The Beginner's Guide to Tobacco Control

A guide for New Zealand tobacco control workers produced by a Tobacco Control Reference Group that included members from HSC, The Quit Group, Te Reo Marama, Community and Public Health (Canterbury District Health Board), and the Ministry of Health

August 2009

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Contents

Introduction

The Beginner's Guide to Tobacco Control is intended to provide all the information you need to get up to speed quickly when you start working in the tobacco control sector.

It includes information on key contacts, the history of tobacco control, public health and health promotion, research, smoking cessation and addiction, priority groups, effects of tobacco, including second-hand smoke, facts and figures, the Framework Convention on Tobacco Control, and the tobacco industry.

Smokefree supporters celebrating the passing of the Smoke-free Environments Amendment Act on the steps of Parliament, Wellington, 3 December 2003

About tobacco and tobacco control

Tobacco use is the leading cause of preventable death in New Zealand, accounting for around 4,300 to 4,700 deaths per year. [1i,2,3] When the deaths caused from exposure to second-hand smoke are included, this estimate increases to around 5,000 deaths per year.[4,5]

Tobacco use is currently responsible for the death of 1 in 10 adults worldwide. If current smoking patterns continue, it will cause some 10 million deaths each year by 2020.[6]

Tobacco is the only legally available product which, when used as the manufacturer intends, kills half its users.

Tobacco control is defined by the World Health Organization (www.who.int/en/) as 'a range of supply, demand and harm reduction strategies that aim to improve the health of a populace by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke'.

Comprehensive tobacco control programmes are the most effective, and usually include a mix of health promotion, tobacco taxation, smoking cessation, research and evaluation, and legislation and enforcement.

The goals of New Zealand's tobacco control programme[7] are:

- to significantly reduce levels of tobacco consumption and smoking prevalence
- to reduce inequalities in health outcomes
- to reduce the prevalence of smoking among Māori to at least the same level as among non-Māori
- to reduce New Zealanders' exposure to second-hand smoke.

The objectives of New Zealand's tobacco control programme are to:

- prevent smoking initiation
- promote smoking cessation
- prevent harm to non-smokers from second-hand smoke
- improve support for monitoring, surveillance and evaluation
- improve infrastructural support and coordination for tobacco control activities.

Tobacco control features as one of the Government six health sector targets

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1 Peto R, Lopez AD, Boreham J, et al. 2006. *Mortality from smoking in developed countries 1950-2000.* Second edition. www.ctsu.ox.ac.uk/~tobacco/, retrieved 24 June 2009.

2 Public Health Intelligence. 2002. *Tobacco Facts May 2002 (Public Health Intelligence Occasional Report no 2).* Wellington: Ministry of Health.

3 Peto R, Lopez A. 1994. Mortality from Smoking in Developed Countries 1950-2000: Indirect estimates from national vital statistics. New York. Oxford University Press.

4 Ministry of Health. 2004. Looking upstream: Causes of death cross-classified by risk and condition, New Zealand 1997. Wellington: Ministry of Health.

5 Tobias M, Turley M. 2005. Causes of death classified by risk and condition, New Zealand 1997. Australian and New Zealand Journal of Public Health, 29, 5-12.

6 World Health Organization. 2006. Why is tobacco a public health priority? Retrieved 19 June 2009 from national vital statistics. New York: Oxford University Press.

7 Ministry of Health. 2004. *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004–2009)*. Wellington: Ministry of Health.

(www.moh.govt.nz/healthtargets). The targets aim to provide better help for smokers to quit smoking.

Key players in tobacco control

This section contains information on the major players in tobacco control in Aotearoa-New Zealand, as well as internationally. Summaries and contact details are provided, with links to each organisation's website.

National

Health Sponsorship Council (HSC)

HSC (www.hsc.org.nz) is a Government agency that promotes health and encourages healthy lifestyles. Its focus is to reduce the personal, social, financial and health care costs associated with negative health behaviours. To do this, HSC provides leadership and uses a comprehensive approach that draws on the principles and practices of public health, health promotion and communication, and social marketing. Its mission is to promote health and encourage healthy lifestyles.

HSC works in the areas of tobacco control, sun safety, problem gambling and obesity prevention.

To encourage and enable people to make healthier lifestyle choices, HSC draws on the experience and success of commercial marketing and communication techniques to plan, execute and evaluate its programmes. HSC uses the tried and tested approaches of the commercial sector to improve people's health. This approach is used worldwide and is known as social marketing.

This approach is consumer-oriented, responding to individual needs and wants. It is systematic, staged, underpinned by academic and consumer research, and is directly geared to achieving specific and measurable health goals over the short, medium and long term.

The goal of HSC's tobacco control work is that New Zealanders reject tobacco and adopt a smokefree lifestyle. This is achieved by two objectives: to reduce smoking uptake, and to increase cessation. Some of the work that HSC conducts to meet these objectives includes:

- reducing the number of settings in which young people are exposed to smoking behaviour (including in and around homes and cars, and public and recreational settings)
- reducing media portrayals of tobacco
- increasing young people's ability to resist tobacco
- reducing inequality in smoking uptake among Māori.

Ministry of Health

The Ministry of Health (Manatū Hauora) (www.moh.govt.nz/moh.nsf) is the Government's principal agent and advisor on health and disability. It provides policy advice to the Government on health and disability issues, administers health regulations and legislation, funds health and disability support services, plans and maintains nationwide frameworks and specifications of services, and monitors sector performance.

The Ministry is also responsible for funding public health services such as smoking cessation initiatives like subsidised nicotine replacement therapy (nicotine patches, gum and lozenges), health promotion and social marketing campaigns, and enforcement of tobacco control legislation. District

Health Boards (DHBs) are responsible for the health of their local populations and are contracted by the Ministry to deliver tobacco control services.

The Ministry of Health's website (www.moh.govt.nz/tobacco) is the primary website for information on tobacco control. It contains a wealth of up-to-date information on many aspects of tobacco control and is the place to look for tobacco-related consultation documents, media releases and recent Ministry-commissioned research.

The Smokefree Law website (www.smokefreelaw.co.nz) is managed by the Ministry of Health, and has information on the Smoke-free Environments Act 1990; and the 2003 changes to the Act, information for groups affected by the changes, resources, research and evaluation related to the changes, and frequently-asked questions about the legislation.

Action on Smoking and Health (ASH)

ASH (www.ash.org.nz/) is an incorporated society with charitable status which operates as an independent non-government organisation (NGO). ASH is committed to preventing the uptake of smoking among young people and reducing the prevalence of smoking among all New Zealanders, particularly Māori, young women and pregnant women.

ASH provides an information service to health promoters and education providers, policy makers, politicians, media, students, community groups and members of the public on issues relating to tobacco and public health, including:

- information on prevalence and consumption and the health consequences of smoking
- legislation
- second-hand smoke
- tobacco control strategies
- litigation.

The Quit Group

The Quit Group (www.quit.org.nz) is a charitable trust set up to run quit smoking programmes in New Zealand. It provides:

- the Quitline (0800 778 778), offering free telephone support, resources and low-cost nicotine replacement therapy (NRT) in the forms of patches, lozenges and gum
- online 'community', offering interactive resources on quitting smoking and order forms to obtain print resources and low cost NRT (www.quit.org.nz/members/nrt_non_member/form).
- Txt2Quit, offering tips and advice on quitting smoking through mobile phone text messaging (www.txt2quit.org.nz)
- the Quit Cards programme, giving health providers access to low-cost NRT for their clients (www.quit.org.nz/page/providers/QuitCards.php)
- the Quit@Work programme, offering support to workplaces wishing to help their employees quit smoking (www.quit.org.nz/page/providers/QuitAtWork.php)
- culturally appropriate services (www.quit.org.nz/page/aboutQuit/contacts.php) for Māori and Pacific clients
- national advertising campaigns to encourage smokers to call the Quitline and other

cessation providers

- liaison with DHBs, to refer smokers to the Quitline or other cessation providers
- in-depth research (www.quit.org.nz/page/providers/research/research.php) into smoking-related issues.

Aukati Kai Paipa

Aukati Kai Paipa (www.aukatikaipaipa.co.nz/) is a kanohi ki te kanohi service that is delivered locally within most communities. The programme offers Māori and their whānau the opportunity to address their smoking addiction, through a range of services. Services include free nicotine patches or gum, motivational counselling and ongoing support.

The goal of the service is to reduce smoking prevalence and consumption amongst Māori and increase the number of positive changes in smoking behaviour (such as maintaining smokefree environments, particularly for tamariki).

Smokefree Coalition

The Smokefree Coalition (www.sfc.org.nz/) is a charitable trust established to advocate for a smokefree New Zealand. It is a coalition of 22 health groups with the common goal of reducing the death and disease caused by tobacco use. The Smokefree Coalition also produces a fortnightly electronic newsletter – Smokefree Coalition Tobacco Control Update (www.sfc.org.nz/tcu/index.php) – that is distributed to everyone who is listed in the Tobacco Free/Tupeka Kore Directory (www.sfc.org.nz/pdfs/smokefreedirectory2009.pdf).

The Smokefree Coalition (along with The Quit Group) moderates the Smokefree Contacts data-map (www.smokefreecontacts.org.nz); an online resource to the tobacco control community and the public.

Te Reo Mārama (TRM)

Since 1998, Te Reo Marama (www.tereomarama.co.nz/) has been dedicated, on behalf of the Auahi Kore-Tupeka Kore community and the wider Māori community, to tobacco resistance. The main role undertaken is to advocate evidence-based positions on tobacco-related issues at a local, national and international level.

Cancer Society of New Zealand

The Cancer Society of New Zealand (www.cancernz.org.nz/) is a non-profit organisation that aims to minimise the impact of cancer on New Zealanders. With one in four deaths from cancer attributable to smoking, tobacco control is a key part of the Cancer Society's public heath work.

The Society has been a major player in the development of tobacco control in New Zealand and continues to play an active role in tobacco control (www.cancernz.org.nz/HealthPromotion/TobaccoControl/). The Society works to reduce smoking rates through advocacy for legislative and policy changes and through public education.

Key areas of the Society's work in 2009 are:

- promoting legislative change to address tobacco displays and other issues around the retailing of tobacco

- working with social services to promote quitting messages
- working with local councils (www.smokefreecouncils.org.nz/) to promote the extension of outdoor smokefree areas including council events and outdoor dining areas.

Cancer Society health promoters (www.cancernz.org.nz/HealthPromotion/HPStaff/) are located around Aotearoa-New Zealand.

The Cancer Society is launching a new site using the www.cancer.org.nz URL by the end of 2009.

Heart Foundation of New Zealand

The Heart Foundation (www.nhf.org.nz/) is the charity that leads the fight against cardiovascular disease (heart, stroke and blood vessel disease). As well as health promotion activities that target the risk factors for heart disease (including smoking), the Heart Foundation is funded to provide smoking cessation training (www.nhf.org.nz/index.asp?PageID=2145828552) to health professionals.

The Pacific Heartbeat Programme (www.pacificheart.org.nz/), a community health promotion initiative of the Heart Foundation, was established in 1991. Its primary objective is to make a difference to the health of Pacific peoples. Pacific Heartbeat provides smokefree promotion and training (www.pacificheart.org.nz/index.asp?pageID=2145826786) in Auckland, along with nutrition and cessation training nationally. It is also funded to provide cessation training for health professionals (www.pacificheart.org.nz/index.asp?PageID=2145834926) who work with Pacific peoples. Contact info@pacificheart.org.nz for more information.

Te Hotu Manawa Māori

Te Hotu Manawa Māori (www.tehotumanawa.org.nz/) is a national Māori organisation, based in Auckland, whose role is to reduce death and disability in Māori from heart disease.

Te Hotu Manawa Māori is the only national organisation with a sole focus on Māori heart health and working to reduce the impact of the determinants of heart disease. It provides smart, innovative Māori solutions in clinical Māori heart health solutions (www.tehotumanawa.org.nz/heart-guide/about.cfm), Māori nutrition (www.tehotumanawa.org.nz/nutrition-and-physical/about.cfm), Māori physical activity (www.tehotumanawa.org.nz/nutrition-and-physical/about.cfm), and the prevention and reduction of Māori uptake of tobacco (www.tehotumanawa.org.nz/smokefree/about.cfm) and access of Māori to cessation services (www.tehotumanawa.org.nz/smoking-cessation/about.cfm).

Te Hotu Manawa Māori also provides strategic advice to other organisations such as Health Sponsorship Council, National Heart Foundation and the Kohanga Reo National Trust. It also works in various capacities with other national providers of services for chronic disease states that impact on Māori heart health such as the Cancer Society, Diabetes New Zealand and the Stroke Foundation.

Asthma and Respiratory Foundation

The Asthma and Respiratory Foundation (www.asthmafoundation.org.nz/) advocates for New Zealanders affected by asthma and other respiratory illnesses, leads asthma research, and provides information and advice on respiratory illnesses.

Smokefree Pasifika Action Network (SPAN)

Contact Stephanie Erick-Peleti: stephaniee@nhf.org.nz

A voluntary network, SPAN was established in November 2000 to promote Pacific tobacco control issues. SPAN offers support on a community level to Pacific service providers, and also provides information to Government on tobacco control issues concerning Pacific peoples.

National Pacific Tobacco Control Service (NPTCS)

Contact Stephanie Erick-Peleti: stephaniee@nhf.org.nz

NPTCS seek to ensure Pacific peoples' views are fairly represented on key tobacco issues and in policy development processes. NPTCS offers support for Pacific communities to take action against tobacco smoking through the provision of up-to-date and appropriate information, resources and training.

Health Promotion Forum

The Health Promotion Forum (www.hpforum.org.nz/) is a national umbrella organisation for health promotion in Aotearoa-New Zealand. The Forum provides national leadership and support for good health promotion practice which is consistent with the principles of Te Tiriti o Waitangi (www.nzhistory.net.nz/category/tid/133) and the Ottawa Charter (www.who.int/healthpromotion/conferences/previous/ottawa/en/). Additional roles include advocacy, training and skill development to both member organisations and the health promotion workforce at large; and facilitation of networking, informed debate and contributions to policy development at regional, national and international levels.

Public Health Association (PHA)

PHANZ (www.pha.org.nz/) is a non-party political voluntary association, which provides a major forum for the exchange of information and stimulation of debate about public health in New Zealand. Members take a leading part in promoting public health and influencing public policy through submissions, seminars, the annual conference and communications and media strategy. PHANZ is a member of the World Federation of Public Health Associations (www.wfpha.org/).

Local

District Health Boards (DHBs)

DHB Smokefree Coordinators are charged with the delivery of the DHB tobacco control plans (www.moh.govt.nz/moh.nsf/indexmh/tobacco-strategy). Tobacco control plans are written for each DHB (www.moh.govt.nz/moh.nsf/indexmh/dhb-links) to address the issues of the local population. They usually include cessation, including delivery of the ABC cessation approach (www.moh.govt.nz/moh.nsf/indexmh/abc-smoking-cessation-framework-feb09) (**Ask** all patients if they smoke, provide **Brief** advice to quit to all smokers, offer **Cessation** support); health promotion and enforcement; and often also reflect the contributions of other district stakeholders such as Primary Health Organisations (PHOs) (www.moh.govt.nz/moh.nsf/indexmh/contact-us-pho), other cessation providers and NGOs (www.ngo.health.govt.nz/).

Tobacco control plans are written with reference to district annual plans which are written by DHBs for the Ministry of Health, and include how DHBs are going to reach health targets (www.moh.govt.nz/healthtargets).

Public Health Services (www.moh.govt.nz/publichealth) are funded by DHBs to deliver smokefree health promotion and smokefree legislative enforcement services.

Hospital Smokefree Coordinators may be employed in some larger centres to focus on the delivery of the ABC strategy in hospitals and support the referral process to and from the hospital to community and/or primary care. They also support the implementation of the DHB's smokefree policy. In some regions this role is covered by the DHB Smokefree Coordinator.

