus

In contrast to the new safer nicotine products, snus has been used for over 200 years, but only recently has its relative safety compared to cigarettes been confirmed by independent clinical and epidemiological investigation. Snus is a moist to semi-moist smokeless tobacco product, made from ground tobacco leaves and food-approved additives. The final product is placed in the mouth (not chewed).

Image: Swedish Match file photo

Loose snus is pinched into shape before being inserted into the mouth, often under the upper lip. 'Portion snus' is sold in small teabag-like sachets.

The nicotine content of snus varies between brands, with the most common strength being 8 mg of nicotine per gram of tobacco. Stronger varieties can contain up to 22 mg of nicotine per gram of tobacco.

> *"I have not smoked in five years using snus. Once I got over the ritual habits of smoking, I have found snus superior in every way to cigarettes."*
>
> Snus user [39]

Tobacco-free snus is a recent addition to the range. These products use other plant fibres impregnated with nicotine instead of tobacco.

[36] Mark A Levin (2013) Tobacco control lessons from the Higgs Boson: Observing a hidden field behind changing tobacco control norms in Japan. *American Journal of Law Medicine*. 39 p.471–489

[37] Paralympic Games website (2019): *Tokyo 2020 venues will be smoke-free* https://www.paralympic.org/news/tokyo-2020-venues-will-be-smoke-free

[38] The decline in sales has been calculated from Japan Tobacco Inc monthly sales and share of market.

[39] Reddit user Gunter73 (December 2019), answering a thread comparing snus use to cigarette use https://www.reddit.com/r/Snus/comments/ef3ssr/does_snus_help_relieve_stress_like_cigarettes_do/

Swedish snus is the dominant form of smokeless tobacco in the Nordic countries. It is illegal to sell snus in all European Union countries except Sweden. In Canada and several regions of the USA, it is sold alongside American-produced forms of snus, and in October 2019, the US Federal Drug Administration (FDA) granted the first ever modified risk orders to eight Swedish snus products, meaning they can be advertised with specific information about the lower risks of certain health effects compared to smoking cigarettes.[40]

A European Commission review concluded that complete substitution of smokeless tobacco products for tobacco smoking would ultimately prevent nearly all deaths from respiratory disease currently caused by smoking, and reduce the cardiovascular mortality that currently arises from smoking by at least 50%.[41] There is no significant association between snus and premature deaths, diabetes, pancreatic and oral cancers, heart disease or strokes.

> **substitution of smokeless tobacco products for tobacco smoking would prevent nearly all deaths from respiratory disease caused by smoking**

Substituting Swedish snus for high risk oral or chewed smokeless tobacco (SLT) products could be transformative to health in many LMIC. In India, for example, the use of high risk SLT products is common, especially among women, for whom it is less socially acceptable to smoke; around 70 million girls and women in India aged 15 or over are thought to use SLT on a regular basis. India has the highest global rate of oral cancer due to the high prevalence of SLT use, accounting for around 400,000 deaths annually.[42]

Case study: Sweden and snus – low rates of smoking and the lowest level of tobacco-related mortality in Europe

Sweden provides a unique case study of the impact of snus on smoking. It is the only country in the EU where snus may be sold legally. Snus dominated tobacco use in the country until the early 1900s, when the invention of the cigarette rolling machine popularised the cigarette. However, from the 1960s, the trend reversed and use of snus increased. In 1996, snus became more popular than cigarettes; the reduction in smoking was faster in men than women.

According to the European Commission's Eurobarometer report in 2017, on average, **just 5% of Swedish adults now smoke daily** – a level that is less than one fifth of the EU average of 24%.[43]

Sweden has, for men, the lowest tobacco-related mortality rate in Europe at 152 per 100,000. The rate is less than one third of the European average of 467 per 100,000.[44]

The long-term epidemiological evidence provided by this natural experiment gives us information on the uptake and plausible impact of snus on smoking and tobacco-related disease. It also acts as proof of concept for the potential efficacy and effectiveness of tobacco harm reduction, as identified by the UK Royal College of Physicians:

