

## **10 reasons why blanket bans of e-cigarettes and HTPs in low- and middle-income countries (LMICs) are not fit for purpose**

### **Introduction**

In 2020, The International Union Against Tuberculosis and Lung Disease (The Union), a Bloomberg partner for ‘The Initiative to reduce tobacco use’, published its fourth position statement on e-cigarettes.<sup>1</sup> In it, The Union called for a blanket ban on all electronic nicotine delivery systems (ENDS) and heated tobacco products (HTPs) in low- and middle-income countries (LMICs).<sup>2</sup>

The Union stated:

*In an abundance of caution, the sale of these products should be banned in LMICs; similarly, they should not be manufactured, imported or exported and should also be subject to TAPS (Tobacco Advertising, Promotion, and Sponsorship) bans and smokefree legislations.<sup>1</sup>*

ENDS – otherwise known as e-cigarettes or vaping devices by the consumers who use them – represent a mixed class of products that use an electrically powered coil to heat and transform a nicotine-containing liquid into an aerosol, which is inhaled by the user. HTPs are a class of alternative products that heat tobacco to create an aerosol, which the user inhales. Both are associated with significantly reduced harm compared to traditional cigarettes.

This response to The Union’s report is published by The International Network of Nicotine Consumer Organisations (INNCO), which was formed in 2016 to represent and support consumers of low-risk, alternative nicotine products and to promote Tobacco Harm Reduction (THR) on the global stage. We passionately champion human rights, empowerment of consumers to make safer choices, and pragmatic solutions to combat use of high-risk forms of tobacco.

This document presents 10 reasons why The Union’s proposal to impose a multi-continental ban on e-cigarettes and HTPs has the potential to cause significantly more harm than good.

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<sup>1</sup> The Union. 2020. Where bans are best. Why LMICs must prohibit e-cigarette and HTP sales to truly tackle tobacco. Retrieved from [https://theunion.org/sites/default/files/2020-08/TheUnion\\_TobaccoControl\\_E-CigPaper\\_English\\_07.pdf](https://theunion.org/sites/default/files/2020-08/TheUnion_TobaccoControl_E-CigPaper_English_07.pdf)

<sup>2</sup> LMICs include the majority of the world’s countries and territories – 135 of a total of 218 – in the World Bank classification and by far the majority (84%) of the world’s population: LMICs have 6.44 billion people compared to 1.24 billion in high-income countries (World Bank, 2020). LMICs include countries like Turkey, Mexico, China, South Africa and Malaysia.

**The 10 reasons outlined in this report are:**

1. Bans are an overly simplistic solution to a complex issue and will not work
2. Prioritising the banning of reduced harm alternatives over cigarettes is illogical
3. Reduction and substitution are valid goals for smokers in LMICs
4. People who smoke have the right to choose to reduce their own risk of harm
5. Reduced harm alternatives can significantly contribute to the aims of global tobacco control
6. Lack of research in LMICs is not a valid reason to ban reduced harm alternatives
7. The prohibitionist approach in LMICs is outdated, unrealistic and condescending
8. Bans in LMICs will lead to illicit markets with increases in crime and no tax revenue
9. Banning reduced harm alternatives leads people back to smoking and greater harm
10. Blanket bans in LMICs are a form of ‘philanthropic colonialism’

## ***Foreword by Samrat Chowdhery, President of INNCO***

The global drive to reduce the harm caused by combustible tobacco is a laudable and necessary mission. However, 17 years after the adoption of the WHO Framework Convention on Tobacco Control (FCTC) treaty, several inconvenient truths remain around the global response.

These truths are often overlooked by policymakers because they don't conform to their narrative or methodology. But until these are taken into account, overly simplistic solutions – such as The Union's proposed ban on all ENDS and HTPs in LMICs – will continue to be offered as a blunt and impractical tool for a situation that requires pragmatism and nuance, making meaningful and sustainable change more difficult.

What are these inconvenient truths?

The first is that people who smoke are individuals with their own needs and rights, living in diverse circumstances. Policymakers often overlook this, lumping them together into an amorphous group – particularly those living in LMICs. Regional variations require local considerations. In India for example, there are significantly more users of smokeless tobacco, often high-risk non-food grade smokeless tobacco, than cigarettes smokers.<sup>3</sup> Traditional cessation services may not work in such an environment and for all tobacco users.

