ISPTiD

International Society for the Prevention of Tobacco Induced Disease

http://www.isptid.globalink.org/

An international society committed to the prevention of health problems caused by tobacco

NEWSLETTER

JULY 2006

CONTENTS:

1: Welcome

A warm welcome to the July 2006 newsletter.
After a long break we hope that this is the start of more regular updates to members from the society.
This edition of the newsletter contains details of the upcoming annual conference in Hong Kong in November as well as discussions on topical areas of tobacco disease prevention relating to two of the conferences themes, 'treatment of tobacco dependency' and 'policies, politics, economics and legislation'.
We welcome feedback on the content and format of the newsletter and encourage members to submit contributions for future newsletters.

Dr Megan Pow,
Acting Editor.

2: 5th Annual Conference of the International Society for the Prevention of Tobacco Induced Disease, Hong Kong, November 24th –26th, 2006

Planning for the 5th Annual Conference to be hosted in Hong Kong on November 24th -26th is well underway.
The closing date for abstracts has been extended until the end of July and we encourage all those who have not done so to make a submission, support this year's conference, and enjoy the pre-Christmas light show in the 'City of Lights'.

This year's conference will cover three themes,

- The pathophysiology of multi-organ injuries caused by tobacco.
- Policies, politics, economics and legislation.
- Nursing, dental and medical roles in the treatment of tobacco dependency.

Confirmed speakers include, John R. Britton, Parimal Chowdhury, John P. Cooke, Gerard Dubois, Burke Fishburn, Vinay Hazarey, Denis Kinane, Eric LeGresley, Judith Mackay, Nancy Rigotti, David A. Scott, David Simpson, Il Suh, Taru Kinnunen, Xing Li Wang, Saman Warnakulasuriya, and Alistair Woodward.

The conference will be followed by a workshop on the treatment of tobacco dependency on November 27th -28th . This two day workshop will provide information and training on the prevention of harm from active and passive smoking with the emphasis on the treatment of tobacco dependency. While aimed at nursing, dental, and medical professionals, particularly from Asia and Pacific Rim Countries, all are welcome.

More information regarding the conference, the venue, registration and the associated workshop on smoking cessation can be obtained from http://www.hku.hk/ptid/

We look forward to meeting you all in Hong Kong.

3: Tobacco Harm Reduction: The Smokeless Tobacco Debate

"..some pretty substantial scientific observers espouse the view that snus is far less harmful than cigarettes. Nobody is saying that snus is harmless, but it's a lot less harmful than cigarettes"

Paul Adams, Chairman and CEO of BAT
Sunday Independent, 18 June, 2006

There has been heated debate within the tobacco control community in recent years on the potential role of smokeless tobacco and other 'potential reduced-exposure products' (PREP's) in reducing the burden of tobacco induced disease. The focus of tobacco control has historically been on prevention and cessation of tobacco use, primarily among smokers. However as the rates of decline in smoking prevalence in most developed countries have diminished over the last decade a third approach has been advocated, that of harm reduction. Central to this debate has been the 'Swedish Experience'. The European Commission exempted Sweden from the 1992 directive 92/41/EC banning the sale of oral snuff or snus in the EU. This was continued in the 2001 directive 2001/37/EC. Subsequently Sweden has a high prevalence of snus use (22% men and 3% women) but has the lowest smoking rate, the lowest lung and

oral cancer rates and half the rate of rest of the European Union. Advocates believe that the low smoking and tobacco morbidity/mortality rates are due to the availability and alternative use of snus. As the lobbying for a review of the 2001 directive 2001/37/EC have gained impetus and the traditionally non- smokeless sectors of the tobacco industry have become increasingly interested in smokeless tobacco there has been increased reporting of the 'benefits' of smokeless tobacco in the main stream media. The tobacco control community is strongly divided over this issue which has resulted in conflicting messages to the public which are open to exploitation. As the tobacco industry and the media is showing if the tobacco control community doesn't take control of the issue then they are more than willing to do so.

In the USA Philip Morris has begun testing 'Taboka' which comes in small pouches to be placed between the gum and lip, and RJ Reynolds Tobacco Co. is testing a similar product 'Camel Snus'. Both state that the development is in response to smokers demands, especially because of increasing smoking bans. British American Tobacco last year launched a pilot in Sweden selling branded snus, believing it to be a healthier alternative and has been lobbying the European Commission to review Article 8 of directive 2001/37/EC.

What follows are some key points of the debate with reference to recent and important published papers, health and tobacco control organization statements and mainstream media reporting.

The aim is not to provide a comprehensive review nor to support one side of the argument over the other but rather to stimulate the debate with the hope of making progress towards an evidence based consensus view.

tobacco-related mortality compared to the

No smoke, no spit, just tobacco

Philip Morris picks Indy to test pouch that health experts still dislike

Indianapolis Star, July 8, 2006

Where do you go when you want to sell a new tobacco product?
Try Indianapolis, capital of a state that ranks second only to Kentucky in smoking but where a ban now keeps people from lighting up in most restaurants and public places.

Indianapolis is the exclusive test market for Taboka, a new spitless, smokeless tobacco product from Philip Morris USA.

Feel a nicotine craving during your appetizer? No problem. Pop a white Taboka pouch inside your cheek and absorb the chemicals.
Packs of 12 pouches in tobacco or menthol flavor began appearing Friday in stores that sell cigarettes. They retail for the price of a pack of Marlboros -- $3.55 on average.