Asian Smokefree Communities

Asian Smokefree Communities (www.harbourhealth.org.nz/patient_services/patient_services/asian_smokefree_communities.cfm) is a collaborative partnership, between Waitemata District Health Board (www.waitematadhb.govt.nz/), Harbour Health (www.harbourhealth.org.nz/) and Auckland Regional Public Health Service (www.moh.govt.nz/moh.nsf/indexmh/contact-us-public-health-services#auckland) to create a culturally appropriate, Asian-specific approach to smokefree promotion and smoking cessation in a family-orientated setting.

Smokefree/tobacco control local networks

These networks may be established in your region. They incorporate key contacts from local agencies and other major players in your community (eg, city council, Cancer Society etc) and are often coordinated through the smokefree/tobacco control teams within the Public Health Units (www.moh.govt.nz/moh.nsf/indexmh/contact-us-public-health-services) at DHBs.

Their networks are a useful networking resource for planning programmes and events, such as World Smokefree Day (www.worldsmokefreeday.org.nz/). To find out more about your local network contact the local DHB Tobacco Control Coordinator

Regional offices of the Cancer Society, Heart Foundation and Asthma Foundation

Cancer Society of New Zealand (www.cancernz.org.nz/Society/Divisions/)
Heart Foundation (www.nhf.org.nz/index.asp?pageID=2145820224)
Asthma and Respiratory Foundation (www.asthmafoundation.org.nz/asthma_societies.php)

These regional offices have local coordinators who have varying roles in tobacco control, often as part of a wider brief. For local contact details, see the organisations' national websites.

Primary Health Organisations (PHOs)

PHOs (www.moh.govt.nz/moh.nsf/indexmh/contact-us-pho) are the local provider organisations through which DHBs implement the *Primary Health Care Strategy*.[8] (www.moh.govt.nz/primaryhealthcare) Each PHO is funded for public health initiatives in their area, which may include tobacco control.

PHOs deliver smoking cessation services, based on the ABC (**Ask** all patients if they smoke, provide **Brief** advice to quit to all smokers, offer **Cessation** support).

[8] Ministry of Health. 2001. *Primary Health Care Strategy*. Wellington: Ministry of Health.

International initiatives and websites

Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control (FCTC) (www.who.int/fctc/en/) is a World Health Organization (WHO) (www.who.int/en/) treaty which focuses international attention, resources and action on the global tobacco epidemic. Once a country signs and ratifies the treaty it becomes a legally binding document for that country. The FCTC was negotiated by the 192 member states of the WHO.

The world's first public health treaty, the FCTC contains a host of measures designed to reduce the devastating health and economic impacts of tobacco. After nearly four years of negotiations, the final agreement was reached in May 2003 and provides the basic tools for countries to enact comprehensive tobacco control legislation.

The FCTC also contains numerous other measures designed to promote and protect public health, such as mandating for the disclosure of ingredients in tobacco products, providing treatment for tobacco addiction, encouraging legal action against the tobacco industry, and promoting research and the exchange of information between countries. As at May 2009, 168 participants had signed the Treaty and 164 had ratified it. The conventions and protocols outlined in the Treaty are legally binding on those countries which ratify them. New Zealand ratified the FCTC in January 2004.

For more information see the Framework Convention on Tobacco Control section of this document.

Framework Convention Alliance (FCA)

The FCA (www.fctc.org/) was founded in 1999 and is now made up of more than 350 organisations from more than 100 countries working on the development, ratification, and implementation of the international treaty, the Framework Convention on Tobacco Control (FCTC) (www.who.int/fctc/en/). The WHO FCTC is the world's first global public health treaty, and requires parties to adopt a comprehensive range of measures designed to reduce the devastating health and economic impacts of tobacco.

The FCA's mission is to perform the watchdog function for the WHO FCTC; to develop tobacco control capacity – particularly in developing countries; to support the development, ratification, accession, implementation and monitoring of the FCTC; and to promote and support a network for global tobacco control campaigning.

Tobacco Free Initiative

www.who.int/tobacco/en/

This World Health Organization site (www.who.int/tobacco/en/) has information on the latest research and policy, international events (including World Smokefree/No Tobacco Day (www.who.int/tobacco/wntd/2009/en/index.html), the FCTC (see above) and other key issues in tobacco control on which WHO is focusing.

Tobacco Control Supersite

In the 1990s, a vast quantity of information from the filing cabinets of the tobacco industry became available through legal action in the United States. Over 40 million pages of documents were made available on the internet for 10 years. This is an incredible resource for tobacco control, and has the potential to support comprehensive tobacco regulation, litigation, public health advocacy and historical scholarship.

The tobacco industry document research team at the University of Sydney (http://tobacco.health.usyd.edu.au/) has been funded to find information in the documents that pertains to Australia, New Zealand, the Philippines, Malaysia, Thailand, Indonesia, China and Hong Kong, in association with local consultants from those regions.

The site has two main purposes:

- to enable you to explore internal, previously private tobacco industry documents and read the work of the document research team at the University of Sydney
- to provide access to a wide range of information relevant to smoking prevention and control.

Globalink

Globalink (www.globalink.org/) is a members-only website for the International Tobacco Control Community. It provides tobacco news, a tobacco directory, information on smoking cessation, news and information, and more. It is an important source of international tobacco control updates. Go to the Globalink website to sign up for free membership.

Key documents

Tobacco control specific

Tobacco Trends 2008

This document (www.moh.govt.nz/moh.nsf/indexmh/tobacco-trends-2008) provides an overview of current smoking and tobacco consumption among New Zealanders over time, and presents some data from the 2008 New Zealand Tobacco Use Survey (NZTUS 2008) (www.moh.govt.nz/moh.nsf/indexmh/tobacco-trends-2008-appendix1), including current smoking by age, ethnic group and neighbourhood deprivation, and smoking in youth aged 15 to 19 years.

The Vision: Tobacco free New Zealand/Tupeka Kore Aotearoa by 2020

The tobacco control community has a vision – future generations of New Zealand children will be free from exposure to tobacco and will enjoy smokefree lives. *The Vision* (www.sfc.org.nz/thevision.php) document is available from the Smokefree Coalition website (www.sfc.org.nz/).

Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004–2009)

Clearing the Smoke (www.ndp.govt.nz/moh.nsf/indexcm/ndp-publications-clearingthesmoke) details how the Ministry of Health plans to progress tobacco control activities over the five-year period, 2004–2009. The actions described are of relevance to many different players in the health sector including NGOs and the private sector. Priority is given to actions/strategies which meet the principles of effectiveness (both in terms of cost and evidence base), are equitable, acceptable and have an appropriate reach. Provides evidence and guidance as to what are considered best strategies for tobacco control work.

National Māori Tobacco Control Strategy (2003–2007)

The *National Māori Tobacco Control Strategy* (www.cancernz.org.nz/Uploads/Maori_Strategy_FINAL.pdf) provides an overarching comprehensive strategy for a more focused approach to achieve better health outcomes for Māori within tobacco control matters. It identifies four key strategies in the areas of legislation, health promotion, cessation and research.

National Māori Tobacco Control Action Plan

The *National Māori Tobacco Control Action Plan* (www.cancernz.org.nz/Uploads/Maori_Action_Plans_FINAL.pdf) is the companion document to the Strategy document. The Plan identifies a range of actions and priorities that would assist Māori tobacco control.

Pacific Peoples Tobacco Control Action Plan

The main aim of this document (www.cancernz.org.nz/Uploads/Pacific_Peoples_Action_Plan.pdf) is to identify steps that need to be taken to improve the health outcomes for Pacific peoples' wellness by reducing smoking. The plan identifies six priority action areas for development and improvement, including: health promotion, providing a Pacific voice for tobacco control issues, workforce development, coordination, research and evaluation, and cessation.

Implementing the ABC Approach for Smoking Cessation – Framework and work programme (February 2009)

This document sets out a framework for implementing the ABC approach for smoking cessation (www.moh.govt.nz/moh.nsf/indexmh/abc-smoking-cessation-framework-feb09). It outlines the purpose and goals of the ABC approach, how it relates to different people and organisations in the health system and how it fits alongside other interventions aimed at reducing the number of people who smoke.

New Zealand Smoking Cessation Guidelines: August 2007

This document provides updated guidance for health care workers in their contacts with people who smoke tobacco. The Guidelines (www.moh.govt.nz/moh.nsf/indexmh/nz-smoking-cessation-guidelines) make recommendations for the use of evidence-based interventions in priority population groups, in particular Māori, Pacific peoples, pregnant women and people who use mental health and addiction services.

Framework for Reducing Smoking Initiation in Aotearoa-New Zealand, 2005

This document provides a national framework (www.hsc.org.nz/pdfs/RSI_Framework_Final.pdf) to coordinate activities to reduce the number of New Zealanders who take up smoking. It was developed by an expert advisory group and drew on information from a literature review that looked at risk factors for smoking uptake, priority groups, and effective interventions to reduce smoking initiation, with an emphasis on modifiable risk factors.

New Zealand Tobacco Control Research Strategy 2009-2012

The aim of the soon-to-be-released 2009-2012 Strategy (www.moh.govt.nz/moh.nsf/0/AAFC588B348744B9CC256F39006EB29E/$File/clearingthesmoke.pdf) is to provide a long-term direction for New Zealand researchers and funders in the field of tobacco control research). It builds on the work of the Tobacco Control Research Strategy 2003 (www.allenandclarke.co.nz/Tobacco_Strategy_Book.pdf). The end result will be improved tobacco control in New Zealand and, ultimately, a reduction in tobacco-related illness and deaths. It identifies several priority areas for future tobacco control research and criteria for assessing tobacco control research proposals.

National Drug Policy 2007-2012

The National Drug Policy 2007-2012 (http://www.moh.govt.nz/moh.nsf/indexmh/national-drug-policy-2007-2012) sets out the Government's policy for tobacco, alcohol, illegal and other drugs within a single framework.

Smokefree legislation

Smoke-free Environments Act 1990

www.legislation.govt.nz/act/public/1990/0108/latest/DLM223191.html?search=ts_act_smoke-free+environments_resel&sr=1

Smoke-free Environments Regulations 2007

www.legislation.govt.nz/regulation/public/2007/0039/latest/DLM427193.html

Other important health documents

New Zealand Health Strategy 2000

The New Zealand Health Strategy (www.moh.govt.nz/moh.nsf/indexmh/new-zealand-health-strategy-2000?Open) provides the framework within which DHBs and other organisations across the health sector operate.

Implementing the New Zealand Health Strategy

The *New Zealand Health Strategy* was introduced in 2000 with its goal to ensure a healthier New Zealand – for all New Zealanders. These reports, from the Minister of Health, look at the progress being made in implementing the Strategy (www.moh.govt.nz/moh.nsf/pagesmh/5651?Open).

He Korowai Oranga: Māori Health Strategy

He Korowai Oranga: Māori Health Strategy (www.moh.govt.nz/moh.nsf/pagesmh/812?Open) sets the direction for Māori health development in the health and disability sector. The Strategy provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of whānau.

The overall aim of He Korowai Oranga is whānau ora – Māori families supported to achieve their maximum health and wellbeing.

New Zealand Cancer Control Strategy (2003) and Action Plan 2005-2010

The Strategy (www.moh.govt.nz/moh.nsf/indexmh/nz-cancer-control-strategy?Open) provides a high-level framework for reducing the incidence and impact of cancer in New Zealand and reducing inequalities with respect to cancer. The Action Plan (www.moh.govt.nz/moh.nsf/indexmh/nz-cancer-control-strategy-action-plan-20052010?Open) outlines in detail how the Strategy's objectives can be achieved. The actions identified in the Action Plan extend across the cancer control continuum, which includes primary prevention, screening, early detection, diagnosis and treatment, rehabilitation and support, and palliative care. They also include workforce development, research, data collection and analysis.

Primary Healthcare Strategy (2001)

Launched in February 2001, the *Primary Healthcare Strategy* (www.moh.govt.nz/moh.nsf/indexmh/primary-health-care-strategy-2001?Open) provides direction for ensuring that primary health care services play a central role in improving the health of New Zealanders.

TUHA-NZ

TUHA-NZ (www.hpforum.org.nz/Tuha-nz.pdf) is a useful resource for developing health promotion programmes that recognise the Treaty of Waitangi. It helps establish useful benchmarks for recognising what is good practice, and how to deliver programmes that reflect the three articles of the Treaty.

Journals

Tobacco Control Journal

This is the online version of the journal (tobaccocontrol.bmj.com/) dedicated to the study of the nature and consequences of tobacco use worldwide; the effect of tobacco use on health, the

economy, the environment and society; the efforts of the health community and health advocates to prevent and control tobacco use; and the activities of the tobacco industry and its allies to promote tobacco use.

Journal of Smoking Cessation

This peer-reviewed journal (www.australianacademicpress.com.au/Publications/Journals/smoke_cessation/cessation.htm) of the Australian Association of Smoking Cessation Professionals (AASCP) (www.australianacademicpress.com.au/aascp/index.html) is supported by smoking cessation research groups in the US and UK.

New Zealand Medical Journal

The *New Zealand Medical Journal* (www.nzma.org.nz/journal/index.shtml) is the principal scientific ***journal*** for the profession in the country.

Australian and New Zealand Journal of Public Health

This journal (www.phaa.net.au/journal.php) of the Public Health Association of Australia (www.phaa.net.au/) is published six times a year, in February, April, June, August, October and December.

Nicotine & Tobacco Research

One of the world's few peer-reviewed journals, *Nicotine & Tobacco Research* (ntr.oxfordjournals.org/) is devoted exclusively to the study of nicotine and tobacco. It aims to provide a forum for empirical findings, critical reviews, and conceptual papers on the many aspects of nicotine tobacco, including research from the biobehavioural, neurobiological, molecular biologic, epidemiological, prevention, and treatment arenas.

British Medical Journal

The *British Medical Journal (BMJ)* is an international peer-reviewed medical journal (group.bmj.com/products/journals) and a fully 'online first' publication. All articles appear on bmj.com before being included in an issue of the print journal. The website is updated daily with the BMJ's (www.bmj.com/) latest original research, education, news, and comment articles, as well as podcasts, videos, and blogs.

Health Promotion Practice

Searchable on PubMed (www.pubmedcentral.nih.gov/)

Devoted to the practical application of health promotion and education, this journal (www.pubmedcentral.nih.gov/fprender.fcgi) is useful for professionals involved in developing, implementing, and evaluating health promotion and disease prevention programmes. It would be useful to refer to this journal to explore the applications of health promotion/public health education intervention programmes and best practice strategies in various settings (eg, community, workplace, educational and international).

Health Promotion International

This journal (heapro.oxfordjournals.org/) highlights health promotion innovations from various sectors including education, health services, employment, legislation, the media, industry and community networks. Articles describe not only theories and concepts, research projects and policy

formulation, but also planned and spontaneous activities, organisational change, and social development.

American Journal of Public Health

Available online and in print form, this journal (www.ajph.org/) provides current, in-depth information in the field of public health. Fields of interest include debates on public health issues, reports on practice-based programmes, profiles of leaders and examples of vital public health work and stories from public health history.

Websites

PubMed

A service of the US National Library of Medicine, this website includes over 15 million citations for biomedical articles back to the 1950's. These citations are from MEDLINE and additional life science journals. PubMed (www.pubmedcentral.nih.gov/) includes links to many sites providing full text articles and other related resources. You can search for specific journals or by subject matter.

Cochrane Reviews

Cochrane Reviews (www.cochrane.org/reviews/clibintro.htm#reviews) explore the evidence for and against the effectiveness and appropriateness of treatments (medications, surgery, education etc) in specific circumstances. The complete reviews are published quarterly in The Cochrane Library (www.cochrane.org/reviews/clibintro.htm#library). Each issue contains all existing reviews plus an increasingly wider range of new and updated reviews. You should be able to browse the Cochrane Library at your nearest medical library if you do not have your own subscription.

