

The Beginner's Guide to Tobacco Control

A guide and reference tool for people
working in Tobacco Control.



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Updated September 2013

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Abbreviations and acronyms

There are a lot of abbreviations and acronyms that are used in tobacco control and they can get quite confusing. Here are some of the most common ones:

ASH	Action on Smoking and Health
ABC	A sk about smoking status, give B rief advice, provide C essation support or referral.
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
HPA	Health Promotion Agency
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
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
SFEA	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

Introduction

Welcome to the exciting world of tobacco control where your work will contribute to the reduction in harm caused by tobacco in New Zealand communities. You are joining a passionate sector that is collectively working towards the goal of Smokefree Aotearoa by 2025. This work builds on decades of hard work and progress in tobacco control in New Zealand.

The Beginner's Guide to Tobacco Control is intended to provide you with a range of information to get you up to speed quickly when you start working in the tobacco control sector, and to be an on-going reference tool for your work.



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

The harm caused by tobacco has been well researched and documented since the early 1900s. Today, tobacco is the only legally available product that, when used as the manufacturer intends, kills half of its users. Tobacco is also an extremely addictive product due to nicotine and people find it incredibly difficult to relieve this addiction.

Smoking harms nearly every organ in the body and half of all long-term smokers die prematurely from tobacco-related diseases. In addition to negatively impacting the user, second-hand smoke from cigarette use can cause premature death and disease in children and adults who do not smoke. In fact, there is no risk-free exposure to second-hand smoke.¹

Tobacco use is the leading cause of **preventable** death and disease in New Zealand, accounting for around 4,300 to 4,700 deaths per year.^{2,3,4} When the deaths caused from exposure to second-hand smoke are included, this estimate increases to around 5,000 deaths per year.^{5,6}

Globally, tobacco use is currently responsible for 6 million deaths each year. If current smoking patterns continue, it is estimated that by 2030 it will cause some 8 million deaths each year.⁷

Tobacco control is a field of international public health science, policy and practice dedicated to restricting tobacco use and thereby reducing the death and disease that it causes.⁸

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'. Tobacco control is a priority area for the World Health Organization (WHO), through the Framework Convention on Tobacco Control, and is discussed on page 58.

Comprehensive tobacco control programmes are more effective than one off or simple approach programmes. A comprehensive programme should, and include a mix of health promotion, legislation and regulation, smoking cessation, research and evaluation, and legislation and enforcement.⁹

In New Zealand we have dedicated personnel working in all of these areas and the New Zealand tobacco control programme is regarded as one of the most comprehensive and forward thinking programmes in the world. All of the work that occurs in New Zealand is underpinned by its relevance and contribution to achieving the goal of a Smokefree Aotearoa by 2025.

Broadly, Smokefree Aotearoa 2025 will be achieved by:

- protecting children from exposure to tobacco marketing and promotion
- reducing the supply of, and demand for, tobacco
- providing the best possible support for quitting.

¹ <http://hawaii.gov/health/family-child-health/chronic-disease/tobacco/index.html>. Retrieved 10 September 2013.

² 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.

³ Public Health Intelligence. 2002. *Tobacco Facts May 2002 (Public Health Intelligence Occasional Report no 2)*. Wellington: Ministry of Health.

⁴ Ibid, 2

⁵ Ministry of Health. 2004. Looking upstream: Causes of death cross-classified by risk and condition, New Zealand 1997. Wellington: Ministry of Health.

⁶ 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.

⁷ World Health Organization. 2013. Tobacco Fact Sheet. URL: <http://www.who.int/mediacentre/factsheets/fs339/en/index.html>. Retrieved 16 June 2013.

⁸ http://en.wikipedia.org/wiki/Tobacco_Control. Retrieved 10 September 2013.

⁹ Health Sponsorship Council. 2005. *National framework for reducing smoking initiation in Aotearoa-New Zealand*. Wellington: Health Sponsorship Council.

Smokefree Aotearoa 2025

In March 2011 the New Zealand Government committed to a goal of New Zealand becoming smokefree by 2025. This was in response to a report from the Māori Affairs Select Committee following their inquiry in 2010 into the tobacco industry and the effects of tobacco use on Māori. Further information about the inquiry can be found [here](#).

The New Zealand tobacco control sector is committed to the goal of a smokefree Aotearoa by 2025 (www.smokefree.org.nz/smokefree-2025), meaning:

- that our children and grandchildren will be free from tobacco and enjoy tobacco free lives
- that almost no-one will smoke (less than 5% of the population will be current smokers)
- it will be very difficult to sell or supply tobacco.

The work of the sector is focused on three action streams to support a reduction in smoking rates to below 5% (adult daily smoking):

- cessation
- regulation and legislation
- public support.

Priority goals and objectives from now until 2015 have been identified for each stream and are outlined below. A comprehensive national action plan has been developed to provide the sector with more detail on potential activities to achieve each objective and is available through tobacco control colleagues. A number of regional and local smokefree coalitions and networks have also developed their own action plans that are relevant to their region. Support for developing regional and local action plans is available through the National Smokefree Working Group.

Responsibility and accountability for achieving the 2025 goal is shared between:

- Government
- health services
- the tobacco control sector
- communities.

Whatever your role, you should be able to understand and define exactly how you are contributing to the desired objectives and outcomes and, in turn, to making New Zealand Smokefree by 2025. It is important that the tobacco control sector focuses its work on benefiting those who bear the greatest burden from tobacco use, Māori, Pacific and low socio-economic groups.

Interim Goals

Interim goals for current smoking are vital to monitor progress and focus efforts. Smoking prevalence targets have been set to be achieved by 2018. To reach prevalence rates below 5% by 2025, more than 40,000 smokers need to quit successfully every year and no new smokers start. Failure to meet goals should result in more rigorous policies.

Year	Prevalence NZ ⁱ	Māori	Pacific
2010	21%	45%	30%
2018	10%	19%	11.5%
2025	Smokefree (less than 5%)	Smokefree (less than 5%)	Smokefree (less than 5%)

Action Streams

Cessation

To achieve the 2025 goal a huge number of people need to successfully quit. We know that 80% of current smokers want to be smokefree so the challenge is enabling and supporting them to do so¹⁰.

The goals of the cessation action stream are as follows:

- Smokers make more quit attempts.
- More smokers use nicotine replacement therapy.
- Smokers have full access to excellent cessation support and treatments.
- Smokers know about the support they need.
- Smokers are regularly nudged toward quitting.

In order to achieve these goals the following objectives have been developed:

1. Understand the smoker and their stop smoking needs
2. Put developments from research and innovation into practice
3. Layer cessation for clients for best outcomes
4. Integrate cessation into the health sector
5. Raise awareness of cessation services
6. Develop the cessation workforce.

Legislation and Regulation

Legislation and regulation is important to regulate tobacco products and the environments where they are distributed and used. This is to prevent people from starting to smoke, particularly young people, and supporting current smokers to quit.

The objectives for the Legislation and Regulation action stream are:

1. Tax increases of 40% followed by 20% per annum until 2015.
2. Mandatory registration for all those involved in the tobacco supply chain.
3. Plain packaging.
4. Increased warnings on tobacco packaging.
5. Protection of children from second-hand smoke in cars.
6. Full Implementation of the Framework Convention on Tobacco Control (FTCT) in New Zealand.
7. Enhanced disclosure of the tobacco industry product constituents, sales, volumes and activities

Public Support

Gaining buy-in from the public for tobacco control activities is important. This requires the public to understand what Smokefree 2025 means.

