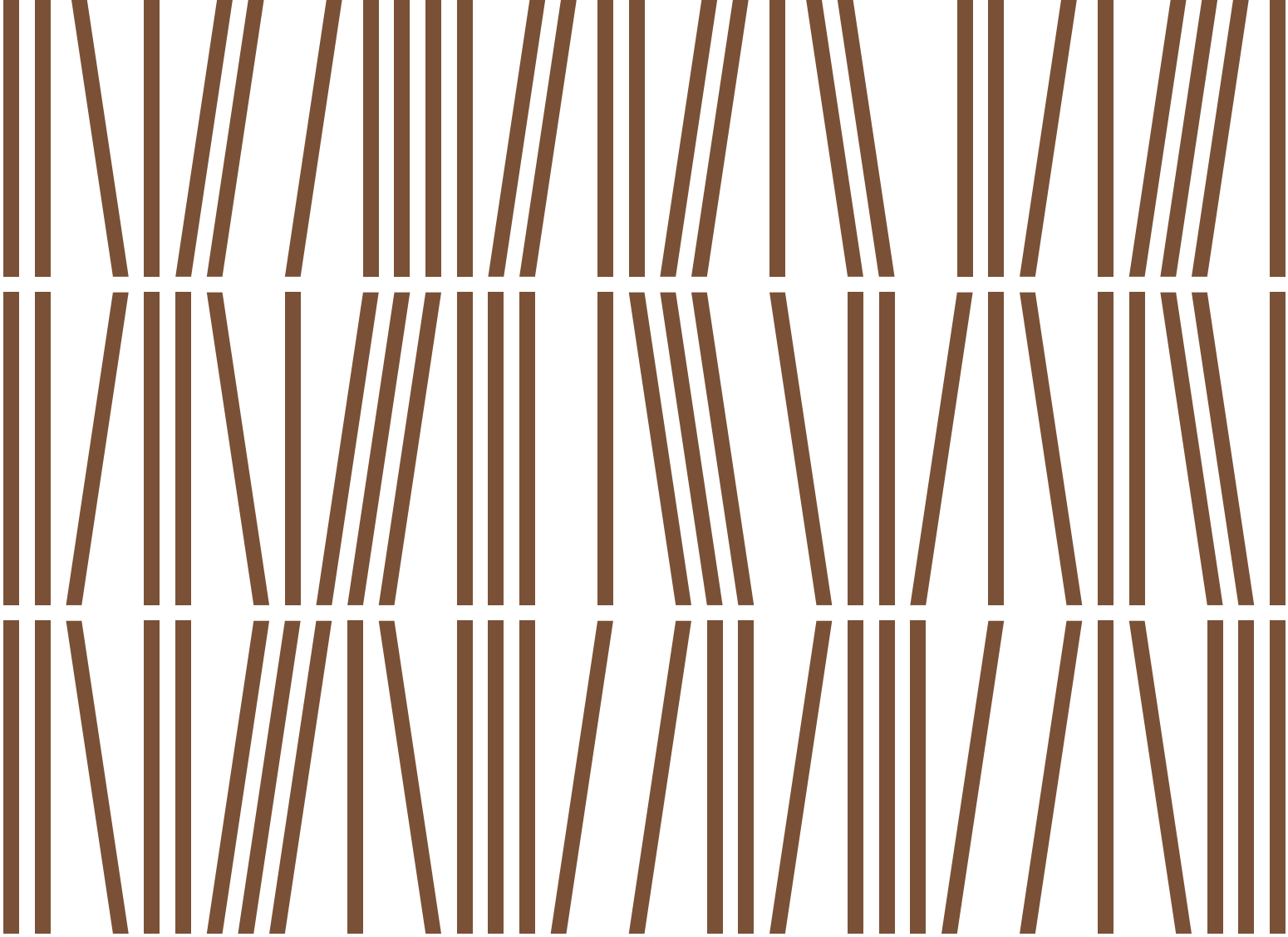


Submission on smokefree environments and regulated products (vaping) amendment bill

MAREWA GLOVER, PhD

2020

Citation: Glover, M. Submission on Smokefree Environments and Regulated Products (Vaping) Amendment Bill. Auckland: Centre of Research Excellence: Indigenous Sovereignty & Smoking, 2020. Health Select Committee Submission.

Published in 2020 by the Centre of Research Excellence: Indigenous Sovereignty & Smoking, PO Box 89186, Torbay, Auckland 0742, New Zealand, www.coreiss.com.