Supporters of the product say it reduces tobacco-related disease associated with cigarettes by 98 percent, but the American Lung Association says smokeless tobacco causes oral cancers, gingivitis and gum disease.

Philip Morris declined to discuss the factors that led it to choose Indianapolis as the guinea pig for Taboka, other than to say Hoosiers represent consumers nationwide.

But health advocates say Indiana provides fertile ground because adult smoking in the state has held steady at about 27 percent for a decade -- while the national average has fallen to 20.6 percent from 23.5 percent.

"It will obviously give them a great test audience -- people who already have an addiction to tobacco," said Nancy Turner, head of the American Lung Association of Indiana.

She said she fears the product could "replace one deadly habit with another.

http://www.indystar.com/apps/pbcs.dll/article?AID=/20060708/BUSINESS/607080474

WE WELCOME ALL TO PARTICIPATE IN THE LIVELY DEBATE ON SMOKELESS TOBACCO IN HONG KONG, NOVEMBER 24-26, 2006.

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❑ THE NEED FOR TOBACCO HARM REDUCTION

Supporters of the harm reduction approach to tobacco control argue that nicotine is 'here to stay', that it is not feasible to eradicate its use, and that it is more realistic to explore safer nicotine delivery systems which could contribute to tobacco harm reduction. While ideally these should be non-tobacco products, the reality appears to be otherwise. Nicotine replacement therapies to date have failed to deliver the same nicotine 'high' as cigarettes which make them less appealing to smokers. They are also regulated as pharmaceuticals and are more expensive than cigarettes thus putting them at a competitive disadvantage. Other tobacco products seemingly have greater acceptability in attracting smokers. If these products are less harmful than smoked tobacco then a change to there use would reduce the harm to the individual and the burden of tobacco induced disease.

A paper by Kozlowski, O'Connor and Edward (Tobacco Control, 2003) entitled "Some practical points on harm reduction: what to tell your lawmaker and what to tell your brother about Swedish snus" outlines the potential role of snus in smoking cessation.

1. "*Quit using tobacco, if you can*. This would provide the greatest health benefit.
2. *Try medicinal nicotine*. If possible substitute cleaner forms of nicotine.
3. *Try snus as the Swedes do*. That Swedish snus is much safer than cigarettes is supported by ample scientific evidence.

- Use a product meeting or exceeding the Gothiatek standard.
- Buy it fresh from a retailer who refrigerates the product
- Use snus that comes in the individual serving pouches or sachets.
- Place the snus under your upper lip, toward the front of your mouth.
- You are switching from cigarettes to snus, not US snuff.

4. *Next try medicinal nicotine*. Try to switch to cleaner forms of nicotine when you feel able.
5. *Next stop using any nicotine if you can*. But you should keep using medicinal nicotine, or even snus, as long as you need to, to keep you from smoking."

❑ REQUIREMENT FOR COMPREHENSIVE REGULATION

> ***"on average Scandinavian or American smokeless tobaccos are at least 90% less hazardous than cigarette smoking. Further, the actual risk can be controlled through regulation – for example setting maximum thresholds for specific carcinogens or other toxins such as heavy metals."***
>
> Bates, Fagerstrom et al (2003)

Those advocating the use of smokeless tobacco as a harm reduction strategy do not deny that smokeless tobacco use is addictive nor that smokeless tobacco is harmless. Rather they argue that it is less harmful than smoked tobacco and that the amount of harm reduction is dependent on the type of smokeless tobacco used with a graduation of decreasing risk from smoked tobacco through betel quid, chewing tobacco, oral snuff, to the lowest Swedish snus.(IARC 2005)

McNeil, Bedi, et al (Tob Control, 2006) investigated the level of toxins in oral tobacco products in the UK compared to leading US brands and Swedish snus. There was large variability between the products for all the measured toxins and carcinogens with the widest being 130 fold. Chewing

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tobaccos, especially that of the Orient were the most toxic with Swedish snus having one of the lowest level of carcinogenic tobacco specific nitrosamines (TSNA's). The different curing, blending, processing and storage methods of the products appear to account for much of the difference. This favors the regulation of such products and the setting of standards for maximal levels of toxic constituents with the aim of tightening such standards as production methods improve to minimize harm. Models for such standards have been proposed in Sweden (the Gothiatek Standard, http://www.gothiatek.com) and Canada.

Smokeless tobacco has not been conclusively linked to the 2 major diseases of smoking, COPD and lung cancer, nor cancers outside the oral cavity, with limited evidence linking Swedish snus to oral cancers. If there is a CVS risk with smokeless tobacco it is substantially less than that of cigarettes and smokeless tobacco produces no environmental tobacco smoke removing the burden of passive smoking. The Royal College of Physicians (RCP 2002) estimates that the harm of smokeless tobacco is 10-1000 times less than that of smoking. If the harm of smokeless tobacco is only 10% that of smoking then smokeless tobacco use would have to increase to 10 times that of current smoking before the total harm would be equivalent.

❑ THOSE FOR AND AGAINST

The harm reduction approach has gained support from several key international organizations.

In 2001, the Institute of Medicine (IOM) in the US released a report "Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction",(http://newton.nap.edu/catalog/10029.html)and laid the foundation for tobacco-related research assessing 'potentially reduced exposure products' (PREPs) that might reduce the risks associated with using tobacco.