"The availability and use of [...] snus in Sweden [...] demonstrates [...] that a substantial proportion of smokers will, given the availability of a socially acceptable and affordable consumer alternative offering a lower hazard to health, switch from smoked tobacco to the alternative product."[45]

As a non-EU member, snus is legal in Norway. Fewer Norwegians smoke (11%) than use snus (12%). Among young women aged 16 to 24, smoking has all but disappeared (1%).[46]

[40] Federal Drug Administration (FDA) (2019). FDA authorizes modified risk tobacco products. https://www.fda.gov/tobacco-products/advertising-and-promotion/fda-authorizes-modified-risk-tobacco-products?utm_source=CTPTwitter&utm_medium=social&utm_campaign=ctp-webfeature

[41] European Commission (2008). Scientific Committee on Emerging and Newly Identified Health Risks. *Health effects of smokeless tobacco products*. Health and Consumer Protection Directorate. https://ec.europa.eu/health/ph_risk/committees/04_scenihr/docs/scenihr_o_013.pdf

[42] Gupta PC, Arora M, Sinha DN, Asma S, Parascandola M (eds.); Smokeless Tobacco and Public Health in India. Ministry of Health & Family Welfare, Government of India; New Delhi; 2016. https://www.mohfw.gov.in/sites/default/files/Final%20Version%20of%20SLT%20Monograph.pdf

[43] European Commission (2017) Special Eurobarometer 458: Attitudes of Europeans towards tobacco and electronic cigarettes https://data.europa.eu/euodp/en/data/dataset/S2146_87_1_458_ENG

[44] WHO (2012) WHO Global Report: mortality attributable to tobacco https://apps.who.int/iris/bitstream/handle/10665/44815/9789241564434_eng.pdf?sequence=1

[45] Royal College of Physicians (RCP) (2016). *Nicotine without smoke; tobacco harm reduction. A report by the Tobacco Advisory Group of the Royal College of Physicians*. Retrieved from: https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction

[46] The Norwegian Directorate of Health (2017) Statistics Norway: 2017 data https://www.ssb.no/en/helse/artikler-og-publikasjoner/snus-more-used-than-cigarettes

One billion lives at stake

Tobacco harm reduction is a pragmatic and compassionate response to one of the biggest health crises facing our world. It offers tens of millions of smokers who either cannot quit by other means, or who want to continue using nicotine, the opportunity to avoid premature death and disability.

Many millions of nicotine users have already adopted safer nicotine products, leaving combustible tobacco behind, with negligible cost to governments and taxpayers. If integrated as part of the response to tobacco use, tobacco harm reduction could make a major contribution to ending smoking.

So why is tobacco harm reduction encountering opposition from many quarters, instead of more widespread adoption and implementation?

The WHO's resistance to tobacco harm reduction

World leaders and policymakers look to the WHO for guidance on how to care for the health of their populations; its role is defined "as the directing and co-ordinating authority on international health work."[47] For low- and middle-income countries especially, with healthcare systems that may still be developing, the WHO offers an essential source of technical and policy support and practical and financial input – and its actions and leadership in many areas of health have saved hundreds of thousands of lives.

However, the WHO's relationship with harm reduction strategies is complex. The organisation and UN drug agencies resisted harm reduction in their response to the spread of HIV/AIDS and blood borne viruses among people who inject drugs. They cited unproven (and now debunked) claims that, for example, provision of clean needles was simply condoning drug use, or that harm reduction was actually a Trojan horse for the legalisation of drugs.

> **tobacco harm reduction is a pragmatic and compassionate response to one of the biggest health crises facing our world**

So far, the WHO has remained implacably opposed to tobacco harm reduction through the use of safer nicotine products. The organisation continues to urge

Image: Ryoji Iwata on Unsplash

signatories to the international legislation concerned with tobacco control, the Framework Convention on Tobacco Control (FCTC), to instigate outright product bans. The alleged Trojan horse in this context is that tobacco harm reduction is a tobacco company ruse to encourage former smokers and young non-smokers through a new product gateway either to return to, or to graduate to, smoking tobacco.