The objectives for the public support action stream are:

1. New Zealanders know about and support the Smokefree 2025 (SF2025) goal and the steps needed to achieve it.
2. New Zealanders have anti-tobacco and pro-smokefree attitudes.
3. Increase the number of smokefree settings.

¹⁰ Ministry of Health. 2010. Tobacco Use in New Zealand: Key findings from the 2009 New Zealand Tobacco Use Survey. Wellington: Ministry of Health.

Monitoring

Continuous monitoring of our progress is essential to ensure that we are on track to achieving our goals. This monitoring at a national level has been factored into the action plan and is the responsibility of the National Smokefree Working Group. The research section on page 53 outlines some of the key monitors and processes that will be used to track progress at a national level.

Smokefree Aotearoa 2025 documents

There are a number of documents that outline the process that has been undertaken to get to where we are today and are a guide for the work of the tobacco control sector towards the 2025 goal. These can be found on the Smokefree website (<http://smokefree.org.nz/smokefree-2025>).

History of tobacco and 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 World War One – 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 World War Two, 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.
- 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 to 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 Heath Sponsorship Council 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; seventeen 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% – 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% 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, including 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% of New Zealanders smoke.
 - Media campaign targeted at youth begins – Why Start? – and runs for three years at a cost of \$1 million 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:
 - Liggett tobacco company in USA admit tobacco causes cancer and heart disease, 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.

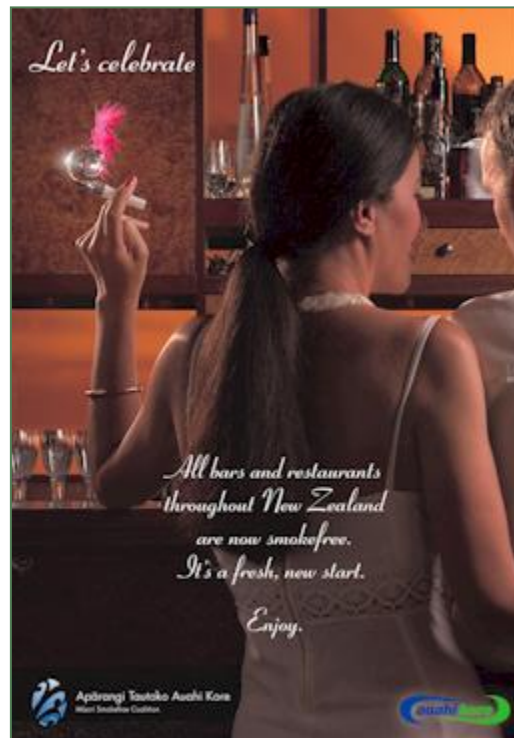
- Smoke-free Environments Amendment Bill No. 2 passed in July, becoming the Smoke-free Environments Amendment Act 1997, amending the Smoke-free Environments Act 1990 to:
 - ban sales of tobacco products to anyone under 18-years-old (was previously 16-years-old)
 - ban sales of cigarettes in packs of 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, 8,500 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.¹¹
 - 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.
 - 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.

¹¹ See the Key players in tobacco control section of this document for more information on Aukati Kai Paipa.

- 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.
 - July: ABC intervention in secondary care set as a national health target.
 - 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).
 - 23 Sept 2009: The Maori Affairs Committee launched an inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori.
- 2010:
 - 28 April: Cigarette tax raised by 10% immediately and set for further increases in January 2011 and 2012.
 - Maori Select Committee hearings completed 29 June.
 - June 30 Te Reo Marama contract is not renewed.
 - July: Primary care participation in health target smoking cessation ABC implementation commences.
 - September 8: Labour MP Iain Lees-Galloway has his Smoke-free Environments (Removing Tobacco Displays) Amendment Bill picked from the ballot of private Members Bills.

- November
 - On 4 November 2010 Associate Minister of Health, Hon Tariana Turia, announced Cabinet decisions outlining a package of increased control measures focused on the tobacco retail environment:
 - prohibiting any visible display of tobacco products for sale
 - tighter legislation regarding the display of trading names for tobacco outlets
 - enabling Smoke-free Enforcement Officers to issue instant infringement fines to those selling tobacco products to individuals under the age of 18
 - clarifying that any contracts and agreements covering trade rebates and discounts for selling tobacco that are inconsistent with the Smoke-free Environments Act are legally void.
- 2011
- 1 July:
 - All prisons became smokefree.
 - 'Better Help for Smokers to Quit is a health target in primary care- a new stop-smoking target 90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit by July 2012".
 - The hospital target continues into 2011/12 "95 percent of hospitalised smokers will be provided with advice and help to quit by July 2012" (the target was previously set at 90 percent).
- 22 July 2011: The Smoke-free Environments (Controls and Enforcement) Amendment Act was passed into law on 22 July 2011. Changes will come into force after 12 months and include:
 - Tobacco displays will be banned. Some retailers may be granted a further 12 month transition period.
 - The banning of 'covert' sponsorship of events (eg, fashion and music shows) including exclusive distribution agreements with tobacco brands.
 - Sales controls are extended to internet sales. Internet sellers must not show images of packs or brands. It must show the mandatory health warnings and comply with the same rules about retailer names not being permitted to promote tobacco names.
 - Enabling Smoke-free Enforcement Officers to issue instant infringement fines to those selling tobacco products to people under the age of 18. Increased penalties for selling tobacco products to minors from \$2,000 to \$5,000 for an individual and up to \$10,000 for a business.
- 2012
 - 1 January: The final instalment (of three) of the 10% tax increases for tobacco products came into effect. Combined with the annual inflation adjustment to the excise duty, the total increase was 14.6%.
 - 29 January: In a statement issued following the annual Australia-New Zealand Leaders' meeting in Melbourne on 29 January: "The Prime Ministers underlined their commitment to strong tobacco control measures and undertook to cooperate closely in their efforts to reduce tobacco use domestically. New Zealand will closely follow progress in implementation of Australia's plain packaging legislation and the countries will look to ensure that no branded tobacco is able to be re-exported from New Zealand to

Australia.”