Their report concluded that, "harm reduction is a feasible and justifiable public health policy – but only if it is implemented carefully to achieve the following objectives:

- Manufacturers have the necessary incentive to develop and market products that reduce exposure to tobacco toxicants and that have a reasonable prospect of reducing the risk of tobacco-related disease.
- Consumers are fully and accurately informed of all the known, potential and likely consequences of using these products.
- Promotion, advertising and labeling of these products are firmly regulated to prevent false or misleading claims, explicit or implicit.
- Health and behavioural effects of using PREPs are monitored on a continuing basis.
- Basic, clinical and epidemiological research is conducted to establish their potential for harm reduction for individuals and populations.
- Harm reduction is implemented as a component of a comprehensive national tobacco control program that emphasizes abstinence-oriented prevention and treatment."

"With the most intensive application of the most effective known programs for prevention and cessation, approximately 10-15% of adults in the United States are expected to be regular users of tobacco in 2010, and they will continue to suffer the consequences. Among this group are many who cannot, or will not stop using tobacco, and it is this group that effective programs and products of harm reduction should be directed."

IOM, Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction. Preface, page x

A panel in the US (Levy et al (Addictive Behav.,2006)), funded by the IOM, predicted that the use in the USA of a "harm reduction" policy that required the smokeless tobacco product meet low nitrosamine standards and be marketed with a warning label consistent with the evidence of relative health risks would accelerate the decrease in smoking prevalence from 1.3 to 3.1 percent over 5 years compared to current smokeless usage.

In 2002, the Royal College of Physicians (RCP) in London released a report, "Protecting Smokers, Saving Lives. The case for a tobacco and nicotine regulatory authority."
(http://www.rcplondon.ac.uk/pubs/books/protsmokers/index.asp)
This report highlighted "the challenges of developments in the tobacco market" where "tobacco companies are designing products which claim reduced risk or other benefits, and smokeless tobacco producers are seeking to exploit very large reductions in risk compared to smoking."
Further to this, in 2003, a number of key European tobacco control figures (Bates, Fagerstrom et al) published a statement "European Union policy on smokeless tobacco. A statement in favour of evidence-based regulation for public health." (http://www.ash.org.uk/html/regulation/html/eusmokeless.html)
This report discusses the EU Directive and comprehensively lays out the case supporting the replacement of Article 8 of directive 2001/37/EC with comprehensive regulatory framework and the evidence and arguments for and against a harm reduction approach.
What all of these organizations support is the use of smokeless tobacco as a harm reduction strategy only if a comprehensive tobacco and nicotine regulatory authority and framework is in place and that the prominence of prevention and cessation in tobacco control remain. This is in keeping with the requirements under the FCTC.

However, the WHO and the CDC/Surgeon Generals Office in the US promote an opposing view.
This year's World No Tobacco Day theme, was "Tobacco: deadly in any form or disguise".

> ***"All tobacco products are addictive, harmful and can cause death, regardless of the form, packaging, or name under which they are presented to the public."***
>
> **WHO, 2006**
> (http://www.who.int/mediacentre/news/releases/2006/pr28/en)

The above statement mentioned the increase in marketing of smokeless tobacco in non-traditional areas such as the Middle East, especially to young women. Consistent with the IOM, the RCP and Bates, Fagerstrom et al the WHO also emphasized the importance of comprehensive legislation for all tobacco products as many products are currently outside most legislative frameworks.
The 1986 Surgeon Generals Report, "The Health Consequences of using Smokeless Tobacco", states that smokeless tobacco is not a safe alternative to cigarettes, while a 1994 Surgeon General Report, "Preventing Tobacco Use Among Young People" concluded that smokeless tobacco was a gateway to cigarette smoking among American youths. These reports along with the IARC 2005 findings that smokeless tobacco is carcinogenic have led to the US CDC and the National Cancer Institute continuing to recommend that the public avoid and discontinue the use of all tobacco products including smokeless tobacco.
The decision of such organizations not to state publicly the evidence that smokeless tobacco is less harmful than cigarettes has riled many in the alternative camp. They argue that this is unethical. However the rationale for this approach appears to be that giving this message to the public would lead to confusion and the misunderstanding

that less harmful equals harmless. This would also open an area for exploitation by the tobacco industry. Supporters however argue that it is unethical to deny the public, especially smokers, such knowledge when the scientific evidence clearly shows that smokeless tobacco is less harmful than smoking.

- **THE WHY NOT. GATEWAYS, REDUCED QUITTING, AND HARM**

Opponents to harm reduction have concerns that it would lead to an increase in smokeless tobacco users, that this would then lead to an increase in young peoples use of cigarettes via a 'gateway' effect and that smokeless tobacco use would lower the rates of tobacco cessation as users would continue with the smokeless products rather than moving from smoking to quitting.
While it is impossible to predict the effect such a harm reduction strategy may have the Swedish experience appears to support the opposing view.
Ramstrom, Foulds (Tobacco Control, 2006) in "Role of snus in initiation and cessation of tobacco smoking in Sweden", concluded that snus use was associated with a reduced risk of becoming a daily smoker and an increased likelihood of stopping smoking. They found that among men whom attempted to quit smoking, snus was the most common cessation aid (58% compared to 38% for all nicotine replacement therapies). Among men who used snus as a single aid 66% succeeded in stopping completely, compared to 47% using nicotine gum or 32% using a patch. Similar findings were found with women.
This supported Furberg et als study (Tobacco Control, 2005) "Is Swedish snus associated with smoking initiation or smoking cessation?" This study used cross-sectional data and concluded that snus use was associated with smoking cessation not initiation, and that Swedish smokers appeared to be using snus as a naturalistic, non-medical smoking cessation aid. In the discussion the author's summed up the debate well;

"We are aware that advocating the use of one addictive tobacco product to diminish the harm from another is a controversial issue, particularly as data supporting the use of snus as an NRT could enhance the market of the tobacco industry. Clearly, eliminating all forms of tobacco would have the most beneficial effect on world health; however many smokers are unable to achieve lasting smoking cessation. From a harm reduction perspective, should snus be shown to be as effective or superior in efficacy to existing NRT's without having adverse health consequences, it may represent a more acceptable means by which to reduce tobacco related health burden."