The second is that pragmatic approaches are absolutely essential to improve outcomes. On a global scale, 'tobacco control' has, in truth, not proven terribly effective. Over 1.3 billion people in the world still use tobacco. The lack of healthcare infrastructure in many countries makes the scale of the task to reduce tobacco use inherently complex and puts the onus on individuals to reduce their harm and risk. Individuals deserve to have awareness about, and access to, all options available to them, especially when their own health – and that of their families – is on the line. "Quit or die" cannot be the only alternatives we offer them.

Another inconvenient truth is the fallacy of The Union assertion that LMICs do not have the regulatory capacity to manage and oversee a market of ENDS and HTPs, and yet somehow will be able to enforce a ban. Such approaches have been proven time and again to lead to thriving illicit markets, which in turn diverts precious resources into fruitless attempts to stop them. Enforcing sustainable regulation is simpler (and significantly more beneficial) than enforcing prohibition.

Equally irrational is that the proposed prohibitionist policy would apply only to the low-risk alternatives and not to high-risk products (i.e. combustible cigarettes). What justification can there be for denying a smoker access to a much safer product while leaving cigarettes on the market?

The final inconvenient truth is one I feel passionately about. LMICs are not a homogenous entity. The bracket includes a vast range of countries, cultures, economies, geographies and people. The Union's proposed ban is inappropriate policy that is not right for any LMIC, but to take such a simplistic, one-size-fits-all approach to all of them smacks of "philanthropic colonialism" – a basic approach imposed

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<sup>3</sup> Global Adult Tobacco Survey 2017. Fact sheet India 2016-17. Retrieved from: [https://www.who.int/tobacco/surveillance/survey/gats/GATS\\_India\\_2016-17\\_FactSheet.pdf?ua=1](https://www.who.int/tobacco/surveillance/survey/gats/GATS_India_2016-17_FactSheet.pdf?ua=1)

upon countries, rooted in the damaging and paternalistic belief that these countries and their citizens cannot be trusted with any level of self-determination or complexity. It pitches inhabitants of LMICs as second-class citizens. Which is, to say the least, offensive.

The intentions of policymakers are generally good, but the truth is that they are often detached from the reality of what is happening on the ground. This is why it is important that the voice of nicotine users in LMICs – as consumers, people who smoke, vapers, people wanting to quit or reduce or substitute, and simply as residents in LMICs – are heard and respected.

LMICs are a heterogeneous and complex assortment of countries. A blunt instruments such as a blanket ban on alternative products will not improve the situation – I believe it will actually worsen it. Every individual deserves the right to choose their own journey towards improving their health.

Therefore, on behalf of those in LMICs, we say loud and clear – **nothing about us without us.**

## **10 reasons why blanket bans of ENDS and HTPs in LMICs are not fit for purpose**

### **1. Bans are an overly simplistic solution to a complex issue and will not work**

The dangers associated with smoking are well known. It is the leading cause of preventable death worldwide, causing more than 8 million deaths per year.<sup>4</sup>

However, progress in ‘tobacco control’ has been limited. Smoking prevalence remains high, with around 1.3 billion tobacco users worldwide – and over 80% of those live in LMICs.<sup>3</sup>

Even in a country like Turkey – an LMIC that is often cited as a success story for having implemented all of the MPOWER strategies – prevalence of smoking has in fact increased, from 27.1% in 2012 to 31.6% in 2016.<sup>5</sup>

Global tobacco control policies such as MPOWER are unworkable in many LMICs due to lack of access to smoking cessation services and other resources. This puts the onus on individuals to make choices to improve their health. There is no benefit in limiting these choices, only the potential for increasing harm.

In this context, it is clear that pragmatic approaches are needed, including the availability of a wide selection of products proven to reduce harm.

Conversely, simplistic solutions to complex public health challenges may be attractive, but they do not work in the long run. Any move to ban harm reduction products, and the almost certain subsequent increase in illicit markets (see Point 8), needs to be evaluated carefully, including open-minded consultations with stakeholders, including consumers, before being implemented.

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<sup>4</sup> WHO Tobacco Fact sheet, 2019. *WHO*. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/tobacco>

<sup>5</sup> Global Adult Tobacco Survey 2016. Fact sheet Turkey 2016-17. Retrieved from: [https://www.tobaccofreekids.org/assets/global/pdfs/en/GATS\\_Turkey\\_2016\\_FactSheet.pdf](https://www.tobaccofreekids.org/assets/global/pdfs/en/GATS_Turkey_2016_FactSheet.pdf)

## 2. Prioritising the banning of reduced harm alternatives over cigarettes is illogical

While smoking is well known to cause harm, nicotine does not itself cause smoking-related diseases.<sup>6</sup> This has been verified in a number of clinical trials of nicotine replacement therapies (NRTs).

