Better to let them smoke and die?
Bloomberg-funded INGOs logic for LMICs is baffling and worrying

Derek Yach

Imagine the outrage if an international non-governmental organization (NGO) focusing on drug abuse called for naloxone manufacturers to not sell their products in low- and middle-income countries (LMICs) on grounds that it would confuse regulators and the public, suggesting instead that they focus on ending opioid abuse using only regulatory and educational approaches? How would NGOs in these countries react if this international NGO went further and called on governments to ban the use of naloxone? Recall that naloxone is about 85-95% effective in preventing death from an opioid overdose.

There is no doubt that if this were the case, governments in LMICs would vigorously oppose such calls and terminate any relationships they had with the NGO. They would argue that effective means of preventing death and improving health should be made universally available. More importantly, they would work to ensure affordability in the poorest countries and communities. This has been the logic applied to access to essential medicines for decades and is underpinned by human rights laws enshrined in several United Nations resolutions taking into consideration domestic law in many countries.

The Union, a major international NGO well financed by the United States (US)-based Bloomberg Philanthropies, recently called on LMICs to ban e-cigarettes and heated tobacco products on grounds that governments need to first strengthen their tobacco control policies, and not get distracted by these tobacco harm reduction (THR) products. The logic is baffling and worrying.

They seem to believe that it is better to let smokers of combustible cigarettes or 'beedis,' or users of a range of toxic smokeless tobacco products in India continue to die from their use, than have access to a range of THR products deemed as less harmful by the US FDA (in the case of snus and IQOS) or Public Health England (in relation to e-cigarettes). Further, they believe that only when tobacco control has reduced all tobacco use should these products be allowed.

Let's take a step back and remember the stakes. In India, there are 267 million users of tobacco, nearly 200 million people use smokeless tobacco products, nearly 72 million use 'beedis' and 37 million use cigarettes. Tobacco use results in one million premature deaths annually from a range of diseases that include oral cancer, lung cancer, tuberculosis, heart disease and chronic lung disease or 9.5% of all deaths in India. Millions more suffer with ill health caused by these conditions. Further, in the context of India, tobacco use is higher in rural areas, among those from poorer households, and those with lower levels of education. Having spent decades in global health, including at the WHO, I find it tough to accept that there has not been a serious and concerted demand that the Union's position be questioned and rejected. It sets a terrible precedent if a US-based philanthropy's effort to adversely influence the policies of governments in ways that may cost millions of lives is allowed to go unopposed.

The writer is President of the Foundation For A Smoke Free World, USA.

Missing Link

The primary tobacco control law in Pakistan—the Prohibition of Smoking in Enclosed Places and Protection of Non-Smokers Health Ordinance—was promulgated almost two decades back in 2002. The Ordinance prohibits the use of tobacco in places of public work or use, including public service vehicles, and seeks to protect the health of non-smokers. It bans the advertisement of tobacco products, cigarette sales to minors, and sale or distribution of cigarettes near educational institutions. However, the Ordinance is silent on the provision of smoking cessation services, which are resultantly missing from public and private healthcare sectors in Pakistan. Smokers who want to quit are on their own. Earlier in 1979, the Cigarettes (Printing of Warning) Ordinance required printing of health warnings on tobacco product packaging. After passage of the 2002 tobacco control law, no new legislation has been enacted at the federal and provincial levels, except for measures such as advertisement guidelines, and printing of pictorial health warnings on cigarette packs, etc., which were introduced through subordinate legislation known as Statutory Regulatory Ordinances.

Unfortunately, Pakistan has failed to devise a national strategy on tobacco control, though it became party to the Framework Convention on Tobacco Control back on February 27, 2005. Although the country did take several tobacco control measures over the last two decades, it appears helpless in the face of growing number of tobacco users. According to latest estimates, there are over 25 million tobacco users in Pakistan. After passage of the 18th Amendment, health became a provincial subject. Worryingly, the provincial governments are nonplussed regarding tobacco use. Today, the world is examining and discussing the role of tobacco harm reduction in helping smokers quit or switch to alternative nicotine delivery systems. The government needs to reinvigorate its efforts for a smoke-free Pakistan. The federal and provincial governments should work together on forging new laws, policies, and regulations for tobacco control in consultation with all stakeholders. Most importantly, scientific evidence should be taken into account when making policies on tobacco harm control. Instead of the knee jerk reaction of banning it, scientific evidence on how tobacco harm reduction can be an essential part of the solution to combustible smoking must be carefully studied.