Haukkala et al, (Addiction, 2006) studied the progression of oral snuff us among Finnish 13 –16 year olds but were unable to determine the direction of causality between combined snuff and cigarette use.

Those who disagree with the use of smokeless tobacco as a means of tobacco harm reduction have strong arguments.
These include, that no form of tobacco is safe and thus no one form should be advocated over another. All tobacco is addictive, addiction is a disease and therefore no one form should be advocated over another. There is presently insufficient evidence to accurately quantify the health impacts of smokeless tobacco. Until this information is available smokeless tobacco should not be publicized as less harmful than tobacco. Smokeless tobacco may be a gateway to smoking initiation among youth. Smokeless tobacco as a harm reduction method would lead to reductions in tobacco cessation and potentially an increase in population tobacco disease burden. Smokeless tobacco has not been compared with NRT in its efficacy in smoking

cessation. Until its efficacy has been shown to be greater than that of NRT in relation to its increased harm it should not be advocated for use in smoking cessation. And, that advocating some forms of tobacco in a harm reduction strategy would be exploited by the tobacco industry.

The institutional supporters of the harm reduction idea attempt to address these concerns in their recommendations for comprehensive legislation, regulation and monitoring of all tobacco products, as well as the need for ongoing research.

The major difference between the two groups appears to be in the 'ideals' of tobacco control (i.e. eliminating all use of tobacco products) versus the aim of reducing the burden of tobacco induced morbidity and mortality, as well as the weight of evidence required to change the tobacco control approach.

❑ UNRESOLVED QUESTIONS

There are many questions in the debate which remain unresolved.

- **What is the primary purpose of tobacco control, a campaign against tobacco or against tobacco induced morbidity and mortality?**
- **At what level of reduced risk would the authorities be negligent in not allowing consumers to be informed about products that do them less harm?**
- **Would the 'Swedish Experience' be replicated elsewhere in the world?**
- **How should claims that are true but may be misunderstood or understood disproportionately ('reduced cancer risk') be dealt with?**
- **What happens when some risks increase and other decrease?**
- **How do you balance individual risk/benefit versus societal?**
- **How should 'smokers rights' to have access to products that do them much less harm be reconciled with possible negative consequences at the population level?**
- **What options are there to 'promote' smokeless tobacco as a much safer alternative to smoking, without promoting tobacco use per se?**
- **How should tobacco and nicotine products be regulated and what regulatory standards should be used?**

We welcome your views.

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4: Tobacco Industry Tactics: Brand Stretching

"..in the future the only way that tobacco brand names can be placed in front of, let alone advertised to the buying public, is via a TMD vehicle". **BAT, 1996** [3]

Over the decades the tobacco industry has developed many sophisticated strategies in response to increasing tobacco control legislation, especially advertising restrictions. Advertising is after all the lifeblood of cigarette sales. What follows is a summary of one of the leading strategies used by the tobacco industry to circumvent advertising restrictions and ensure that their products and brands remain in public view. The majority of quotes are taken directly from internal tobacco industry documents and a complete list of references is available upon request.

- **WHAT IS 'BRAND STRETCHING' AND 'INDIRECT ADVERTISING'?**

A tactic used by the tobacco industry to circumvent tobacco advertising bans and ensure the ongoing promotion of their products to the public.

"Indirect advertising" includes but is not limited to sponsorship, promotional activities and /or "brand stretching" that makes use of the brand name (alone or in conjunction with any other word), logo, symbol, selling message, recognizable color or pattern of colors, or any other indicia of product identification, identifiable with those used for any brand of tobacco product.

" Indirect tobacco advertising is advertising which , while not specifically mentioning the tobacco product, tries to circumvent a tobacco advertising ban or restriction by using brand names, trade names, trade marks, emblems or other distinctive features of tobacco products with the aim or the indirect effect of promoting a tobacco product." International Union Against Cancer (UICC), 2001 [1]

"Brand-stretching" means the association of any tobacco product brand element with a non-tobacco product good or service and the advertising or marketing of such good or service (i.e. Marlboro Classics clothing, Salem Attitude shoes). It is used by the tobacco industry to circumvent tobacco advertising restrictions and the industry refers to it as Trade Mark Diversification (TMD) in its own documents.

"Reverse brand-stretching" from non-tobacco to tobacco products also occurs (e.g. Yves Saint Laurent, Cartier, and Boss).