Contents

Introduction	4
Procedural fairness and democratic deliberation	6
Denormalisation is a flawed intent	7
The amendment is not risk-proportionate	10
Complete prohibition is signalled	14
Nicotine as a constituent must be explicitly exempted	16
People living in rural and remote towns discriminated against	18
Unfair heavier burden of compliance on the vape industry	19
Too much power is vested in one person	21
Conclusions	23
Recent conference posters	24
References	25

Introduction

1. This submission on the Smokefree Environments and Regulated Products (Vaping) Amendment Bill (the Bill) is from me - Professor Marewa Glover. I am a behavioural scientist and Director of the Centre of Research Excellence: Indigenous Sovereignty & Smoking (the Centre), Auckland, New Zealand. My Centre is a New Zealand registered limited liability company. We are an independent research company with a mission to build knowledge and research skills to support Indigenous people around the world to reduce the harms associated with tobacco smoking.

2. Our programme of research has been made possible with a research centre grant from the Foundation for a Smoke-Free World, a United States based not-for-profit organisation whose mission is to end tobacco smoking in this generation. The opinions expressed in this submission represent my views only and in no way represent the views of the Foundation for a Smoke-Free World. Any statements insinuating that my Centre is a vested interest of any tobacco company are false. No tobacco or vaping product company, or pharmaceutical company, has any say in or control over me or my research agenda or our findings, or the FSFW funding decisions.

3. I have worked to reduce the morbidity and mortality of tobacco smoking – which was the original intention of the Smoke-Free Environments Act (1990) – since 1992 when I joined the Public Health Commission. There, I worked alongside Dr Murray Laugesen, one of the authors of that world-leading Act. I have dedicated my career to reducing smoking among Māori and all New Zealanders. Given Murray's retirement, I am the longest-standing New Zealand tobacco control expert still dedicated and working fulltime to deliver on the intent of that Act. I was the first person in New Zealand to obtain a PhD on the topic in 2000. I remain the most senior and most qualified Indigenous expert on this topic in the world. I have over 120 scientific journal articles, and over 50 technical reports on studies I have led or been involved with. It is this depth of experience and the knowledge that I have accumulated combined with my Indigenous perspective that sets my advice apart.

4. My recommendations contained in this submission are influenced by my years of research with hundreds of people who smoke, including many young Māori women. Young Māori women have the highest smoking rates in New Zealand. They are over-represented among the lowest socioeconomic quintiles. They disproportionately have multiple social and economic determinants that undermine their ability to thrive and enjoy equitably the benefits modern New Zealand offers. In this submission I will gauge everything proposed in the Amendment against the effect it could have on two young Māori women: Tui and Maia (pseudonyms).

5. Tui is a young Māori mum in her early twenties. Her first child is 18 months old and she is pregnant. She lives with her partner who is not much older than her. He has a job as a builder's assistant. They don't have a car, but they are renting a house close to Otahuhu shops. The nearest dairy is a five minute walk away. Maia is just sixteen. She lives in a small remote town in Northland. She is pregnant and quite scared about that. She lives with her nanna who wants to be supportive but most of the family are angry about her pregnancy. She was already smoking before becoming pregnant. How will the amended Act help these young women stop smoking?

Procedural fairness and democratic deliberation

6. I have previously written to the Health Select Committee expressing concern that refusal to extend the submission date given the extraordinary ban on business as usual in New Zealand decreed by the Prime Minister to take effect from midnight on Wednesday, 25th March 2020 for 4 weeks, is unfair. I believe that many consumers who will be negatively affected by the proposed law change and who wanted to write a submission, have been prevented from doing so because of loss of access to a computer and the internet (e.g. because libraries are closed, and movement is restricted). Even many small businesses, whose future is threatened by the Bill, are no longer in a position to complete their submissions. They have been forced to close. Some have had to lay off staff. Their attention has been redirected to attend to restructuring their business, applying for aid and staying safe. The disproportionately negative impact of the proposed Bill on groups with higher smoking and vaping rates, such as Māori, Pacific and lower socioeconomically disadvantaged groups, makes the denial of extra time particularly discriminatory and unjust.

Denormalisation is a flawed intent

7. The Amendment proposes substantial amendments to the Smoke-Free Environments Act (SFEA).

8. The Amendment shifts the appropriate and evidence-based focus and intent of the original SFEA from reducing disease and death associated with tobacco use (primarily smoking) to:

   a. preventing "the normalisation of vaping" (clause 9)

   b. stopping (unapproved) people from "encouraging" the use of a regulated product under this Act

   c. stopping (unapproved) people and businesses from "promoting" smoking or vaping behaviour; and to

   d. "reduce the social approval of smoking".

9. These new intentions give precedence to one Anglo-Western behavioural change theory (and it is just a theory and a contested one at that) – denormalization.

10. The 'denormalising' of tobacco use is just one strategy suggested within the World Health Organisation Framework Convention on Tobacco Control, which New Zealand is a signatory to. It has however gained dominance within the tobacco control sector, to the point where some academics have abandoned the wider and more holistic range of strategies.