In the seventh WHO report on the global tobacco epidemic (2019), tobacco harm reduction is positioned as "a manipulative tobacco industry strategy", with the potential to "misinform and mislead consumers and confuse governments" and disrupt "genuine initiatives to assist tobacco cessation".[48]

Unfortunately, this approach is then reflected in the WHO's efforts to tackle non-communicable diseases. In December 2019, the WHO published the final report

[47] WHO Constitution (1946). https://www.who.int/governance/eb/who_constitution_en.pdf

[48] WHO (2019) *Seventh WHO report on the global tobacco epidemic*, p. 33. https://apps.who.int/iris/bitstream/handle/10665/326043/9789241516204-eng.pdf?ua=1

of the Independent High Level Commission on NCDs.[49] The report references the "common understanding" reached at the UN General Assembly in 2018 that "progress and investment to date is insufficient" to reduce premature death and disability from NCDs by 2030 (SDG 3.4).[50]

On tobacco – a leading cause of NCDs – the Commission's final report offers nothing but demand reduction. To reach the goal of reducing deaths from NCDs among the 30 – 69 age group by one third by 2030 (SDG 3.4.1), the Commission predicts that a massive 50% prevalence reduction in tobacco smoking worldwide is required.

But no countries have ever achieved a 50% drop in smoking using mainstream tobacco control measures. It cannot be done – especially as the Commission also notes that MPOWER is currently fully implemented for less than 0.5% of the world's population.[51] The only other mention of tobacco is in reference to the continued "exclusion of the tobacco industry and non-State actors that work to further the interest of the tobacco industry in line with the WHO Framework Convention on Tobacco Control (FCTC)."[52,53] However, the WHO does not try to exclude countries from participating in FCTC meetings even if their governments own substantial shares in the tobacco industry.

Image: Ray Reyes on Unsplash

The scale of the problem, and the limitations of current tobacco control measures, points to the urgent need for tobacco harm reduction to become part of the solution.

Given its leadership and influential role in global health policy, the full benefits of tobacco harm reduction in tackling non-communicable diseases – especially for the 80% of smokers who live in low- and middle-income countries – can only be realised if the WHO overcomes its antipathy towards it.

Harm reduction and the WHO Framework Convention on Tobacco Control

A close look at the WHO FCTC reveals there are, in fact, three strategies the Convention defines as making up tobacco control:

> *"For the purposes of this Convention, 'tobacco control' means a range of* **supply, demand and harm reduction strategies** *that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke."* (emphasis added)
>
> The Framework Convention on Tobacco Control 2005, Article 1d.[54]

[49] The Independent Commission (October 2017 - October 2019) was convened to "advise [the Director General] on bold and at the same time practical recommendations on how to transform new opportunities to enable countries to accelerate progress towards SDG target 3.4 on NCDs."
WHO Independent High Level Commission on Non-Communicable Diseases, Terms of Reference (publication date unknown).
https://www.who.int/ncds/governance/high-level-commission/NCDs-High-level-Commission-TORs.pdf?ua=1

[50] WHO, *Independent High Level Commission on Non-Communicable Diseases Final Report* (December 2019) https://who.canto.global/b/JG898 (Password 689764)

[51] WHO, *Independent High Level Commission on Non-Communicable Diseases Final Report* (December 2019) https://who.canto.global/b/JG898 (Password 689764)

[52] WHO, *Independent High Level Commission on Non-Communicable Diseases Final Report* (December 2019) https://who.canto.global/b/JG898 (Password 689764)

[53] Article 5.3 of the WHO FCTC: *In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.* WHO (2005) Framework Convention on Tobacco Control.
https://www.who.int/tobacco/framework/WHO_FCTC_english.pdf

[54] WHO (2005) Framework Convention on Tobacco Control. https://www.who.int/tobacco/framework/WHO_FCTC_english.pdf

From its inception, the FCTC – the WHO's cornerstone document on tackling the tobacco crisis – has acknowledged that 'tobacco control' should include harm reduction strategies.

The WHO must shift the balance to incorporate a strategy that it already – apparently – endorses.

