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# Tobacco Harm Reduction Under Scrutiny:

## Trends in E-cigarette Use and Polysubstance Use Among Clients in South African Substance Use Treatment Centres


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# ACKNOWLEDGMENT


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- My co-authors and collaborators
  - Prof. Lekan Ayo-Yusuf
  - Ms Arshima Khan
  - Prof. Andrew Scheibe
  - Mr. Mukhethwa Londani
  - Prof. Nadine Harker





**E-cigarettes and harm reduction: a view from sub-Saharan Africa**

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***Referenced Paper:*** *Egbe, C. O., Khan, A., Scheibe, A., & Ayo-Yusuf, O. A. (2024). E-cigarettes and harm reduction: a view from sub-Saharan Africa. Tobacco Control, 33(4), 419-421.*


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PRESENTATION ROADMAP

# Navigating from theoretical harm reduction benchmarks to empirical clinical surveillance and legislative action

PART 1

## Conceptual Foundations & Harm Reduction Critique

- **Harm Reduction Definitions**
  Contrasting genuine public health models (HRI/WHO) with commercial tobacco industry co-optation.
- **Five-Pillar Harm Reduction Evaluation**
  Benchmarking toxicology, equity/access, youth recruitment, population cessation failure (OR=0.72), and corporate dual use.
- **The Theoretical Disconnect**
  Why industry harm reduction fails when it expands net nicotine dependence and corporate profits.

PART 2

## Empirical Surveillance & Prevalence Trends

- **SACENDU Methodology**
  Sentinel surveillance across 114 treatment facilities, 9 provinces, and 59,426 client admissions.
- **Fivefold Prevalence Surge**
  Tracking e-cigarette growth from 0.3% (2022) to 1.5% (2024), $p < 0.001$.
- **Baseline Clinical Context**
  Why low absolute prevalence (0.8%) conceals a steepening, high-risk clinical uptake slope.

PART 3

## Clinical Disparities, Polysubstance Co-Use & Models

- **Demographic Cleavages**
  Disproportionate adoption in females (1.4% vs 0.7%), youth <20 (1.2%), and affluent groups.
- **94.4% Polysubstance Overlap**
  Primary co-use dominated by cannabis (34.7%), alcohol (25.4%), methamphetamine, and crack.
- **Multivariable Logistic Regression**
  Independent predictors: Tobacco (AOR=4.23), OTC meds (AOR=2.32), and crack cocaine (AOR=1.52).
- **3-Phase Clinical Trajectory**
  Mapping transition from perceived self-medication to high-potency nicotine co-dependence.

PART 4

## Regional Dilemmas & Evidence-Based Interventions

- **Sub-Saharan African Realities**
  Early epidemic stage (<10% smoking) exploited amid an FCTC Article 14 cessation service vacuum.
- **Regulatory Evasion & FCTC 5.3**
  Commercial lobbying maneuvers designed to weaken health laws and bypass excise taxation.
- **Three Actionable Priorities**
  Mandatory intake screening, passing South Africa's Tobacco Products Bill, and longitudinal cohort tracking.

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CONCEPTUAL & POLICY FRAMEWORK

# Real-World Treatment Data Challenges Industry Harm-Reduction Claims

Contrasting commercial marketing narratives with empirical findings in vulnerable clinical populations

## Commercial Harm-Reduction Narrative

- Smoking Cessation Alternative: E-cigarettes are promoted by manufacturers as a safer harm-reduction substitute for adult combustible cigarette smokers seeking to quit.
- Isolated Behavioural Model: Assumes a 1-to-1 single-substance replacement where clients switch from combustible cigarettes to e-cigarettes without increasing overall addiction.
- Policy & Lobbying Vehicle: Tobacco corporations leverage harm-reduction messaging in South African policy discourse to oppose stricter regulations and excise taxes.

## SACENDU Empirical Evidence

- Rapid 5-Fold Uptake: E-cigarette use is surging rapidly among treatment admissions, growing from 0.3% in 2022 to 1.5% in 2024 rather than remaining a marginal niche.
- Polysubstance Co-Occurrence: 94.4% of e-cigarette users report concurrent use of another primary substance (alcohol, cannabis, stimulants, or prescription meds).
- Compounded Addiction Vulnerability: Vaping acts as a co-occurring habit or self-medication tool, adding high-potency nicotine dependence to severe substance use disorders.

**CRITICAL IMPLICATION: Commercial harm-reduction narratives assume clean, single-substance substitution. Real-world clinical surveillance reveals that e-cigarettes entrench secondary nicotine dependence across complex polysubstance regimens.**

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DECONSTRUCTING HARM REDUCTION

# Public Health Harm Reduction vs. Commercial Tobacco Co-Optation

Evaluating harm reduction benchmarks defined by Harm Reduction International (HRI) & WHO against corporate vaping promotion

## 1. Genuine Public Health Model

- **Evidence-Based Interventions**
  Defined by Harm Reduction International as pragmatic policies, programmes, and practices mitigating health and social harms without requiring abstinence as a precondition.
- **Proven Core Measures**
  WHO endorses needle/syringe programmes, opioid agonist maintenance therapy (OAMT), and naloxone for people who inject drugs.
- **Key Public Health Benchmark**
  Empirical research confirms authentic harm reduction interventions reduce morbidity and mortality without increasing drug use initiation or youth uptake.