It is exposure to the toxic chemicals released when tobacco is combusted (e.g. when a cigarette is lit) and the fumes from burning tobacco leaves are inhaled that primarily causes life-threatening diseases and premature deaths.

But today, safer non-combustion nicotine products, such as e-cigarettes, HTPs and snus, are available, and are significantly less harmful than smoking. An expert independent evidence review published by Public Health England (PHE) concluded that e-cigarettes are at least 95% less harmful than smoking.<sup>7</sup> Another PHE report concluded on HTPs that “the available evidence suggests that heated tobacco products may be considerably less harmful than tobacco cigarettes and more harmful than electronic cigarettes”.<sup>8</sup> In its ruling on an HTP, the U.S. Food and Drug Administration (FDA) concluded that marketing the product is “appropriate for the protection of the public health because, among several key considerations, the products produce fewer or lower levels of some toxins than combustible cigarettes”.<sup>9</sup> Similarly, the U.S. FDA has concluded that completely switching from smoking cigarettes to using certain snus products lowers health risks.<sup>9</sup>

With this in mind, it seems illogical to apply a ban only to reduced harm alternative products and not to cigarettes, which are significantly more harmful. By denying smokers access to a much safer alternative while leaving cigarettes on the market, policymakers would leave only two options on the table – quit or die. With a wide range of safer nicotine products readily available, this approach is unnecessary and makes little sense.

It should be noted that many LMICs are already quite familiar with non-combustible tobacco products in the form of various oral smokeless tobacco (e.g. gutkha, pan masala, chew, etc.), although some of these are associated with significant risks, similar to smoking. It is important not to forget users of

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<sup>6</sup> Nicotine without smoke, 2016. 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>

<sup>7</sup> PHE Review, 2019. E-cigarettes around 95% less harmful than tobacco estimates landmark review. *Public Health England Expert Review*. Retrieved from <https://www.gov.uk/government/news/e-cigarettes-around-95-less-harmful-than-tobacco-estimates-landmark-review>

<sup>8</sup> McNeill A, Brose LS, Calder R, et al. 2018. Evidence review of e-cigarettes and heated tobacco products 2018. A report commissioned by Public Health England. London: Public Health England. Retrieved from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/684963/Evidence\\_review\\_of\\_e-cigarettes\\_and\\_heated\\_tobacco\\_products\\_2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684963/Evidence_review_of_e-cigarettes_and_heated_tobacco_products_2018.pdf)

<sup>9</sup> FDA new release, 2019. The U.S. Food and Drug Administration. FDA News release: FDA grants first-ever modified risk orders to eight smokeless tobacco products. Retrieved from <https://www.fda.gov/news-events/press-announcements/fda-grants-first-ever-modified-risk-orders-eight-smokeless-tobacco-products>



smokeless tobacco when we talk about harm reduction. Smokeless tobacco consumers using high-risk forms of oral tobacco should be given information about, and access to, reduced harm products too.

### 3. Reduction and substitution are valid goals for smokers in LMICs

An individual who smokes may not be ready to quit but may be ready to take action in some way to reduce risk. Smoking reduction for example, has been shown to be a promising intervention, which may lead to complete cessation.<sup>10</sup> Meanwhile replacing combustible tobacco with alternative nicotine products can significantly reduce risk of harm by at least 95%.<sup>6</sup>

This may be particularly relevant in LMICs, because studies show that intention to quit is dramatically lower in LMICs than high income countries (HICs).<sup>11</sup> This is also evident in a north-south divide. While intention to quit smoking in the Global North is about 75%, the Global South still “lags far behind”.<sup>12</sup> For example, one survey revealed that 41% of Indian smokers and smokeless tobacco users did not want to quit<sup>13</sup>, while another revealed intention to quit smoking was under 20% in five countries – Brazil (18.7%), China (16%), Russia (14.5%), Malaysia (14.2%), and (10.5%) for Indonesia.<sup>14</sup>

With current tobacco control strategies showing meagre results in many LMICs, and NRTs unaffordable to most tobacco users in these nations despite being included in the list of WHO essential medicines<sup>15</sup>, the introduction of accessible, market-driven harm reduction measures into the mix is a vital way forward. In Africa, where tackling tobacco use remains a low public health priority despite significant financial investments into tobacco control measures, providing access to lower-risk alternatives helps further the overall mission to reduce mortality and morbidity.<sup>16</sup>

With these points in mind, it is clearly a poor public health strategy to restrict access to harm reduction alternatives in LMICs. Substitution should be an equally valid and viable goal for smokers in LMICs as those in HICs.