11. Denormalisation is employed when the goal is to completely eradicate the use of tobacco, that is, it is prohibitionist in its intent.

12. The tools of denormalisation are:

    a. restrictive legislation to send a strong message to the public that the Government does not approve of the behaviour and will no longer tolerate it

    b. to reset social norms

    c. the use of social pressure and encouraging the public to police and punish people who do not conform

    d. stigmatising people who engage in the behaviour, and in the case of smoking, inciting disgust, hatred and abuse, toward people who smoke

    e. encouraging discrimination against people who engage in the behaviour. For example, many Government employers will not employ people who smoke. Many landlords will not rent to people who smoke.

    f. punishments, such as, increasing the cost of the behaviour through tax, levies, minimum pack sizes, minimum pricing rules and imposing greater operating costs by increasing the administration required to comply with legislation. Restricting access to the product, for instance making people travel further to purchase the product is another way of increasing the financial cost, but also the cost in terms of their time. Making them buy online, for example, because their local store no longer sells the product – this too increases the cost by adding postage.

    g. extending restrictions on where people can smoke or vape, beyond the minimum required to protect the health of others, helps marginalise people who use tobacco or nicotine. Making these places obvious, such as making people who smoke or vape stand within an unsheltered square painted on the concrete outside, is designed to deliberately encourage public scrutiny and scorn. This social control mechanism of course dates back to medieval, and likely earlier, times – but that does not mean it is an appropriate intervention to be used today.

13. In western countries, denormalization-led legislation to deter smoking, use of oral nicotine and tobacco products (e.g. snus) and vaping is usually accompanied by public health campaigns drawing on a 'pedagogy of disgust'(1). Consequently, anti-smoking/vaping/snus campaigns reinforce negative class, race, gender and unwellness perceptions (2). This contributes to stigmatising the smoker, who becomes the target of abuse and isolation, which can lead to feelings of shame and further isolation from support services. The tobacco control programme that will result from this Amendment will be particularly harmful to groups who already experience multiple marginalities, e.g. Māori and people with mental health conditions. Research suggests that the negative effects of marginalities are cumulative.

14. Denormalisation is deliberately dehumanising and seeks to strip people of their dignity. This is not an ethical public health strategy and yet it is the theory that appears to undergird the tone of the Amendment.

15. The punitive tone of the Amendment is inconsistent with a kaupapa Māori perspective drawing on Māori knowledge, beliefs and values. Denormalisation has been a key strategy of colonising nations and is still being used in New Zealand to stigmatise and marginalise Māori. I know that the 50+ Māori stakeholders who were consulted in 1993 on how to reduce smoking among Māori did not agree with treating people like this. I know because I was the Public Health Commission policy analyst who recorded their korero (discussion) and wrote the report.

16. Young women like Tui and Maia, are already subjected to multiple marginalities: being obviously Māori, young and pregnant, being unemployed, and they smoke. Maia has the additional stigma of being a solo mum. Tui has an additional stigma that taints people who live in Otahuhu because of its high proportion of non-Pākehā and lower socioeconomic people. The punitive tone of the Amendment and the likely punitive and stigmatising approaches public health will implement having been given Government approval for their ideas, will have negative effects for Tui and Maia – effects that will make it more likely that they will continue to be triggered to smoke.

17. The intent of the original SFEA should not be amended.

18. The purpose of the Amendment should be:

    a. to regulate vaping, tobacco heating devices and all non-combustible oral nicotine and tobacco products, not covered by the Medicines Act, to provide consumers with confidence that the products have been manufactured in accordance with minimum quality standards.

    b. to restrict the advertising and sale of all products covered by the Act to people aged 18 and above.

19. Restricting the sale of all tobacco and nicotine products to people aged 18 and over will mean that Maia won't be able to buy vaping products to switch to. The original SFEA did not make it illegal for parents to "distribute" cigarettes to their own children. It is important that the Amendment does not restrict parents from supplying harm-reduced alternatives to smoking to their teenagers aged under 18 who smoke. The Amendment prohibits the sale of vaping products intended for distribution to minors. Somehow parents of a minor who smokes, need to be able to access harm reduced alternatives if the minor cannot quit smoking via other means. This is especially important for Maia who is pregnant.