## 2. Commercial Industry Co-Optation

- **Shareholder Profit Motive**
  Transnational tobacco corporations co-opt harm reduction language while aggressively manufacturing and marketing combustible cigarettes to satisfy shareholders.
- **Recreational Product Engineering**
  Devices are engineered with nicotine salts, high absorption rates, and child-friendly flavours designed to maximize recreational consumer retention.
- **Regulatory Evasion & FCTC 5.3**
  Industry leverages harm-reduction rhetoric to lobby against taxes and smoke-free laws, directly violating WHO FCTC Article 5.3 safeguards.

## 3. Sub-Saharan African Mismatch

- **Early Epidemic Dynamics**
  Sub-Saharan Africa is at an early stage of the tobacco epidemic, with several nations having adult daily smoking prevalence below 10%.
- **Expansion vs Reduction**
  Introducing unregulated e-cigarettes risks sparking a fresh nicotine epidemic among youth and non-smokers, rather than reducing established population smoking harms.
- **Health System Constraints**
  Low- and middle-income nations face severe resource constraints and lack cessation infrastructure (FCTC Article 14), leaving markets unprotected.

**THE THEORETICAL DISCONNECT: Genuine harm reduction decreases aggregate population morbidity without recruiting new users. Commercial tobacco harm reduction expands net nicotine dependence while protecting corporate cigarette revenues.**

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CRITICAL CRITERIA EVALUATION

# Five Critical Flaws of Commercial E-Cigarette Harm Reduction

Benchmarking electronic nicotine delivery systems against the five core principles of harm reduction (Egbe et al., BMJ Tob Control 2024)

[CRITERION 1]

## 1. Minimising Negative Health Impacts

- **Heavy Metal Toxicity**
  Aerosols contain toxic trace metals (nickel, lead, chromium) causing reactive oxygen species and endothelial DNA damage.
- **Non-Linear Harm**
  Lower toxin levels do not equal less disease; cardiovascular dysfunction does not follow a linear dose-response curve.

[CRITERION 2]

## 2. Alignment with Justice & Human Rights

- **Economic Inaccessibility**
  Premium device pricing in SSA restricts access to wealthy elites while cheap combustible cigarettes remain widespread.
- **Distorted Consent**
  Corporate suppression and distortion of health risks by industry undermines autonomous, informed decision-making.

[CRITERION 3]

## 3. Targeted at Established Smokers

- **Youth Lifestyle Appeal**
  Aggressively marketed to nicotine-naive adolescents via thousands of candy flavours, sleek designs, and nicotine salts.
- **3–4× Gateway Effect**
  Meta-analyses demonstrate youth who vape are 3 to 4 times more likely to transition to combustible cigarette smoking.

[CRITERION 4]

## 4. Supporting Positive Change (Cessation)

- **Population Inefficacy**
  In real-world cohorts, e-cigarette users show 28% lower odds of quitting smoking than non-users (OR = 0.72; 95% CI: 0.57–0.91).
- **Populations 'Softening'**
  Populations under tobacco control smoke fewer cigarettes and make more quit attempts, disproving the 'hardened smoker' myth.

[CRITERION 5]

## 5. Dual-Use Dilemma & Industry Conflict

- **Compounded Toxicity**
  Most adult smokers transition to dual use rather than quitting; concurrent use yields worse overall health harms than smoking alone.
- **FCTC 5.3 Violation**
  Transnational firms market vapes while aggressively manufacturing cigarettes to protect shareholder profits.

**SYNTHESIS: E-cigarettes fail all five harm reduction principles in sub-Saharan Africa—they introduce toxic heavy metals, pricing barriers, youth nicotine recruitment, real-world cessation failure, and predatory corporate dual use.**

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SURVEILLANCE METHODOLOGY & SAMPLE PROFILE

# SACENDU Surveillance Captured 59,426 Client Admissions Across 114 Centres

Retrospective cross-sectional study of secondary clinical surveillance data across South Africa (2022–2024)

**59,426**
**Analytical Sample**
Total treatment admissions

**114**
**Treatment Centres**
Public & private facilities

**9**
**Provinces Monitored**
Nationwide coverage

**1996**
**Surveillance Since**
E-cigs tracked from 2022

## Study Design & Temporal Spread

**Design:** Retrospective cross-sectional study using secondary SACENDU surveillance records.

**Surveillance Period:** Covered three full calendar years: 2022 through 2024.

**Temporal Distribution:** 2022: 37.2% (n=22,095)

2023: 35.4% (n=21,041)

2024: 27.4% (n=16,290).