Bans of nicotine alternatives will do more harm than good

In 2020, The International Union Against Tuberculosis and Lung Disease (The Union) published its fourth position statement on e-cigarettes, calling for a blanket ban on all electronic nicotine delivery systems (ENDS) and heated tobacco products (HTPs) in low- and middle-income countries (LMICs).

The International Network of Nicotine Consumer Organisations (INNCO) has developed a report in response to The Union, titled '10 reasons why blanket bans of e-cigarettes and HTPs in low- and middle-income countries (LMICs) are not fit for purpose.' The objective of the report is to spark conversation about the right to reduce harm as a human rights issue and to highlight the inherent injustice associated with denying people access to safer alternatives simply because of where they live. The 10 reasons outlined in the report are:

1. **Bans are an overly simplistic solution to a complex issue:** While smoking prevalence remains high, progress in 'tobacco control' has been limited. Global tobacco control policies such as MPOWER are unworkable in many LMICs due to lack of access to smoking cessation services, hence underlining the need for pragmatic approaches including the availability of a wide selection of products proven to reduce harm.

2. **Prioritizing the banning of reduced harm alternatives over cigarettes is illogical:** Nicotine itself does not cause smoking-related diseases. An expert independent review published by Public Health England concluded that e-cigarettes are at least 95% less harmful than smoking. It seems illogical to apply a ban only to reduce harm alternative products and not to cigarettes, which are significantly more harmful.

3. **Reduction and substitution are valid goals for smokers in LMICs:** Replacing combustible tobacco with alternative nicotine products can significantly reduce risk of harm by at least 95%. Studies show that intention to quit is dramatically lower in LMICs than High-Income Countries (HICs). With NRT unaffordability and current tobacco control strategies in many LMICs showing meager results, adding accessible, market-driven harm reduction measures is a vital way forward.

4. **People who smoke have the right to choose to reduce their own risk of harm:** Every smoker should have the right to choose their own path to better health. By removing reduced harm alternatives from the market – while leaving the significantly more dangerous cigarettes available – countries would remove this right from the individual.

5. **Reduced harm alternatives can significantly contribute to the aims of global tobacco control:** Reduced harm products are an essential part of the tobacco control equation. The FCTC itself recognises 'harm reduction' as a key strategy in tobacco control, and states that "tobacco control means a range of supply, demand and harm reduction strategies." However, very few countries have adopted all or even most of the MPOWER measures at best-practice level.

6. **Lack of research in LMICs is not a valid reason to ban reduced harm alternatives:** Lack of research in LMICs is not in itself a reason to reject and ban harm reduction methods, including reduced-harm alternative tobacco products. Just as the MPOWER evidence has not been developed for every country, neither should evidence of reduced harm alternatives be required in every nation. Yes, more research needs to be conducted in LMICs on tobacco control and specifically harm reduction measures – but we should not deny people living in poor and developing countries access to potentially life-saving products in the meantime.

7. **The prohibitionist approach in LMICs is outdated, unrealistic and condescending:** A 'prohibitionist approach' does not allow for finding innovative solutions to the challenge of decreasing the use of combustibles across the spectrum. Embracing reduced-harm alternatives would be pragmatic, and could save many lives.

8. **Bans in LMICs will lead to illicit markets with increases in crime and no tax revenue:** Blanket bans do not work. Rather than achieving a public health goal, banned products are pushed underground into uncontrolled illicit markets, leading to increases in crime and depriving governments of tax revenue. A blanket ban on e-cigarettes will lead to the same outcome, but also deny people who smoke and want to use safer products a chance to switch.

9. **Banning reduced harm alternatives leads people back to smoking and greater harm:** The risk and harm associated with cigarettes is conclusive. Yet it is not cigarettes that The Union is calling to ban in LMICs, but their less harmful substitutes. The simple fact is that without alternative options – and faced with the old fashioned "quit or die" approach – many will continue to smoke or return to smoking.

10. **Blanket bans in LMICs are a form of 'philanthropic colonialism:'** Global organisations such as the WHO, Bloomberg Philanthropies and The Union wield great influence in LMICs through sponsorship of healthcare programs and public initiatives. This influence manifests itself through top-down policymaking approaches, telling LMICs what is best for them. A better use of investment would be to fund local research to help LMICs develop their own insights and solutions for their respective situations.