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"*In a global environment of ever increasing restriction in the availability of traditional advertising media, parallel communication devices such as sponsorships and trademark diversification now represent the only major alternatives for tobacco marketers."*
"Sponsorships have a parallel communication role and can often add vitality to the consumers perception of a brand. But however well targeted, sponsorships as a rule cannot adequately communicate a brand's creative positioning. It is possible for properly selected and managed Trademark Diversifications to accomplish this objective." BAT, 1991 [2]

"Trademark diversification" or "TMD", "alibi advertising", and "parallel communication" are synonymous terms for brand-stretching used by the tobacco industry.

- **IS BRAND STRETCHING AND INDIRECT ADVERTISING A FORM OF CIGARETTE ADVERTISING?**

YES.

" <u>TMD</u>
<u>Definition</u>
The development and marketing of non tobacco products or services bearing the brand name in a manner appropriate to maintaining brand awareness.
<u>Objectives</u>
To provide an effective longterm communications vehicle which will survive restrictions or bans on cigarette advertising." BAT, date unknown. [24]

"Opportunities should be explored by all companies so as to find non-tobacco products, and other services which can be used to communicate the brand or house name, together with their essential visual identifiers. This is likely to be a long-term and costly operation, but the principal way nevertheless to ensure that cigarette brands can be effectively publicized when all direct forms of communication are denied." BAT, 1979 [4]

Tobacco advertising and indirect tobacco advertising share two common characteristics: the same brand name (alone or in association with another word) and same imagery/themes. Marlboro cigarettes and Marlboro Classic clothing share the name 'Marlboro', the western theme and are aimed at the same target group.
Brands such as Marlboro and Camel have been constructed over decades and are among the most heavily marketed brand names on the planet. By using the same names, images and themes a clear link between indirect advertising and tobacco advertising has been established. Both the names and the associated images are powerfully linked to cigarettes regardless of the product they purport to be advertising.
The Belgian Court in 1999 found;
"Whatever may be the purpose to market products with the same brand name as known tobacco products, the advertising for these products has the consequence to promote the brand also and can be considered an indirect way of advertising tobacco products".[1]

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Marlboro Classic clothing, Marlboro Country Travel, Camel watches, boots and clothing, Mild Seven watches, Salem Active wear, Winston clothing, Kent Travel, Peter Stuyvesant Travel, Benson & Hedges Bistro, Dunhill Accessories and Salem Cool Planet have all appeared in response to direct advertising bans, while Cartier, Boss, Yves Saint Laurent and even Harley Davidson brand names now appear on cigarettes (reverse brand-stretching).

- **THE TOBACCO INDUSTRY CLAIMS THAT WHEN VIEWING ADVERTISMENT FOR DIVERSIFICATION PRODUCTS *"consumers do not make a direct link with the parent product"*. [5] IS THIS TRUE?**

NO.

LUCKY STRIKE TREND SHOP

In their own words the tobacco companies state;

"All TMD advertising should result in a clear consumer association of the TMD with the core brand."

"To date LUCKY STRIKE Clothes and BARCLAY direct advertising research has been completed. In both cases, consumers clearly associated the TMD ads with the cigarette brands."

"A further measure of TMD advertising effectiveness can be gained by monitoring in-market brand awareness. Perhaps an ideal test case is Hong Kong where electronic broadcast of cigarette advertising was banned as of December 1990. Beginning in November of 1990 and continuing to this date, KENT brand TV advertising has been replaced by KENT Leisure Holidays commercials. Initial tests of unaided awareness are encouraging." BAT, 1991 [2]

"..respondents may take the view that the TMD activity/advertising is designed to promote the cigarette rather than, or in addition to the TMD product itself. Although less positive this would still represent an achievement of the objectives." BAT, undated [7]

"This concept, if executed properly, should succeed in establishing MLW as a status and giving added value to Marlboro cigarettes which respondents saw in danger of being classed as "anyone's cigarette" due to its large share of smokers."

"The classics concept succeeds both in terms of its communication and its content in reinforcing Marlboro's desired image amongst its prime target group."

"There was an overriding acceptance of and identification with the Classics concept, both by smokers and non-smokers, which they see as coherent with Marlboro's overall image. This coherency is the indispensable condition to create and develop a synergic effect between our leisure wear and cigarette activities." Philip Morris (PM), 1987.[8]

"Research to ensure that the cigarette brand target smokers have a favorable attitude and interest in the non-tobacco product must be carried out. Furthermore the aim should be to choose a product

which will actually enhance the tobacco brand image." BAT, 1979.[4]

"Research indicated interest in ML Classics among our target…..Having different logo from the pack and having no rooftop helped us win our court case in Finland." PM, 1990s [6]

Express provisions forbidding indirect tobacco advertising were added to the Finnish Tobacco Act in 1995. One of the reasons for this amendment was that prior attempts to put a stop to indirect tobacco advertising by pointing to existing provisions forbidding advertising had failed. In 1988, the Supreme Administrative Court reversed an injunction issued by the National Board of Health against advertising for Marlboro Classics clothing with a vote of 4-3.

Several studies have shown that indirect advertising is associated with youth smoking.[15,16]
In a 1987 Philip Morris document the target group for Marlboro Classics was described as 15 – 35 years. (PM, 1987 [8])
Norway's tobacco advertising ban was extended in 1994 to include indirect advertising after research showed that half of youngsters were familiar with tobacco products through indirect advertising. [1]

- **WHY AND HOW HAS BRAND STRETCHING AND INDIRECT ADVERTISING DEVELOPED?**

Tobacco brand-stretching/trademark diversification has developed in response to increasing tobacco advertising restrictions. Tobacco industry documents clearly show that this has been a carefully constructed long term project to prepare for and circumvent future restrictions in tobacco advertising.