**Data Context:** Reflects treatment episodes at specialized substance rehabilitation centres.

## Statistical & Analytical Protocol

**Software:** All analyses executed using STATA version 17.

**Descriptive Statistics:** Frequencies and cross-tabulations to assess e-cigarette prevalence.

**Multivariable Modeling:** Logistic regression to evaluate associations between vaping and primary drugs.

**Weighting & Significance:** Weighting not applied (non-randomized clinical census); significance set at $p < 0.05$.

## Baseline Population Demographics

**Gender Distribution:** 83.6% Male (n=49,601) vs 16.4% Female (n=9,713).

**Racial Profile:** 69.6% Black African, 20.5% Coloured, 7.7% White, 2.2% Indian.

**Age Structure:** 53% younger than 30 years; 84% younger than 40 years old.

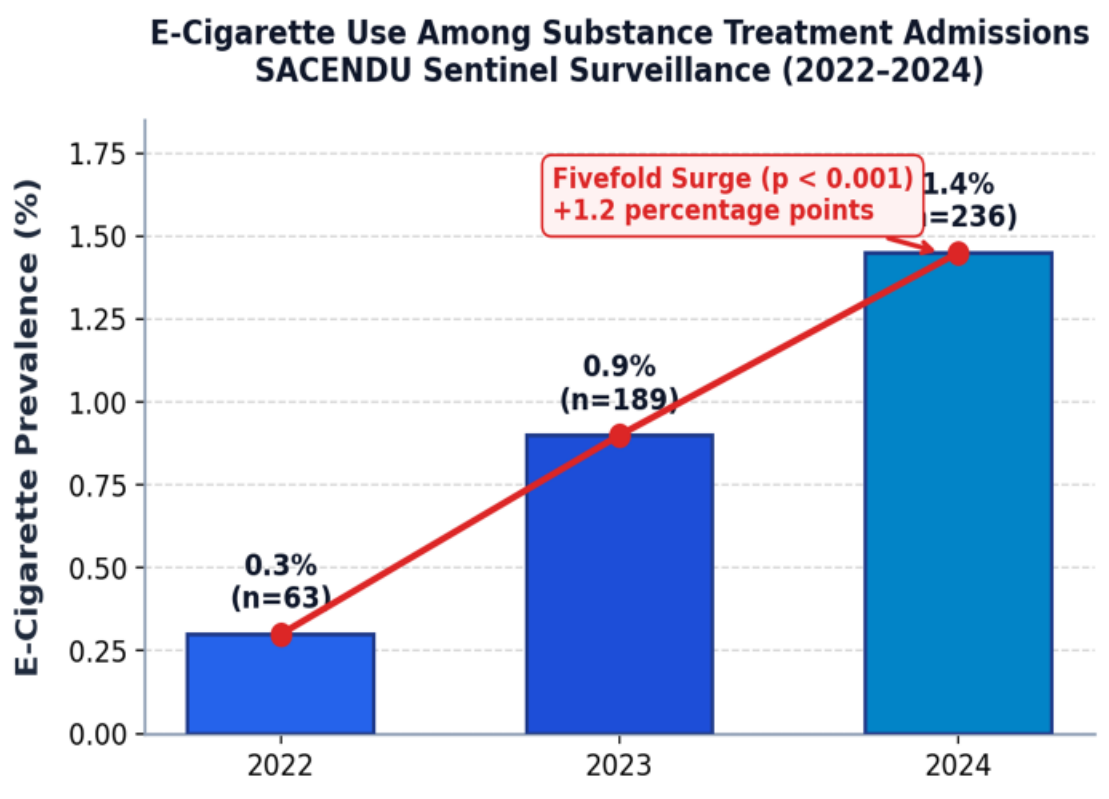
**Socioeconomic Context:** 84.9% secondary education; 59.9% unemployed at admission.

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PREVALENCE TRENDS & TRAJECTORY

# E-Cigarette Use Grew Fivefold from 0.3% to 1.5% Between 2022 and 2024

Baseline clinical prevalence remains low at 0.8% overall, but annual adoption is steepening rapidly




## Fivefold Prevalence Increase (p < 0.001)

- From 0.3% (n=63) in 2022 to 0.9% (n=189) in 2023, reaching 1.4%–1.5% (n=236) in 2024.
- Prevalence increased by 1.2 percentage points in just 24 months, indicating rapid clinical penetration.

## Total Baseline Sample Prevalence: 0.8%

- Across the full 3-year study, 461 clients reported e-cigarette use out of 59,426 total admissions.
- While absolute prevalence remains low, the steep upward slope signals an emerging public health challenge.

## Regulatory Inaction vs Commercial Influx

- E-cigarettes entered South Africa around 2014 without comprehensive statutory regulation.
- A decade later, nicotine delivery devices are increasingly visible among individuals entering treatment.

Source: SACENDU Surveillance (2022–2024). Chi-square test for trend across surveillance years: p < 0.001.

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## SUMMARY OF FINDINGS FROM SACENDU DATA

**59,426**

**ADMISSIONS ANALYZED**

114 treatment centres across all 9 provinces

**5× Surge**

**PREVALENCE INCREASE**

0.3% in 2022 → 1.5% in 2024 ($p < 0.001$)

**94.4%**

**POLYSUBSTANCE CO-USE**

Concurrent alcohol, cannabis, or illicit drug use

**AOR = 4.23**

**DUAL NICOTINE ADDICTION**

Primary tobacco users 4× more likely to vape

### RESEARCH AFFILIATIONS & INSTITUTIONAL EVIDENCE BASE

- South African Community Epidemiology Network on Drug Use (SACENDU) | South African Medical Research Council (SAMRC)

SOCIODEMOGRAPHIC DISPARITIES

# Female, Youth, Tertiary-Educated, and Affluent Cohorts Show Elevated Vaping Rates

Bivariate analysis demonstrates statistically significant demographic cleavages across all variables (all $p < 0.001$)

## Gender: 2× Higher Rate in Females

- Female Clients: 1.4% e-cigarette prevalence (136 users / 9,713 total admissions)
- Male Clients: 0.7% e-cigarette prevalence (350 users / 49,601 total admissions)
- Statistical Disparity: $p < 0.001$. Although men make up 84% of total treatment admissions, female clients are twice as likely to report e-cigarette use.

## Age: Marked Youth Concentration

- Adolescents (<20 years): 1.2% prevalence (149 / 12,551) — Highest of any age cohort
- Young Adults (20–29): 0.8% (142 / 18,873) • Ages 30–39: 0.7% (124 / 18,213)
- Older Adults (50+ years): 0.5% (14 / 2,692) • Trend significance: $p < 0.001$
- Generational Takeaway: Vaping is heavily skewed toward youth; 53% of sample is <30 years.

