

Nicotine pouches: Harm reduction or a new generation of nicotine users?

My preteen son came home from summer day camp and told me his counselor had given the group two rules: “Be on time” and “Don’t ask about my mints.” Naturally, he was very curious to know what these mints were and why they were so important.

The “mints” were nicotine pouches: small, discreet sachets tucked between the upper lip and gum, where saliva releases nicotine for absorption by the oral mucosa. Unlike traditional smokeless tobacco products, such as chewing tobacco, nicotine pouches contain no tobacco leaf; their nicotine is either extracted from tobacco or produced synthetically. They may also contain flavorings, bulking agents, humectants, and pH-altering agents to facilitate absorption. Because they produce no smoke, vapor, or odor and require no spitting, they can be used almost anywhere, often without anyone noticing.¹

In Canada, because pouches do not contain tobacco and are considered nicotine replacement therapy, they fall under the Food and Drugs Act rather than the Tobacco and Vaping Products Act, a regulatory distinction that Health Canada has recognized it may need to change.² Mint-flavored Zonnic (a product of Imperial Tobacco) can be legally sold in Canada by pharmacies to people 18 years of age and older for nicotine replacement therapy, and it must have a natural product number. Yet, unauthorized nicotine pouches are readily available online and can be found in convenience stores and gas stations. These grey-market products may contain higher concentrations of nicotine, as well as flavors and additional ingredients not on the label.³

As tobacco use among young people continues to decline, nicotine pouches are

moving in the opposite direction.⁴ In the United States, the 2025 National Youth Tobacco Survey found that overall youth tobacco use had fallen to 7.2%.⁴ E-cigarettes remained the most commonly used product (5.2%), followed by nicotine pouches, which had more than doubled in prevalence over the past 4 years (0.8% in 2021 vs 1.7% in 2025).

JAMA published similarly concerning numbers from the Monitoring the Future study of US students in grades 10 and 12.⁵ Between 2023 and 2024, past-30-day use of nicotine pouches doubled from 1.3% to 2.6%, while lifetime use rose from 3% to 5.4%. Despite declining e-cigarette use, dual use of e-cigarettes and pouches increased.⁵ Canadian data tell a similar story. In a survey of nearly 14 000 Quebec secondary-school students participating in the COMPASS study, 2.6% reported using nicotine pouches in the past month, and nearly one-quarter were unsure about the health risks.⁶

The appeal to youth is not difficult to understand. Nicotine pouches are discreet, easy to conceal, and available in appealing flavors, and they can be used without obvious signs of smoking or vaping. But while they may represent a less harmful source of nicotine for adults who would otherwise smoke, they are not harmless—and nicotine is highly addictive.⁷

The World Health Organization published a report in May 2026 examining how nicotine pouches are marketed and how countries might regulate them.⁸ A *JAMA* article captured the WHO’s concern in a commentary: “Fruity flavours, festivals, and F1—WHO report reveals how nicotine pouches hook consumers.”⁷ Around the same time, in June 2026, the US Food

and Drug Administration authorized reduced-risk marketing claims for some nicotine pouches. Can both perspectives be true? Can nicotine pouches be a less harmful alternative for adults who smoke while simultaneously being perilously attractive to young people who might never have used nicotine otherwise?

The evidence that nicotine pouches help people quit smoking is surprisingly limited. A 2025 Cochrane review included only four small studies and concluded that there was “very uncertain” evidence that nicotine pouches led to slightly higher smoking abstinence compared with no intervention.⁹ Evidence about long-term health effects is also limited. The American Heart Association cautioned that smokeless oral nicotine products may negatively affect some biomarkers of cardiovascular disease risk and could increase the risk of oral cancers.¹⁰

This leaves physicians navigating a nuanced but important distinction. For an adult who smokes and cannot quit, switching from combustible tobacco to nicotine pouches may reduce exposure to harmful chemicals. But for a young person who does not use nicotine, we certainly would not recommend starting. The individual-level harm reduction message and the population-level prevention message are not contradictory, but they can become confused.

Perhaps this is a lesson we should have learned from vaping: “reduced risk” does not mean “safe.” As physicians, we may be well positioned to counsel patients on this distinction. But as a parent, making nicotine tastier, quieter, and easier to conceal scares me. I will *definitely* be asking about the “mints.” ■

—Caitlin Dunne, MD, FRCSC

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Alhgoḥ: A new online course advancing Indigenous cultural safety in primary care

I have participated in and supported Indigenous health initiatives for the past 20 years, focusing on increasing representation of Indigenous people in health professions and increasing awareness of Indigenous health among non-Indigenous professionals. I was driven to advance Indigenous health—and later cultural safety and Indigenous-specific anti-racism initiatives—because I grew up both in the inner city and on reserve experiencing the impacts of segregation and isolation. These impacts on health included lack of access, unsafe care, and poorer outcomes. I was driven to address the disparities faced by my community by becoming a physician; however, I quickly realized that to have a wider-reaching impact, I would need to support broader system change.