Tobacco Control Research Steering Group

The Tobacco Control Research Steering Group was formed in 2007 as the result of a joint Ministry of Health/Health Research Council initiative. The Ministry funds the Steering Group and appoints its members. The Steering Group's functions are to:

- provide strategic advice annually to the Ministry and wider sector on current and long-term tobacco research priorities for New Zealand
- advise researchers on opportunities and processes for accessing research funding, and act as a conduit for linking researchers to potential funders
- identify tobacco control research workforce needs and potential opportunities for workforce development
- help improve the knowledge and skills of the tobacco control sector.

The Vision

The tobacco control sector has a vision: Tobacco free New Zealand/Tupeka Kore Aotearoa by 2020 (www.sfc.org.nz/thevision.php). In this vision, future generations of New Zealand children will be free from exposure to tobacco and will enjoy smokefree lives.

Taking action

The vision is about creating a national identity that protects our children by being proud to be tobacco free. This will be achieved through evidence-based changes that reduce the supply of, and demand for, tobacco.

The goals

By 2020 exposure of children to tobacco will be eliminated by achieving the following goals.

- There will be no supply of, or demand for, tobacco as consumer products in Aotearoa/New Zealand.
- Children will be protected from exposure to tobacco and the marketing and promotion of tobacco products.
- All smokers will be empowered to quit and supported by effective quit-smoking support services and products.

Getting connected

Whatever your role in tobacco control, one of the most important things you can do is get connected with others in the sector. The following newsletters, networks and websites will keep you in touch with colleagues, and up-to-date with the latest topics, issues and research.

Tobacco Control Update

A fortnightly e-newsletter from the Smokefree Coalition (www.sfc.org.nz/tcu/index.php).

Quit Chat

A three-monthly e-newsletter from The Quit Group (www.quit.org.nz/page/media/newsletters.php).

HSC Chat Sheet

A quarterly electronic newsletter (www.hsc.org.nz/chatsheets/chatindex.html).

NZ Tobacco Control Network (NZTAN).

NZTAN is an online discussion and networking forum for those with an interest in tobacco control. NZTAN members must be legitimate tobacco control stakeholders. Potential subscribers to the group will be subject to referee checks.

To subscribe, send an e-mail to the network administrator *Janine Paynter*: jpaynter@ash.org.nz.

Include the names and email addresses of two referees, preferably tobacco control stakeholders, who can verify your email address and occupation. The email address for posting information to the discussion group is nztan@globalink.org.

Tobacco-free/Tupeka Kore Directory

Contact and organisation details (www.sfc.org.nz/pdfs/smokefreedirectory2009.pdf) for people working in tobacco control.

Smokefree contacts map

This map, on the Smokefree Coalition website, (www.smokefreecontacts.org.nz/) lists a variety of people and services which are dedicated to helping New Zealand become free from tobacco. You will find contact details for:

- help to quit smoking
- advocacy and information
- smokefree law and enforcement
- education and training
- health promotion
- people working in research
- useful smokefree services

Smokefree.org

A portal provided by HSC (www.smokefree.co.nz/) with six main sections summarising the information available on various tobacco control-related websites, and providing links to those

websites. These websites include:

- Smokefree schools (www.smokefreeschools.org.nz/)
- Smokefree outdoor areas (www.smokefreecouncils.org.nz/)
- Smoking Not Our Future (www.notourfuture.co.nz/)
- World Smokefree Day (www.worldsmokefreeday.org.nz/)
- Endangered Species campaign
- Protect our Children (tobacco displays) (protectourchildren.org.nz/)
- Second-hand smoke (www.secondhandsmoke.org.nz/).

Your local smokefree/tobacco control network

These networks incorporate key contacts from local agencies and other major players in your community and are generally coordinated through the smokefree/tobacco control teams within the Public Health Units at DHBs (www.moh.govt.nz/moh.nsf/indexmh/contact-us-dhb) . To find out more about your local network contact your local DHB tobacco control coordinator.

Globalink

A members-only website for the International Tobacco Control Community.

Globalink (www.globalink.org/) provides tobacco news, a tobacco directory, information on smoking cessation, news and information, and more. It is an important source of international tobacco control updates.

DHB quit data

Sign up to receive regional statistics on Quit Group service usage every quarter, by emailing quit@quit.org.nz.

Abbreviations and acronyms

There can be a bewildering number of abbreviations and acronyms in tobacco control. Here are some of the most common ones:

ASH	Action on Smoking and Health
DHB	District Health Board
DAPs	DHBs' District Annual Plans
ETS	Environmental Tobacco Smoke
FCTC	Framework Convention on Tobacco Control
GDP	Gross Domestic Product
HEAT	Health Equity Assessment Tool
HRC	Health Research Council
HSC	Health Sponsorship Council
MoH	Ministry of Health
NDP	National Drug Policy
NGO	Non-Government Organisation
NMTCS	National Māori Tobacco Control Strategy
NRT	Nicotine Replacement Therapy(s)
OECD	Organisation for Economic Cooperation and Development
PHA	Public Health Association
PHO	Primary Health Organisation
PHS	Public Health Services, based in Public Health Units
PHU	Public Health Unit
PHB	Pacific Heartbeat
SFC	Smokefree Coalition
SFE	Smoke-free Environments (as in Smoke-free Environments Act)
SHS	Second-hand smoke
SOP	Supplementary Order Paper
TCP	DHBs' Tobacco Control Plans
THMM	Te Hotu Manawa Māori
TRM	Te Reo Mārama
TUHA-NZ	Treaty Understanding of Hauora in Aotearoa-New Zealand
WHO	World Health Organization
WSD/WSFD	World Smokefree Day

How the tobacco control sector works

Organisations and individuals involved in tobacco control often work in one or more of the following areas (which often overlap):

- health promotion
- research
- enforcement
- policy development
- cessation
- advocacy.

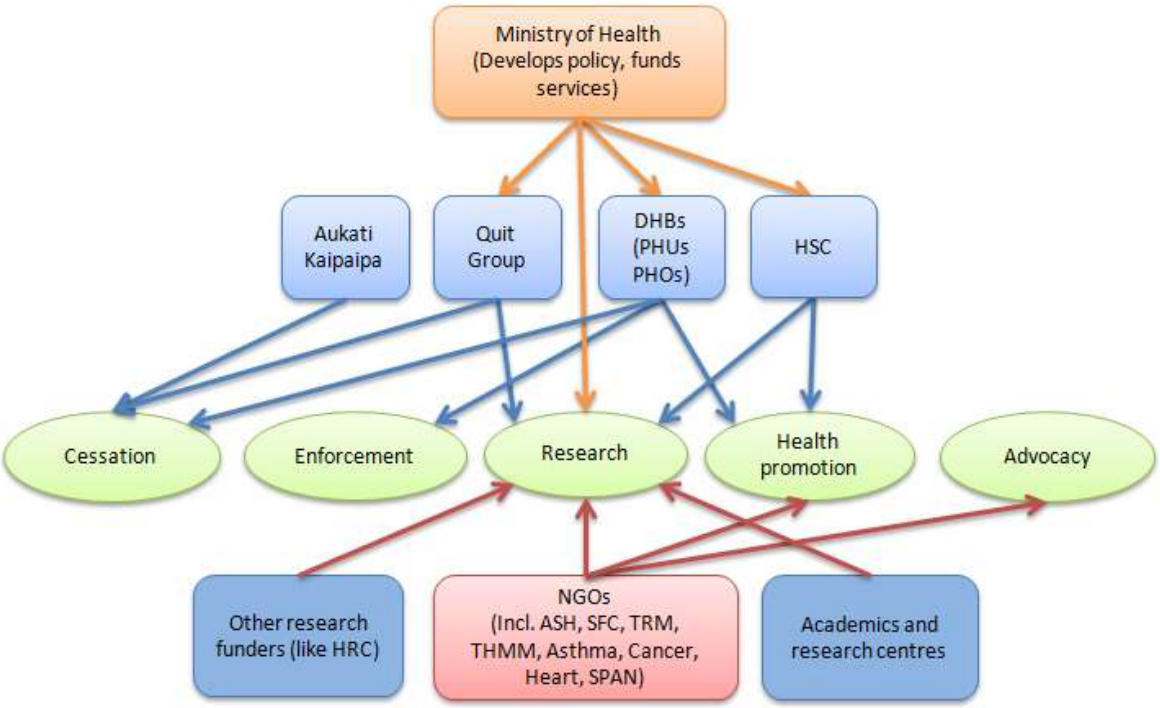
Together, these areas and approaches contribute to a comprehensive tobacco control programme – one that aims to reduce smoking prevalence (the number of people who currently smoke) and reduce smoking uptake (the number of young people who begin to smoke).

By keeping in contact with colleagues who work on other topics, areas or issues, you'll gain a better understanding of the 'big picture' of tobacco control, be able to work smarter (using existing knowledge and resources), and reduce the risk of duplication.

There are a large number of organisations and individuals who work in tobacco control.

- There are a number of others that, while not directly involved in tobacco control work, often make contributions. For example, councils (www.smokefreecouncils.org.nz/) who support having smokefree parks or dairies that refuse to sell cigarettes.

The tobacco control sector



History of tobacco control

Tobacco is a plant that contains the drug nicotine. The leaves of the tobacco plant can be prepared for smoking, chewing or inhaling. People have used tobacco, or other plants that contain nicotine, for many centuries. A brief history of tobacco and tobacco control in New Zealand follows. For further details, check out the references listed at the end of this section.

- Tobacco first found and cultivated in the Americas and brought to Europe by Christopher Columbus and other explorers in the 15th and 16th centuries
- Brought to England by Sir Walter Raleigh during the reign of Queen Elizabeth I
- Introduced to New Zealand by Captain Cook
- 1860: Tobacco used as an incentive to Māori to sign the Treaty of Waitangi
- Late 1900s: The invention of machines to mass-produce cigarettes altered smoking habits forever by increasing the convenience and accessibility of cigarettes

1910–1950s

- 1914–1918: Cigarettes became very popular among soldiers during the First World War – pipes and cigars were inconvenient in the trenches while cigarette packs fitted nicely into shirt pockets. Soldiers were given free cigarettes every day and after the war cigarette smoking became much more acceptable. After the Second World War, three-quarters of the adult male population, and one-quarter of New Zealand adult females, were smokers
- 1930s: Medical professions began to notice an increase in lung cancer – previously an unusual disease. 'The most salient fact in the history of lung cancer (www.smokinglungs.com/cighist.htm), is that before the invention of cigarettes, it was very, very rare'
- By the 1950s, American and British research began to identify smoking, particularly cigarettes, as a leading cause of the increase in lung cancer rates
- 1948: First New Zealand Department of Health posters linking cancer with smoking
- 1953: In New Zealand, tobacco consumption by weight per adult peaked

1960–1980s

- 1964: The Surgeon General's report on smoking and health linked smoking to heart disease, other kinds of cancer, and many other health problems
- 1963: Cigarette advertising banned on New Zealand television and radio by broadcasting authorities in response to the Medical Association's call for a ban on advertising
- 1973: Tobacco industry agrees to restrict billboard and cinema tobacco advertising
- 1973: First health warnings on cigarette packets
- 1979: Tobacco defined as a toxic substance in the toxic substances legislation
- 1984: Māori men and women had highest rates of lung cancer incidence reported from any cancer registry in the world
- 1984: Labour Government initiates a tobacco control programme
- 1985: Minister of Health publicised a 'comprehensive policy to promote non-smoking', asking Government to commit to a tobacco control programme including: public involvement and health education, quit clinics for adults, restricted adolescent access to

tobacco, regulation of tar yields, increased taxation, smokefree environments, health warnings and a ban on advertising tobacco products and tobacco brand name sponsorships

- 1986: Great Smokefree Week supported with $0.5 million Government funding for TV advertising
- 1986: Budget raises tax, industry adds its margins and tobacco prices rise 53 percent
- 1987: New and varied health warnings linking smoking to heart and lung disease appear on the front and back of cigarette packets sold in New Zealand
- 1987: Department of Health goes totally smokefree. Strong public support for restrictions on smoking at work and indoors in public
- 1988: Amendment to Toxic Substances Act banned tobacco product sales to those under 16. Domestic airlines go smokefree
- 1989: Coalition to End Tobacco Advertising and Promotion launched in Wellington. First announcement of Government intention to introduce legislation to ban tobacco advertising
- From 1985–1990, New Zealand had the most rapid rate of reduction in smoking consumption in the Organisation for Economic Cooperation and Development (OECD)

HSC's Smokefree/Auahi Kore branding, introduced in 1990

1990s

- From 1990–1998, tobacco tax was adjusted for inflation at least annually
- 1990: Smoke-free Environments Bill introduced to Parliament in May and passed into law in August 1990. Implementation of the Smoke-free Environments Act 1990 incorporated earlier bans and additionally:
  - placed restrictions on smoking in many indoor workplaces
  - required all workplaces to have a policy on smoking and to review that policy annually
  - placed bans on smoking in public transport and certain other public places, and restricted smoking in cafes, restaurants and casinos
  - regulated the marketing, advertising, and promotion of tobacco products and the sponsorship by tobacco companies of products, services and events
  - banned the sale of tobacco products to people under the age of 16 years (raised to 18 years in 1998)
  - provided for the control and disclosure of the contents of tobacco products
  - established the HSC to replace tobacco sponsorship. The HSC introduced the Smokefree brand

- National Government takes office in October, promising to repeal the ban on tobacco sponsorship and advertising
- 1991: Economic recession at its maximum; 17 percent price increase in cigarettes results in 15 percent decline in cigarette sales
- 1992: Tobacco product consumption per adult is the lowest among OECD countries
- 1993:
  - Environmental Protection Agency in USA says environmental tobacco smoke (also known as second-hand smoke) causes cancer and is causal for glue ear
  - Smoke-free Environments Act amended to allow existing tobacco sponsorships to continue until 1995 (two years longer than in the initial legislation)
  - Australia prohibits tobacco sponsorships from 1995 bringing Australian and New Zealand policies in line
  - contract established with Te Hotu Manawa Māori to coordinate and strengthen tobacco control among Māori. Until this there was no-one working full-time on Māori smoking
  - smoking prevalence among adults at 27 percent – no decrease since 1989
- 1994:
  - launch of Auahi Kore programme by Te Hotu Manawa Māori
  - HSC begins to replace major tobacco sponsorships with smokefree sponsorships
  - Public Health Commission sets a target of 20 percent adult smoking rate or less by 2000 – requiring further Government intervention to be achievable
- 1995:
  - 1 January: All tobacco product advertising in shops comes down, except point-of-sale notices
  - 31 March: All Air New Zealand flights smokefree except for flights to Japan and Korea
  - 1 July: All tobacco sponsorships end and sponsorship signs come down – a few exemptions until December 1995 included Winfield Cup Rugby League matches held in Auckland
  - October: Smoke-free Environments Amendment Bill No. 2 introduced into Parliament
- 1996:
  - census reveals that 23.7 percent of New Zealanders smoke
  - media campaign targeted at youth begins – Why Start? – and runs for three years at a cost of $1million annually
  - 31 May: First national celebration of World Smokefree Day (WSFD). Held annually, WSFD is the only global event established to call attention to the health effects of using and being exposed to tobacco products
- 1997:
  - Ligget tobacco company in USA admit tobacco causes cancer, heart disease and is addictive and also admit to marketing to children
  - inaugural national Māori Auahi Kore conference held at Wainuiomata Marae
  - first national Smokefree Conference held in Wellington attended by 120 people – theme is 'Consensus for a Smokefree New Zealand'. Conference held again 1998 and biennially since
  - Smokefree Coalition first receives Government funding
  - Smoke-free Environments Amendment Bill No. 2 passed in July, becoming the Smoke-

free Environments Amendment Act 1997, amending the Smoke-free Environments Act 1990 to:

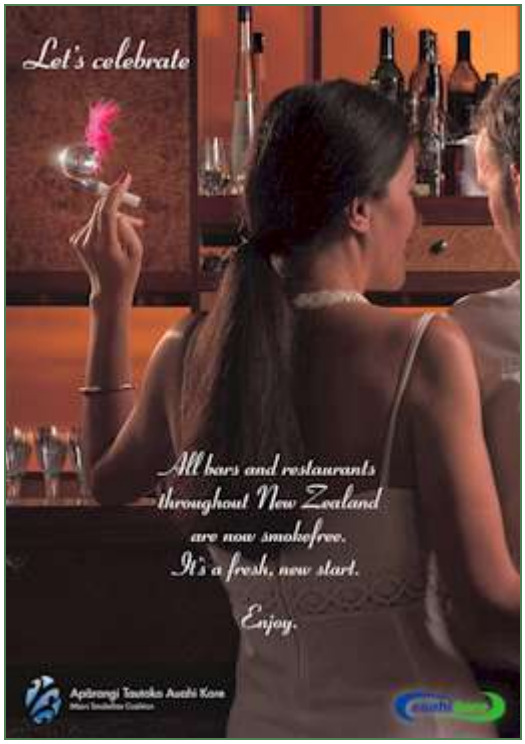
  - ban sales of tobacco products to anyone under 18 yrs (was previously 16 yrs)
  - ban sales of cigarettes in packs of less than 20
  - clarify the regulatory powers of the Act to limit harmful constituents in tobacco products
  - ban incentives to retailers to promote tobacco products
  - reduce size of point-of-sale tobacco advertising
- 1998:
  - September: Quitline and Quit/Me Mutu pilot campaign launched in Waikato and Bay of Plenty. At completion of six-month trial, 8500 calls were received, out of 100 000 smokers in the region
  - Apārangi Tautoko Auahi Kore (ATAK) – Māori Smokefree Coalition established. Name of organisation changed in 2005 to Te Reo Marama
- 1999:
  - launch of national Quitline and Quit/Me Mutu campaign at the Public Health Association Conference
  - mid-1999 – launch of Aukati Kai Paipa, a two-year pilot cessation programme for Māori[9]
  - introduction of Smoke-free Environments (Enhanced Protection) Amendment Bill, which proposed greater protection for workers, volunteers and the public than the Smoke-free Environments Act 1990, particularly against exposure to second-hand smoke

2000 – the New Millennium

- 2000:
  - November – subsidised nicotine patches and gum available through the Quitline and via authorised community providers
- 2001:
  - Supplementary Order Paper (SOP) further enhanced changes suggested by the Smoke-free Environments (Enhanced Protection) Amendment Bill
  - Smoke-free Environments Amendment Bill (a combination of the Smoke-free Environments (Enhanced Protection) Amendment Bill 1999 and the SOP) referred to the Health Select Committee
- 2003:
  - agreement reached on the Framework Convention on Tobacco Control (FCTC) – the world's first public health treaty designed to reduce the health and economic effects of tobacco
  - June: New Zealand signs FCTC
  - development and distribution of the National Māori Tobacco Control Strategy 2003-2007 and accompanying action plans

[9] See the Key players in tobacco control section of this document for more information on Aukati Kai Paipa.

- August to December 2003, second-hand smoke in the workplace TV commercial 'Let's clear the air' runs on television. The commercial was developed by HSC and The Quit Group
- 3 December: Smoke-free Environments Amendment Bill was passed and received Royal Assent on 10 December, becoming the Smoke-free Environments Amendment Act 2003



All licensed premises and other workplaces became smokefree indoors in New Zealand in December 2004.

- 2004:
  - 1 January: All buildings and grounds of schools and early childhood centres required to be smokefree
  - 27 January: New Zealand ratifies FCTC, making the conventions and protocols outlined in the document legally binding to New Zealand
  - 29 March: Ireland becomes first country to go completely smokefree in workplaces, banning smoking in all workplaces, including pubs, bars and restaurants
  - April: Smokefree homes campaign launches. The campaign was developed by HSC and The Quit Group
  - 2004 and 2005, Ministry of Health's smokefree legislation media campaign on air
  - 10 December: All licensed premises (bars, restaurants, cafes, sports clubs, casinos) and other workplaces (including offices, factories, warehouses, work canteens and 'smoko' rooms) become smokefree indoors in New Zealand
  - All Australian states (with exception of the Northern Territory) announce the intention to go smokefree by 2007
- 2005:
  - 28 February: FCTC comes into force when the 40th country formally ratifies

- 2006:
  - 2006 to present: Cancer Society-led Out of Sight, Out of Mind tobacco displays campaign runs
  - 29 April: Tobacco company Phillip Morris International apologise to Māori after being confronted by Te Reo Mārama at the annual Altria Shareholders Meeting in the USA
  - July: The Quit Group's 'Video Diaries' campaign launched
  - 3 May: Justice Lang hands down ruling that compensation will not be awarded to the family of Janice Pou. Mrs Pou's children sought $310,000 from British American Tobacco and WD and HO Wills after their mother Janice Pou died of lung cancer in 2002
  - September: HSC's smokefree cars campaign is launched
  - December: HSC launches the youth-targeted Smoking Not Our Future campaign
- 2007:
  - September 2007, in Auckland: New Zealand hosts the first ever Oceania Tobacco Control Conference
- 2008:
  - 28 February: Introduction of graphic health warnings on tobacco packs
  - February: all medical practitioners who have the right to prescribe are able to distribute Quit Cards without undertaking additional cessation training
  - 21 April: Smokefree community's vision for a Tobacco free Aotearoa in 2020 is confirmed at a National Heart Foundation hui
  - June: The Quit Group's Txt2Quit service is launched
  - June: The Quit Groups 'Pack Warning' campaign launched
  - 24 September: the Commerce Commission, acting on complaints from tobacco control groups, issues warnings about the use of misleading descriptors on tobacco packs. The warnings are issued to the three major tobacco companies supplying the New Zealand market – British American Tobacco (New Zealand) Limited, Imperial Tobacco Co. of New Zealand Limited and Philip Morris (New Zealand) Limited
- 2009:
  - 5 April: HSC's Face the Facts campaign begins
  - May: 168 participants had signed the Framework Convention on Tobacco Control (FCTC) and 164 had ratified it
  - September: all medical practitioners who have the right to prescribe are able to distribute low-cost NRT on a script (instead of using Quit Cards)

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Public health and health promotion

An effective tobacco control programme includes a mix of strategies and tools that fall under the umbrella of health promotion. This section has brief information about the field of public health, and where health promotion fits within the public health framework. Links are provided to information such as the determinants of health, and the Ottawa Charter and the Treaty of Waitangi and their importance to public health and health promotion in New Zealand. There are also links to key Māori models of health.

Public health

Public health has been defined as:

… the art and science of preventing disease, promoting health, and prolonging life through the organised efforts of society.[10]

Public health takes a population health approach, which places a greater emphasis on the health of the population, the role of the community, health promotion and preventative care, and the need to involve a range of professionals. This also takes into account all factors which determine health (determinants of health) and plans how these factors can be addressed.

The determinants of health include:

- peace
- shelter
- education
- food
- sufficient income
- a stable eco-system
- sustainable resource use
- social justice and equity.

For behaviours such as tobacco use, stopping people smoking in the first place is far more effective in reducing disease and death than treating diseases caused by smoking once they have occurred.

Public Health Workforce Development (www.publichealthworkforce.org.nz/what-is-public-health.aspx).

Health promotion

Health promotion sits within the framework of public health.

The World Health Organization (WHO) (www.wpro.who.int/health_topics/health_promotion/) defines health promotion as '... the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health'.[11]

In 1986 in Ottawa, Canada, the World Health Organization (WHO) developed an approach to improving the health of populations and individuals. This is known as the Ottawa Charter

[10] Acheson D. 1988. *Public Health in England: A report of the Committee of Inquiry into the Future Development of the Public Health Function*. London: HMSO.

[11] World Health Organization. 1986. *Ottawa Charter for Health Promotion*. Geneva: WHO.

(www.who.int/healthpromotion/conferences/previous/ottawa/en/) and is used in New Zealand as a framework for planning public health strategies.

The Jakarta Declaration on health promotion into the 21st century (www.who.int/healthpromotion/conferences/previous/jakarta/declaration/en/index.html) (the statement of the fourth International Conference on Health Promotion) reaffirmed the five key strategies of the Ottawa Charter as essential for success in promoting health and specified the following priorities for health promotion in the 21st Century:

- promote social responsibility for health
- increase investments for health development
- consolidate and expand partnerships for health
- increase community capacity and empower the individual
- secure an infrastructure for health promotion.

Health inequalities

Significant inequalities in health status exist between various groups within New Zealand, particularly Māori, Pacific and lower socioeconomic groups. These differences in health status do not usually occur by accident but are caused by differences in experiences of various factors.

For example, a person who starts to smoke may be influenced by the friends they associate with (individual and lifestyle factors), these friends may be influenced by the way they relate to their immediate community (social and community factors), the social and physical environment of the community may be influenced by the economic climate of that community (living and working conditions) and so forth.

Research suggests that those groups most affected by health inequalities are also more likely to have higher rates of smoking. Smoking can be seen as a symptom of health inequalities as people who smoke are more likely to have less access to the key determinants of health. Smoking can also be seen as a cause of health inequalities as people who smoke tend to have less disposable income, which in turn affects the key determinants of health.

Further information about health inequalities is available in the Ministry of Health's publication *Reducing Inequalities in Health:* (www.moh.govt.nz/moh.nsf/wpg_index/Publications-Reducing+Inequalities+in+Health)

Further information about health promotion can be found on the Health Promotion Forum website (www.hpforum.org.nz/), including:

- health promotion and the Treaty of Waitangi
- health promotion and the Ottawa Charter
- Māori approaches to health promotion.

Smokefree legislation

The Smoke-free Environments Act, (www.legislation.govt.nz/act/public/1990/0108/latest/DLM223191.html) passed in 1990, regulated smokefree workplaces and public areas, the marketing, advertising, and promotion of tobacco products and covered the monitoring and regulation of the presence of harmful constituents in tobacco products and tobacco smoke.

On 3 December 2003, an amendment (www.legislation.govt.nz/act/public/2003/0127/latest/DLM234940.html) to the Smoke-free Environments Act 1990 was passed. The amendment (the Smoke-free Environments Amendment Act 2003) required, among other things, that:

- the buildings and grounds of schools and early childhood centres became smokefree from 1 January 2004
- licensed premises (bars, restaurants, cafes, sports clubs, casinos) became smokefree indoors from 10 December 2004
- other workplaces became smokefree indoors from 10 December 2004 – including offices, factories, warehouses, work canteens and 'smoko' rooms
- the display of tobacco products in retail outlets was restricted, and a 'smoking kills' sign erected near the display from 10 December 2004
- herbal smoking products were included in smoking bans
- the access of those under 18 years of age to smoking products was further restricted.

Smoke-free Environments Regulations 2007

These regulations (www.legislation.govt.nz/regulation/public/2007/0039/latest/DLM427193.html) are made under the Smoke-free Environments Act 1990 and set out the new labelling requirements for retail packages of cigarettes and other tobacco products, which includes packages displaying graphic pictorial health warnings.

For further information, see the Ministry of Health's Smokefree Law (www.moh.govt.nz/smokefreelaw) website.

Enforcing the smokefree legislation

Each public health region has staff designated as smokefree officers, who focus on enforcing the Smoke-free Environments Act. Smokefree officers respond to complaints of alleged breaches of the Act. They work out of DHB Public Health Units. It is important to know who the designated officers are in your region, so you can refer complaints to them, and work with them.

A *Smokefree Enforcement Manual* is available to designated smokefree officers. Copies of the manual are available from the Ministry of Health's tobacco control team.

Smoking cessation and addiction

Smoking cessation

The Ministry of Health funds a range of initiatives and smoking cessation programmes to help further reduce smoking prevalence in New Zealand. A number of tobacco control workers therefore focus on the area of smoking cessation – or helping people to quit smoking.

The ABC approach is used to deliver cessation services in New Zealand (**Ask** all patients if they smoke, provide **Brief** advice to quit to all smokers, offer **Cessation** support.) For more information about the ABC approach see the online e-learning tool (smokingcessationabc.org.nz/).

Organisations/individuals providing smoking cessation interventions and services include:

- The Quit Group (www.quit.org.nz/page/index.php)
- Aukati Kai Paipa (www.aukatikaipaipa.co.nz/)
- Smokechange (www.smokechange.co.nz/Home) (for pregnant women and their partners)
- health professionals including GPs, midwives, dentists, optometrists, nurse practitioners, and community health workers, by providing Quit Cards for nicotine replacement therapy, and giving support and advice
- District Health Boards.

The Quit Group

The Quit Group (www.quit.org.nz/page/index.php) manages the Quit Cards programme. Quit Cards providers can distribute Quit Cards for subsidised nicotine patches, gum and lozenges to people who want to quit smoking.

Free smoking cessation training, to become a Quit Cards provider, is available from

- The National Heart Foundation (www.nhf.org.nz/):
- Te Hotu Manawa Māori (www.tehotumanawa.org.nz/).

The Quit Group also runs the Quitline – 0800 778 778, and manages the Txt2Quit and Quit@Work (www.quit.org.nz/page/providers/QuitAtWork.php) programmes: – working with employees to reduce smoking rates in their workforce, and improve health and wellness.

Aukati Kai Paipa

Aukati Kai Paipa (www.aukatikaipaipa.co.nz/) provides a face-to-face service developed specifically to meet the needs of Māori women and their whānau.

Smokechange

Smokechange (www.smokechange.co.nz/Home) provides support to change smoking in pregnancy.

Addiction

Many smokers become addicted to nicotine.

Nicotine's relaxation effect, improved mood effect, and improved cognitive performance effect are greatest when the nicotine is delivered rapidly to the brain through inhaled smoke or through other rapid high-dose delivery systems.[12] The extent to which smokers are addicted to nicotine is comparable with addiction to 'hard' drugs such as heroin or cocaine.[13]

Smoking is an addiction with three parts:

1. Addiction to nicotine

Nicotine is one of thousands of chemicals in cigarettes. It's addictive and causes most of the withdrawal symptoms when smokers first stop.

2. Habit

Habits also create needs or cravings.

3. Feelings

Feelings are also important. Cigarettes are often connected with moods or feelings. People smoke for pleasure when happy, and for comfort when sad; for a break when tired or for something to do when excited.[14]

Nicotine replacement therapy

Nicotine replacement therapy (NRT) (www.quit.org.nz/page/providers/resources/resources.php) works by replacing some of the nicotine smokers usually get from tobacco smoking. NRT, such as patches, gum and lozenges, are safe and have not been shown to cause cancer or heart disease.

NRT reduces the severity of withdrawal symptoms associated with smoking cessation (urges to smoke, irritability, restlessness and poor concentration), and in doing so makes quitting easier.[15] However it is not a 'magic bullet' and smokers using NRT need to be committed to quitting smoking.

There are a number of different NRT products available in New Zealand (patch, gum, lozenge, sublingual tablet and inhaler) which all roughly double the chances of quitting for good.[16] They provide nicotine in different ways, for example, the patch may be best to relieve background craving while faster acting products such as nicotine gum or lozenges can relieve acute cravings.[17]

NRT patches, gum and lozenges are currently subsidised and are available on prescription and via

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12 Jones RT, Benowitz NL. 2002. Therapeutics for nicotine addiction (chapter 107). In Davis KL, Charney D, Coyle JT, Nemeroff C (eds). *Neuropsychopharmacology: The Fifth Generation of Progress*. American College of Neuropsychopharmacology.