- 19 April: Cabinet agreed to introduce a plain packaging regime in alignment with Australia approved plain packaging in principle. Minister Tariana Turia announces public consultation on plain packs. A final decision will be made in consultation with the public later in the year.
- May 25:
 - Government announced in Budget 10% increase in tobacco excise over and above inflation each year for the next four years, beginning 1 January 2013 followed by annual increases in the year 2014, 2015 and 2016.
 - The Customs and Excise (Tobacco Products - Budget Measures) Amendment Bill had its first reading and was referred to Parliament's Finance and Expenditure Committee on 25 May.
- July 23:
 - Government launched the plain packaging consultation - see <http://www.beehive.govt.nz/minister/tariana-turia/release>.
 - As part of the requirements of the Smoke-free Environments (Controls and Enforcement) Amendment Act 2011, a complete ban on the display of tobacco products at tobacco retailers came into effect. The Smoke-free Environments (Controls and Enforcement) Amendment Act 2011 came fully into force. The retail display ban is the big ticket item, but other provisions eg, requirements for signs and warnings etc and a new infringement notice (ie. instant fine) scheme also came into force.
- 2013
- Jan 1:
 - First of four annual tax increases at 10%, in addition to the annual CPI adjustment.
 - Specifics:
 - Cigarette smokers will pay 49 cents per cigarette in excise and smokers of 0.7 g Roll Your Owns will pay the same.
 - This is an excise increase of 11.086%.
 - Reduced subsidisation on NRT. Cost will go up from \$3 to \$5 for a three-month supply.
 - February 9: Prime Ministers Key and Gillard. Prime Ministers John Key and Julia Gillard met in Queenstown on 9 February 2013 for the annual Australia-New Zealand Leaders' meeting, reaffirming their strong commitment to the closest possible relations between Australia and New Zealand. The Prime Ministers underlined their commitment to strong tobacco control measures and undertook to cooperate closely in their efforts to reduce tobacco use domestically and in the Pacific region. New Zealand will closely follow progress in implementation of Australia's plain packaging legislation. Australia welcomed New Zealand's in-principle agreement in 2012, subject to the outcome of a consultation process, to introduce plain packaging, and awaits with interest New Zealand's further consideration of tobacco control measures following the completion of its public consultation process.

What is in tobacco?

- Tobacco smoke contains over 4,000 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.
- There is 8-20 mg of nicotine in each cigarette.
- Approximately 1mg of nicotine is absorbed by the body, per cigarette smoked, going almost directly to the brain.
- Effect on body-nicotine:
 - raises the heart rate and blood pressure and slows circulation (lowers body temp)
 - causes rapid shallow breathing
 - is both a relaxant and a stimulant – it changes brain activity – improves reaction times, and brings on euphoria, hence is addictive
 - affects appetite – possibly due to inhibiting insulin release, leading to hyperglycaemia
 - 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

Tar:

- is a sticky brown substance that 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

Carbon monoxide:

- is a poisonous gas (found in car exhaust fumes)
- takes the place of oxygen in the blood
- In combination with nicotine carbon monoxide 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)

Hydrogen cyanide:

- Damages the lung-clearing system causing accumulation of toxic agents in lungs.

Additives

A number of additives are included in cigarettes, including:

- ammonia, menthol and sweetener.

Pin-up

The Smoker's Body

Every 6.5 seconds someone dies from tobacco use, says the World Health Organization. Research suggests that people who start smoking in their teens (as more than 70 percent do) and continue for two decades or more will die 20 to 25 years earlier than those who never light up. It's not just lung cancer or heart disease that cause serious health problems and death. Below, some of smoking's less publicized effects — from head to toe.

Pin up

Le corps du fumeur

Selon l'Organisation mondiale de la Santé, le tabagisme provoque en décès toutes les 6,5 secondes. Les chercheurs estiment que ceux qui commencent à fumer à l'adolescence (c'est le cas de plus de 70 % des fumeurs) et continuent pendant 20 ans ou plus ont une espérance de vie réduite de 20 à 25 ans par rapport à ceux qui n'ont jamais touché une cigarette. Il n'y a pas que le cancer de pneumonie ou maladies de cœur qui entraînent de graves problèmes de santé et des décès. Voici ci-dessous une description des effets secondaires du tabagisme moins connus et affectant l'ensemble du corps humain, de la tête aux pieds.

1. **Portraits** Les portraits sont souvent ternes et fatigués chez les fumeurs. Les yeux sont souvent irrités et les lèvres sèchent. Les fumeurs ont souvent une peau plus sèche et plus grisonnante.
2. **Cataracts** Les cataractes sont une opacification du cristallin, la lentille naturelle de l'œil, qui empêche la lumière de passer correctement à travers l'œil. Les fumeurs ont un risque accru de développer des cataractes.
3. **Wrinkling** Le tabac provoque le vieillissement prématuré de la peau. Les fumeurs ont plus de rides et de lignes d'expression que les non-fumeurs.
4. **Hearing loss** Les fumeurs ont un risque accru de perdre l'audition.
5. **Cancer** Le tabac est la cause principale de nombreux cancers, notamment du cancer du poumon, de la gorge, de la cavité nasale, de la cavité buccale, de l'œsophage, du pancréas, du rectum, du col de l'utérus, du vagin, du testicule et de la vessie.
6. **Tooth decay** Le tabac contribue à la formation de la plaque dentaire et à la carie.
7. **Emphysema** L'emphyseme est une maladie pulmonaire chronique qui provoque une inflammation et une destruction des sacs aériens des poumons.
8. **Osteoporosis** Les fumeurs ont un risque accru de développer l'ostéoporose, une maladie qui affaiblit les os.
9. **Heart disease** Le tabac est un facteur de risque majeur de maladies cardiovasculaires, y compris les maladies coronariennes, l'infarctus et l'AVC.
10. **Stomach ulcers** Le tabac augmente le risque de développer des ulcères d'estomac.
11. **Discoloured fingers** Les doigts des fumeurs ont souvent une teinte jaunâtre ou brune.
12. **Cervical cancer and miscarriage** Le tabac augmente le risque de développer un cancer du col de l'utérus et de perdre un bébé pendant la grossesse.
13. **Defeated sperm** Le tabac réduit la qualité et la quantité du sperme.
14. **Buerger's disease** La maladie de Buerger est une maladie rare qui affecte les artères et les veines des mains et des pieds.

1. **Portraits** Les portraits sont souvent ternes et fatigués chez les fumeurs. Les yeux sont souvent irrités et les lèvres sèchent. Les fumeurs ont souvent une peau plus sèche et plus grisonnante.
2. **Cataracts** Les cataractes sont une opacification du cristallin, la lentille naturelle de l'œil, qui empêche la lumière de passer correctement à travers l'œil. Les fumeurs ont un risque accru de développer des cataractes.
3. **Rides** Le tabac provoque le vieillissement prématuré de la peau. Les fumeurs ont plus de rides et de lignes d'expression que les non-fumeurs.
4. **Perte d'audition** Les fumeurs ont un risque accru de perdre l'audition.
5. **Cancer** Le tabac est la cause principale de nombreux cancers, notamment du cancer du poumon, de la gorge, de la cavité nasale, de la cavité buccale, de l'œsophage, du pancréas, du rectum, du col de l'utérus, du vagin, du testicule et de la vessie.
6. **Caries** Le tabac contribue à la formation de la plaque dentaire et à la carie.
7. **Emphyseme** L'emphyseme est une maladie pulmonaire chronique qui provoque une inflammation et une destruction des sacs aériens des poumons.
8. **Ostéoporose** Les fumeurs ont un risque accru de développer l'ostéoporose, une maladie qui affaiblit les os.
9. **Maladies du cœur** Le tabac est un facteur de risque majeur de maladies cardiovasculaires, y compris les maladies coronariennes, l'infarctus et l'AVC.
10. **Ulcères d'estomac** Le tabac augmente le risque de développer des ulcères d'estomac.
11. **Coloration des doigts** Les doigts des fumeurs ont souvent une teinte jaunâtre ou brune.
12. **Cancer du col et avortements spontanés** Le tabac augmente le risque de développer un cancer du col de l'utérus et de perdre un bébé pendant la grossesse.
13. **Altération du sperme** Le tabac réduit la qualité et la quantité du sperme.
14. **Maladie de Buerger** La maladie de Buerger est une maladie rare qui affecte les artères et les veines des mains et des pieds.