## Race: Striking Population Disparities

- White Clients: 3.7% prevalence (171 / 4,573) — Highest overall subgroup
- Indian Clients: 1.3% prevalence (17 / 1,287)
- Coloured Clients: 1.1% prevalence (137 / 12,144)
- Black African Clients: 0.4% prevalence (154 / 41,198) • $p < 0.001$
- Structural Factor: Nearly 10× difference between White and Black African clients.

## Socioeconomic Proxy: Education & Employment

- Tertiary Education: 1.9% prevalence (91 / 4,671) vs Secondary: 0.6% (317 / 49,388)
- Primary / No Education: Primary: 1.1% (44 / 3,852) • No education: 0.9% (2 / 232)
- Employment Status: Students: 1.4% (158 / 11,342) • Employed: 1.4% (153 / 11,302)
- Unemployed Clients: 0.4% (158 / 35,277) • $p < 0.001$ (Economic access barrier)

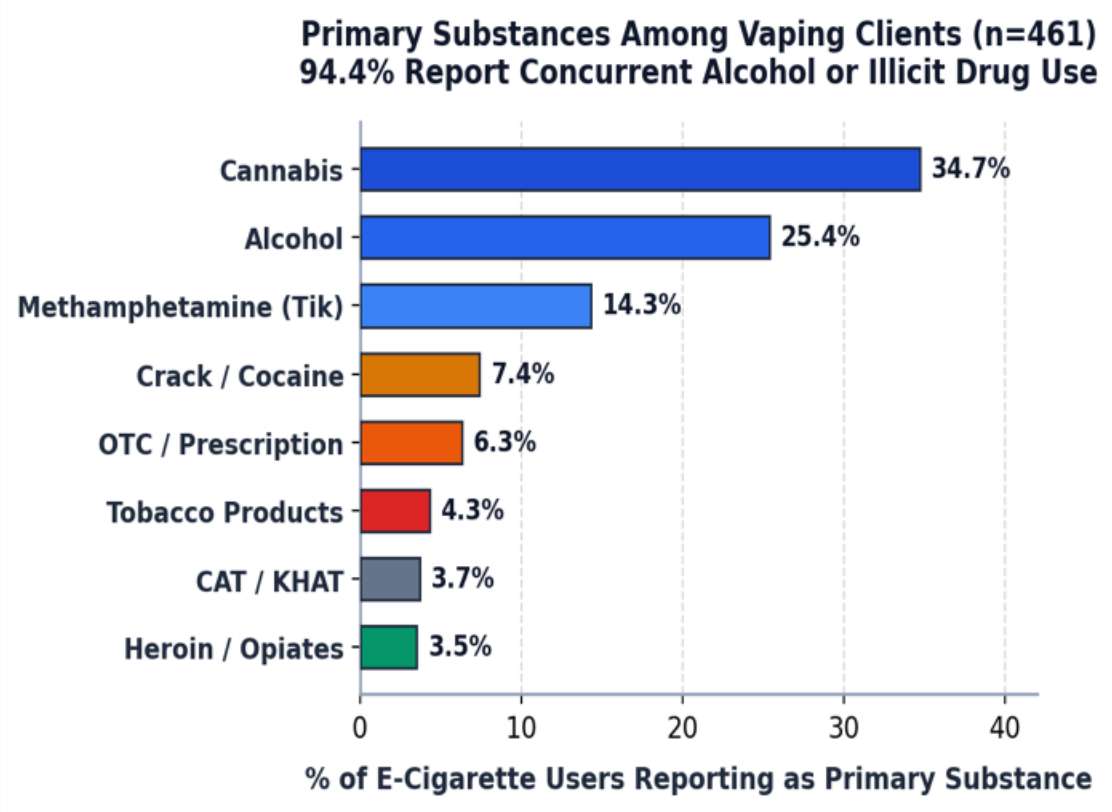
Source: Table 1 SACENDU Surveillance (2022–2024). All chi-square tests for sociodemographic differences statistically significant at $p < 0.001$.

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POLYSUBSTANCE CO-USE LANDSCAPE

# 94.4% of E-Cigarette Users Reported Concurrent Primary Illicit or Alcohol Use

Vaping co-occurs overwhelmingly alongside severe primary substance use disorders rather than in isolation




## 94.4% Co-Use Rate

- Among e-cigarette users, 94.4% reported at least one primary substance of abuse, including cannabis, alcohol, methamphetamine, crack, or prescription drugs.
- Demonstrates that vaping does not occur in an isolated cessation bubble.

## Top Primary Substances: Cannabis & Alcohol

- Cannabis (34.7%, n=160): Most common primary drug among vapers (vs 34.0% non-users, $p = 0.741$; not significantly different).
- Alcohol (25.4%, n=117): Significantly higher among vapers than non-vapers (25.4% vs 18.4%, $p < 0.001$).

## Significant Divergences vs Non-Users

- Crack / Cocaine (7.4% vs 3.2%): More than double the rate among vapers ($p < 0.001$).
- OTC / Prescription Meds (6.3% vs 1.3%): Nearly 5× higher among vapers ($p < 0.001$).
- Heroin / Opiates (3.5% vs 16.3%): Significantly lower among vapers ($p < 0.001$).

Source: Table 2 SACENDU Surveillance (2022–2024). Cross-tabulations between primary substance and e-cigarette use status.