13 Royal College of Physicians. 2000. *Nicotine addiction in Britain*. London: Royal College of Physicians.

14 The Quit Group, *Understanding your addiction*. www.quit.org.nz/page/quittingSmoking/helpWithQuitting/understandingYourAddiction.php. Retrieved on 11 May 2009.

15 West R, Shiffman S. Effect of oral nicotine dosing forms on cigarette withdrawal symptoms and craving: a systematic review. *Psychopharmacology* (Berl) 2001;155(2):115-22.

16 Silagy C, Lancaster T, Stead L, Mant D, Fowler G. 2006. Nicotine replacement therapy for smoking cessation. *Cochrane Database of Systematic Review(*2).

17 McRobbie H, Maniapoto M. 2009. Getting the most out of nicotine replacement therapy. www.bpac.org.nz/magazine/2009/april/nrt.asp. Retrieved on 11 May 2009.

Quit Cards. The nicotine inhaler and sublingual tablets are available over the counter (unsubsidised).

It is generally recommended that NRT is used for eight to twelve weeks. People are unlikely to become addicted to NRT, but some may need to use it for longer than others, especially those people who are more highly dependent.[18]

Safety

NRT is safe. It is not associated with increased rates of cancer or heart disease and can be used in the vast majority of people who smoke. Compared to tobacco smoke, NRT supplies less nicotine less rapidly, and without harmful substances. Even in special groups of smokers, such as those who are pregnant and those with cardiovascular disease, NRT use usually outweighs the risk of continued smoking.[19, 20]

Refer to the Smoking Cessation Guidelines (www.moh.govt.nz/moh.nsf/indexmh/nz-smoking-cessation-guidelines) for more information about the use of NRT.

[18] Hajek P, McRobbie H, Gillison F. Dependence potential of nicotine replacement treatments: effects of product type, patient characteristics, and cost to user. *Prev Med 2007;44(3):230-4*.

[19] McRobbie H, Hajek, P. Nicotine replacement therapy in patients with cardiovascular disease: guidelines for health professionals. *Addiction 2001;Nov;96((11)):1547-51*.

[20] Benowitz N, Dempsey D. Pharmacotherapy for smoking cessation during pregnancy. *Nicotine Tob Res 2004;6 Suppl 2:S189-202*.

Priority groups

The Ministry of Health has three tobacco control priority groups:[21]

- Māori
- Pacific peoples
- Pregnant women.

Within each of these groups, keeping young people smokefree is also a priority.

Data from Tobacco Trends 2008[22] (www.moh.govt.nz/moh.nsf/indexmh/tobacco-trends-2008)shows:

- 21 percent of people aged 15 years and over are smokers
- 45.4 percent of Māori aged 15 to 64 are smokers
- 31.4 percent of Pacific peoples aged 15 to 64 are smokers.

Daily smoking prevalence amongst 14-15 year olds in 2008 was 7 percent compared to 12 percent in 2003 and 16 percent in 1999.[23]

Māori

The traditional world of the Māori was auahi-tupeka (smokefree). There wasn't even an original Māori word to describe the act of smoking. James Cook brought the first tobacco and over the last 200 years, and smoking it steadily became popular among Māori.[24]

Māori smoking rates

Today, Māori smoking rates are much higher than the smoking rates of other adult New Zealanders. Twenty percent of Māori deaths each year are attributable to tobacco use.[25] This is a significant loss of cultural knowledge and language.[26]

Māori (29 percent) are also more likely than non-Māori (17 percent) to be exposed to second-hand smoke in their home at least one day a week.[27]

The prevalence of smoking among *taiohi* Māori (youth) remains high compared to non-Māori – particularly in females – but has dropped significantly. In 2007 the prevalence of year 10 female

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21 Ministry of Health. 2009. *Implementing the ABC Approach for Smoking Cessation. Framework and work programme*. Wellington: Ministry of Health.

22 Ministry of Health. 2009. *Tobacco Trends 2008: A brief update of tobacco use in New Zealand*. Wellington: Ministry of Health.

23 Paynter J. 2009. *National Year 10 ASH Snapshot Survey, 1999-2008: Trends in tobacco use by students aged 14-15 years*. Report for the Ministry of Health, Health Sponsorship Council an Action on Smoking and Health. Auckland, New Zealand. www.ash.org.nz/pdf/ASHYear10Report19992008.pdf. Retrieved on 16 June 2009.

24 Te Hotu Manawa Maori website: www.tehotumanawa.co.nz. Retrieved on 20 May 2009.

25 Ibid.

26 Te Reo Marama website: www.tereomarama.co.nz. Retrieved on 28 January 2009.

27 Gillespie J, Milne K. 2004. *Second-hand smoke in New Zealand homes and cars. Exposure, attitudes and behaviours in 2004.* Wellington: HSC Research and Evaluation Unit.

Māori who smoked daily was 22 percent compared to 13 percent for male Māori.[28]

Of students aged 14 to 17 who smoked daily, 30 percent of Māori males reported first trying a cigarette at seven years old or younger, and 31 percent of Māori females first experimented at eight to nine years of age.[29]

What's being done?

Māori are the priority group for tobacco control programmes, because of high Māori smoking rates.

The *National Māori Tobacco Control Strategy (2003-2007)* (www.cancernz.org.nz/Uploads/Maori_Strategy_FINAL.pdf) and The *National Māori Tobacco Control Action Plan* (www.cancernz.org.nz/Uploads/Maori_Action_Plans_FINAL.pdf) provided a blueprint for a focused approach to achieve better health outcomes for Māori. The Action Plan identified a range of actions and priorities for Māori tobacco control. Development of a new strategy is being undertaken.

Groups like Te Reo Mārama and Te Hotu Manawa Māori have a specific focus on improving and protecting the health of all Māori by contributing to efforts in reducing tobacco use, exposing the tobacco industry's role, exposure to second-hand smoke and the adverse health consequences. There is a focus on providing 'by Māori, for Māori' services, and on supporting policy and funding decisions that will lead to a decline in the smoking rates of Māori.

Aukati Kai Paipa (www.aukatikaipaipa.co.nz/) is a kanohi ki te kanohi service that is delivered locally within most communities. The programme offers Māori and their whānau the opportunity to address their smoking addiction, through a range of services. Services include free nicotine patches or gum, motivational counselling and ongoing support.

The Quit Group (www.quit.org.nz/page/index.php) aims to improve quit rates among Māori. Media campaigns and other promotions are developed with the aim of reaching Māori, and Māori Quitline Advisors are available to provide a quality service to Māori clients.

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[28] Paynter J. 2009. *National Year 10 ASH Snapshot Survey, 1999-2008: Trends in tobacco use by students aged 14-15 years*. Report for the Ministry of Health, Health Sponsorship Council and Action on Smoking and Health. Auckland, New Zealand. Retrieved on 16 June 2009.

[29] Health Sponsorship Council. 2005. *Reducing smoking initiation literature review: A background discussion document to support the national framework for reducing smoking initiation in Aotearoa-New Zealand*. Wellington: Health Sponsorship Council.

Pacific peoples

Tobacco use is not a traditional part of Pacific peoples' culture, even though some Pacific countries started to cultivate tobacco after colonisation. Many Pacific peoples' religions are opposed to smoking.[30]

Pacific smoking rates

Smoking rates of Pacific peoples are much higher than the rates for all adult New Zealanders. Smoking is linked to a number of high priority areas in Pacific peoples' health including diabetes, obesity and heart disease. Second-hand smoke is linked to glue ear, asthma and meningococcal disease in children[31].

A high number of Pacific peoples report that they have no thoughts of quitting or of needing to consider quitting some day (51 percent for Pacific peoples, 48 percent for Māori and 40 percent for Pakeha).[32]

In 2006, 8.5 percent of Pacific boys and 13 percent of Pacific girls smoked daily; compared to 4.1 percent of European boys and 6.1 percent of European girls.[33]

It should be noted that smoking prevalence varies greatly across different Pacific ethnicities.

A still from the Quit Group's 'heart attack' advertisement which featured a Samoan smoker and was aimed at encouraging Pacific peoples to quit smoking.

What's being done?

Lowering the smoking rates within Pacific communities will significantly contribute to reducing inequalities in health outcomes. To start to work towards this, A *Pacific Peoples Tobacco Control Action Plan*[34] (www.cancernz.org.nz/Uploads/Pacific_Peoples_Action_Plan.pdf) was developed in

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30 Ministry of Health. 2004. *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*. Wellington: Ministry of Health.

31 The Quit Group. 2003. *Health, Smoking and Cessation: Research Findings from Pacific Health Service Provider and Community Leader Fono Groups*. Unpublished Report: The Quit Group.

32 Ministry of Health. 1999. *Taking the Pulse: The 1996/1997 New Zealand Health Survey*. Ministry of Health: Wellington.

33 Scragg R. 2007. *Report of 1999-2006 National Year 10 Smoking Snapshot Surveys.* Prepared for Action on Smoking and Health and HSC.

34 Pacific Tobacco Control Interim Group. 2004. *Pacific Peoples Tobacco Control Action Plan*. Wellington: Pacific Tobacco Control Interim Group.

2004. The Plan identifies steps that need to be taken to improve the health of Pacific peoples, by reducing smoking and six priority areas for development and improvement:

- health promotion
- providing a Pacific voice for tobacco control issues
- workforce development
- coordination
- research and evaluation
- cessation.

The Pacific Health and Disability Action Plan[35] (www.moh.govt.nz/moh.nsf/pagesmh/1351?Open) sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific peoples and non-Pacific peoples. The second priority in the Action Plan addresses the promotion of Pacific healthy lifestyles and wellbeing and identifies tobacco as a risk factor influencing Pacific health.

The action plan highlights:

- exploring smoking cessation prevention programmes for Pacific peoples
- encouraging smokefree Pacific environments
- improving the availability of services.

The Smokefree Pacific Action Network (SPAN) has been a long-standing Pacific voice in tobacco control. Originally formed in Auckland, it offers smokefree services on a voluntary basis.

Pacific Heartbeat (www.pacificheart.org.nz/) provides national cessation and regional smokefree training to promote smokefree lifestyles for Pacific peoples within Aotearoa-New Zealand.

The Ministry of Health funds a number of Pacific cessation services.

The Quitline has Pacific Quitline Advisors and resources in different Pacific languages (www.quit.org.nz/page/providers/resources/resources.php).

Pregnant women

While overall smoking rates continue to decrease, smoking during pregnancy remains a source of considerable and serious negative health outcomes for women and babies in New Zealand. For this reason, the Ministry of Health has identified pregnant women as a priority group for reducing the harm caused by tobacco.

Smoking during pregnancy reduces the growth and health of babies and increases the risks of a number of complications and illnesses for both the mother and baby.

Quitting smoking before or during pregnancy, and avoiding exposure to second-hand smoke, has a positive impact on the health of both the mother and the unborn baby. It also reduces the likelihood of related health problems for the child after birth.

Babies born to women who smoke during pregnancy have a greater chance of premature birth, low birth weight, stillbirth, and infant mortality. Smoking during pregnancy can also affect the development of babies' lungs, which increases the risk of many health problems.[36, 37]

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[35] Minister of Health. 2002. *The Pacific Health and Disability Plan*. Wellington: Ministry of Health.

[36] US Department of Health and Human Services. 2004. *The Health Consequences of Smoking: what it means to you*. US

Chemicals in tobacco smoke are passed onto the baby through the placenta. Nicotine causes the blood vessels to constrict, which decreases the amount of oxygen going to the unborn baby and is an important contributor to low birth weight.[38] Mothers who smoke also pass nicotine onto their babies through their breast milk.[39]

It has been estimated that around 50 New Zealand babies die every year from SIDS as a result of exposure to second-hand smoke,[40] and emerging evidence suggests that smoking during pregnancy is an even stronger risk factor for SIDS than exposure to second-hand smoke.[41]

Pregnant women's smoking rates

Data recorded in 2006 show that prevalence of smoking in women of childbearing age (15-39 years) ranges from 26-29 percent, depending on the specific age group. However, rates are highest in Māori (39-61 percent) and Pacific peoples (27-47 percent), compared to Pākehā (22-27 percent).[42]

Smoking cessation interventions for pregnant and breastfeeding women

The New Zealand Smoking Cessation Guidelines (www.moh.govt.nz/moh.nsf/indexmh/nz-smoking-cessation-guidelines) have a specific section on cessation support for pregnant and breastfeeding women. In summary, cessation efforts should be encouraged in all women of child-bearing age who smoke and at any time throughout a pregnancy. While there are concerns about potential adverse effects of nicotine in fetal development, the main benefit of using NRT (gum, lozenge, sublingual tablet and inhalers should be used in preference to patches) is the removal of all other toxins contained in tobacco smoke. Furthermore, NRT typically provides less nicotine than tobacco smoke.

The Guidelines conclude that, in current expert opinion, NRT can be considered safe to use during pregnancy, following an assessment of the risks and benefits.

What's being done?

The Ministry of Health introduced the Tackling Smoking in Pregnancy project in 2008, which aims to reduce the rates of smoking in women of childbearing age and during pregnancy, thereby improving the quality of care and outcomes for pregnant women and their babies.

This will be achieved in three ways:

Department of Health and Human Services, Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004. www.cdc.gov/tobacco/data_statistics/sgr/sgr_2004/00_pdfs/SGR2004_Whatitmeanstoyou.pdf. Retrieved on 11 February 2008.

37 US Department of Health and Human Services. 2006. *The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General.* US Department of Health and Human Services, Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. www.cdc.gov/tobacco/sgr/sgr_2006/index.htm. Retrieved on 11 February 2008.

38 American Council on Science and Health. 2003. *Cigarettes: What the warning label doesn't tell you*. Second edition. New York, American Council on Science and Health. www.acsh.org/publications/pubID.206/pub_detail.asp Retrieved on 11 February 2008.

39 US Department of Health and Human Services. 2004. *The health consequences of smoking: a report of the Surgeon General.* U.S. Department of Health and Human Services, Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. www.cdc.gov/tobacco/sgr/sgr_2004/index.htm. Retrieved on 11 February 2008.

40 Woodward A, Laugesen M. 2001. How many deaths are caused by second hand cigarette smoke? *Tobacco Control 2001; 10: 383-388*. http://tobaccocontrol.bmj.com/cgi/content/abstract/10/4/383. Retrieved on 11 February 2008.

41 McMaster University. 2008. *Link Between Smoking In Pregnancy And Sudden Infant Death Syndrome Explained.* www.sciencedaily.com/releases/2008/01/080129125422.htm. Retrieved on 4 March 2008.

42 Ministry of Health. 2006. *Tobacco Trends 2006: Monitoring tobacco use in New Zealand*. Wellington: Ministry of Health.

- developing a coordinated whole of health sector approach to routinely and systematically address smoking during pregnancy, in line with the New Zealand Smoking Cessation Guidelines
- ensuring that evidence based specialist cessation services are accessible for all women in New Zealand who require intensive support
- creating an environment that increases wider public understanding of the significant harms of smoking during pregnancy and the importance of quitting.

The Ministry is also implementing a monitoring and surveillance programme of smoking in pregnancy to support this project, and for ongoing use.[43]

Cessation services for pregnant women include Aukati Kai Paipa (www.aukatikaipaipa.co.nz/) and Smokechange (www.smokechange.co.nz/Home).

The Ministry of Health has also funded The Quit Group to produce a pregnancy TVC (www.quit.org.nz/page/media/campaigns/campaigns.php), which was launched in June 2009.

Young people

Although not an official Ministry of Health priority group, children and young people are an important subset of the three priority groups, and in particular Māori and Pacific peoples.

The transition from being a non-smoker to becoming an addicted smoker is a process rather than a single event.

Youth smoking rates

Data on smoking among year 10 school students has been collected annually among approximately 30,000 children since 1999. Smoking rates for year 10 young people (aged 14 and 15) have been steadily declining. Overall prevalence of daily smoking was 15.6 percent and regular smoking (monthly or more often) 28.6 percent in 1999 and had dropped to 7 percent daily and 12 percent regular smoking in 2008.[44]

What's being done?