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

For an interactive tool visit the [Quitline website](http://www.quit.org.nz/19/reasons-to-quit/smoking-and-your-body) (<http://www.quit.org.nz/19/reasons-to-quit/smoking-and-your-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.¹² Smoking also increases the risk of developing diseases of the urinary tract, pelvis, bladder and digestive tract.¹³
- Smoking causes one in four of all cancer deaths in New Zealand.¹⁴
- 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 13,00 people in New Zealand having untreatable blindness due to current and past smoking.¹⁵
- Tobacco plays a significant role in health inequalities within New Zealand for both youth¹⁶ and adults.¹⁷ Higher smoking prevalence is seen among low-income groups, Māori and Pacific peoples.^{18,19}

Second-hand smoke

- Inhaled smoke contains more than 4,000 chemicals including acetone (paint stripper), ammonia (toilet cleaner), cyanide (rat killer), DDT (insecticide) and carbon monoxide (car exhaust fumes).²⁰
- 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.²¹
- Second-hand smoke is the leading environmental cause of preventable death in New Zealand.²²
- It is estimated that in New Zealand, 347 deaths per year are caused by past exposures to second-hand smoke.²³

¹² Vineis P, Alavanja M, et al. 2004. Tobacco and cancer: recent epidemiological evidence. *Journal of National Cancer Institute* 96: 99-106.

¹³ Ministry of Health. 2005. *Tobacco Facts 2005*. Wellington: Ministry of Health.

¹⁴ Laugesen M. 2000. *Tobacco Statistics 2000*. Wellington: Cancer Society of New Zealand.

¹⁵ Wilson G, et al. 2001. Smoke gets in your eyes: smoking and visual impairment in New Zealand. *NZ Med J*, 114, 471-4.

¹⁶ 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.

¹⁷ 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.

¹⁸ 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.

¹⁹ Ibid, 17.

²⁰ 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](http://www.ndp.govt.nz/moh.nsf/pagescm/1003/$File/chemicalconstituentscigarettespriorities.pdf). Retrieved on 4 January 2007.

²¹ 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.

²² Woodward A, Laugesen M. 2001. How many deaths are caused by second-hand cigarette smoke? *Tobacco Control*, 10, 383-8.

²³ Ibid.

- Second-hand smoke is a risk factor for:
 - coronary heart disease
 - lung cancer
 - acute stroke
 - nasal sinus cancer.²⁴
- Exposure to second-hand smoke increases the risk of stroke, with three times the risk in men compared to women.²⁵
- Many people exposed to second-hand smoke experience eye irritation, headache, cough, sore throat, dizziness and nausea.²⁶
- 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.²⁷
- 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.²⁸
- In New Zealand each year second-hand smoke causes:
 - more than 500 hospital admissions of children under age two years suffering from chest infections²⁹
 - more than 27,000 GP consultations for asthma and other respiratory problems³⁰
 - 1,000 cases of glue ear³¹
 - 50 cases of meningococcal disease³²
 - 20,000 asthma attacks in children³³
 - 50 deaths from SIDS (cot death).³⁴
- Exposure to second-hand smoke affects development and behaviour, leading to reduced language skills, reduced academic achievement, hyperactivity and reduced attention spans.^{35,36}
- Having a smokefree home is one way of protecting your children from second-hand smoke.³⁷

²⁴ International Agency for Research on Cancer. 2002. *Passive Smoking: A summary of the evidence, May 2004*. France: IARC.

²⁵ 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.

²⁶ International Agency for Research on Cancer. 2002. *Passive Smoking: A summary of the evidence, May 2004*. France: IARC.

²⁷ Second-hand Smoke website: www.seconhandsmoke.co.nz/media/homes.shtml. Retrieved on 28 January 2008.

²⁸ 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.

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

³² Ibid.

³³ Ibid.

³⁴ Woodward A, Laugesen M. 2001. How many deaths are caused by second-hand cigarette smoke? *Tobacco Control*, 10, 383-8.

³⁵ 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.

³⁶ Law KL et al. 2003. Smoking during pregnancy and newborn neurobehaviors. *American Academy of Pediatrics*, 111(6), 1318-23.

³⁷ 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.

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% 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.³⁸

The tangible costs of smoking to New Zealand in 2005 were around NZ\$1.7 billion, or about 1.1% 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.

For an interactive tool visit the Quitline website (<http://www.quit.org.nz/21/reasons-to-quit/money-benefits>).

Many budget advice services are aware of the impact that smoking has financially and a number also offer cessation advice and support.

The Cost of Tobacco

30g POUCH TOBACCO
SMOKING CAUSES LUNG AND HEART DISEASE

\$34.50

or

POTATOES 2.5KG
Minted Garden Peas 1kg
WHEATMEAL SANDWICH
WHEATMEAL SANDWICH
MILK

\$32.50

For help to quit smoking talk to your local health provider or visit quit.org.nz or aukatikaipaipa.org.nz

smokefree
AOTEAROA
NEW ZEALAND
2025

The above infographic can be downloaded from [here](http://smokefree.org.nz/2013-tools-resources) (<http://smokefree.org.nz/2013-tools-resources>).

³⁸ O'Dea D, Thomson G, Edwards R, Gifford H. 2007. *Tobacco Taxation in New Zealand*. Wellington: Smokefree Coalition and ASH NZ.

Smoking cessation

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

The New Zealand Smoking Cessation Guidelines recommend the ABC approach.

ABC prompts health care workers to **Ask** about smoking status; to give **Brief advice** to stop smoking **and** make an offer of help to quit to *all* smokers and for those who wish to stop smoking and refer for, or provide, evidence-based **Cessation support**. For more information see [Implementing the ABC approach](http://www.health.govt.nz/publication/implementing-abc-approach-smoking-cessation-framework-and-work-programme) (www.health.govt.nz/publication/implementing-abc-approach-smoking-cessation-framework-and-work-programme). An [online e-learning tool](#) provides an overview of the ABC approach and can be completed in less than 30 minutes. Registered health professionals who do not have prescribing rights, can register to become Quit Card providers after completing the online assessment. Non-registered health workers can become Quit Card providers by undertaking free training delivered by the National Heart Foundation (www.nhf.org.nz/).

A wide range of organisations and individuals provide smoking cessation interventions and services and it is a good idea to find out what services are offered in your area. There may even be a simple flyer or list that has been developed to inform the public.

Common cessation services include:

- Quitline (www.quit.org.nz)
- [Aukati Kai Paipa](http://www.aukatikaipaipa.co.nz/) (www.aukatikaipaipa.co.nz/)
- [Smokechange](http://www.smokechange.co.nz/Home) (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.

Quitline

The Quitline offers cessation support via phone – 0800 778 778, online - www.quit.org.nz and text. People who register with Quitline are placed on a three month programme and receive ongoing follow-up support. Quitline can receive referrals from other health providers and offers referrals to face-to-face providers for extra support.

Quitline (www.quit.org.nz) manages the Quit Card programme. Quit Card providers can distribute Quit Cards for subsidised nicotine patches, gum and lozenges to people who want to quit smoking.

Aukati Kai Paipa

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

New Zealand Government Health Targets

Tobacco control features as one of the Government's six health sector targets (www.moh.govt.nz/healthtargets).