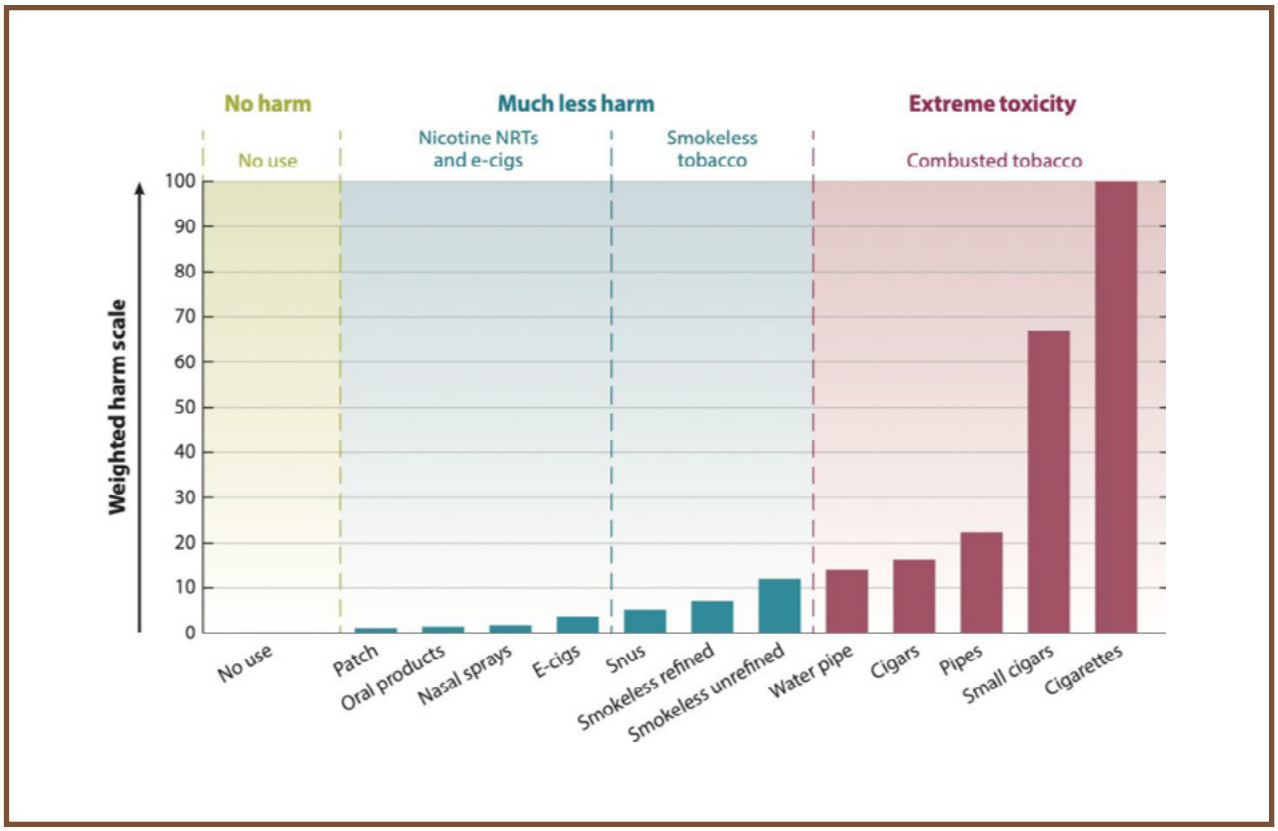
20. A recent review of the evidence on the effects of nicotine on pregnancy outcomes concluded that there is no reason to doubt that switching to smokefree tobacco and nicotine products is better than continuing to smoke. The review conducted by a colleague and I (3) found some studies suggest that using non-smoked products containing nicotine during pregnancy is associated with an increased risk of some negative birth outcomes, but it remains clear the effect is less than that from smoking. There are conflicting results but the evidence does not support denying pregnant women's use of smokefree products if the alternative is that she would continue to smoke.

The amendment is not risk-proportionate

21. The evidence for regulating combustible tobacco products was strong. The evidence is not strong and does not support the proposed heavy restrictions on the import, advertising, sale and distribution of non-combustible nicotine and tobacco products listed in the Amendment.

22. One of the biggest clues that the Amendment is not about reducing tobacco-related disease and premature deaths is the complete ban on oral tobacco products.

23. There is strong evidence that smokeless oral tobacco and nicotine products, such as Swedish style snus represent very low risks to health. Swedish snus has been estimated to be at least 95-98% safer than smoking (4).



Source: Nutt, et al. (2014) Estimating the harms of nicotine-containing products using the MCDA approach. Eur Addict Res, 2014;20:218-225.

24. In a recent survey of 340 vapers who attended the December Oceania Vape Day in Auckland we found that of New Zealand people who vape, 40% had tried and 14% already used snus/tobacco or nicotine pouches. (Research poster attached).