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<sup>10</sup> Begh, R., Lindson-Hawley, N., and Aveyard P, 2015. Does reduced smoking if you can't stop make any difference? *BMC Med.* 13:257.

<sup>11</sup> Saqib, M.A.N., Rafique, I., Qureshi, H., et al. 2019. “Burden of tobacco in Pakistan: findings from global adult tobacco survey 2014”, *Nicotine & Tobacco Research.* 21(1):136.

<sup>12</sup> Kumar N, Janmohamed K, Jiang J et al. 2020. An overview of tobacco control interventions in the Global South. *Drugs and Alcohol Today.* May 25.

<sup>13</sup> Singh PK, Yadav A, Lal P, et al. 2020. Dual burden of smoked and smokeless tobacco use in India 2009–2017: a repeated cross-sectional analysis based on Global Adult Tobacco Survey. *Nicotine Tob Res.*

<sup>14</sup> Caixeta, RB., Sinha, DN., Khoury, RN, et al. 2013. Antismoking Messages and Intention to Quit — 17 Countries, 2008–2011. *MMWR Morb Mortal Wkly Rep.* May 31; 62(21): 417–422.

<sup>15</sup> Kishore, S.P., Bitton, A., Cravioto, A. et al. 2010. Enabling access to new WHO essential medicines: the case for nicotine replacement therapies. *Global Health.* 6, 22.

<sup>16</sup> Burning Issues: Global State of Tobacco Harm Reduction 2020. London: Knowledge-Action-Change.



#### **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.

Harm reduction to improve public health is not a new phenomenon: needle exchange programs and methadone substitution for people who use drugs; malaria control interventions; and even use of seatbelts in cars. The common factor in all these initiatives has been the involvement of the ‘users’ and taking their needs into consideration.

Tobacco control does not need to reinvent the wheel in order to utilise harm reduction as a strategy to dramatically reduce, or even end, the use of combustibles. What is needed is broad-based consultation of what will work for the people who smoke.

A missing component for tobacco harm reduction currently is ‘health education’ so that smokers know their rights and avenues. Awareness of and access to alternative products is lower in many LMICs than HICs. For instance, a recent study showed that awareness of e-cigarettes was 10.9% in Indonesia and 21% in Malaysia, 31% in Mexico and 34% in Brazil, all considerably lower than in HICs<sup>17,18</sup> Awareness and use of e-cigarettes was greatest in HICs and lowest in LMICs.<sup>17</sup>

Rather than being presented with a narrowing list of options, the one billion people who smoke – and the millions who use low-risk alternatives – should be consulted to find solutions to a highly complex issue.

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<sup>17</sup> Palipudi KM, Morton J, Bunnell R, et al. 2015. Awareness and Current Use of Electronic Cigarettes in Indonesia, Malaysia, Qatar, and Greece: Findings From 2011-2013 Global Adult Tobacco Surveys. *Nicotine & Tobacco Research* 18(4)

<sup>18</sup> Gravely S, Driezen P, Ouimet J et al. 2019. Prevalence of awareness, ever-use and current use of nicotine vaping products (NVPs) among adult current smokers and ex-smokers in 14 countries with differing regulations on sales and marketing of NVPs: cross-sectional findings from the ITC Project. *Addiction*. 114(6):1060-1073

## 5. Reduced harm alternatives can significantly contribute to the aims of global tobacco control

The FCTC itself recognises ‘harm reduction’ as a key strategy in tobacco control. Its Article 1(d) states that “tobacco control means a range of supply, demand and harm reduction strategies.”

Policymakers should embrace harm reduction as a valid goal, particularly in LMICs where access to cessation programs is extremely limited in several countries. This is particularly pertinent when examined alongside policy approaches in other areas, such as alcohol or unhealthy foods, where harm reduction is championed in policy circles.

Global tobacco control efforts implicitly reflect the complexity of the task. The FCTC contains 38 separate articles, including nine core demand reduction provisions for countries to implement. The six MPOWER measures were subsequently published to prioritise the interventions ostensibly best suited to decrease the use of (mainly combustible) tobacco.

However, very few countries have adopted all or even most of the MPOWER measures at best-practice level.<sup>19</sup> As noted previously, Turkey – which has banned harm reduction alternatives like e-cigarettes – has not succeeded despite the implementation of all MPOWER measures.