The targets aim to provide better help for smokers to quit smoking where:

- 95% of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking
- 90% of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking
- 90% of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer) are offered advice and support to quit.

The health targets were introduced to the New Zealand health system in 2007/08. They are reviewed annually to ensure they align with government health priorities. For more information on the targets, the reasons for them, who is responsible and how they will be measured and reported on visit the MOH website.

Addiction

Nicotine is the main chemical within tobacco and tobacco smoke that is addictive. Dependence on tobacco can be formed after smoking very few cigarettes.³⁹ The extent to which smokers are addicted to nicotine is comparable with addiction to 'hard' drugs such as heroin or cocaine.⁴⁰

Nicotine exerts its dependence produces effects on the 'mesolimbic dopamine system' – the reward pathway. Nicotine, acting on this pathway, rewards the behaviour of smoking.

People may initially smoke for the positive, or rewarding, effects. However, over time people typically smoke to relieve the symptoms of tobacco withdrawal. Smoking takes away urges to smoke and feelings of irritability, poor concentration and low mood. This effect of smoking is often perceived as positive and is why people who smoke often say that smoking relieves stress, even though it is smoking that caused the withdrawal symptoms in the first place.

However, addiction is not simply about the drug and is influenced by a number of other factors, such as individual characteristics and social environment.

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.⁴¹ 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, mouth spray and inhaler) that all roughly double the chances of quitting for good.⁴² 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.⁴³

NRT patches, gum and lozenges are currently subsidised and are available on prescription or via a Quit Card. The nicotine inhaler and sublingual tablets are available over the counter (unsubsidised).

It is generally recommended that NRT is used for eight to 12 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.⁴⁴

There are a number of useful videos available at www.youtube.com/user/StartRightNRT that can be shared with users of NRT to ensure that it is being used correctly and is, therefore, helpful in stopping smoking.

³⁹ DiFranza JR, 2012. *Nicotine Confesses. It's not you. It's me.* Lulu.com

⁴⁰ Royal College of Physicians. 2000. *Nicotine addiction in Britain.* London: Royal College of Physicians.

⁴¹ 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.

⁴² Stead LF, Perera R, Bullen C, Mant D, Lancaster T. Nicotine replacement therapy for smoking cessation. *Cochrane Database of Systematic Reviews* 2008, Issue 1. Art. No.: CD000146. DOI: 10.1002/14651858.CD000146.pub3.

⁴³ McRobbie H, Maniopot M. 2009. Getting the most out of nicotine replacement therapy. www.bpac.org.nz/magazine/2009/april/nrt.asp. Retrieved on 11 May 2009.

⁴⁴ 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.

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, using NRT use usually outweighs the risk of continued smoking.^{45, 46}

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

New Products

Research continues on new products that deliver nicotine in a more comparable way to cigarettes in order to control cravings more effectively and, therefore, increase the success of quit attempts.

Medication

A range of medications are also available to support those who want to quit⁴⁷, including:

- Varenicline (Champix)
- Bupropion (Zyban)
- Nortriptyline

Varenicline (Champix)

Varenicline was developed especially to help people stop smoking. It works by binding to nicotine receptors in the reward centres in the brain. This reduces the severity of tobacco withdrawal symptoms while simultaneously reducing the rewarding effects of nicotine. Varenicline has demonstrated a good safety profile so far. However, adverse event data from general use in the population are not yet available. There are no known clinically significant drug interactions.

Bupropion (Zyban)

Bupropion is an antidepressant medication that almost doubles the chances of long-term abstinence from smoking. Its action in helping people to stop smoking is independent of its antidepressant effects, so it works even in people without a history of depression. Like NRT, it acts to reduce the severity of withdrawal symptoms, but it may also have other actions that help people stop smoking. Evidence that bupropion is more or less effective than NRT or nortriptyline is limited. However, evidence from three Randomised Controlled Trials (RCTs) suggests that it is less effective than varenicline. There is also evidence from two RCTs that bupropion improves short-term (but not long-term) smoking abstinence rates for people with schizophrenia and that it has a good safety profile in this group.

Nortriptyline

Nortriptyline is a tricyclic antidepressant that has been shown to be as effective as bupropion and NRT in aiding smoking cessation. Its action in helping people to stop smoking is independent of its antidepressant effects, and it works in those without a history of depression. Its main advantages are its low cost and the ability to monitor therapeutic blood

⁴⁵ McRobbie H, Hajek, P. Nicotine replacement therapy in patients with cardiovascular disease: guidelines for health professionals. *Addiction* 2001;Nov;96((11)):1547-51.

⁴⁶ Benowitz N, Dempsey D. Pharmacotherapy for smoking cessation during pregnancy. *Nicotine Tob Res* 2004;6 Suppl 2:S189-202.

⁴⁷ Ministry of Health. 2007. New Zealand Smoking Cessation Guidelines. Wellington: Ministry of Health.

levels. The main concern with using nortriptyline, like other antidepressants in its class, is the risk of adverse cardiovascular effects. There are a number of contraindications and precautions with its use.



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 three multinational companies that dominate the New Zealand market- British American Tobacco (New Zealand) Ltd (BATNZ), Imperial Tobacco New Zealand Ltd (ITNZ), Philip Morris (New Zealand) Ltd (PMNZ).
- These three tobacco companies dominate the New Zealand tobacco market, comprising over 98% of the tobacco market in New Zealand.⁴⁸
- All of the major tobacco companies in New Zealand are part of global 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 and is based in the United States.
- 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.
- In 2011 Philip Morris International reported over \$76 billion of revenue. This is equivalent to over half of New Zealand's GDP in the same year.⁴⁹ The New Zealand Government collected a total of \$1.237 billion in tobacco excise tax for the year ended June 2012.^{50 51}

⁴⁸ ASH New Zealand 2013. Analysis of Tobacco Returns.

⁴⁹ <http://www.tradingeconomics.com/new-zealand/gdp> accessed 14 August 2013

⁵⁰ Financial Statements of the Government of New Zealand for the Year Ended 30 June 2012. Published 28 Oct 2012

⁵¹ The Treasury. 2006. www.treasury.govt.nz/financialstatements/year/jun05/25.asp. Retrieved on 1 June 2006.



Graeme Amey (General Manager of BATNZ at the time of the Maori Affairs select committee inquiry in to the tobacco industry).

The following were Graeme's quotes from his oral submission the committee.

Has BATNZ any marketing strategies?

"No (marketing strategies)."

"Well our marketing strategy is to provide our products to New Zealand consumers, to make them available for sale."

Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Maori

The purpose of the inquiry was to gain a comprehensive understanding of the actions of the tobacco industry to promote tobacco use among Maori, the impact of tobacco use on the health of the Maori population, and the wider economic, social, cultural and developmental impacts that arise from such health effects and tobacco use more generally. As part of the inquiry, the committee intends to considered policy and legislative measures to address the findings. The terms of reference were to inquire into:

- the historical actions of the tobacco industry to promote tobacco use amongst Maori
- the impact of tobacco use on the health, economic, social and cultural wellbeing of Maori
- the impact of tobacco use on Maori development aspirations and opportunities
- what benefits may have accrued to Maori from tobacco use
- what policy and legislative measures would be necessary to address the findings of the inquiry.

The full report along with recommendations can be downloaded [here](#).

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 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.