MULTIVARIABLE LOGISTIC REGRESSION

# Tobacco, Prescription Drugs, and Crack Cocaine Independently Predict Vaping

Controlling for confounding reveals independent associations between primary substances and e-cigarette use

| Primary Substance | OR | 95% CI | p-value | AOR | 95% CI | p-value |
|---|---|---|---|---|---|---|
| Alcohol | 1.51 | 1.22–1.86 | <0.001 | 1.16 | 0.89–1.51 | 0.266 |
| CAT / KHAT | 1.01 | 0.62–1.64 | 0.965 | 1.22 | 0.73–2.04 | 0.447 |
| Methamphetamine | 0.62 | 0.48–0.81 | <0.001 | 0.82 | 0.61–1.09 | 0.163 |
| Cannabis | 1.03 | 0.85–1.25 | 0.741 | 0.80 | 0.62–1.02 | 0.072 |
| Crack / Cocaine | 2.40 | 1.69–3.42 | <0.001 | **1.52** | 1.02–2.27 | **0.039*** |
| Heroin / Opiates | 0.18 | 0.11–0.30 | <0.001 | **0.40** | 0.24–0.68 | **0.001*** |
| Tobacco Products | 5.38 | 3.41–8.50 | <0.001 | **4.23** | 2.58–6.93 | **<0.001*** |
| OTC / Prescription | 4.99 | 3.40–7.31 | <0.001 | **2.32** | 1.52–3.55 | **<0.001*** |

## Key Regression Takeaways

- Dual Nicotine Use (AOR 4.23): Primary tobacco users have over 4× the adjusted odds of vaping ($p < 0.001$), demonstrating dual/poly-tobacco use rather than clean smoking cessation.
- Prescription Misuse (AOR 2.32): Clients using OTC/prescription medications show >2× odds of vaping ($p < 0.001$), highlighting high clinical vulnerability and self-medication.
- Stimulant Risk (AOR 1.52): Crack cocaine remains an independent positive predictor of e-cigarette use ($p = 0.039$).
- Protective Effect (AOR 0.40): Heroin/opiate clients are 60% less likely to vape ($p = 0.001$), reflecting distinct demographic/socioeconomic profiles.

Source: Table 3 Multiple Logistic Regression, STATA v17. Models control for mental health conditions, sociodemographics, and primary drug classes.

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CLINICAL SYNTHESIS & RISK TRAJECTORY

# Vaping Adds Secondary Nicotine Addiction Rather Than Facilitating Cessation

A conceptual framework explaining how perceived harm reduction transitions into compounded polysubstance dependence

PHASE 1

## Stage 1: Perceived Cessation & Self-Medication

- **Misleading Safety Beliefs**
  Clients perceive e-cigarettes as 'clean' or harmless alternatives compared to illicit drugs or combustible cigarettes.
- **Symptom Management**
  Vaping is frequently initiated to self-medicate untreated anxiety, depression, craving, or withdrawal symptoms.
- **Marketing Normalization**
  Commercial harm-reduction narratives penetrate clinical populations, encouraging uptake under the guise of wellness.

PHASE 2

## Stage 2: High-Potency Nicotine Co-Dependence

- **Rapid Pharmacokinetics**
  Modern electronic nicotine delivery systems deliver high-concentration nicotine salts rapidly across the blood-brain barrier.
- **Entrenched Addiction**
  Rather than displacing illicit substances, nicotine dependence is layered directly onto existing drug habits (94.4% co-use).
- **Neurochemical Synergy**
  Concurrent nicotine and stimulant (crack) or depressant (alcohol) use reinforces underlying addiction pathways.

PHASE 3

## Stage 3: Complicated Recovery & Relapse Risk

- **Dual-Withdrawal Burden**
  Nicotine withdrawal symptoms (irritability, craving, insomnia) interfere with rehabilitation and detoxification protocols.
- **Clinical Blindspot**
  Treatment centres typically do not screen for or treat vaping, leaving clients vulnerable to ongoing dependence.
- **Threat to Long-Term Sobriety**
  Persistent nicotine dependence and behavioral vaping rituals may serve as behavioural triggers for primary drug relapse.

**CLINICAL CONCLUSION: Vaping does not act as an isolated off-ramp from addiction in treatment clients; it adds a second neurochemical hook that complicates detoxification and threatens long-term recovery.**

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REGIONAL & STRUCTURAL POLICY CONTEXT

# Commercial Vaping Influx Threatens Tobacco Control in Sub-Saharan Africa

Analyzing unique regional vulnerabilities, low baseline smoking, and corporate exploitation of cessation vacuums

## Early-Stage Tobacco Epidemic

- **Low Baseline Smoking**
  Daily smoking prevalence in several sub-Saharan African countries is currently below 10%, representing a successful foundation of tobacco control.
- **Risk of Reigniting Epidemic**
  Aggressive marketing of e-cigarettes risks creating a new generation of nicotine-dependent consumers where smoking rates were previously low or declining.
- **Reversing FCTC Gains**
  Introducing novel nicotine delivery systems undermines progress achieved under the WHO Framework Convention on Tobacco Control.

## The Cessation Service Vacuum

- **FCTC Article 14 Deficit**
  Comprehensive cessation infrastructure, behavioural counseling, and affordable nicotine replacement therapies are largely absent across Africa.
- **Exploitation by Industry**
  Tobacco manufacturers exploit this treatment vacuum by promoting e-cigarettes as 'cessation tools' in the absence of evidence-based clinical services.
- **Commercial Market Creation**
  The industry creates a privatized commercial market for nicotine maintenance instead of supporting accessible public health cessation.