Reducing smoking prevalence through tobacco control is thus complex and multifaceted, and reduced harm products are an essential part of the equation. This has been proven in HICs. Why would it be any different in LMICs? However, it is concerning that the vast majority of concerted tobacco control interventions implemented to date have been in HICs, despite most of the burden being in LMICs.<sup>20</sup>

Of particular interest is the “O” measure of MPOWER – Offer help to quit tobacco use. The WHO states that population-based interventions offering help “greatly increase (tobacco users’) chances of successfully quitting”.<sup>19</sup> However, as the WHO reported recently, only 13 new countries have started providing comprehensive cessation programs since 2007. In total, only 23 of the organisation’s 194 member states currently provide smoking cessation services at best-practice levels, and most of these are HICs.<sup>19</sup>

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<sup>19</sup> WHO report on the global tobacco epidemic, 2019. Geneva: World Health Organization. Retrieved from: [http://www.who.int/tobacco/global\\_report/en](http://www.who.int/tobacco/global_report/en)

<sup>20</sup> Sinha, D.N., Suliankatchi, R.A., Gupta, P.C., et al. 2018. “Global burden of all-cause and cause-specific mortality due to smokeless tobacco use: systematic review and Meta-analysis”. *Tobacco Control*, 27(1):35-42

In another 2019 report, WHO predicted that to reach the goal of reducing deaths from noncommunicable diseases (NCDs) among the 30–69 age group by one-third by 2030 (SDG 3.4.1), a 50% prevalence reduction in tobacco smoking worldwide is required.<sup>21</sup> But almost no country has achieved a 50% drop in smoking using traditional tobacco control measures. It is asking the impossible, particularly in LMICs.

Reduced harm alternatives would help, not hinder, the aims of global tobacco control.

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<sup>21</sup> WHO Independent High-level Commission on Noncommunicable Diseases, 2019. Geneva. World Health Organization. Retrieved from: <https://www.icn.ch/sites/default/files/inline-files/WHO%20NCDs%20final%20report.pdf>

## 6. Lack of research in LMICs is not a valid reason to ban reduced harm alternatives

While there is significant evidence from several HICs supporting the correlation between increasing use of ENDS and reduction in the number of people smoking combustible tobacco<sup>6,22,23,24,25,26,27</sup>, there is a distinct lack of similar research in LMICs.

A review of tobacco control studies in the Global South (which contains a large percentage of LMICs) found that only 4% detailed harm reduction.<sup>12</sup> As concluded in a recent paper, “researchers and policymakers should broaden scholarship around harm reduction to enhance tobacco control efforts”.<sup>12</sup> A rare large survey in India indicated that e-cigarettes could potentially be an effective partial or complete substitute for tobacco use for some smokers.<sup>28</sup> The paper noted that the government had recently decided to ban these products although “it is unlikely that the implemented ban in India represents a balanced approach, especially when considering that there has been no research on the profile of Indian vapers”.<sup>28</sup>

But the 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.

There is a rich body of evidence from HICs supporting the impact of alternative options on reducing smoking prevalence and reducing harm. There is no valid reason to think LMICs will be any different. This research is valid worldwide.

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.

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<sup>22</sup> Ash. 2019. Use of e-cigarettes (vaporisers) among adults in Great Britain. Retrieved from <https://ash.org.uk/wp-content/uploads/2019/09/Use-of-e-cigarettes-among-adults-2019.pdf>

<sup>23</sup> Park, M. and Choi, J., 2019. Differences between the effects of conventional cigarettes, e-cigarettes and dual product use on urine cotinine levels. *Tobacco Induced Diseases*, 17(February).

<sup>24</sup> Bullen, C., Howe, C., Laugesen, M., et al., 2013. Electronic cigarettes for smoking cessation: a randomised controlled trial. *Lancet*, 382(9905): 1629-37.

<sup>25</sup> Ratajczak, A., Jankowski, P., Strus, P., and Feleszko, W., 2019. “Heat-not-burn tobacco product use and its impact on quit attempt”, *Journal of Environmental Research and Public Health*.

<sup>26</sup> Kotz, D., Böckmann, M. and Kastaun, S., 2018. The Use of Tobacco, E-Cigarettes, and Methods to Quit Smoking in Germany. *Deutsches Aerzteblatt Online*.