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.health.govt.nz/publication/reducing-inequalities-health)

Focus

To achieve an overall prevalence of adult smoking of less than 5% by 2025 for *all* populations, significant work must be focused on improving outcomes for Māori and Pacific. Therefore, the audiences which must receive the most benefit of the work undertaken by the tobacco control sector are:

- Māori
- Pacific peoples
- pregnant women
- young people.

Data from New Zealand Health Survey 2011/12⁵² (<http://www.health.govt.nz/publication/health-new-zealand-adults-2011-12>) shows:

- 18% of people aged 15 years and over are current smokers
- 41% of Māori aged 15 years and over are current smokers
- 26% of Pacific peoples aged 15 years and over are current smokers.

Daily smoking prevalence among 15 to 17 year olds in 2011/12 was 6% compared to 14% in 2006/07.

Daily smoking prevalence among 14 to 15 year olds is available from the ASH Year 10 Snapshot Survey, which showed that in 2012, 4% of Year 10 students were daily smokers, unchanged from 2011.⁵³

⁵² Ministry of Health. 2012. *The Health of New Zealand Adults 2011/12: Key Findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

⁵³ Action on Smoking and Health. 2013. *National ASH Year 10 Snapshot Survey 1999-2012 Fact Sheet 1: Youth Smoking in New Zealand*. Auckland: Action on Smoking and Health. URL: <http://www.ash.org.nz/wp-content/uploads/2013/04/Factsheet-1-2012-Youth-smoking-in-NZ.pdf>. Retrieved on 17 June 2013.

Māori

The traditional world of Māori was tobacco free - James Cook brought the first tobacco. There wasn't even an original Māori word to describe the act of smoking.⁵⁴

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.⁵⁵ This is a significant loss of cultural knowledge and language.⁵⁶

Māori youth (56%) are also more likely than non-Māori non-Pacific youth (25%) to be exposed to second-hand smoke in their home at least one day a week.⁵⁷

The prevalence of smoking among *taiohi* Māori (youth) remains high compared to non-Māori – particularly in females – but has dropped significantly. In 2012 the prevalence of year 10 female Māori who smoked daily was 20% compared to 16% for male Māori.⁵⁸

Of students aged 14 to 17 who smoked daily, 30% of Māori males reported first trying a cigarette at seven-years-old or younger and 31% of Māori females first experimented at eight to nine years of age.⁵⁹



What's being done?

Māori are, and should be, the audience group to receive the most benefit from nearly all tobacco control initiatives at local and national level. This is to reduce the high Māori smoking rates and the inequality in tobacco use and health compared to all adults.

One by-Maori for Maori-service that aims to support whānau to stay auahi kore and quit is [Aukati Kai Paipa](http://www.aukatikaipaipa.co.nz/) (www.aukatikaipaipa.co.nz/). This 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.

⁵⁴ Te Hotu Manawa Maori website: www.tehotumanawa.co.nz. Retrieved on 20 May 2009.

⁵⁵ Ibid.

⁵⁶ Te Reo Marama website: www.tereomarama.co.nz. Retrieved on 28 January 2009.

⁵⁷ Health Sponsorship Council. 2009. *2008 HSC Year 10 In-depth Survey Report*. Wellington: Health Sponsorship Council Research and Evaluation Unit. URL: <http://www.hpa.org.nz/sites/default/files/FULL-REPORT-2008-Year-10-Indepth-Survey.pdf>. Retrieved 17 June 2013..

⁵⁸ Action on Smoking and Health. 2013. *National ASH Year 10 Snapshot Survey 1999-2012 Fact Sheet 5: Youth Smoking in New Zealand Maori and Non-Maori*. Auckland: Action on Smoking and Health. URL: <http://www.ash.org.nz/wp-content/uploads/2013/04/Factsheet-5-2012-Youth-Smoking-Maori-vs-Non-Maori.pdf>. Retrived on 16 June 2013.

⁵⁹ 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.

Hapai Te Hauora delivers the National Māori Tobacco Control Service – Te Ara Hā Ora. Te Ara Hā Ora works with Māori to take action to eliminate tobacco from Māori communities. Service pathways to achieve this goal include enhancing collaboration, growing Māori leadership, providing training and evidence based applicable information and resources. Te Ara Hā Ora is dedicated to ensuring that Māori are strongly represented in local, regional and national tobacco control initiatives, especially in regards to policy development opportunities.

Quitline offers tailored support to meet the needs of Māori. Its text support service is available in Te Reo and it has developed a bi-lingual quit smoking resource for Māori (<http://www.quit.org.nz/85/help-to-quit/publications>). A high proportion of Quitline Advisors are of Māori descent. Quitline also makes referrals to face-to-face providers such as Aukati Kai Paipa and works with iwi to support regional initiatives. In addition, Quitline develops advertising campaigns specifically for Māori.

Pacific peoples

Tobacco use is not a traditional part of Pacific peoples' cultures, even though some Pacific countries started to cultivate tobacco after colonisation. Many Pacific peoples' religions are opposed to smoking.⁶⁰

Pacific smoking rates

Overall, smoking has decreased within the adult New Zealand population (18%).⁶¹ For Pacific people however, smoking rates have not decreased and remain high. Specifically, one in four adults is a current smoker (26%).

In New Zealand, smoking is most common in young adults (18 to 34 years).⁶² A review of recent surveys indicated that:

- 'regular' smoking amongst 14 to 15 year olds was highest among Maori (20.9%), then Pacific (12.2%) and NZ European young people (7.2%);⁶³
- females were more likely to be smoking than males⁶⁴
- Cook Island young people had the highest rates of smoking, with over a quarter being current smokers (26%)
- 70% of Pacific youth who reported to be smoking had tried to cut-down or give-up.

The uptake of smoking has been associated with:

- household smoking and parental smoking⁶⁵
- exposure to smoking depicted in movies, particularly for adolescent smoking⁶⁶.

⁶⁰ Ministry of Health. 2004. *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*. Wellington: Ministry of Health.

⁶¹ Ibid, 51

⁶² Ibid, 51

⁶³ ASH New Zealand. 2011. National Year 10 ASH Snapshot Survey, 1999-2010: trends in tobacco use by students aged 14-15 years. Report for Ministry of Health, Health Sponsorship Council and Action on Smoking and Health: Auckland, New Zealand.

⁶⁴ Helu SL, Robinson E, Grant S, Herd R, Denny S. 2009. Youth '07 The health and wellbeing of secondary school students in New Zealand: Results for Pacific young people. Auckland: University of Auckland

⁶⁵ Fidler JA, West R, Van Jaarsveld CHM, Jarvis MJ, Wardle J. 2008. Smoking status of step-parents as a risk factor for smoking in adolescence. *Addiction*, 103, 496-501.

⁶⁶ Sargent JD, Stoolmiller M, Worth KA, Dal Cin S, Wills TA, Gibbons FX, Gerrard M, Tanski SE. Exposure to smoking depictions in movies: Its association with established adolescent smoking. *Archives of Pediatrics & Adolescent Medicine* 2007;161:849-856.

The ASH 2010 Snapshot Survey found that:

- a high number of Pacific students (45%) were more likely to report that one or both of their parents smoked, compared to NZ Europeans (32%)
- Pacific students (20%) were more likely to report that people smoked inside their home compared to NZ Europeans (16%).

Overall, these associations identify the impact of parents and the home environment on smoking. In particular, the role of parental and maternal care offers opportunities to reduce smoking. Equally, interventions that promote environmental changes warrant exploration.