In 2005, the Health Sponsorship Council undertook the *Reducing Smoking Literature Review*,[45] (www.hsc.org.nz/pdfs/RSI_Lit_Rvw_Final.pdf) from which the *Framework for Reducing Smoking Initiation in Aotearoa-New Zealand* [46] (www.hsc.org.nz/pdfs/RSI_Framework_Final.pdf) was developed. The Framework proposed a comprehensive suite of interventions and initiatives to reduce smoking initiation in Aotearoa-New Zealand. The Framework has been developed for use by health providers, health funders, policy makers and researchers.

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[43] Ministry of Health. 2009. *Implementing the ABC Approach for Smoking Cessation. Framework and work programme*. Wellington: Ministry of Health.

[44] Paynter J. 2009. *National Year 10 ASH Snapshot Survey, 1999-2008: Trends in tobacco use by students aged 14-15 years*. On behalf of Action on Smoking and Health, Health Sponsorship Council and the Ministry of Health. www.ash.org.nz/pdf/ASHYear10Report19992008.pdf. Retrieved on 16 June 2009

[45] HSC. 2005. *Reducing Smoking Initiation Literature Review. A background discussion document to support the national Framework for Reducing Smoking Initiation in Aotearoa-New Zealand*. HSC: Unpublished report.

[46] HSC. 2005. *Framework for Reducing Smoking Initiation in Aotearoa-New Zealand.* HSC: Unpublished report.

Evidence shows that the most prominent risk factors for smoking initiation are: affordability of, and access to, tobacco products; peer smoking; parental factors (parental smoking, pocket money provision, permitting smoking in the house, parenting style); the family environment; low self-esteem; and participation in risk-taking behaviours. The most prominent protective factors include (in addition to reducing the risk factors detailed above) doing well within the school environment, participation in community or sports clubs, spiritual connectedness, and family connectedness.

The Framework suggests that interventions to reduce smoking initiation in New Zealand must:

- be integrated and comprehensive
- address individuals within their social context
- aim to reduce risk factors and enhance protective factors
- target specific groups in multiple settings concurrently.

A number of organisations with an interest in tobacco control have a focus on reducing the number of young people who start to smoke. For example, the Health Sponsorship Council's programme Smoking Not Our Future (www.notourfuture.co.nz/).

Other groups help young people to quit smoking. The Quit Group's Txt2Quit (www.txt2quit.org.nz) programme, for example, uses texting to provide free quit support and advice. The programme is particularly targeted to 16 to 24 year olds.

Research

Most tobacco control programmes and interventions in New Zealand are informed by evidence in their development, and then research is used to determine whether they are effective.

Tobacco control research:

- tells us which interventions are the most effective in reducing the harm caused by the use of tobacco
- tells us how effective existing interventions are, and how they could be improved
- shows which populations groups are benefiting most from tobacco control interventions
- enables us to continually build on what we know about tobacco control.

For more information about tobacco control research in New Zealand will be available when the *New Zealand Tobacco Control Research Strategy 2009-2012* is released later in 2009.

The New Zealand Tobacco Control Research Strategy

The New Zealand Tobacco Control Research Strategy 2009-2012 (www.moh.govt.nz/moh.nsf/0/AAFC588B348744B9CC256F39006EB29E/$File/clearingthesmoke.pdf) provides a long-term direction for New Zealand researchers and funders in the field of tobacco control. It builds on the work of the Tobacco Control Research Strategy 2003 (www.allenandclarke.co.nz/Tobacco_Strategy_Book.pdf).

The goal of the Strategy is to contribute to a tupeka kore/tobacco free Aotearoa/New Zealand by 2020. The end result of the Strategy will be improved tobacco control in Aotearoa-New Zealand and, ultimately, a reduction in tobacco-related illness and deaths. It identifies several priority areas for future tobacco control research and criteria for assessing tobacco control research proposals.

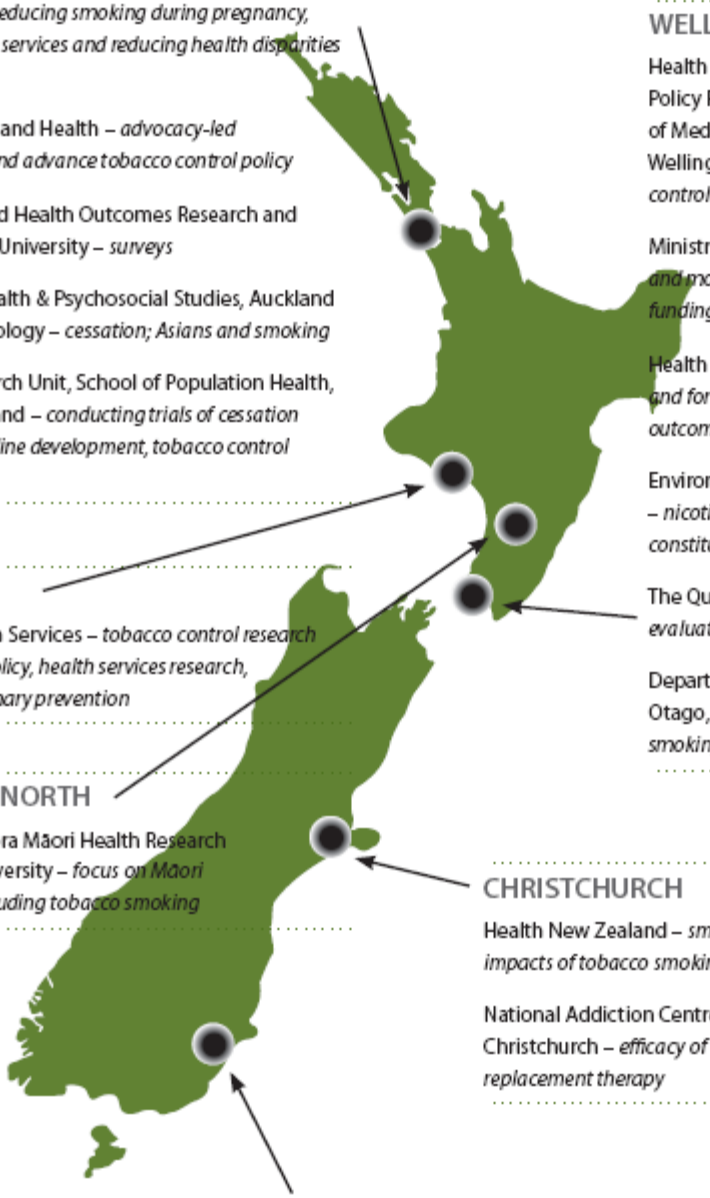
Tobacco Control Research Steering Group

The Tobacco Control Research Steering Group was formed in 2007 as the result of a joint Ministry of Health/Health Research Council initiative. The Ministry funds the Steering Group and appoints its members. The Steering Group's functions are to:

- provide strategic advice annually to the Ministry and wider sector on current and long-term tobacco research priorities for New Zealand
- advise researchers on opportunities and processes for accessing research funding, and act as a conduit for linking researchers to potential funders
- identify tobacco control research workforce needs and potential opportunities for workforce development
- help improve the knowledge and skills of the tobacco control sector.

New Zealand hubs of tobacco control research

Organisations with a sustained involvement in tobacco control research are listed. The principal (but not sole) focus of each organisation's tobacco control research is summarised in italics.



AUCKLAND

Centre for Tobacco Control Research, Auckland University – *Māori and Pacific Island-focused projects focusing on reducing initiation, reducing smoking during pregnancy, improving cessation services and reducing health disparities due to smoking*

Action on Smoking and Health – *advocacy-led research to inform and advance tobacco control policy*

Centre for Social and Health Outcomes Research and Evaluation, Massey University – *surveys*

School of Public Health & Psychosocial Studies, Auckland University of Technology – *cessation; Asians and smoking*

Clinical Trials Research Unit, School of Population Health, University of Auckland – *conducting trials of cessation interventions, guideline development, tobacco control research*

WHANGANUI

Whakauae Research Services – *tobacco control research with emphasis on policy, health services research, evaluation, and primary prevention*

PALMERSTON NORTH

Te Pumanawa Hauora Māori Health Research Centre, Massey University – *focus on Māori health research, including tobacco smoking*

WELLINGTON

Health Promotion and Public Health Policy Research Unit, Wellington School of Medical Health, University of Otago, Wellington – *policy oriented tobacco control research*

Ministry of Health – *National surveillance and monitoring; commissioning and funding research*

Health Sponsorship Council – *monitoring and formative, process, impact and outcome evaluations*

Environmental Science and Research – *nicotine metabolism and tobacco constituents*

The Quit Group – *cessation research and evaluation*

Department of Medicine, University of Otago, Wellington – *Clinical trials of novel smoking cessation therapies*

CHRISTCHURCH

Health New Zealand – *smokeless tobacco, health impacts of tobacco smoking, e-cigarettes*

National Addiction Centre, University of Otago, Christchurch – *efficacy of long term nicotine replacement therapy*

DUNEDIN

Cancer Society Social &.Behavioural Research Unit, University of Otago – *youth smoking and cancer determinants*

Dunedin Multidisciplinary Health and Development Research Unit, Preventive and Social Medicine, Dunedin School of Medicine – *longitudinal studies*

Department of Marketing, School of Business, University of Otago – *experimental studies and surveys*

Tobacco control university papers

University papers in tobacco control are available at some New Zealand universities. Examples of courses offered are:

1. University of Auckland School of Population Health

POPLHLTH 753: Special Topic: Tobacco Control
(www.fmhs.auckland.ac.nz/soph/postgrad/_docs/coursepdfs/POPLHLTH_753.pdf)

The University of Auckland offers this course to introduce students to theory and research developed within public health and epidemiological contexts that are related to tobacco control. Students will review major theoretical issues and will consider current trends and future challenges to tobacco control. Topics covered will relate to three main themes (1) Reducing initiation, (2) Interventions to reduce smoking related harm, and (3), Smoking cessation and treatment of nicotine dependency.

2. Auckland University of Technology

567529 - Tobacco Control
(www.aut.ac.nz/papers/health/ak3680/567529?paper_code=567529&pgID=946&SQ_DESIGN_NAME=papers)

The Auckland University of Technology offers an undergraduate course on tobacco control. The course Discusses tobacco control policy and legislation and considers the demographics and prevalence of tobacco use in New Zealand and internationally. Examines the relationship between tobacco use and health inequalities and describes a comprehensive range of population based tobacco control strategies.

3. Auckland University of Technology

567528 - Smoking Cessation
(www.aut.ac.nz/papers/health/ak3680/567528?paper_code=567528&pgID=946&SQ_DESIGN_NAME=papers)

The Auckland University of Technology offers an undergraduate course on smoking cessation. The course identifies bio-psychosocial factors which contribute to nicotine addiction and develops treatment intervention skills which will assist people to quit smoking. The course aims to enhance your smoking cessation practice skills with in-depth knowledge and understanding in a series of engaging interactive workshops.

4. University of Otago, Wellington

The Department of Public Health (www.wnmeds.ac.nz/academic/dph/) at the University of Otago (www.wnmeds.ac.nz/index.html), Wellington runs an annual summer school with a range of courses on public health. The programme often includes courses on tobacco control.

Effects of tobacco

What is in tobacco?

- Tobacco smoke contains over 4000 chemicals, many of which are highly toxic.
- It contains 40 known cancer-causing substances (it should be noted that nicotine is not cancer-causing).
- There is no safe 'low tar' cigarette and no known safe level of smoking.

Nicotine ($C_{10}H_{14}N_2$)

- Nicotine is a drug that occurs in tobacco. It causes addiction but is not cancer-causing.
- 8-20 mg is contained in each cigarette.
- Approximately 1mg of nicotine is absorbed by the body, per cigarette smoked, going almost directly to the brain.
- Effect on body:
  - it raises the heart rate and blood pressure and slows circulation (lowers body temp)
  - it causes rapid shallow breathing
  - it is both a relaxant and a stimulant – it changes brain activity – improves reaction times, and brings on euphoria, hence addictive
  - it affects appetite – possibly due to inhibiting insulin release, leading to hyperglycaemia
  - it increases basal metabolic rate – which is the energy a person uses at complete rest. (The body is always using energy for essential functions such as building new cells, keeping the heart beating, breathing, sending messages through the nerves and for warmth.)

Tar

- Is a sticky brown substance which stains fingers, teeth and lungs.
- Is inhaled in tobacco smoke.
- Includes nitrogen, hydrogen, carbon dioxide and carbon monoxide.
- A pack a day smoker inhales 150 ml of tar per year.

Carbon monoxide (CO)

- Is a poisonous gas (found in car exhaust fumes).
- Takes the place of oxygen in the blood.
- In combination with nicotine is thought to cause heart disease.
- The amount inhaled varies according to how a cigarette is smoked and the way cigarettes are manufactured.

Hydrogen cyanide (HCN)

- Damages lung-clearing system (think snot!) causing accumulation of toxic agents in lungs.

Additives

- For example, ammonia, menthol and sweetener.

***The smoker's body*, a World Health Organization Tobacco Free Initiative poster detailing the harmful effects smoking has on the human body**

Health effects of smoking

Harm to the smoker

- Smoking increases the risk of developing diseases of the respiratory and circulatory systems. These include cancers of the lung, oral cavity, pharynx, larynx, oesophagus and pancreas.[47] Smoking also increases the risk of developing diseases of the urinary tract, pelvis, bladder and digestive tract.[48]
- Smoking causes one in four of all cancer deaths in New Zealand.[49]
- Tobacco is the only consumer product that kills half its users when used as the manufacturer intends.
- Smoking is a major cause of blindness, with about 1300 people in New Zealand having untreatable blindness due to current and past smoking.[50]
- Tobacco plays a significant role in health inequalities within New Zealand for both youth[51] and adults.[52] Higher smoking prevalence is seen among low-income groups, Māori and Pacific peoples.[53,54]

Second-hand smoke

- Inhaled smoke contains more than 4000 chemicals including acetone (paint stripper), ammonia (toilet cleaner), cyanide (rat killer), DDT (insecticide) and carbon monoxide (car exhaust fumes).[55]
- Second-hand smoke is a mixture of the smoke given off by the burning end of tobacco products (sidestream smoke) and the mainstream smoke exhaled by smokers.[56]
- Second-hand smoke is the leading environmental cause of preventable death in New Zealand.[57]
- It is estimated that in New Zealand, 347 deaths per year are caused by past exposures to

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47 Vineis P, Alavanja M, et al. 2004. Tobacco and cancer: recent epidemiological evidence. *Journal of National Cancer Institute* 96: 99-106.

48 Ministry of Health. 2005. *Tobacco Facts 2005*. Wellington: Ministry of Health.

49 Laugesen M. 2000. *Tobacco Statistics 2000*. Wellington: Cancer Society of New Zealand.

50 Wilson G, et al. 2001. Smoke gets in your eyes: smoking and visual impairment in New Zealand. *NZ Med J*, 114, 471-4.

51 Scragg R. 2007. *Report of 1999 – 2006 year 10 snapshot smoking surveys,* Action on Smoking and Health NZ. www.ash.org.nz/pdf/Reportof2006Year10Survey_FINAL.pdf. Retrieved on 14 December 2007.

52 Blakely T, Tobias M, Atkinson J, Yeh, LC, Huang K. 2007. *Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981 – 2004*. Wellington: Ministry of Health.

53 Hill S, Blakely T, Howden-Chapman, P. 2003. *Smoking Inequalities: Policies and patterns of tobacco use in New Zealand. 1981 to 1996*. Wellington: Ministry of Health.

54 Blakely T, Tobias M, Atkinson J, Yeh, LC, Huang K. 2007. *Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981 – 2004*. Wellington: Ministry of Health.