25. Just like we encourage people who use nicotine replacement products to use a combination of nicotine patch and nicotine gum or lozenges (combination therapy) if needed to increase their likelihood of staying quit, some people who vape also use oral tobacco or nicotine pouches to:

    a. enable them to completely abstain from smoking

    b. reduce how much vapor they consume, because if any longer-term health effects are going to emerge, it is theorised that those health effects will result from inhaling vapor. That is, using oral nicotine or tobacco pouches is a harm reduction strategy for vapers, just like vaping is a harm reduction strategy for people who smoke.

    c. avoid scorn / admonishments from others. The stigmatisation of vaping and ridiculing of people who vape is well advanced in New Zealand. Also, many environments, including workplaces have already enacted the bans on vaping that the Amendment seeks to make legal. Some people who vape occasionally use oral nicotine or tobacco pouches in environments where vaping has been banned, and in environments where they might become a target for abuse from others.

26. It is important to note, that for the last 27 years, the Ministry of Health have been saying that it was illegal to import for sale Swedish style snus products. Strictly this wasn't true (5). The original SFEA banned oral tobacco products that were intended for chewing. Swedish style tobacco pouches are not chewed. They are placed under the upper lip in the mouth. The Amendment makes it clear that the Ministry of Health were stretching the truth by now making it very clear in this Amendment that such products will be banned.

27. It is estimated that 5000 New Zealanders die from a smoking-related disease every year. That's 135,000 over the last 27 years. We could have saved thousands of these people from the chronic disease they had to live with and that killed them prematurely, if we had encouraged them to switch to snus. In this same period, Sweden has reduced their incidence of smoking-related diseases to the lowest in Europe. Their smoking prevalence rates have also reduced. Only 5% of Swedish adult males now smoke. Disallowing snus was one of the biggest fails of public health in New Zealand. This Amendment has the chance to undo that mistake.

28. Oral nicotine and tobacco products that meet minimum quality standards for production should be permitted for import, advertising and sale to adults aged over 18.

29. Applying similarly restrictive regulations to vaping products sends the message that the Government considers vaping to be as bad as smoking tobacco. The Amendment does not take a risk-proportionate approach and will discourage switching from smoking to vaping.

30. I bought a vape kit for Tui. Being a casual acquaintance, I wasn't in a position to do more than give her a kit and encourage her to try it. I don't know what she did with it. Whenever I saw her she was still smoking.

She was still smoking after the birth of her baby. Maybe if there'd been a specialist vape shop in Otahuhu… but no: 1) children are not allowed inside the R18 environ of a vape shop; and 2) it was hassle enough for her to load the pram with her 2 year old and new infant and walk to the corner dairy and back. Some days she would nip out to the dairy for milk etc while the children were sleeping (leaving them alone in the house for at minimum 10 minutes). Cigarettes remain the most convenient, although more expensive. They are also still the norm in her whānau. And vaping? Well, that's being as maligned and as even implied in the Amendment – there are unknown "risks" that children and young people need to be protected from. Many people like Tui and her mother conclude they may as well keep smoking.

31. It is imperative that vape products and oral nicotine/tobacco pouches continue to be sold wherever tobacco is sold, including in dairies and petrol stations. The attractiveness of these greatly harm-reduced alternatives for sale in "generic" retail outlets should not be undermined by limiting the flavours to mint, menthol and tobacco. This will reduce the effectiveness of the products for assisting people who smoke to completely transition away from smoking. Some people, like Tui without childcare or transport, and people who live rurally, will never have access to a specialist vape store, and this will become increasingly the case as the administrative burden and cost of complying with the proposed law makes it economically unviable for smaller vape merchants to stay in business.

Complete prohibition is signalled

32. The Amendment signals very clearly that vaping products, but not the less harmful oral tobacco products, are only being allowed to assist people who currently smoke to quit smoking. The Amendment signals that the only acceptable way to see these products is as a cessation tool.

33. The Amendment makes it very clear that people under 18 years of age and people who do not smoke are to be prevented from initiating vaping.

34. The need for smoking or using nicotine is being thought of as if it is a virus, like the coronavirus-19. That we can simply make it harder for the behaviour to spread and harder for people to do and miraculously the psychological drive to use a psychoactive substance, that is nicotine via smoking or vaping, will be eliminated. The thinking behind the Amendment is based on a fantasy that goes like this:

    a. stop new people from starting to smoke (something we have not been able to do for 50 years)

    b. prohibit stores from selling vape products to people who do not smoke

    c. eventually there will be no more smokers and then there will be no new customers buying vape products

    d. increase the levies and compliance costs on vape stores to increase the cost of vape products and encourage the remaining people who vape to stop; and

    e. finally, there will be no smokers or vapers.

35. The Amendment is based on flawed policy advice. It is based on wishful thinking rather than scientific assessment of robust evidence. Because it has no logical tie to reality and the robust evidence of what works to help people stop smoking, it will fail. Worse, it will deliver unintended negative effects that will do harm (which is not ethical). For an example, of the types of unintended harms that result from poor policy, please see our attached conference poster on the costs associated with the increasing number of aggravated robberies for tobacco that are occurring because of excessive tax increases on tobacco.