Preventing Smoking with Pacific People

In regards to smoking cessation, there is evidence that supports:

- tailoring Quitline and other generic services to better meet the needs of Pacific people
- enhancing awareness and access to NRT and appropriate support services⁶⁷
- adopting a culturally appropriate and holistic approach including a focus on family, cultural and spiritual aspects^{68,69}.

The train-the-trainer model was identified as a potential means of achieving these within the New Zealand health workforce. Any training, however, must be well supported to ensure the transfer of training⁷⁰.

What could help with current service provisions for young people and pregnant smokers include:

- anonymous, confidential and easy-to-access approaches, such as the internet and texting
- specific advice for the needs of pregnant women and the dissemination of this advice to health professionals.

⁶⁷ Glover M., Nosa V., Watson D., Paynter J. (2010) WhyKwit: A qualitative study of what motivates Māori, Pacific Island and low socio-economic peoples in Aotearoa/New Zealand to stop smoking. Auckland: University of Auckland, School of Population Health, Centre for Tobacco Control Research.

⁶⁸ Ministry of Health. 2004. *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*. Wellington: Ministry of Health.

⁶⁹ Suaalii-Sauni, T., Wheeler, A., Saafi, E., Agnew, F., Warren, H., Erick, M., Hingano, T. (2009). Exploration of Pacific perspectives of Pacific models of mental health service delivery in New Zealand. *Pacific Health Dialogue*, 5(1), 18-27.

⁷⁰ M. D'Eon, D. AuYeung. 2001. Follow-up in Train-the-trainer CME Events Development. *The Journal of Continuing Education in the Health Professions*, 21(1), p. 33.



A young Pacific tobacco control advocate.

An image used by the ASPIRE2025 research collaboration on a project: “Consumer testing of terminology and key messages”.

What’s being done?

Lowering the smoking rates within Pacific communities will significantly contribute to reducing inequalities in health outcomes.

Tala Pasifika - the National Pacific Tobacco Control Service (www.talapasifika.org.nz) was launched in November 2009 to provide Pacific peoples with a voice to provide input and advice into policy development processes and to enhance Pacific leadership on tobacco issues.

There are five key principles that guide the work that we do:

- Community Leadership
- Advocacy
- Responsiveness
- Partnership
- Evidence Based

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 nationally:

- Pacific Quit Smoking Service, Greenlane, 0800 86 7848 ; pacificquit@adhb.govt.nz.
- Southseas Healthcare; Otara Town Centre, (09) 273 9017; www.southseas.org.nz.
- Ngati Whatua o Orakei Health Services, Glen Innes, (09) 578 0967; www.orakeihealth.co.nz.
- Kaute Pasifika Trust, Hamilton, (07) 834 1482 ext 202.
- Pacific Health Services Porirua, (04) 388 2154 or (04) 388 2157; masone@phsporirua.co.nz.
- Pacific Trust Canterbury, Christchurch (03) 366 3900; info@pacifictrust.co.nz.

Quitline offers resources in different Pacific languages (<http://www.quit.org.nz/85/help-to-quit/publications>) and a high proportion of its advisors are of Pacific descent. Quitline also makes referrals to face-to-face Pacific providers and works with them to support regional initiatives.

Pacific Cessation

A number of themes have emerged from current literature that have found the need to:

- develop a better understanding of Pacific perspectives on health and particularly for specific ethnic groups
- provide culturally-competent services to improve responsiveness to Pacific peoples and their perspectives
- adopt a holistic approach to engaging Pacific people that captures the importance of family, culture and spirituality
- adopt approaches that retain and enhance cultural links between Pacific people and their communities
- maintain connections to churches, as churches offer an opportunity to engage Pacific families in a manner that promotes partnership, the role of church leaders, empowerment and the potential to tailor interventions to the needs of different ethnic groups.

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, pregnant women have been identified 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 have a positive impact on the health of both the mother and the unborn baby. Quitting 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 the baby's lungs, which increases the risk of many health problems.^{71 72}

Chemicals in tobacco smoke are passed to the baby through the placenta. Nicotine causes the blood vessels to constrict, which decreases the amount of oxygen going to the unborn baby - an important contributor to low birth weight.⁷³ Mothers who smoke also pass nicotine onto their babies through their breast milk.⁷⁴

It has been estimated that around 50 New Zealand babies die every year from SIDS as a result of exposure to second-hand smoke⁷⁵ and emerging evidence suggests that smoking during pregnancy is an even stronger risk factor for SIDS than exposure to second-hand smoke.⁷⁶

Pregnant women's smoking rates

Data recorded in 2006 show that prevalence of smoking in women of childbearing age (aged 15 to 44 years) ranges from 7-31%, depending on the specific age group. However, rates are much higher in Māori (42-55%).⁷⁷

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 at any time throughout a pregnancy. While there are concerns about potential adverse effects of nicotine in fetal development, the main benefit of using

⁷¹ US Department of Health and Human Services. 2004. *The Health Consequences of Smoking: what it means to you*. 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, 2004. www.cdc.gov/tobacco/data_statistics/sgr/sgr_2004/00_pdfs/SGR2004_Whatitmeanstoyou.pdf. Retrieved on 11 February 2008.

⁷² 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.

⁷³ 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.

⁷⁴ *ibid.*

⁷⁵ 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.

⁷⁶ 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.

⁷⁷ Ministry of Health. 2006. *Tobacco Trends 2006: Monitoring tobacco use in New Zealand*. Wellington: Ministry of Health.

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?

Helping pregnant women who smoke to quit is an important part of the Ministry of Health's work programme on tobacco control. The Ministry funds a number of pregnancy-specific cessation services throughout New Zealand (eg, Smokechange www.smokechange.co.nz/Home), and ensures that pregnant women are a key focus for other cessation services, such as The Quitline (www.quit.org.nz/) and Aukatika Kai Paipa (www.aukatikaipaipa.co.nz/).

In 2012, the Ministry introduced a new indicator to the Better help for smokers to quit target, which focuses on pregnant women. This indicator encourages clinicians to provide:

90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer, with advice and support to quit.

Although the Ministry is still looking for an appropriate method of data collection for this target, the Ministry's work to support clinical staff to provide support to pregnant women continues. This work includes:

- working with key stakeholders
- developing a smoking cessation training programme for midwives
- integrating the ABC protocol into the existing protocols of clinicians who work with pregnant women (eg, including ABC in the MMPO's case files)
- creating an environment that increases the public's understanding of the harms of smoking during pregnancy and the importance of quitting.

Young people

Children and young adults 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 16% and regular smoking (monthly or more often) 29% in 1999 and had dropped to 4% daily and 8% regular smoking in 2012.⁷⁸

What's being done?

In 2005, the Health Sponsorship Council undertook the *Reducing Smoking Literature Review*,⁷⁹ (<http://www.smokefreeschools.org.nz/sites/all/files/RSILitRvwFinal.pdf>) from which

⁷⁸ Action on Smoking and Health. 2013. *National ASH Year 10 Snapshot Survey 1999-2012 Fact Sheet 1: Youth Smoking in New Zealand*. Auckland: Action on Smoking and Health. URL: <http://www.ash.org.nz/wp-content/uploads/2013/04/Factsheet-1-2012-Youth-smoking-in-NZ.pdf>. Retrieved on 17 June 2013

⁷⁹ 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.

the Framework for Reducing Smoking Initiation in Aotearoa-New Zealand⁸⁰ (http://www.smokefreeschools.org.nz/sites/all/files/RSI_Framework_Final-4.pdf) was developed. The Framework proposed a comprehensive suite of interventions and initiatives to reduce smoking initiation in Aotearoa-New Zealand. The Framework was developed for use by health providers, health funders, policy makers and researchers.