## Regulatory Evasion & FCTC 5.3

- **Corporate Interference**
  Tobacco companies leverage harm-reduction rhetoric to lobby against health warnings, flavor bans, and excise taxes, violating FCTC Article 5.3.
- **Flawed Policy Transfer**
  Harm reduction frameworks designed for high-income countries with high smoking prevalence are inappropriate for sub-Saharan Africa's young demographic profile.
- **Need for Precautionary Laws**
  Countries require robust baseline tobacco control legislation before permitting novel nicotine products into commerce.

**POLICY IMPERATIVE: Introducing e-cigarettes without comprehensive baseline tobacco control laws compromises public health. Sub-Saharan Africa must prioritize FCTC Article 14 cessation and enforce Article 5.3 protections against industry lobbying.**

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EVIDENCE-BASED POLICY & CLINICAL PRIORITIES

# Surveillance, Clinical Screening, and Regulatory Controls Must Urgently Align

Actionable recommendations for South African healthcare authorities, treatment providers, and policymakers

## 1. Clinical Screening & Care Protocols

- **Mandate Intake Screening**
  Incorporate standardized e-cigarette screening questions into routine SACENDU admission protocols across all 114 centres.
- **Integrated Nicotine Cessation**
  Develop clinical guidelines and support structures for clients seeking to quit e-cigarettes concurrently with primary drug treatment.
- **Address Self-Medication**
  Train addiction counsellors to recognize when clients use e-cigarettes to cope with underlying psychiatric distress or withdrawal.

## 2. Regulatory & Legislative Scrutiny

- **Enact Tobacco Control Bill**
  Accelerate passage and enforcement of the Control of Tobacco Products and Electronic Delivery Systems Bill.
- **Scrutinize Marketing Claims**
  Challenge commercial harm-reduction advertising using local empirical data demonstrating high polysubstance co-use.
- **Restrict Youth Appeal & Access**
  Ban youth-appealing flavourings and close regulatory loopholes in line with WHO FCTC guidelines.

## 3. Longitudinal Epidemiological Research

- **Track Post-2024 Trajectory**
  Maintain continuous surveillance to determine whether the fivefold growth trend accelerates further into late 2026.
- **Monitor Cannabinoid Vaping**
  Investigate the overlap between e-cigarette devices and vaping of cannabis extracts (THC/CBD) or synthetic cannabinoids.
- **Evaluate Relapse Impacts**
  Conduct prospective cohort studies to evaluate whether concurrent e-cigarette use affects treatment retention and relapse rates.

South African Community Epidemiology Network on Drug Use (SACENDU) • South African Medical Research Council (SAMRC)
Synthesis informed by Egbe et al. (BMJ Tobacco Control, 2024).

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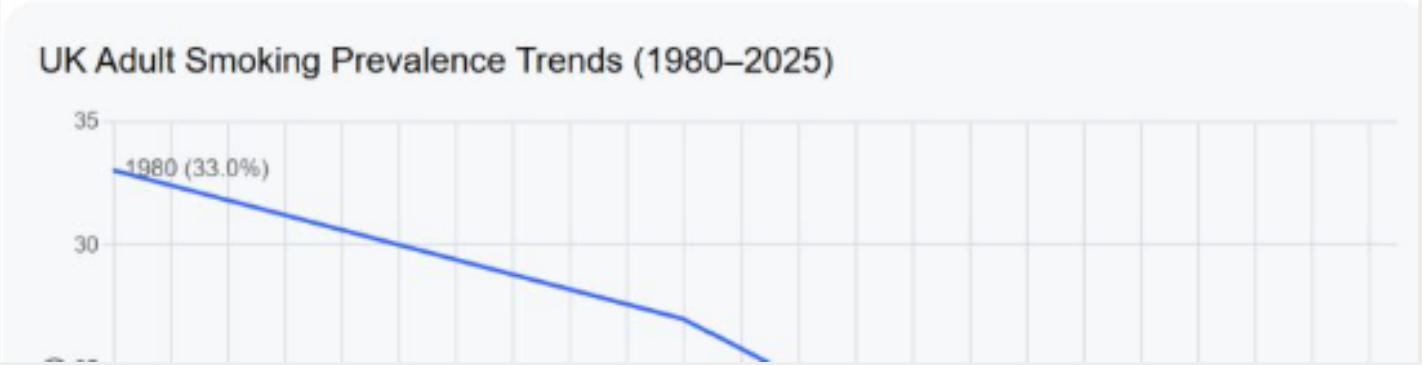