When 'better safe than sorry' isn't better

The 'precautionary principle' codifies the adage 'better safe than sorry' for policymakers of all kinds: it advocates for the adoption of precautionary measures when evidence is uncertain, and the stakes are high.

The global public health world is divided on tobacco harm reduction and for many, the 'precautionary principle' wins out. Citing uncertainty over a range of issues, such as short- and long-term health harms of safer nicotine products, the risk of gateway progression to smoking or nicotine dependency in young people, or continued smoking through dual use, many in public health would rather apply the precautionary principle than adopt tobacco harm reduction measures.

Rational application of the precautionary principle is right and proper in many areas of human activity. In tobacco harm reduction, however, application of the precautionary principle is not rational. It ignores the extraordinarily high and well-documented stakes of the status quo – seven million lives lost to tobacco-related disease every year. It also dismisses a significant and constantly growing international evidence base addressing many of the concerns. Being extremely cautious about potential risks, while ignoring huge and likely potential benefits, is not an appropriate way to implement the precautionary principle.

> **in tobacco harm reduction, application of the precautionary principle is not rational**

Just because we don't know everything, does not mean that we don't know anything about safer nicotine products.

A rational approach to 'Big Tobacco'

Reasoned suspicion of the tobacco industry and its motives mean that many understandably find it difficult to accept that the market – and the industry which caused so many problems – could be part of the solution.

But as the market for their products wanes in higher income countries, due in no small part to the implementation of tobacco control measures, the industry has recognised the disruptive power of innovative products to reduce their profits. They still manufacture and sell cigarettes, but many are also investing in new risk-reduced products.

Product research and development in order to support innovation of this type requires sustained, significant investment. That investment is not currently forthcoming from philanthropy or public health.

Perhaps a more rational approach accepts that "businesses can adopt business practices and market products that are either health harming or innovative products that are health-improving or displace health-harming products. Sometimes the same companies can do both."[55]

A rational approach to nicotine

Public health thinking has been dominated by the tobacco control narrative for decades so that all tobacco use is seen as a problem. The lens through which professionals have viewed the issue has been 'anti-tobacco' for so long that it is understandably challenging to abandon this view to move towards a 'neutral' stance on nicotine use without tobacco combustion.

But is objection to the use of nicotine rooted in moral or ideological constructs rather than clinically-based health concerns?[56]

Global public health has made enormous strides in combatting infectious diseases; two have been eradicated, smallpox and rinderpest, with programmes now tackling polio, yaws and malaria.

Five more infectious diseases have been identified as potentially eradicable. One of them is measles. Yet the proliferation of fake news communicated by lay anti-vaccine

[55] Joint consultation submission to the WHO High Level Commission on NCDs by David Abrams, Clive Bates, Ray Niaura and David Sweanor (2018) https://www.who.int/ncds/governance/high-level-commission/Ottawa-University.pdf?ua=1

[56] Knowledge-Action-Change (KAC) (2018). *No Fire, No Smoke: The Global State of Tobacco Harm Reduction 2018*, p.70. https://gsthr.org/report/full-report.

groups has had a very real impact on many thousands of lives. Myth and misinformation about the measles vaccine has seen increases in outbreaks in both high- and low-income countries, reversing the trends towards eradication in higher income countries.

Anti-tobacco harm reduction information, on the other hand, has come from official government, medical and public health sources in many countries and from within the WHO itself.

There is an underlying philosophical problem here. Aside from misguided activists, few could argue that everything should be done to eradicate a communicable and infectious killer disease.

But when it comes to non-communicable diseases, which are often seen in public health ranks as the result of lifestyle choices, then the battle can be framed in moral terms rather than health pragmatism. For some in public health, the pleasurable aspects of nicotine consumption for consumers can be hard to embrace.

People who use nicotine in properly regulated safer nicotine products do so without causing themselves or society significant harm.

The response to the global public health crisis of tobacco-related illness could be transformed if policymakers separated 'nicotine use' from 'tobacco consumption'.