Nicotine as a constituent must be explicitly exempted

36. The Amendment, under subpart 2 – constituents of regulated products section 54 "Limits on harmful constituents of tobacco products and herbal smoking products" states that (1) A manufacturer or an importer must not offer for sale or export any tobacco product or herbal smoking product that— (a) contains, or generates in its emissions, a harmful constituent prohibited by regulations.

37. "Harmful constituent" is defined as "a substance declared by regulations to be a harmful constituent".

38. We were not provided with a copy of said regulations.

39. The intent of this section of the Act is to protect consumers from flavouring ingredients that have been identified to exceed established levels for safe consumption.

40. It needs to be explicitly stated in this Amendment that nicotine is to be exempted when the Director General determines what is a harmful constituent.

41. Leaving this vagary in the Amendment provides the Director General with the ability to ban nicotine - the essential ingredient in all tobacco and nicotine products. Removal of nicotine would collapse the demand for legal tobacco and nicotine products. It would not eliminate the desire of many people to use nicotine and the blackmarket would increase. People who vape would be driven back to mixing their own e-liquids which defeats the purpose of the Amendment. Forcing people who use tobacco and nicotine products into withdrawals en masse would be a cruel and abhorrent act.

42. Nicotine as an essential component of tobacco products is protected under several trade agreements and investment laws (6).

People living in rural and remote towns discriminated against

43. The Amendment requires that the Director-General must not give approval for a specialist vape retailer to establish unless satisfied that— the retail premises for the sale of the vaping products are a fixed permanent structure; and at least 85% of the person's total sales are or will be from the sale of vaping products.

44. People living in rural areas and small towns should have equitable access to a range of desired and effective vape products, including a range of flavours beyond mint, menthol and tobacco flavours.

45. The above (at 43) requirements and restrictions on specialist vape retailers in the Amendment make it economically unviable for them to situate themselves in rural areas and some small towns.

46. The following restrictions should be struck out of the Amendment:

    a. that "specialist vape retailers" have to be located in a fixed permanent structure. This will close the current dedicated mobile vape stores that serve some rural and smaller isolated towns.

    b. that at least 85% of the store's total sales are or will be from the sale of vaping products. This will prohibit current outlets that were once solely tobacconists and that now also stock a full range of vape products, and who are dedicated to supporting the transition of their customers who smoke to vaping. In smaller towns, there may not be enough custom to support a business to establish and operate if they are limited to primarily selling vape products.

Unfair heavier burden of compliance on the vape industry

47. The Amendment makes a distinction between specialist vape retailers and generic retailers, such as dairies, supermarkets and service stations.

48. The Amendment establishes a licensing system, essentially, for specialist vape retailers only. This imposes an unfair operational burden on businesses that are specialist vape retailers compared with generic retailers of tobacco and vaping products. Many small convenience stores would not be able to afford the costs of complying with such a system if an equivalent licensing system was imposed upon them.

49. Whilst the words “licensing system” are not explicitly used in the Amendment, all the components of a licensing system are there. The Amendment requires specialist vape retailers to apply to the Director General of Health to become an approved retailer.

50. I do not, and have never, supported the establishment of a licensing system for tobacco retailers and I do not support the establishment of such a system for vape retailers. It is an unnecessary burdensome bureaucratic process that will increase business overheads which will increase the costs of the products to the consumer.

51. The Amendment requires that the Director General establish and administer a product register. Manufacturers and importers of vaping products must notify the Director General of every vaping or smokeless tobacco product before marketing it, and they must certify that the product meets any applicable standards.

52. The Amendment provides for the Director General to fully recover the costs of all functions associated with establishing this (licensing and product registration) system, and the Director General can set fees, for example for applying, and the Director General can charge the registered retailers levies to ensure the costs are recovered. The costs of establishing and administering the database, processing applications, annual returns, the product register, training, supporting and paying a national workforce of enforcement officers to monitor compliance with the Act, and if necessary prosecuting where there are breaches will run into the millions each year.

53. Increasing the overheads of vaping product manufacturers, importers and specialist vape retailers, and as a consequence, increasing the cost of the currently cheaper harm-reduced alternatives to smoking, will reduce that differential in price which is an important factor motivating people to try vaping, and succeed at completely transitioning from smoking to vaping.

54. The Amendment lacks detail around expected costs to manufacturers, importers and retailers of vaping products. There is no detail on, or assurance that there will be any, checks to prevent the Director General from exploiting this system to deliberately make the cost of staying in business increasingly unviable. That is, this (licensing) system could be employed to effect a sinking lid policy. A sinking lid policy would see fewer and fewer manufacturers, importers and retailers being approved over time.