55 The Quit Group and the Health Sponsorship Council. 2000. *Break Free*. Wellington: Ministry of Health.
Fowles J, Bates M, Noiton D. 2000. *The Chemical Constituents in Cigarettes and Cigarette Smoke: Priorities for Harm Reduction.* Ministry of Health.
www.ndp.govt.nz/moh.nsf/pagescm/1003/$File/chemicalconstituentscigarettespriorities.pdf. Retrieved on 4 January 2007.

56 Department of Health and Human Services, United States. 2006. *The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General.* www.surgeongeneral.gov/library/secondhandsmoke/. Retrieved on 14 December 2007.

57 Woodward A, Laugesen M. 2001. How many deaths are caused by second-hand cigarette smoke? *Tobacco Control,* 10, 383-8.

second-hand smoke.[58]

- Second-hand smoke is a risk factor for:
  - coronary heart disease
  - lung cancer
  - acute stroke
  - nasal sinus cancer.[59]
- Exposure to second-hand smoke increases the risk of stroke, with three times the risk in men compared to women.[60]
- Many people exposed to second-hand smoke experience eye irritation, headache, cough, sore throat, dizziness and nausea.[61]
- Children are especially vulnerable to second-hand smoke as their lungs are smaller and more delicate. They are therefore seriously affected by tobacco smoke and the chemicals it contains.[62]
- Children exposed to second-hand smoke are more likely to need hospital care, are more susceptible to coughs, colds and wheezes and are off school more often.[63]
- In New Zealand each year second-hand smoke causes:
  - more than 500 hospital admissions of children under age two years suffering from chest infections[64]
  - more than 27,000 GP consultations for asthma and other respiratory problems[65]
  - 1,000 cases of glue ear[66]
  - 50 cases of meningococcal disease[67]
  - 20,000 asthma attacks in children[68]
  - 50 deaths from SIDS (cot death).[69]
- Exposure to second-hand smoke affects development and behaviour, leading to reduced language skills, reduced academic achievement, hyperactivity and reduced attention spans.[70,71]
- Having a smokefree home is one way of protecting your children from second-hand

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58 Ibid.

59 International Agency for Research on Cancer. 2002. *Passive Smoking: A summary of the evidence, May 2004*. France: IARC.

60 Bonita R, Duncan J, et al. 1999. Passive smoking as well as active smoking increases the risk of acute stroke. *Tobacco Control* 8, 156-60.

61 International Agency for Research on Cancer. 2002. *Passive Smoking: A summary of the evidence, May 2004*. France: IARC.

62 Second-hand Smoke website: www.secondhandsmoke.co.nz/media/homes.shtml. Retrieved on 28 January 2008.

63 Woodward A, Laugesen M. 2001. *Morbidity attributable to second-hand cigarette smoke in New Zealand*. Report to the Ministry of Health. Wellington: Department of Public Health, Wellington School of Medicine.

64 Ibid.

65 Ibid.

66 Ibid.

67 Ibid.

68 Ibid.

69 Woodward A, Laugesen M. 2001. How many deaths are caused by second-hand cigarette smoke? *Tobacco Control,* 10, 383-8.

70 Samet JM. 1999. *Synthesis: The Health Effects of Tobacco Smoke Exposure on Children*. Department of Epidemiology. School of Hygiene and Public Health: John Hopkins University.

71 Law KL et al. 2003. Smoking during pregnancy and newborn neurobehaviors. *American Academy of Pediatrics*, 111(6), 1318-23.

smoke.[72]

Economic effects of smoking

The annual tobacco tax take is about NZ$1 billion per year, and has been at that level for some years. This is just under 2 percent of total tax revenues.

The average amount spent by New Zealand's 750,000 smokers is approximately $2,135 each per year, of which approximately $1,500 is tax revenue.[73]

The tangible costs of smoking to New Zealand in 2005 were around NZ$1.7 billion, or about 1.1 percent of GDP. This includes costs incurred because of lost production due to early death, lost production due to smoking-caused illness, and smoking-caused health care costs.

The intangible costs in 2005 were of the order of 62,800 life-years lost to smoking-induced premature death, and 19,000 quality-adjusted life-years lost to smoking-caused illness.

[72] Gillespie J. 2004. Second-hand smoke: Exposure, attitudes, and behaviours: Monitoring trends 1999 to 2004 - preliminary findings. Wellington: Health Sponsorship Council Research and Evaluation Unit.
Cancer Society. 2004. Second-hand Smoke Hazards: Smokefree lifestyle factsheet series. www.cancernz.org.nz/Uploads/IS_TC_shandhaz.pdf. Retrieved on 21 January 2008.

[73] O'Dea D, Thomson G, Edwards R, Gifford H. 2007. *Tobacco Taxation in New Zealand.* Wellington: Smokefree Coalition and ASH NZ.

Facts and figures

Prevalence and trends

At a glance

- The estimated smoking rate for people aged 15 years and over for 2008 is 21 percent. This is generally consistent with the downward trend over the last 25 years.
- Among youth aged 15 to 19 years, 20.8 percent were current smokers in 2008.
- Half of youth aged 15 to 19 years had never tried smoking, not even one puff. This prevalence is significantly higher than in 2006 (39 percent).
- Nearly 60 percent of youth current smokers aged 15 to 17 years reported buying cigarettes in the past month.
- Among youth, roll-your-own cigarettes were more likely to be smoked by 15- to 17-year-olds than 18- to 19-year-olds. The most common reason given for smoking roll-your-own cigarettes among 15- to 17-year-olds was that they were cheaper than manufactured cigarettes.
- Māori (45.4 percent) and Pacific peoples (31.4 percent) were more likely to be current smokers compared with the total population aged 15 to 64 years.
- People living in the most deprived neighbourhoods were 1.5 times more likely to be smokers than people living in the least deprived areas
- The amount of tobacco available per person for consumption in New Zealand in 2008 increased by less than 1 percent from 2007.[74]
- Daily smoking prevalence amongst 14-15 year olds in 2008 was 7 percent compared to 12 percent in 2003 and 16 percent in 1999. Students are significantly less likely to be smokers in 2008 compared to 2003 and 1999.[75]

Different data sets in use

In New Zealand, three population-based datasets provide representative information about smoking prevalence. These are the:

1. New Zealand Health Survey (NZHS)
2. New Zealand Tobacco Use Survey (NZTUS)
3. Census.

Both the NZHS and the NZTUS are surveys that are part of a National Health Monitor, managed and disseminated by the Ministry of Health. Other surveys that measure the prevalence of smoking in New Zealand are not covered in this report.

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[74] Ministry of Health. 2009. *Tobacco Trends 2008: A brief update of tobacco use in New Zealand*. Wellington: Ministry of Health.

[75] Paynter J. 2009. *National Year 10 ASH Snapshot Survey, 1999-2008: Trends in tobacco use by students aged 14-15 years*. On behalf of Action on Smoking and Health, Health Sponsorship Council and the Ministry of Health. www.ash.org.nz/pdf/ASHYear10Report19992008.pdf retrieved on 16 June 2009.

The advantage of the NZHS and the NZTUS is that both are able to produce separate estimates for daily and non-daily smokers, whereas the census cannot. The NZTUS also covers a range of smoking-related estimates such as exposure to second hand smoke, quit attempts etc.

For further information about the different datasets used in tobacco control in New Zealand, see: Ministry of Health. 2008. *Monitoring Tobacco Use in New Zealand: A technical report on defining smoking status and estimates of smoking prevalence*. Wellington: Ministry of Health: (www.moh.govt.nz/moh.nsf/indexmh/monitoring-tobacco-use-in-nz-technical-report#download)

Framework Convention on Tobacco Control

What is the Framework Convention on Tobacco Control (FCTC)[76]?

The FCTC is a legally binding treaty which was negotiated by the 192 member states of the World Health Organization (WHO): (www.who.int/tobacco/en). The world's first public health treaty, the FCTC contains a host of measures designed to reduce the devastating health and economic impacts of tobacco. The final agreement, reached in May 2003 after nearly four years of negotiations, provides the basic tools for countries to enact comprehensive tobacco control legislation.

As at May 2009, 168 participants had signed the Treaty and 164 had ratified it.

Key provisions in the treaty encourage countries to:

- enact comprehensive bans on tobacco advertising, promotion and sponsorship
- obligate the placement of rotating health warnings on tobacco packaging that cover at least 30 percent (but ideally 50 percent or more) of the principal display areas and can include pictures or pictograms
- ban the use of misleading and deceptive terms such as 'light' and 'mild'
- protect citizens from exposure to tobacco smoke in workplaces, public transport and indoor public places
- combat smuggling, including the placing of final destination markings on packs
- increase tobacco taxes.

The FCTC also contains numerous other measures designed to promote and protect public health, such as mandating the disclosure of ingredients in tobacco products, providing treatment for tobacco addiction, encouraging legal action against the tobacco industry, and promoting research and the exchange of information among countries.

The New Zealand Government is a ratified party to the FCTC.

How can the FCTC further international tobacco control?

In addition to specific obligations contained within the FCTC, the process of negotiating the FCTC has already strengthened tobacco control efforts in scores of countries by:

- giving governments greater access to scientific research and examples of best practice
- motivating national leaders to rethink priorities as they respond to an ongoing international process
- engaging powerful ministries, such as finance and foreign affairs, more in tobacco control
- raising public awareness about the strategies and tactics employed by the multinational tobacco companies
- mobilising technical and financial support for tobacco control at both national and international levels
- making it politically easier for developing countries to resist the tobacco industry
- mobilising non-governmental organisations (NGOs) and other members of civil society in support of stronger tobacco control.

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[76] Much of this information is sourced from the Te Reo Marama website: www.tereomarama.co.nz. Retrieved on 23 May 2009.

What relevance is the FCTC to indigenous peoples?

The FCTC has two specific references to indigenous peoples.

The Preamble which states:

The Parties to this Convention are*: Deeply concerned* about the high levels of smoking and other forms of tobacco consumption by indigenous peoples.

The Guiding Principles – Article 4, 2 (c):

To achieve the objective of this Convention and its protocols and to implement its provisions, the Parties shall be guided, inter alia, by the principles set out below:

2. Strong political commitment is necessary to develop and support, at the national, regional and international levels, comprehensive multisectoral measures and coordinated responses, taking into consideration:

(c) the need to take measures to promote the participation of indigenous individuals and communities in the development, implementation and evaluation of tobacco control programmes that are socially and culturally appropriate to their needs and perspectives.

What is the timetable for the FCTC?

The FCTC was adopted unanimously by the World Health Assembly on 21 May 2003 and was closed for signature on 29 June 2004. On November 29, 2004, Peru deposited the 40th instrument of ratification at the UN in New York, the minimum number required for the treaty to enter into force.

Is the FCTC legally binding and enforceable?

Framework conventions and protocols are legally binding only on countries which ratify them. The onus is on national governments to implement the FCTC and protocols developed under the treaty.

Why do we need an international treaty on tobacco control? Isn't national action sufficient?

- The tobacco epidemic is an international problem. Developing countries are set to bear the brunt of the problem in the future.
- The tobacco industry is a global industry. Faced with increased regulation and greater awareness of the health risks of smoking in Europe and North America, tobacco multinationals are stepping up their activities in developing countries in search of new markets.

A number of aspects of the tobacco problem are particularly transboundary in nature and can only be dealt with effectively by international action, including:

- tobacco industry marketing campaigns executed across a number of different countries simultaneously, including through satellite television
- smuggling of cigarettes, often coordinated by the tobacco industry on an international level, involving operations in numerous countries.

For further information go to the Framework Convention Alliance , (www.fctc.org).

For information on tobacco from the World Bank , (www1.worldbank.org/tobacco).

For more information on the Framework Convention, see the World Health Organization's website , (www.who.int/tobacco/en/).

Tobacco industry

1994: Tobacco company executives testify before Congress that nicotine is NOT addictive.

Some key facts about the tobacco industry in New Zealand:

- No tobacco is grown commercially in New Zealand – it is all supplied from overseas, most of it by one of the three multinational companies that dominate the New Zealand market: British American Tobacco, Philip Morris, and Imperial Tobacco.
- These three tobacco companies account for 97 percent of the total cigarette market in New Zealand.[77] The other 3 percent comes from smaller companies or specialty import products.
- The most popular brand of cigarettes in New Zealand is British American Tobacco NZ's Holiday brand. The Holiday brand accounts for 31 percent of all cigarette sales.[78]
- All of the major tobacco companies in New Zealand are part of large multi-national companies. BATNZ is part of British American Tobacco and ITNZ is part of Imperial Tobacco, both of which are based in the United Kingdom. PMNZ is part of Philip Morris International which belongs to the Altria group of companies, and is based in the United States. Altria Group is the parent company of Kraft Foods, Philip Morris International, Philip Morris USA and Philip Morris Capital Corporation.
- Annual financial reports of the three parent tobacco companies are filed in the country where they are based. Copies of the annual reports, including financial information, can be found on the parent company websites.
- Altria Group reported net revenue of $149.4 billion (NZ) for 2005. As a comparison, the real Gross Domestic Product for New Zealand in 2005 was $125.9 billion.[79] The New Zealand Government collected a total of $842 million in tobacco excise tax in 2005.[80]
- Approximately 10,000 outlets sell tobacco products across New Zealand. AC Nielsen service station consumer data (2005) showed that tobacco products were the number one product

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77 Euromonitor International. 2005. Tobacco in New Zealand. (www.euromonitor.com/reportsummary.aspx?folder=Tobacco_in_New_Zealand&industryfolder=Tobacco). Retrieved on 1 June 2006.

78 Laugesen, M. 2005. Tobacco manufacturers' returns for the 2004 calendar year. (www.ndp.govt.nz/tobacco/tobaccoreturns/2004/analysis/analysis-2004.doc). Retrieved on 1 June 2006.

79 Statistics New Zealand 2006. www.stats.govt.nz. Retrieved on 1 June 2006.

80 The Treasury. 2006. www.treasury.govt.nz/financialstatements/year/jun05/25.asp. Retrieved on 1 June 2006.

category, in terms of dollar sales, for service stations.[81] Tobacco products make up more than 35 percent of service station business. The same survey showed a 14 percent growth in sales of roll-your-own tobacco in 2005.

[81] C-store Magazine. 2006. Tobacco still smokes its competition in service stations. *C-store Magazine Vol. 8:2, 5*.

Questions and answers

Sponsorships and partnerships

As the tobacco control environment in New Zealand has evolved, the need for sponsorship has diminished, as legislation now requires that many sporting environments be smokefree/auahi kore (especially indoors). In addition, an increasing number of councils have made their sports grounds smokefree, including many club grounds.

In general, it is not recommended to 'pay' sports teams or clubs to go smokefree. There may be some value in entering a partnership with a club who wants to go smokefree. For example, you may help them with policy development and suggested implementation and perhaps offer a 'reward' of some description or assist to pay for signage.

It's important that smokefree/auahi kore is not seen as being about 'free stuff'. It needs to be kaupapa driven and communicated as a healthy lifestyle message and the bulk of the work should be done by the club.

Remember, there are many thousands of sports teams and clubs around the country and you cannot help them all. Think strategically when entering into any partnerships – how are you going to get the best outcome and impact the most people?

The HSC has many years of experience in sponsorships and partnerships and it may be worth calling the smokefree/auahi kore team to get their thoughts on your local opportunities.

My organisation has been invited to partner with another to promote a local smokefree initiative

Partnerships between groups such as Public Health Units, Cancer Society, Plunket, councils etc happen all the time and make a valuable contribution to promoting and supporting the smokefree/auahi kore message.

They can be a good idea when resources and budgets are limited. As well, many voices united in one message are stronger than a sole voice.

For every partnership you enter into, you should consider the following questions.