"All major international tobacco companies pursue a TMD strategy in one form or another and all (with the possible exception of Dunhill) have the same motivation,
"To maintain cigarette brand name/imagery communication for as long as possible in the face of increasingly hostile legislation." "
BAT, undated [9]

"*..establish[ing] unique images for leading brands and at the same time ensur[ing] that after above-the-line phase out, the advertising campaigns already in place could be easily transferred to…other media*". PM, 1974.[10]

The industry argues that their diversification of tobacco brands is legitimate. However there is unequivocal evidence to the contrary:
"Except where diversification is required to support the tobacco business or where it is part of plans to establish financial services activities in new territories, the aim should be to reduce the level of non-tobacco activities." BAT, 1992.[11]

The strategy has been long term, well planned and is constantly evolving. The tobacco industry pioneer of trademark diversification was RJR Nabisco with Camel in the form of Camel boots, watches, expeditions and Camel Trophy. The first diversification products appeared in Germany in the late 1970s and were extended to the rest of Europe in the 1980s. Philip Morris founded Marlboro Leisure Wear (later Marlboro Classics) in 1974. The diversification products have been carefully developed and researched to attract the same target audience as the cigarettes and contain the same imagery.

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"In order to serve our advertising and promotional purposes, diversifications must adhere to the following 3 basic criteria:
1. The profile of the diversification buyer must be close to the profile of the smokers we have or want to have.
2. The image of the product (or service) representing the diversification must be close and consistent with the image of the brand(s) we intend to advertise.
3. Both the product (or the service) and the P.O.S network must be of high quality and visited by a large proportion of our target group." PM, 1993[19]

Across Europe, the introduction of tobacco brand diversification products has followed increasing advertising restrictions.

"We have noticed that several PM affiliates (Switzerland, France, Scandinavia) are now strongly demanding Marlboro Classics to challenge better the local advertising restrictions." PM, 1987 [12]

Similar restrictions in Asia were circumvented by the introduction of Kent Holidays and Salem Attitude clothing and shoes in Hong Kong and Benson and Hedges Coffee Houses in Malaysia.
Hundreds of diversification vehicles are now in the market. The favored products are leisure wear, lifestyle products and travel.

In anticipation of restrictions limiting brand-stretching and indirect advertising, tobacco companies have distanced themselves from their diversification arms so as to make them appear as legitimate, stand alone businesses and thus survive outside scrutiny. This involves the use of complex business structures. Despite this outward appearance the tobacco companies maintain control.

"The formulation of the concepts and the checking and vetting of the operation must be in the hands of the Company, and not left to outside agencies who seldom appreciate the finer aspects of the cigarette business." BAT, 1979 [4]
A 1990's PMI document discussing proposed amendments to the Marlboro Classics License agreement stated one of the reasons for the amendment as being, "*to ensure stricter control over brand image as the business grows and evolves*". PMI, 1997[17]

The conflict between the intentions of the public health sector (and the legislature), and the tobacco industry is exemplified by the legal battle in France.
France was one of the first countries where tobacco companies evolved the art of indirect advertising, in answer to the 1976 law known as "Loi Veil". The law only allowed tobacco advertising through graphical or pictorial display of the product, its packaging, or its trade symbol. Advertising for cigarettes could no longer be associated with cowboys or adventurous travel. Leading cigarette brands continued their advertising strategy and used the same visuals with the classical ad themes for advertisements of lighters or matches with the same brand name. A court judgment in 1983 stopped the advertisement for Camel Lighters on billboards as the ads carried the same visual image as the cigarette ads. The Loi Evin of 1991 strengthened the provisions but did not disarm the tobacco industry. The RJ Reynolds headquarters were raided in 1995 where internal documents described ways to circumvent legal restrictions by promoting products and services such as Camel Boots and Winston Clothes. The RJR Nabisco affiliate World Brands Inc. mission was described as: "to identify, to develop, and take responsibility for diversification programmes of the brand, to increase the perception and the effect of the image of the leading brands of RJR Nabisco". And that "WBI will attack any local or European Community legal restriction,

whose validity could be doubtful, through lobbying or, if necessary, through legal action in order to protect its commercial liberty."
The strategy plan 1992-1996 of RJ Reynolds Tobacco France stressed that, "compared with most of its competitors, RJR France seems to be better prepared to face legal restrictions as a result of the greater number of license activities for the logo (Camel Trophy Watches, Camel Boots, Camel Collection/shops, Winston clothes) in order to maintain the Camel and Winston communication."
On the basis of these and other documents the advertising for Camel Boots and Camel Trophy was condemned by the French Court on 19/10/1998. (International Union Against Cancer (UICC) ,2001[1])

As indirect tobacco advertising restrictions have increased, reverse brand stretching is now occurring with the appearance of Yves St Laurent, Cartier and Boss branded cigarettes. Few countries have legislation restricting this form of diversification and advertising, thus leaving it vulnerable to exploitation. There is wide scope for the continued advertising of tobacco through such a loop hole.

- **THE WAY FORWARD**

Under the FCTC signatories are required to address all forms of indirect advertising including brand stretching. This requires clear, comprehensive legislation, ideally permissive in nature, which is actively enforced. Reviewing international experience is invaluable and necessary to ensure that countries reviewing or enacting such legislation do not allow room for circumvention by the tobacco industry.