> *"I was surprised how the desire to vape or smoke disappeared completely as soon as I switched to snus. It's much more enjoyable and the nicotine lasts much longer. I can trail run without getting out of breath and cigarettes smell like hell now."*
>
> Snus user [57]

Medical myth, misinformation and media muddle

The tobacco industry has a long history of egregious duplicity over the consequences of smoking. This history, combined with an underlying antipathy to the non-medical use of nicotine, has led to the creation of a broad coalition of academics, clinicians, anti-tobacco campaigners and government and medical agencies who unite to condemn tobacco harm reduction. Their campaigning is often well-funded by philanthropic and international bodies.

Independent harm reduction evidence and its authors have been vilified, for example, with misrepresentation of evidence about the dangers of vaping compared to smoking, and disputes over the role of safer nicotine products in aiding smokers to switch from smoking or quit altogether. Much of the media, interested only in 'bad news' stories, often focuses its attention here. This causes confusion and mistrust among both smokers and health professionals.

Deaths and illness linked to vaping in the US in 2019 – wrongly and consistently attributed solely to vaping nicotine liquid – are a case in point. Investigating agencies, and therefore mainstream media, took months to identify and communicate clearly that the majority of affected users were vaping THC liquids containing additives harmful to human health if inhaled, including thickening agent Vitamin E acetate.[58,59] Some surveys have shown that more current smokers now believe vaping is as dangerous as smoking – with the inevitable outcome that they continue smoking tobacco.[60]

The inconvenient truth is that proponents of tobacco control who argue against access to safer nicotine products are paradoxically perpetuating the sale and use of the very thing they are trying to eradicate: the tobacco cigarette. They are supporting the industry they are focused on destroying, to the detriment of wider public health concerns. The inescapable truth is that antipathy to tobacco harm reduction protects and supports much higher risk cigarettes.

[57] Reddit user BeatDukeAutomaton (December 2019), answering a thread comparing snus use to cigarette use https://www.reddit.com/r/Snus/comments/ef3ssr/does_snus_help_relieve_stress_like_cigarettes_do/

[58] Blount, B., Karwowski, M., Shields, P. et al (2019) Vitamin E Acetate in Bronchoalveolar-Lavage Fluid Associated with EVALI New England Journal of Medicine (DOI: 10.1056/NEJMoa1916433) https://www.nejm.org/doi/full/10.1056/NEJMoa1916433#article_Abstract

[59] Boyd, C. (2019) Vaping and lung disease: the CDC's lesson in how not to handle an illness outbreak. *Filter magazine*. https://filtermag.org/vapes-and-lung-disease-the-cdcs-lesson-in-how-not-to-handle-an-illness-outbreak/

[60] Action on Smoking and Health (ASH) (2019) *Use of e-cigarettes among adults in Great Britain*. https://ash.org.uk/wp-content/uploads/2019/09/Use-of-e-cigarettes-among-adults-2019.pdf

Tobacco harm reduction: protecting health and upholding human rights

Harm reduction is an evidence-based public health strategy grounded in human rights. It enables people to make healthier choices and live healthier lives.

The 1.1 billion people who smoke tobacco every day in order to use nicotine must not be denied access to products that can help them avoid poor quality of life, disease, and premature death.

Wherever they live, people who use nicotine should have the right to gain access to information, services and products that can reduce the harms they face, enabling them to achieve a higher quality of health and life should they wish to do so. Just like everyone else, people who use nicotine deserve to achieve their fullest health potential.

Individual governments should adhere to their obligations under the international covenants they are party to, to create policy, regulation and legislation that enables people who smoke to make healthier choices. At present, only a few governments are fully allowing and facilitating these rights.

> *"As I've continued to use an e-cigarette, I've found that the strength of nicotine [I use] is gradually getting lower and lower. I'm a non-smoker now, and I will never turn back."*
>
> Paul [61]

Consumers want safer nicotine products. Many millions have already chosen to switch away from combustible tobacco – at negligible cost, and with significant benefits, to governments and taxpayers.

But the public health potential of tobacco harm reduction cannot be realised if regulation and control decisions continue to be based on sensational media coverage, flawed science and misleading public information.