55. The biggest businesses will survive the longest, that is, the tobacco companies.

56. It is a positive that the Amendment does not introduce an excise tax on vaping products. All harm reduced alternatives to smoking tobacco should be taxed proportional to harm. No tax to begin with is appropriate to maintain the price differential between combustible tobacco and vaping products to ensure that particular motivation to switch from smoking to vaping is maintained.

57. The Amendment does however introduce taxation on vaping products which will see the price of the products increase. Levies are a tax. The costs of the above ‘licensing’ system and product register will be recovered from the registered approved businesses. Registered retailers may be charged for applying to become approved. Manufacturers and importers may be charged for submitting their annual sales return. They may be charged for each application to register a product. They will be charged levies on top of all this. This is a kind of tax by stealth.

Too much power is vested in one person

58. The Amendment provides no process for stakeholders – the consumers, industry, independent public health experts and iwi (tribal) / Māori organisations to advise on, support or object to the details of the regulations or their administration going forward. There are no checks and balances to ensure the Director General of Health does not abuse the significant power invested in them. As a politically appointed role, this does introduce some vulnerability for people who smoke and vape and who want to access other harm reduced nicotine or tobacco products that might be more effective substitutes for smoking for them.

59. An independent advisory committee, such as ACART which is used for providing advice on Assisted Reproductive Technology should be established to ensure that decisions are evidence based, pay due heed to the needs of consumers and that the implementation of the Amended Act is democratic and fair.

60. Restrictions on advertising, promotion, sale and distribution of regulated products are found in clause 26 of the Bill, which proposes a new Part 2 of the Act. The Amendment proposes a new section 23 of the Act that provides that a person cannot "publish a regulated product advertisement in New Zealand..." A "regulated product advertisement" is defined under clause 5 of the Bill to mean: any words, whether written, printed or spoken... used to.. encourage the use of a regulated product...

61. "Publish" is defined very broadly in the Act to include "disseminate by any means" or "bring to the attention of the public in New Zealand in any other manner" (7). The breadth of the definitions of "publish" in the Act, and "advertisement" in the Amendment mean that the proposed scope of the prohibition on anything promoting vaping is very broad.

62. Whilst the wording used was probably not intended to affect any research, the Amendment could, as it is written be inappropriately used to censure, and therefore censor, researchers and their research results depending on how the conclusion in research is stated. Consumer groups, such as vaper's forums could also be censured.

63. Researchers and consumers should be protected from having to argue this point. The wording needs to be much clearer as to what is considered a publication under this section. Research publications, posts on social media and consumer and expert opinions should be explicitly exempted.

64. The Amendment is even less clear regarding whether advice to the public about switching from smoking to vaping is captured by the prohibition of publishing a "regulated product advertisement". This will likely crucially depend on how the advice is presented. The Amendment creates a mine field for researchers, who should be able to conduct their scientific activity in the normal way, but instead will have to carefully craft research conclusions to ensure advice fits the narrative the Act seeks to embed in law. Similarly, vapers' consumer groups and forums could be undermined.

65. The potential of this prohibition could stifle well-meaning harm reduction advice and peer support provided by vapers' forums and groups. I recommend the removal of the need for genuine smoking cessation advice to tread carefully so not to fall foul of provisions more deliberately designated to restrain advertising.

66. Researchers and academics, and vapers' forums in which consumers provide peer support, should be explicitly recognised alongside registered health practitioners and other specified health workers to give advice and recommendations about vaping products to people who smoke.