5: Oral Health and Tobacco Cessation

Post Conference Workshop on
Treatment of Tobacco Dependency
27 - 28 November 2006

Li Ka Shing Faculty of Medicine
Department of Community Medicine, School of Public Health
Department of Nursing Studies
Faculty of Dentistry, Prince Philip Dental Hospital

The importance of oral health professionals in tobacco control has often been underestimated but is well recognized by the Society and is a theme of this year's conference.
Several recent oral health publications have focused on tobacco use cessation, with the April edition of *Oral Health & Preventive Dentistry* 2006 being dedicated to the topic.
To update member's three of the most recently published review articles on tobacco cessation in the oral health setting are summarized below.

- **Gordon JS, Lichtenstein E, Severson HH, Andrews JA. Tobacco cessation in dental settings: research findings and future directions. *Drug Alcohol Rev*. January 2006; 25(1):27-37.**

Review of published trials and current studies relating to tobacco cessation in dental settings.

ABSTRACT:
The hazards associated with cigarette smoking and smokeless tobacco use have been well documented. In addition to its association with many cancers and coronary conditions, tobacco plays a role in the aetiology of a number of oral morbidities. Dental care practitioners are a largely untapped resource for providing advice and brief counselling to tobacco-using patients, and there are good reasons to believe that

they can be effective. Data from seven randomised trials indicate there is ample evidence for the efficacy of dental office-based interventions, but adoption of these tobacco cessation activities into practice has been slow. The limited research on dissemination of tobacco interventions is promising, but there is a need to develop and evaluate new methods for encouraging adoption, implementation and maintenance of tobacco interventions into routine dental care. Several studies currently under way may help to increase the effectiveness and dissemination of office-based tobacco cessation programmes into routine dental care. If dental practitioners provided cessation assistance routinely to their patients and achieved even modest success rates, the public health impact would be enormous. Researchers and clinicians must continue to work together towards universal adoption of effective tobacco cessation interventions at each clinical encounter.

- **Watt RG, Benzian H, Binnie V, Gafner C, et al. Public Health Aspects of Tobacco Control: Setting the Agenda for Action by Oral Health Professions Across Europe. *Oral Health & Preventive Dentistry* 2006; 4:19-26.**

Reviews current data and literature to outline of the current public health aspects of tobacco control and cessation in Europe under the FCTC, and highlighting the role of oral health professionals.
Major barriers limiting progress in cessation in primary dental care.
These included;

- Doubts about effectiveness of advice
- Lack of time and cost concerns
- Lack of knowledge and skill
- Fear of affecting patient/dentist relationship
- Lack of tailored back-up resources
- Assume responsibility of other health
- Outdated concepts of prevention and behaviour change.

Emphasis and recommendations to overcome these barriers included;

- Integrating tobacco related topics into a wide range of subjects, such as dental public health, behavioural sciences, communication skills, oral pathology, oral diagnosis and periodontology.
- Encouraging participation in cessation workshops via linking to continuing professional development points.
- Reviewing prescription guidelines so that dentists can prescribe nicotine replacement therapies and bupropion.
- Increasing the role of dental associations and professional groups in tobacco control. Currently only 50% of National Dental Associations in OECD countries have a written policy on tobacco control.
- Review the funding for dental care such that is compensation for preventative care.
- Increased research in key areas such as primary prevention targeted at youth, RCTs evaluating effectiveness of different strategies and personnel in cessation across various settings, most effective referral pathways, relapse prevention and evaluation of different incentive and compensation systems aimed at encouraging oral health professionals active involvement in cessation activities.

- **Needleman I., Warnakulasuriya S., et al. Evaluation of tobacco use cessation (TUC) counselling in the dental office. *Oral Health***

***& Preventive Dentistry* 2006; 4(1):27-47.**

This paper reviews interventions for which evidence of efficacy exists, using published trials, studies, guidelines and systematic reviews.

The effect of tobacco-use cessation counseling in the dental office was examined with findings that dental health care providers had the greatest opportunity for intervention but that only 48% of dentists reported counseling compared to 96% in one study. In the UK only 50% asked about smoking with only 30% providing brief cessation advice. The data from the USA was more promising but 40% do not ask about tobacco use and 60% do not routinely advise quitting. Less than one half of US dental schools and programmes provide clinical tobacco intervention services.

Cessation trials were reviewed. These included different methods from brief intervention through to complex, including pharmacological supports. Findings were similar to findings in the medical setting though there was much heterogeneity between the studies. The magnitude of effect is thus unclear though not the direction of impact. Further research is recommended.

Barriers to tobacco-use counseling in the dental practice were also examined.

Three types of barriers are described, barriers to implementing, barriers to participation (by clinicians or patients), and barriers to effectiveness of tobacco use cessation counseling. Comprehensive lists of each type of barrier are provided along with the supporting evidence. No one factor was identified as most influential with the magnitude of each barrier being different in each setting. Various recommendations are made as to addressing these barriers in practice with the aim of meeting the WHO objective that "given the evidence, tobacco cessation activities should be as natural as oral hygiene measures in dental offices".

6: New and Notable

- **NICOTINE VACCINE:**

LeSage MG, Keyler DE, Pentel PR. Current status of Immunologic Approaches to Treating Tobacco Dependence: Vaccines and Nicotine-specific Antibodies. The AAPS Journal 2006; 8 (1) Article 8. (http://www.aapsj.org)

(The following was summarized from the original article)

History of Nicotine vaccine:

An immunologic approach to treating drug dependence was first suggested over 30 years ago, when it was reported that immunization against heroin could reduce the likelihood that monkeys would self-administer the drug.