In the past few years, British Columbia has formally recognized Indigenous-specific racism and implemented new regulatory standards for Indigenous cultural safety, cultural humility, and anti-racism. This has included many health organizations, including Doctors of BC, health authorities, and the College of Physicians and Surgeons of BC (CPSBC), signing declarations of commitment to cultural safety; publishing the *In Plain Sight* report; developing the Health Standards Organization's *British Columbia Cultural Safety and Humility Standard*; and publishing the CPSBC's *Cultural Safety, Cultural Humility and Anti-Racism* practice standard.¹ This foundational regulatory framework has supported the shift from acknowledging harms experienced by Indigenous people in accessing care to implementing changes to address them.

This shift became evident when I started receiving feedback from physicians

wanting to understand what this looks like at the bedside and in their practices. Their college standards called for them to be self-reflective, anti-racist, relational, and trauma informed, but many struggled with where and how to start. In my work in primary and community care, there seemed to be an even wider gap, with limited support available, few facilitators, and increasing pressures on clinicians and staff. Acknowledging this gap, in 2021, primary care teams from the First Nations Health Authority and the Ministry of Health developed a working group with representatives from across the system, including Doctors of BC, the Ministry of Health, the regulatory colleges, and leaders in cultural safety. The group identified the need for more clinical tools and skills to translate the standard into practice as the number one priority. The tools would need to be practical, accessible, and relevant to everyday scenarios that clinicians may encounter.

With this clarity of purpose, the group developed a proposal that led to the Cultural Safety, Humility, and Indigenous-Specific Anti-Racism Provincial Primary Care Project. In discussions with other cultural safety and anti-racism clinician educators, it became apparent that we were often presenting the same topics to similar groups. We determined that an asynchronous introductory course for clinicians would help expand the reach of this education. The target audience would be primary and community care clinicians, particularly those prescribing treatments. We thought it would also be helpful for those new to practice or British Columbia. The course would need to be open-access, free, and accredited to minimize barriers for busy

clinicians. It would be rooted in translating practice standards into actionable bedside teaching using case studies and reflective exercises. The course would also provide resources and next steps to encourage clinicians to continue their cultural humility and anti-racist journeys.

After almost 2 years of development, the online course, *Alhgoḥ Together as One, Together as Community: Pathway to Indigenous Cultural Safety*, was released through the UBC CPD eLearning platform on 21 June 2026 in recognition of National Indigenous Peoples Day.² *Alhgoḥ* is a Dakelh word from the Lheidli T'enneh traditional territory, which encompasses Prince George, where the idea and development of the course began. *Alhgoḥ* represents the personal and collective responsibility we have as medical professionals to provide culturally safe, respectful, and anti-racist care. To learn more, please visit the course registration page.³

Providing leadership and content for this course has deepened my own understanding of the journey toward a safer, more inclusive health care system. I was able to work with a dedicated and inspiring team committed to promoting social justice in a way that heals and connects. The next step for the project team is to develop microlearnings that build on key concepts highlighted in the course and support the development of a provincial community of practice. There is no destination with this work; it is an ongoing journey, and I'm incredibly grateful and proud to be part of it. ■

—Terri Aldred, MD

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- *Medications for Heart Failure with Reduced Ejection Fraction (EF)*: Developed in partnership with the HeartLife Foundation, a patient-led advocacy and support organization, this educational handout supports clear, consistent, and respectful communication with patients and caregivers. It is available in English, French, Arabic, Farsi, Punjabi, Simplified Chinese, Traditional Chinese, Spanish, and Tagalog.

The GDMT tool kit is currently being implemented across BC's Heart Function Clinics and disseminated in both specialty and primary care settings. Patients with HFrEF benefit from optimized GDMT, and all practitioners in BC, including family physicians and nurse practitioners, are now eligible to prescribe these medications and obtain Fair PharmaCare coverage through Special Authority application. We strongly encourage BC prescribers to review and use the GDMT tool kit in their practice.

Support for BC prescribers

Cardiac Services BC is available to provide educational presentations and support to BC health care providers and their teams. Contact Ms Valerie Barrette, provincial clinical nurse specialist, at valerie.barrette@phsa.ca to request an education session for your group. ■

Competing interests

Dr Hawkins is on the advisory boards of GSK and Novo Nordisk, has received speakers bureau and honoraria from AstraZeneca, has consulted for AstraZeneca and Roche, has received grants and research support from AstraZeneca, and has been involved with a clinical trial involving AstraZeneca. No other authors declared competing interests.

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