If the WHO is to meet its ambitious goals to tackle non-communicable diseases, it must recognise, adopt and communicate the benefits of tobacco harm reduction to governments, policymakers and the public.

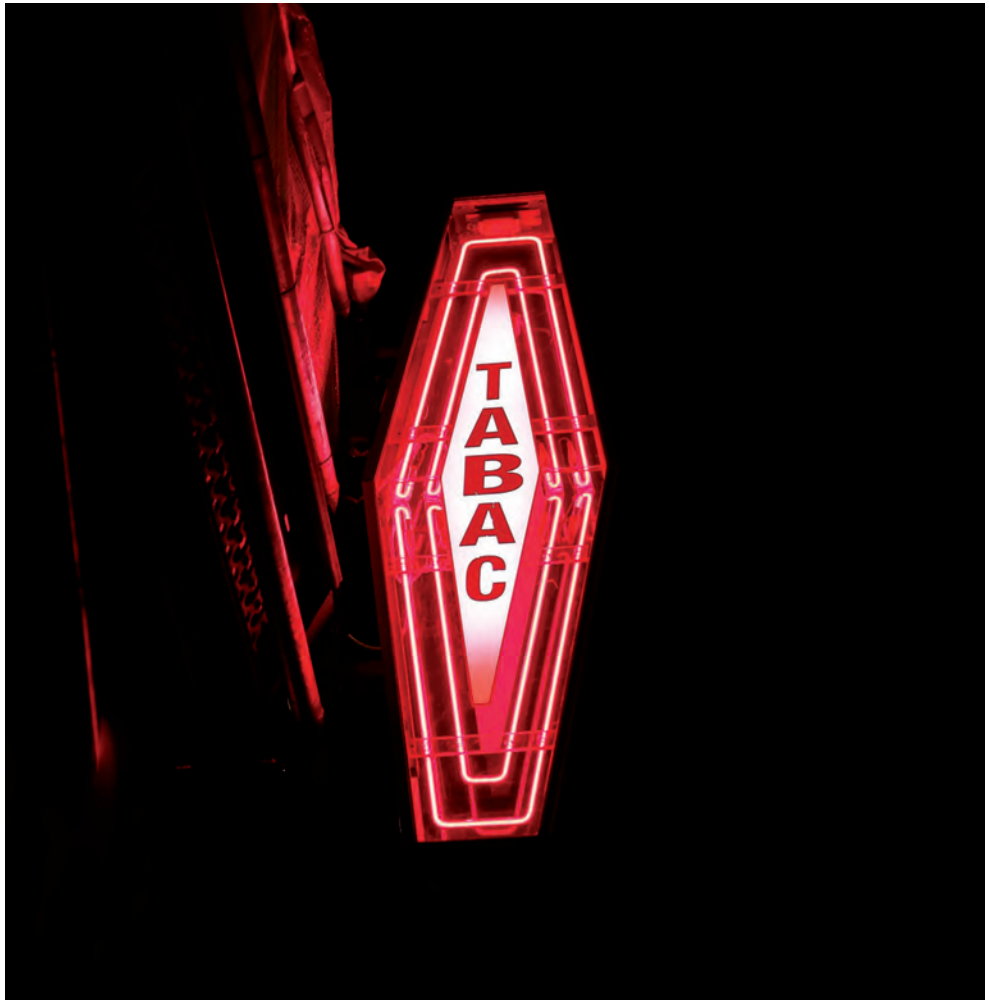

Image: Ray Reyes on Unsplash

When tobacco harm reduction is properly integrated into the response to the health crisis caused by tobacco smoking, deaths and disease will reduce – and faster than tobacco control measures will ever achieve alone.

Tobacco harm reduction protects health and upholds human rights. A billion lives are at stake.

[61] Paul is a UK vaper interviewed for The Switch, a video made by the New Nicotine Alliance (NNA) and the National Centre for Smoking Cessation Training (NCSCT). All videos accessible at the NNA website: https://nnalliance.org/nnaresources/switch-videos