<sup>27</sup> Pasquereau, A., et al., 2019. Usage de la cigarette électronique, tabagisme et opinions des 18-75 ans’. *Sante Publique*. Retrieved from [https://www.researchgate.net/publication/337542002\\_USAGE\\_DE\\_LA\\_CIGARETTE\\_ELECTRONIQUE\\_TA\\_BAGISME\\_ET\\_OPINIONS\\_DES\\_18-75\\_ANS\\_Barometre\\_de\\_Sante\\_publicue\\_France\\_2017](https://www.researchgate.net/publication/337542002_USAGE_DE_LA_CIGARETTE_ELECTRONIQUE_TA_BAGISME_ET_OPINIONS_DES_18-75_ANS_Barometre_de_Sante_publicue_France_2017)

<sup>28</sup> Sharan RN, Chanu TM, Chakrabarty TK and Farsalinos K. 2020. Patterns of tobacco and e-cigarette use status in India: a cross-sectional survey of 3000 vapers in eight Indian cities. *Harm Reduction Journal*. 17(21)

## 7. The prohibitionist approach in LMICs is outdated, unrealistic and condescending

The aim of ending smoking has been outlined and agreed to by governments across the globe via the UN Sustainable Development Goals, WHO Noncommunicable Disease Targets, and others. However, progress in meeting the global target set by governments to cut tobacco use by 30% by 2025 remains off track.<sup>19</sup>

A ‘prohibitionist approach’ does not allow for finding innovative solutions to the challenge of decreasing the use of combustibles across the spectrum. It stigmatises people who smoke, negates the potential of behaviour change and – given this age of digital media and social networks where information flows seamlessly across regions – borders on condescension and discrimination of people who want to continue to use nicotine but without deadly harm. Such discriminatory policies also serve to further increase health inequalities between HICs and LMICs.

It has been shown that positively framed messaging is most effective, with negative, prohibitive messages described as easy to ignore, even triggering urges to smoke for some.<sup>29</sup>

The prohibitionist “quit or die” approach outlined in The Union position puts nicotine (and unwittingly its users) and combustibles in the same category, telling policymakers in LMICs they should not give the opportunity to people who smoke to consider options and chose safer nicotine delivery systems, as if they do not have the ability to make up their own mind. In doing so, it is not only patronising and discriminatory, but also overlooks a significant public health opportunity – to encourage people who smoke who are not ready to quit to switch to reduced-harm alternatives. In addition, formulation of a policy directed at a certain demographic (in this case nicotine users) without their input will almost inevitably cause that policy to fail.

Embracing reduced-harm alternatives would be pragmatic, and could save many lives. It has the potential to be successful, because it needs less effort to reduce the harm – i.e. it does not require complete nicotine cessation.<sup>30</sup>

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<sup>29</sup> Cataldo JK, Hunter M, Petersen AB, and Sheon N. 2015. Positive and instructive anti-smoking messages speak to older smokers: a focus group study. *Tob Induc Dis*; 13(1):2.

<sup>30</sup> Bates C. E-cigarettes, vaping and public health. A summary for policy-makers. Retrieved from <https://www.clivebates.com/documents/vapebriefing.pdf>

## **8. Bans in LMICs will lead to illicit markets with increases in crime and no tax revenue**

Prohibition may be relatively simple to write into law, but it is much harder to deliver in reality than consumer protection legislation. It has been shown repeatedly that prohibitionist policies lead to illicit markets.

Bhutan, a small Himalayan country, completely banned cigarettes in 2004, making it illegal to use and sell cigarettes and other tobacco products. Ten years later, the 2014 WHO fact sheet on Bhutan indicates that 33% of male population still smokes.<sup>31</sup> This is due to the emergence of a thriving illicit market, driven by Bhutanese youth, who are among the highest in the region to be using tobacco products.<sup>32</sup>

Blanket bans do not work. Rather than achieving a public health goal, banned products are pushed underground into unregulated and 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. For example, in Singapore, a ban in 2010 has “fuelled a thriving black market in the devices”. Illicit market retailers of e-cigarettes in Singapore sell at a large mark-up of 300% over the original price of the products.<sup>33</sup>

In Mexico, Brazil and Thailand, bans on safer alternatives have led to illicit market conditions, with little dent on availability, while eliminating the processes required to prevent access to minors. Lack of regulation also makes it impossible for governments to track epidemiological data around the use of such products. The Union states that prohibition of ENDS and HTPs will aid tobacco control, yet in Mexico for example, the illicit market in cigarettes remains rampant, with around 50% of Mexican smokers purchasing cigarettes illegally.<sup>34</sup>

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<sup>31</sup> WHO Factsheet, Bhutan, 2018. Retrieved from [https://apps.who.int/iris/bitstream/handle/10665/272671/wntd\\_2018\\_bhutan\\_fs.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/272671/wntd_2018_bhutan_fs.pdf?sequence=1)

<sup>32</sup> Gurung, Mongal Singh et al. “Current tobacco use and its associated factors among adults in a country with comprehensive ban on tobacco: findings from the nationally representative STEPS survey, Bhutan, 2014.” Population health metrics vol. 14 28. 8 Aug. 2016.