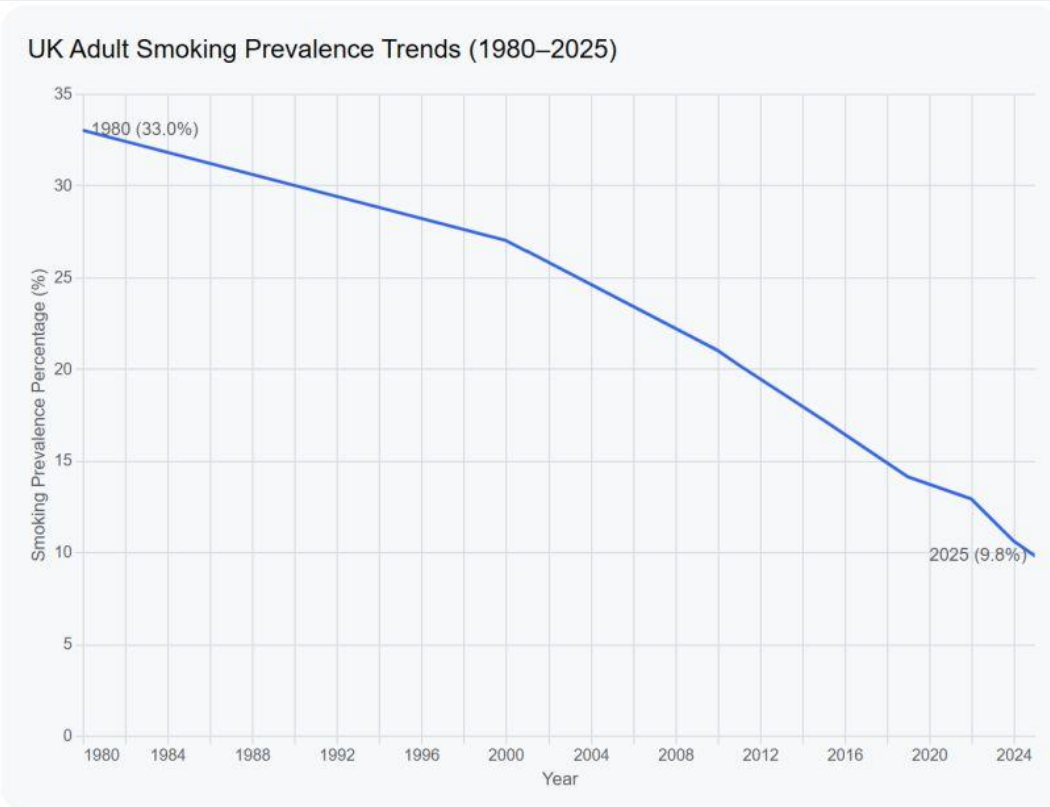
**John C. Dicey, FRSA** • 2nd
Founder & CEO of The Freedom Faculty Ltd and former Global CE...
2w • Edited

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Smoking cessation didn't start in 2010! Have you ever wondered why the architects of the harm reduction policy (attractively packaged, sweetshop flavoured, groovily named nicotine products being available in our corner shops and supermarkets) avoid publishing this kind of graph? Do you see what I see?

Smoking was on its way out long before they imposed the nationwide social experiment that the UK public never agreed to... which led to a brand new, booming nicotine industry hell-bent on getting our kids addicted. The policy makers spent more than a decade formulating the harm reduction strategy regardless of the fact that smoking rates continued to fall... and launched it anyway. Narcistic radicals drunk on the "cleverness" of their already out of date ideology.




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Original research

OPEN ACCESS

# High-nicotine e-cigarettes and nicotine dependence among United States young and older adults, 2017–2022

John P Pierce [1,2] David R Strong [1,2] Siyuan Ping [3] Matthew D Stone [1,2] Natalie E Quach [1,2] Jiayu Chen [2] Brian Q Dang,[4] Dennis R Trinidad [1,2] Sara B McMenamin [2] Yuyan Shi [2] Karen Messer [1,2]