Studies using various vaccines and nicotine- specific antibodies in rodents have shown that immunization can significantly reduce the behavioral effects of nicotine that are relevant to tobacco dependence. These findings provide proof of principle that immunologic interventions could have utility in the treatment of tobacco dependence.

Mechanism: (development)

Nicotine is too small (molecular weight 167 kD) to elicit an immune response (it is not immunogenic). Thus regular tobacco users do not have antibodies against it. Nicotine is rendered immunogenic by conjugating the drug itself or a structurally related compound (ie. hapten) to an immunogenic carrier protein to form a complete immunogen, referred to as a conjugate vaccine.

Immunisation against nicotine involves using nicotine-specific antibodies that bind nicotine in serum. The antibody is excluded from the brain because it is too large to cross the blood- brain barrier. When an immunized subject receives nicotine, a

substantial fraction of the drug is bound to antibody, sequestered in blood, and prevented from entering the brain to thereby produce its reinforcing effects on tobacco use.

In addition, vaccination markedly slows nicotine's elimination half-life. Consequently, the rate of smoking could be reduced by prolonging the effect of nicotine from each cigarette and delaying the nicotine deprivation that leads to smoking the next cigarette.

Current studies in Humans:

The results of phase I and II clinical trials have been reported for 3 nicotine vaccines: Nic VAX, Nic Qb, and TA- NIC. The vaccination schedule in these clinical trials consisted of 2 to 6 doses of vaccine at an interval of 2 to 4 weeks and a later booster dose was administered in 2 trials.

No adverse events have been reported other than local reactions and mild systemic reactions (eg. Flu- like symptoms in placebo and vaccine groups was not significantly different, suggesting that they were the result of the adjuvant used rather than the immunogen. All symptoms resolved within 1 to 4 days without medical intervention.

Potential efficacy

In the TA-NIC trial, participants were instructed to quit after receiving 6 vaccine injections at 1 of 3 does over 12 weeks and were then boosted at 32 weeks. Quit rates were greater in the group receiving the highest vaccine dose than in the control group (38% vs 8%).

Advantages of Immunologic Approaches

Immunologic approaches to treating tobacco dependence have 3 key advantages.

1. Immunization appears to be safe because of its low cross-reactivity with compounds other than nicotine.
2. Immunization only requires a brief series of monthly injections to produce effects that can endure for months. The lack of major side effects and relatively minimal dosing requirements could be associated with improved patients compliance.
3. Its unique mechanism of action makes it well suited for combination with other pharmacotherapies.

Potential concerns

1. The lack of control over antibody levels and large variability between subjects is the primary limitation of vaccination.
2. The slow development of antibody levels and onset of effect could discourage tobacco users who are eager to quit from trying vaccination, as treatment would need to be initiated months before the quit attempt.
3. Passive immunization is much more expensive and requires more frequent dosing, and potential side effects could occur (eg, allergic reactions).
4. Studies are needed to assess the safety of immunizing pregnant smokers and the efficacy of immunization in reducing fetal exposure to nicotine.
5. There is concern that compensatory increases in smoking could occur to surmount the effects of immunization, possibly leading to increases in exposure to other harmful constituents in tobacco. However, there has been no evidence of compensation in either animals self-administering nicotine or smoking in humans.

Potential public health benefits:

1. The research to date suggests that immunological interventions could play an important role in future treatments for tobacco dependence.
2. The primary role of such interventions will likely be in preventing relapse in smokers who are motivated to quit and might prevent progression to full relapse..
3. Immunologic intervention is in facilitating reduction of tobacco use in people who are unwilling or unable to quit.
4. Immunological interventions when combined with behavioral interventions will maximize the effectiveness in motivating abstinence from tobacco use.

- **NIC LITE:**

Nicotine Drink Touts Alternative to Smoking.
ABC News, June 24, 2006.

Nic Lite is a new nicotine product on the market. It is a lemon flavored drink containing 4mg of purified Nicotine in 8 oz that was first made available at Los Angeles International Airport and marketed at smokers to get them through flights when unable to smoke. It is now also available at convenience stores and the manufacturers are wanting to offer it in bars as many are now also smoke free.
The clear marketing aim of the drink is to help smokers make it through until they can smoke again rather than as a cessation aid. Critics are concerned that the product is classified as a dietary supplement by the FDA and thus devoid of much regulation. Concerns have also been raised about its addictive properties, its availability and gateway effect to smoking among youth as well as reducing smoking cessation.
More information is available via company website http://www.nichonica.com/

Supplement Facts
Serving Size: 8 fl. oz. (237 mL)
Servings per container: 1

Amount Per Serving		%DV
Calories	0	0%
Total Fat	0g	0%
Total Carbohydrate	0g	0%
Sugars	0g	0%
Total Protein	0g	0%
Nicotine	4mg	†

*Percent Daily Value are based on a 2000 calorie diet.
† Daily Value not established

Other ingredients: Potassium Benzoate, Natural Flavors

These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.

Lastly, a few images of the tobacco advertising you will see on your trip to Hong Kong.

Marlboro store, Hong Kong, May 2006.

Hawker stands, Pedder Street, Central, June 2006.

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