<sup>33</sup> TNP, 2015. Banned but demand fuels lucrative trade of electronic cigarettes. <https://tnp.sg/news/singapore/banned-demand-fuels-lucrative-trade-electronic-cigarettes>

<sup>34</sup> Organización Panamericana de la Salud, 2017. Instituto Nacional de Salud Pública. Encuesta Global de Tabaquismo en Adultos. México 2015. Cuernavaca, Mexico.

Meanwhile in South Africa, the government prohibited sale of tobacco products as part of its COVID-19 strategy in 2020. However, the ban failed in what it was intended to do, with smokers buying cigarettes in large quantities and uncommon, black market brands becoming more prevalent. It led to a thriving illegal trade that will be increasingly difficult to eradicate even when the COVID-19 crisis is over.<sup>35</sup>

This raises a key question – if policymakers believe LMIC governments are ill-equipped to properly regulate reduced harm products, how will they manage blanket bans and the illicit markets that will inevitably emerge?

Responsibly implemented regulation enables more control while at the same time protecting consumer rights and choices. It also may produce a revenue stream in taxation, although it is important that countries enact risk-proportionate taxation and not impose taxes on lower-harm products with the aim of offsetting losses from falling combustible tobacco sales.

In the Philippines, a House of Representatives committee recently approved a bill regulating the sale of e-cigarettes and HTPs.<sup>36</sup> The legislators noted not only the public health benefits associated with embracing harm reduction policies, but also the major financial gains, estimated at P108.9 billion (approximately \$2.26 billion USD) in additional taxes over the next five years.<sup>37</sup> For LMICs, especially during the economic strains caused by a pandemic, closing the door on a significant revenue stream goes against public interest.

Even in LMICs where e-cigarettes may not be subject to strict regulation, there is still a strong possibility of a ‘self-regulating’ market. In the US before regulation of e-cigarettes was introduced, a study revealed that the operators of vaping shops “anticipated the eventual regulation of vaping devices and e-liquids, and some were already self-regulating”.<sup>38</sup> This is a health-conscious, consumer-focused industry, and retailers that sell e-cigarettes are sensitive and reactive to consumer criticism. This ensures self-regulation in the absence of formal regulation.

It is also important to note that low-risk alternatives represent a private industry solution to a public health problem. Minimal public infrastructure, investment or resources are needed, but the results could contribute significantly to public health goals of reducing use of toxic tobacco products and thereby reducing preventable NCDs such as cancers, heart and lung disease.

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<sup>35</sup> Van Walbeek, C., Filby, S. and van der Zee, K. Smoking and quitting behaviour in lockdown South African: Results from a second survey. Research Unit on the Economics of Excisable Products. Retrieved from [http://www.reep.uct.ac.za/sites/default/files/image\\_tool/images/405/Publications/reports/Lockdown%20Survey%20Final.pdf](http://www.reep.uct.ac.za/sites/default/files/image_tool/images/405/Publications/reports/Lockdown%20Survey%20Final.pdf)

<sup>36</sup> Manila Bulletin, 2020. Joint House committees approve e-cigs and heated tobacco bill. Retrieved from: <https://mb.com.ph/2020/08/27/joint-house-committees-approve-e-cigs-and-heated-tobacco-bill/>

<sup>37</sup> Ordinario, 2020. House committee OK’s bill regulating e-cigarettes. *BusinessMirror*. Retrieved from: <https://businessmirror.com.ph/2020/08/31/house-committee-oks-bill-regulating-e-cigarettes/>

<sup>38</sup> Nayak P, Barker DC, Huang J et al. 2018. No, the government doesn’t need to, it’s already self-regulated’: a qualitative study among vape shop operators on perceptions of electronic vapor product regulation. *Health Education Research*. 33(2):114–124

## 9. Banning reduced harm alternatives leads people back to smoking and greater harm

One of the perverse anomalies of bans and strict legislation on alternative products such as e-cigarettes and HTPs is that the legislation is often stricter – or at least as strict – as for cigarettes themselves.

The risk and harm associated with cigarettes is conclusive. Yet it is not cigarettes that The Union is calling to ban in LMICs (indeed it has explicitly stated that it does not propose a ban of cigarettes), 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.