- What will my organisation get out of this partnership? Remember, often it will not be about your organisation but about the kaupapa – and this isn't necessarily a bad thing. Partnerships are not about every organisation getting their logo on a sign!
- Will the partnership help my organisation to further its smokefree and public health goals?
- Will the partnership result in my organisation's key messages reaching our priority audiences?
- Is it something that would be better done by another agency?
- Is it a good return on our investment – in terms of staff time, and any resources or funding contributed?
- Does the partner have similar goals and objectives to our organisation? (For example, it is unlikely to be appropriate for you to partner with a fast food company; whereas it would be far more appropriate to partner with an organisation like the Asthma and Respiratory Foundation).

Before you agree to a partnership, talk to colleagues with experience in this area, to get a sense of any history and other opportunities.

Smokefree talks and presentations

I've been asked to talk to a school class about smoking. Should I do it?

Speaking to students as part of a health education curriculum class is not usually appropriate. Current evidence on effective best practice in smokefree education indicates that the classroom teacher is best placed to deliver the programme. This practice is also in line with the Health Promoting Schools [82], (www.hps.org.nz) recommendations on education sessions.

Your role is to support schools and teachers to identify and use smokefree resources and tools. It may be enough to simply direct them to appropriate resources, including the Smokefree/Auahi Kore Schools website: (www.smokefreeschools.org.nz).

Your professional judgment is required and sometimes exceptions may occur where it is appropriate for you to present to a class. For example, in a research/learning capacity to help identify issues, to focus test new resources and ideas, or in an advisory role to a student advocacy group.

A school has asked me to help some students quit smoking

There are a number of services available that can offer expert support and advice to students (and school staff) who wish to quit smoking. These include:

- health centres and local GPs
- Aukati Kai Paipa , (www.aukatikaipaipa.co.nz)
- local quit smoking services
- Quitline, (www.quit.org.nz)
- Txt2Quit, (www.quit.org.nz/txt2quit/page/txt2quit_5.php)
- Smokestop, (www.smokestop.co.nz)
- Quit Blog, (www.quit.org.nz/page/blog/blog.php?actionShow=recent&page=1)

Unless you are specifically trained in smoking cessation, refer schools to existing quit smoking services. A good starting place for schools is the Smokefree/Auahi Kore Schools website: (www.smokefreeschools.org.nz/quitting.php), which has links to the above quit smoking services, and provides information about supporting staff and students to quit.

Creating new resources

I think we need a new smokefree resource, should I develop one?

A large number of smokefree/auahi kore resources already exist, and the chances are the resource you need has already been developed. So before deciding to produce a new resource, it is important to find out what is already available.

Firstly, check out the Ministry of Health's Healthed website: (www.healthed.govt.nz/resources/search-resources.aspx?id=19). Over 50 different tobacco control

[82] Health Promoting Schools (www.hps.org.nz) focuses on schools as an integral part of the wider community and offers practical ways for children and young people, teachers, managers, parents and community members to contribute to schools and the wider community being healthy settings.

resources can be ordered for free from this site. The resources have gone through a thorough development process, including pre-testing with target groups, and are regularly updated or revised to ensure the information they contain is accurate. Each resource is written and designed to be easily understood.

If you decide to go ahead and develop a resource, make sure you look at the Ministry of Health's *National Guideline for Health Education Resource Development in New Zealand*: (www.moh.govt.nz/moh.nsf/pagesmh/2162?Open). This publication is designed to assist public health service providers to develop appropriate resources. It sets out the main steps to be taken; incorporating planning, financial, cultural and practical issues that need to be considered during the development and production of a resource.

Also, bear in mind that Ministry of Health contracts generally require all new resources, including those for tobacco control, to be approved prior to publication. Ask your manager who to contact within the Ministry. It is advisable to get in touch early to avoid delays in production later on.

Programme planning and evaluation

I've been asked to develop a project plan – where do I start?

Developing a project plan enables you to be clear about what you want to achieve and how you are going to achieve it. Having a well thought-through project plan before you start work on a programme, project or initiative will keep you on track, and make it much more likely that you'll achieve your objectives and make a real difference.

A project plan provides an opportunity to set out ideas and to seek the input and approval of others (perhaps your own team or, if working by yourself, public health workers in other regions). A plan should be written and approved for each year a project is running, as a plan is often a basis for budget approval. Although some projects are ongoing (such as reducing exposure to second-hand smoke), it is still important to have something which tells you where you are going, and helps identify where you have come from.

You may want to use the Project planning template included at the end of this document when planning your work. It includes a description of key terms, such as goals, objectives and strategies.

How do I develop an evaluation plan?

Evaluating projects lets you find out what worked well, what could be done better next time, and how your project or initiative can be amended to be more effective.

In deciding what sort of evaluation to carry out, it is important to think about what will be most useful to the development of your programme, be appropriate for where your programme is at, and meet the expectations of all those involved.

Three broad types of evaluation are outlined below.

Formative evaluation: improving programme planning and development

Formative evaluation is gathering information in order to plan, refine and improve your programme before it is designed and implemented. This type of evaluation is appropriate when your programme is in planning or in the early stages of development and/or your programme needs improvement.

Formative evaluation activities include:

- finding out what has been done in your field (through literature reviews, accessing the internet)

- conducting a needs assessment
- defining the intended population
- conducting qualitative research with your target audience
- developing a sound programme plan.

Process evaluation: documenting programme delivery

Process evaluation documents the things that you do during a programme – for example, what is being done, how, when, cost, and what people think of it. This type of evaluation helps you to understand why a programme produces the results it does.

Process evaluation activities include:

- documenting what was done to plan and organise the programme – for example, recording meetings, keeping records of day-to-day activities in your diary
- finding out how programme participants and other key people perceived the programme
- documenting what resources have been used to implement the programme, including time, money and people. This is useful information to be able to compare what resources you thought you would use with what was actually used, and to establish resources for future use
- demonstrating programme reach – that is, whether the programme reached the intended audience.

Impact and outcome evaluation: measuring programme effects

Impact and outcome evaluation looks at the effects the programme has had, both intended and unintended. Intended effects should be covered by your objectives, while unintended effects are useful to consider in light of whether they aided or inhibited the programme.

Impact evaluation refers to the immediate effects of a programme and examines the extent to which the objectives have been met by the strategies that were put in place. Some typical impact evaluation activities include:

- getting feedback from participants about their perceptions of the programme
- collecting data on people's knowledge, attitudes and behaviour before (baseline data), during and after the programme has been implemented, to establish changes that can be linked to the programme
- assessing the extent to which the programme met its objectives
- assessing positive or negative effects of a programme
- reviewing process evaluation information.

Outcome evaluation refers to longer-term goals of the programme. What were the long-term effects of the changes in people's knowledge, attitudes and behaviour? What were the end results?

Undertaking worthwhile outcome evaluation takes a lot of resources, skills and longer time-frames which can make it unrealistic to undertake in your role. Because outcome evaluation looks at changes to participants' knowledge, behaviours and attitudes, consideration also needs to be given to other programmes or events which might have impacted on the participants, either positively or negatively. In most cases, impact evaluation is a more appropriate and manageable option for health promotion providers.

Working with the media

I've been asked to do an interview with the local paper, what should I do?

Talking to the media is a great opportunity to get your message across – for free! But before you do an interview, make sure you have considered the following points.

- Are you able to speak to the media? Many organisations have communications sections or communications managers who you will need to talk to before commenting to media. Some organisations may be quite happy for you to talk to media, while others may have designated spokespeople – and you might not be one of them! It's really important to ensure you have the green light to talk to the media, before doing so.
- Have you thought about your key messages? Take a few minutes before your interview to think about what messages you want to give to the public, via the media. Writing these down can help – particularly for an interview carried out over the telephone, because then you can refer to your notes.
- Have you thought about any 'tricky questions' or risks? Is the journalist likely to ask you any 'left of field' questions? Are there any issues you do not wish to discuss, that the journalist may push you on? Before your interview, think of the worst possible questions you could be asked, and develop responses to them. Those questions probably won't come up, but if they do, you'll be ready
- Are you the best person to front the issue? For example, if the reporter wants to talk about second-hand smoke, would the local Asthma and Respiratory Foundation representative be the most appropriate person for them to talk to?

For further information about getting media coverage, see your organisation's communications manager. If you would like to take part in media training, contact the Public Health Association, (http://www.pha.org.nz/) (PHA): media@pha.org.nz. The PHA provides free media training sessions for some health organisations. Alternatively, media training may be available through your organisation.

Project planning template[83]

Date of this plan _____

Project title _____

Organisation _____

Project coordinator _____

Team _____

Group at whom the project is aimed (who will benefit from your project?)

_____

Timeframe (when do you expect your project to finish, or is it ongoing?)

_____

A. Project description

1. Expected outcome/goal

This describes the overall aim/goal of the project (eg, 'To reduce exposure to second-hand smoke in targeted settings', or 'To reduce the number of people who smoke, by creating a supportive quitting environment').

In tobacco control work you may not see an outcome straight away, or in fact within a year's time. You are often sowing seeds which might not grow straight away – and may not always be something you are able to directly measure – and which may not contribute to national statistics.

2. Objectives

'Objectives' describe what the programme intends to achieve in working towards the expected outcome (eg, 'To increase community awareness of risks around second-hand smoke'). Objectives can be based on actual or theoretical risk factors. For example, a risk factor for smoking uptake is parental smoking, so an objective could be to 'increase quitting behaviour among parents and caregivers'. Objectives should be specific, realistic and measurable. By measuring progress or

[83] Adapted with the permission of Community and Public Health, Canterbury District Health Board.

achievements for each objective you can indicate the success of the project in working toward the expected outcome. Measurement of progress or achievements for each objective is therefore a key part of the evaluation process.

3. Strategies

'Strategies' are the practical things you will do to achieve your objectives (eg, 'Localise HSC's Face the Facts campaign'). Each project is likely to include many different strategies, and detailed evaluation of all of them may not be necessary. However, it is often useful to review the effectiveness of some strategies. This is also known as 'process evaluation'. In particular, think about how your strategies relate to or link in with national strategies around tobacco control. They should be part of wider tobacco control work – not unrelated.

4. Measures or performance indicators

'Measures' or 'performance indicators' are the aspects of your project which you choose to use for evaluation to measure your progress on each objective. Measurement of overall outcomes may be difficult. However, your measures should help you to answer the questions: 'Have I achieved my objectives?' and 'How effective were my strategies?'

In choosing suitable measures for your project, it may be helpful to ask one or more of the following questions for each objective or strategy.

- How many? (e.g. How many joint ventures were undertaken?)
- How well? (e.g. Did we choose the best people to work with?)
- What happened? (e.g. How much media coverage was achieved?).

You may decide not to formally evaluate all of your strategies (you should choose the ones where evaluation will be most helpful). However, thinking about these questions at the planning stage will allow you to collect whatever information you need along the way.

It is recommended that you set the information in points 2 to 4 in a table: for example:

Objective	Measure	Strategies	Estimated date of completion

5. Checking for programme logic

At this stage, is it useful to note the importance of checking for sound programme logic – that is, that there is a logical link between performance indicators and the contribution they make towards the programme's strategies, objectives and goals.

While effective planning is undertaken from the 'top down' – that is, starting with a goal and defining objectives, strategies and measures from this – it is also important that your programme is based on sound logic. A way of checking this is to look back up the chain and check that the activities you plan to do are related to the strategies; and that the strategies you identify to meet your objectives are selected based on the knowledge that they will work towards meeting those objectives; and finally, that the objectives relate to the programme's goal.

B. Project rationale

This section asks you to describe the relationship of your project to organisational and service plan requirements.

6. Research

In this section you should show that your project is in response to an important public health need, and that you have carefully considered the most appropriate way of meeting that need. Try to create a link between your project and the wider context of what's happening in tobacco control. Ensure your project fits within the evidence of what works in tobacco control? (See *Clearing the Smoke: A five year plan for tobacco control in New Zealand:* (www.ndp.govt.nz/moh.nsf/indexcm/ndp-publications-clearingthesmoke) for a summary of effective tobacco control interventions).

Ensure that you indicate how any background research demonstrates (a) the need for this project/programme, and (b) the link between the objectives you have set and your expected outcome.

7. Service plan/Strategic business plan

Indicate how this project relates to your organisation's service plan and/or strategic business plan.

8. Ottawa Charter

The five strategies of the Ottawa Charter, (www.who.int/healthpromotion/conferences/previous/ottawa/en/) help guide what is considered 'good' or effective health promotion practice. This section should indicate how the project relates to the Ottawa Charter. It is not always important, nor always appropriate, that you attempt to make your project address every strand of the Ottawa Charter – in fact, it may be that the emphasis should, or need, only be on one or two strands. For instance, a project around decreasing exposure to second-hand smoke might only have relevance to three strands of the Ottawa Charter – creating supportive environments, strengthening community action and building healthy public policy – and each might have a different emphasis at different stages of the project.

9. Treaty of Waitangi

Commitment to the Treaty of Waitangi should be reflected in your project proposal and you should outline this here. In considering the implications of the Treaty for your project, you could ask yourself the following questions.

- How is the project relevant to Māori development?
- What health gains for Māori can be expected from the project?
- Is the project sensitive to Māori cultural beliefs and values?

Read the TUHA-NZ document: (www.hpforum.org.nz/Tuha-nz.pdf) for practical ways to make your work Treaty-based.

10. Key linkages

Describe your project's key linkages (eg, groups, organisations, individuals who will assist/support the project/programme's implementation). Think about your contacts in the community who are working in tobacco control, and sometimes those outside of tobacco control who may have an interest in the project you are working on.

11. Resources

Indicate the resources required (include an estimate of your own and any other staff time and an estimate of resources/people required outside of your organisation).

12. Budget

Provide a breakdown of the project budget.

C. Project review and evaluation

13. Project review

At specific intervals in the course of your project, it is important to take time to review progress. How this happens will vary for each project.

At least one report should be completed on each project for each financial year (July-June). Things to consider covering in this report include:

- describing the whole project
- describing progress report meetings with an evaluation facilitator
- giving the results of any evaluation
- indicating whether (and how) the project met its objectives
- indicating whether the project met planned timelines
- reflecting on lessons learnt during the project
- including information about budget and resource use
- making recommendations for the future based on lessons learnt during the project.

14. Evaluation[84]

Evaluation is about trying to find out whether what you are doing can be done better.

Some key points about evaluation follow.

- The evaluation information gathered is used to improve a programme and to inform those making decisions about the programme.
- The evaluation will be easier to do and to set up if it is planned at the same time as the programme.
- Programme evaluation which starts at the planning stages helps to set programme goals.
- Objectives and performance indicators can provide a picture of what your programme looks like in practice or look at what sort of effect your programme had.
- It is important to think about how the evaluation information will be used in the end – is it to improve programme performance, or to let funders know of the value of the programme?

You may want to use one of the following evaluation methods.

Formative evaluation: gathering information in order to plan, refine and improve your programme, as it is designed and implemented. This type of evaluation is appropriate when your programme is in

[84] Waa A, Holibar F, Spinola C. 2000. *Programme Evaluation: An Introductory Guide for Health Promotion*. Alcohol and Public Health Research Unit: University of Otago.

planning or in the early stages of development and/or your programme needs improvement.

Process evaluation: documenting the things that you do during a programme – eg, what is being done, how, when, cost, and what people think of it. This type of evaluation helps you to understand why a programme produces the results it does.

Impact and outcome evaluation: measuring the effects the programme has had, both intended and unintended. Intended effects should be covered by your objectives, while unintended effects are useful to consider in light of whether they aided or inhibited the programme. Impact evaluation refers to the immediate effects of a programme and examines the extent to which the objectives have been met by the strategies that were put in place. Outcome evaluation refers to longer-term goals of the programme. What were the long-term effects of the changes in people's knowledge, attitudes and behaviour? What were the end results?

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[i] Peto, R., Lopez, A.D., Boreham, J., & Thun, M. (2006). *Mortality from smoking in developed countries 1950-2000*. Second edition. www.ctsu.ox.ac.uk/~tobacco/, retrieved 24 June 2009