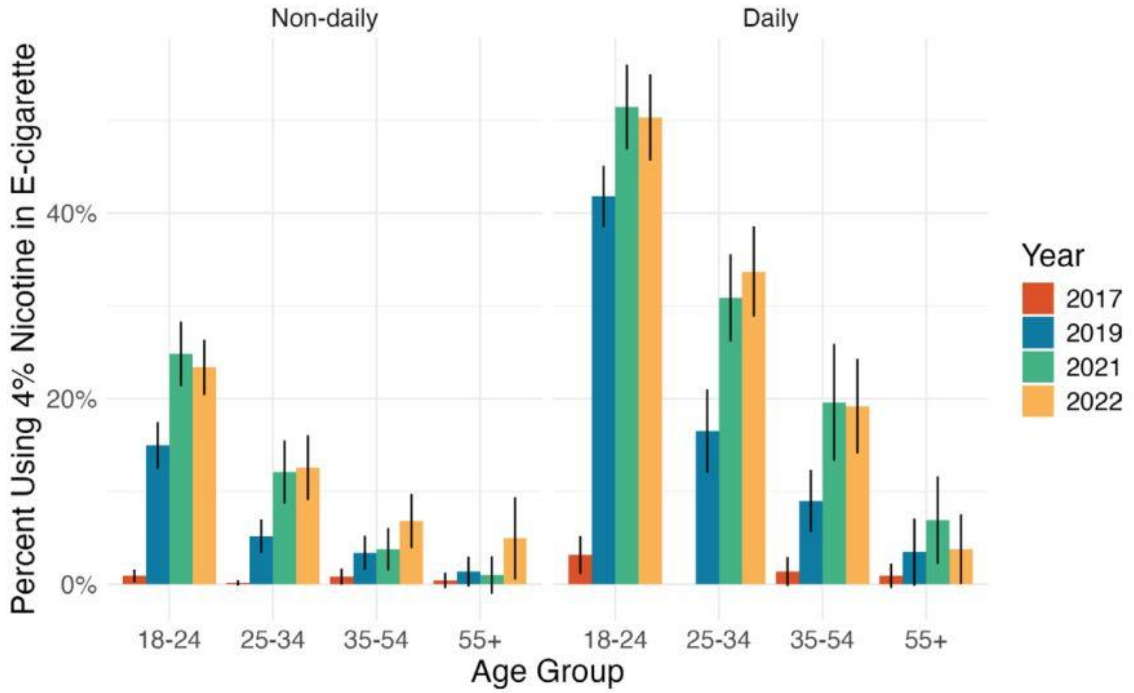
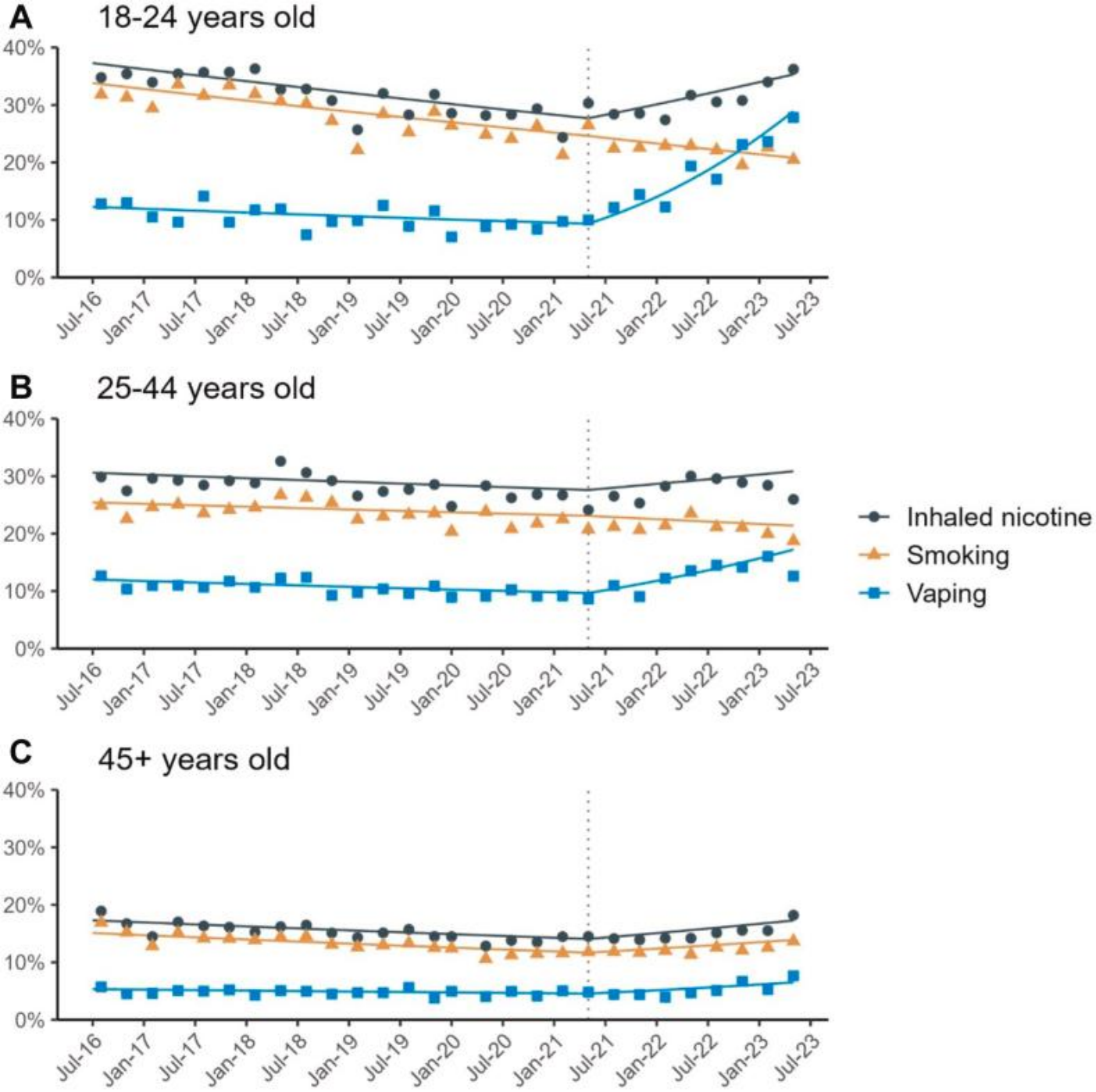



**Figure 1** The percentage of United States adults who vaped e-cigarettes with 4+% nicotine concentration in each of four age groups and by daily or non-daily vaping status: Population Assessment of Tobacco and Health (PATH) Study Wave 4 (2017) to Wave 7 (2022).

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***Source:*** *Tattan-Birch H, Brown J, Shahab L, Beard E, Jackson SE. Trends in vaping and smoking following the rise of disposable e-cigarettes: a repeat cross-sectional study in England between 2016 and 2023. Lancet Reg Health Eur. 2024;42:100924. Published 2024 May 23. doi:10.1016/j.lanepe.2024.100924*



**Ravi Singh** • 1st
On a Mission to Make India Smoke-Free | Founder, Cignix.com | Evidence-Based ...
2d

In a bold pivot, a man known for burning down half the neighbourhood has unveiled his vision for "a fire-free future". At the launch, he said,
# "We are committed to transformation".
# "Our new low-flame matches are 95% less fiery".
# "We will keep setting fires, but only for adults who choose to burn".

When asked when he'd stop lighting fires, he replied: "That's a decision for the market".

Sounds absurd? It's the tobacco industry's smoke-free pitch.

The same companies promising a "smoke-free future" still sell cigarettes by the hundreds of billions every year. Combustibles remain the core of their business. The "solution" is a side product, sold to the same customers, and is a tool for customer acquisition.

You can't be the arsonist and the fire brigade at once. If they truly wanted a smoke-free future, they'd stop selling smoke. Agree?

**#TobaccoControl #HarmReduction #PublicHealth #QuitSmoking #NicotineFreeIndi**

@cignix

Most smokers believe “I need a cigarette to focus”. But a cigarette isn’t a focus tool. It’s a focus tax.




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