We have seen this in countries where bans or strict legislation has been introduced. Take South Korea for example. The country quickly became the world's second-largest market for HTPs after Japan.<sup>39</sup> In 2019, 360 million HTP packs were sold, taking more than 10 percent of the total tobacco sales in the country.<sup>40</sup>

HTPs also encouraged more cigarette-cessation attempts. 2.3% of male cigarette smokers switched to sole consumption of HTPs, and dual users of cigarettes and HTPs had a higher quit attempt rate than cigarette-only smokers by 9.8%.<sup>41</sup>

However, in 2018, South Korea's Ministry of Food and Drug Safety published a study critical of HTPs and around the same time, taxes on such products were increased by 68%. These factors appear to have convinced many Koreans to return to combustible cigarettes.<sup>42</sup>

Similarly, the 2020 ban of ENDS and HTPs in Mexico is expected to see many of the 1.2 million users of ENDS in the country switch back to smoking regular cigarettes, leading to worse public health outcomes.<sup>43</sup>

We can expect the same to happen if prohibitive regulations are introduced across other LMICs – no one interested in public health could consider this a good outcome.

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<sup>39</sup> World's No 2 heated tobacco market. 2019. *Tobacco Journal International*. Retrieved from [http://www.tobaccojournal.com/World\\_s\\_No\\_2\\_heated\\_tobacco\\_market.55353.0.html](http://www.tobaccojournal.com/World_s_No_2_heated_tobacco_market.55353.0.html)

<sup>40</sup> He-rim, J., 2020. Rivals join hands for global heated tobacco market. *Korea Herald*. Retrieved from <http://www.koreaherald.com/view.php?ud=20200129000725>

<sup>41</sup> Brand Shares – Cigarette in South Korea. *Euromonitor*. Retrieved from <https://c11.kr/bo13>

<sup>42</sup> Kim, T. 2018. Heat-not-burn cigarettes heat up controversy. *J Periodontal Implant Sci*; 48(4): 201.

<sup>43</sup> Mexico Ledger, 2019. Will clampdown on vaping send users back to smokes? Retrieved from: <https://www.mexicoledger.com/zz/news/20191005/will-clampdown-on-vaping-send-users-back-to-smokes>



## **10. Blanket bans in LMICs are a form of ‘philanthropic colonialism’**

LMICs are not a homogenous entity. The bracket includes a vast range of countries, cultures, economies, geographies and people. Blanket approaches such as that proposed by The Union to ban e-cigarettes and HTPs in LMICs disregards all these nuances and smacks of philanthropic colonialism, defined as “barging in as outsiders and forcing their solutions on other people’s problems”.<sup>44</sup>

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.

The Union’s fits-all solution would be imposed in a way that does not take local intricacies and complexities into account. Decisions like these are taken “for the good” of countries and their people, but without true consultation or understanding of the situation at the local level.

To put it bluntly, policies such as these inherently view the inhabitants of LMICs as second-class citizens. These are policy decisions that do not consider individuals, their rights, and their battle to quit or reduce and the difficulties involved.

At INNCO, our motto is “nothing about us without us”. It is wrong to deny more than a billion tobacco users, most of those in LMICs, a voice and a choice. Consumers have the right to be heard.

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<sup>44</sup> Kredell M, 2012. Buffetts share thoughts on philanthropy. USC News. Retrieved from: <https://news.usc.edu/30622/buffetts-share-thoughts-on-philanthropy/>

## **Conclusions**

Scientific and technological progress in recent years has led to the advent of alternative tobacco products that are associated with significantly less risk to users than cigarettes. Blanket bans of such products are poorly considered and will do more harm than good. Such bans will mean that more people will keep using cigarettes, or obtain alternative products through illicit markets with no safeguards.

Many people want to quit, but repeatedly fail. Some wish to limit harm. If the more than 1 billion people who smoke in the world had access to safer alternatives and were encouraged to use them rather than having that access denied, the potential health benefits could be extraordinary.

People who smoke in LMICS – and let us not forget they are hundreds of millions of individuals – should have the agency to make decisions about these products themselves, particularly when their own health is on the line. We believe that awareness of and access to reduced harm products is a fundamental human right, and that denial of this right will prevent significant health benefits in LMICS.

### **About this document:**

This report was developed independently by INNCO in conjunction with experts in the field of healthcare, policymaking and tobacco harm reduction from all over the world, including LMICS.

### **About INNCO:**

Founded in 2016, the International Network of Nicotine Consumer Organisations (INNCO) is a global member association that advocates for tobacco harm reduction and access to, and proportionate regulation of, low-risk alternative nicotine products. INNCO's role is to enable coordination and cooperation across its organizational network around the world, as well as engage in targeted national- and regional-level projects to help significantly reduce the number of people who die from smoking-related illnesses each year.