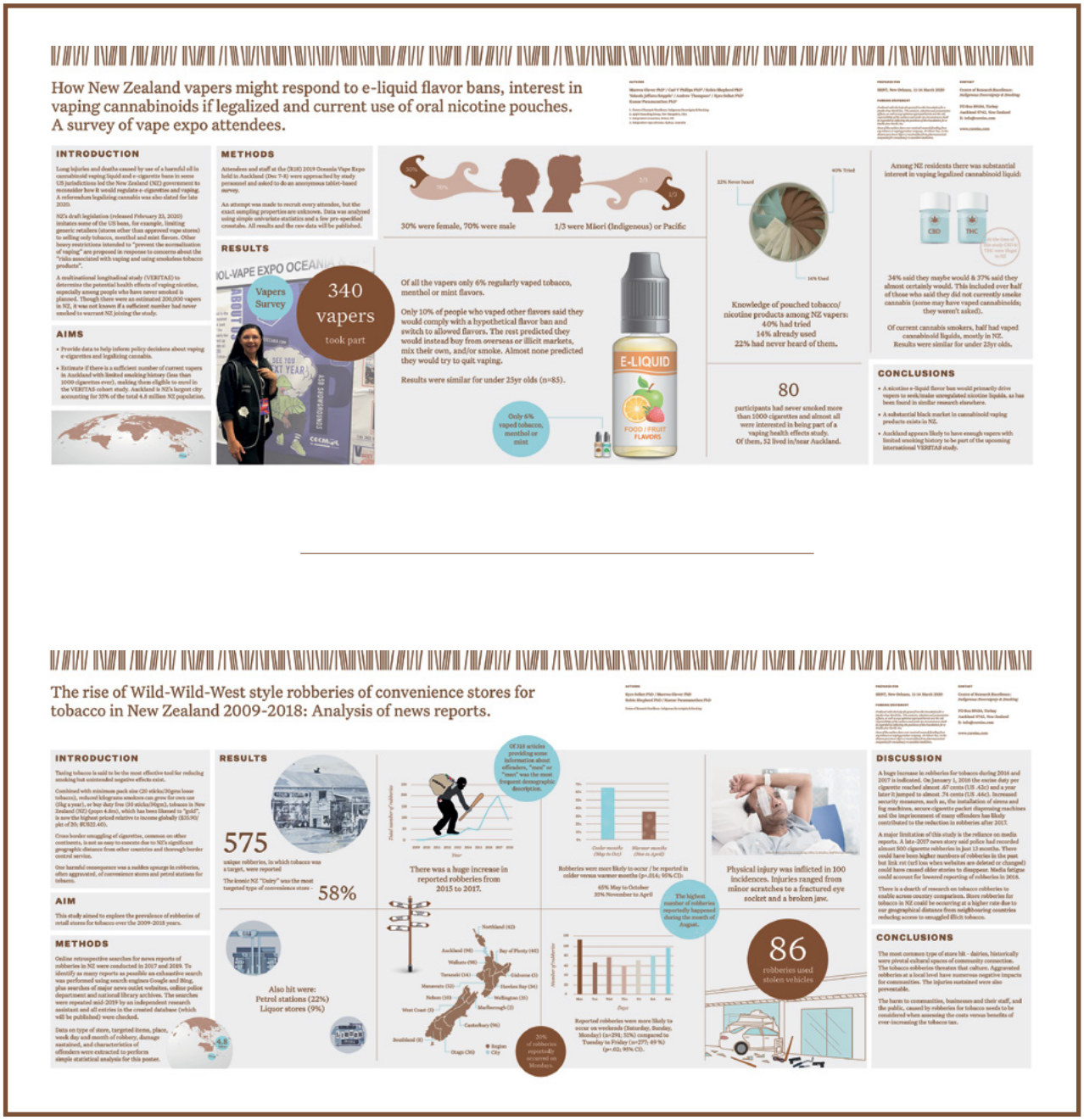
Conclusions

67. There is a lot more that I think is wrong in the Amendment, but I have tried to focus on the forest rather than the trees. I have tried to focus on explaining the major flaws in the rationale underpinning the Amendment and the major flaws in it.

68. Overall, it treats what are very low risk alternatives to smoking unfairly. The Amendment is not risk proportionate. The heavy treatment of harm reduced nicotine and tobacco products is not supported by evidence. This Amendment is more a social experiment than a piece of legislation that will reduce smoking-related disease and premature deaths.

69. The Amendment has paid no heed at all to the disproportionately higher rates of smoking among Māori, and particularly among Māori women. Tui and Maia will not be helped to stop smoking by this proposed law change.

Recent conference posters



Source: Society for Research on Nicotine and Tobacco 2020 https://cdn.ymaws.com/www.srnt.org/resource/resmgr/conferences/2020_annual_meeting/SRNT20_Abstracts_NEW_0227202.pdf

References

1. Lupton D. (2015), The pedagogy of disgust: the ethical, moral and political implications of using disgust in public health campaigns, Critical Public Health, Vol. 25, No. 1, pp. 4-14, DOI: 10.1080/09581596.2014.885115 10.1080/09581596.2014.885115.

2. Frohlich KL., Mykhalovskiy E., Poland BD., Haines-Saah R., Johnson J. (2012). Creating the socially marginalised youth smoker: the role of tobacco control. Sociology of Health and Illness. Vol. 34, pp. 978–93. doi:10.1111/j.1467-9566.2011.01449.x

3. Glover, M. & Phillips, CV. Potential effects of using noncombustible tobacco and nicotine products during pregnancy: a systematic review. Harm Reduction Journal 2020 17(6):1-12.

4. Shapiro H. No Fire, No Smoke: The Global State of Tobacco Harm Reduction 2018. London: Knowledge-Action-Change, 2018.

5. Crampton, E. (2018). Northland DHB missed the memo. Offsetting behaviour. Blog post, 28 May. https://offsettingbehaviour.blogspot.com/2018/05/northland-dhb-missed-memo.html.

6. Kelsey, J. (2012). International trade law and tobacco control. Auckland: University of Auckland.

7. Smoke-free Environments Act 1990, s 2 at “publish”.