Full policy report available at https://innco.org/why-bans-in-low-middle-income-countries-dont-work/

GFN21 scheduled for June 17-18

The 8th edition of the Global Forum on Nicotine (#GFN21) https://gfn.events/ will take place in Liverpool on June 17-18. Based on the theme 'The Future for Nicotine,' GFN21 will address some of the concerns prompted by recent reviews and reports that will have an impact in different parts of the world, as well implications for discussions at the postponed FCTC COP 9 meeting, later this year (programme outline available at https://gfn.events/programme).

Since there will still be restrictions preventing many people from travelling and participating in the conference, its proceedings will be broadcast live via the GFN·TV platform. Participants will have opportunities to chat online and to have their short presentations posted on the conference website and available during the event (visit https://gfn.events/gfn-fives for more information). Some conference content will be posted online in advance to provide time for presenters to engage in live hosted panel discussions.

Free event registration can be done by visiting https://gfn.events/register-now. Registration fee to attend the conference in person is £60 (inclusive of VAT).

Smoking prevalence among world's indigenous peoples mostly neglected

Very few countries are monitoring tobacco smoking status among indigenous people, new research has found. This is despite that the World Health Organisation has warned that indigenous peoples are being left behind by global tobacco control efforts.

Titled 'Smoking Prevalence Among Indigenous Peoples of the World,' the report has been produced by the Centre of Research Excellence: Indigenous Sovereignty and Smoking, which has an international focus on reducing tobacco-related harms among indigenous peoples globally.

"We found a small number of studies on smoking among one or some indigenous peoples for another 10 countries. These studies appeared to be researcher-initiated and they occurred irregularly. There is clearly no plan to address the invisibility of smoking among most of the world's indigenous groups," said the lead author Dr. Marewa Glover, one of New Zealand's leading tobacco control researchers.

"Smoking prevalence is disproportionately higher among some of the indigenous people compared to the non-indigenous peoples in the same countries. If smoking prevalence is higher, then so too might the smoking-related disease burden and deaths be higher. The overwhelming lack of data makes it impossible to know how widespread

this inequity is. It also perpetuates the neglect of indigenous people's health needs," Dr. Glover said.

"This report sets a baseline for monitoring global progress on reducing smoking for indigenous peoples. Gaps in information are identified providing a useful guide for researchers looking to make a real difference for indigenous peoples," Dr .Glover said.

Smoking tobacco is associated with an estimated 6.2 million premature deaths globally per year. Because of that, reducing tobacco smoking is a key objective if the SDG target to reduce premature deaths from noncommunicable diseases by one-third by 2030 is to be reached.

Indigenous peoples number over 476 million, making up about 6% of the world's population. Their right to be recognized as distinct population groups is set out in the UN Declaration on the Rights of Indigenous Peoples, which most of the countries reviewed for the study have signed up to. But of the 105 countries presented in the report, only 5 governments had smoking statistics for their indigenous people.

Full report available at https://coreiss.com/file/display/publication/22/smoking_prevalence_among_indigenous_peoples_of_the_world.pdf

Menthol cigarette ban has limited impact on smoking prevalence in EU

The menthol cigarette ban, which went into effect for the European Union's 27 member countries on May 20 last year, has resulted in limited impact on smoking prevalence in the EU. According to surveys of adult menthol cigarette smokers in eight EU countries before and after the ban, post-ban survey responses mirrored the pre-ban counterparts, with few exceptions.

The data indicates that quit rates among adult menthol cigarette smokers were relatively low, at approximately 8% overall in the post-ban survey. Across the eight markets, an average of 40% of respondents indicated that they reduced their menthol cigarette consumption, but either continued or increased their consumption of non-menthol varieties. Nearly 20% surveyed switched to other menthol tobacco products not affected by the ban, with a majority having switched to e-cigarettes. Thirteen percent of the respondents started

buying menthol cigarettes from other sources; and another 13% began buying products to manually add a menthol flavour to regular tobacco products. In the post-ban survey, about one-quarter of respondents were not aware of the ban.

The surveys were sponsored by the Foundation For A Smoke Free World to evaluate the validity of the supposition that such a ban would discourage people from starting smoking or encourage them to quit. Details of survey available at https://www.smokefreeworld.org/eu-menthol-cigarette-ban-survey-2/

Source: *Euromonitor Post-ban Store Audits, July-November 2020*

To know more about us, **please visit: www.aripk.com** and **www.panthr.org**
Follow us on **www.facebook.com/panthr.emr** | **https://twitter.com/panthr4** | **https://instagram.com/panthr.ari**
Office # 08, First Floor, Al-Anayat Mall, G-11 Markaz, Islamabad, Pakistan   **Tel:** +92 51 8449477   **Email:** info@aripk.com