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
- 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.

The Health Promotion Agency's campaign Smoking Not Our Future (<https://www.facebook.com/notourfuture>) is focused on engaging young people around tobacco and its use, and moving to a Smokefree New Zealand. The campaign has used a number of celebrities who the audience relates to to establish and deliver the messages. The campaign has been able to move the focus to the audience creating their own messages for the campaign.

This campaign used television advertising as the main communication tool, complemented by a number of new media executions ie, Facebook, Twitter and online games, and event activations at relevant youth events to connect to the audience.

Quitline offers a variety of services suited to young people. Its Txt2Quit programme, provides support and advice in the form of texts for three months. Its online Quit Blogs are another popular tool.

⁸⁰ HSC. 2005. *Framework for Reducing Smoking Initiation in Aotearoa-New Zealand*. HSC: Unpublished report.

Smokefree legislation

Smoke-free Environments Act 1990

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 and work canteens
- the display of tobacco products in retail outlets was restricted
- 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.

A further amendment on 23 July 2011 (which came into force a year later following the passing of regulations):

- prohibited the display of tobacco products in retail outlets
- prohibited the display of trading names where these include words or phrases that effectively advertise tobacco products
- provided for new regulation-making powers for incidental matters covering product notices, price lists, health warnings and other signs (the Smoke-free Regulations 2007 were subsequently amended)
- provided an infringement notice scheme to enforce the prohibition on the sale of tobacco products to people under 18 years
- helped enforce the law against supplying tobacco products at a reduced charge or with rewards, by making relevant contracts and agreements unenforceable to the extent they prevent or limit compliance.

For guidance on implementing the prohibition on display of tobacco products see <http://www.health.govt.nz/publication/guidelines-implementing-prohibition-display-tobacco-products>.

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 are responsible for enforcing the Smoke-free Environments legislation. 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. Contact details for all public health units are available on the Ministry of Health website (<http://www.health.govt.nz/our-work/regulation-health-and-disability-system/smokefree-law/smokefree-complaints>). (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).

How the tobacco control sector works

There are many different players in the exciting world of tobacco control, including:

- policy makers
- researchers
- health promoters
- community workers
- cessation practitioners and quit coaches
- advocates
- iwi
- whānau
- communities
- teachers, students.

The work that you do is part of the bigger picture of tobacco control and will make a difference. Talk to people about where your organisation fits into the sector at both a local and national level.

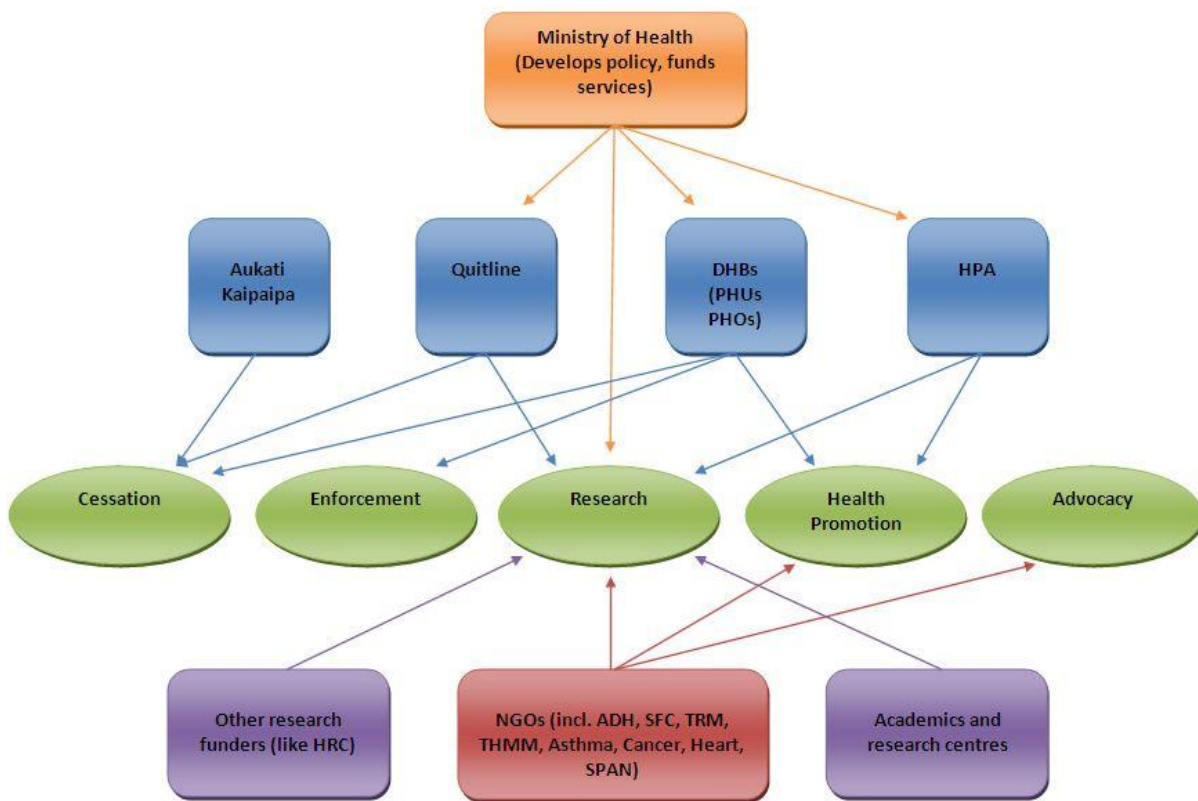
Organisations and individuals involved in tobacco control often work in one or more of the following areas (which often overlap):

- health promotion
- research and evaluation
- enforcement
- policy development
- cessation
- advocacy
- media
- leadership.

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), reduce smoking uptake (the number of young people who begin to smoke), and reduce the harm from second-hand smoke.

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

The tobacco control sector



Key players in tobacco control

This section contains information on the current 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

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 such as Quitline and face-to-face services and enforcement of tobacco control legislation. 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.

The Health Promotion Agency

The Health Promotion Agency (www.hpa.org.nz) is a Crown entity established under the New Zealand Public Health and Disability Amendment Act 2012.



The HPA was formed on 1 July 2012 through the merger of the Alcohol Advisory Council (ALAC) and Health Sponsorship Council (HSC) and some health promotion functions previously delivered by the Ministry of Health.

The HPA is funded from Vote Health, the levy on alcohol produced or imported for sale in New Zealand and part of the problem gambling levy.

The HPA holds the vision that:

- New Zealanders realise their potential for good health and improved quality of life.
- New Zealand's economic and social development is enhanced by people leading healthier lives.

The mission of the HPA is "inspiring all New Zealanders to lead healthier lives." To achieve this vision and mission, the HPA works with partners including medical professionals, researchers and academics, community groups, public health advocates, government agencies, industry groups, the media and many others who are aligned with them goals.

HPA leads and supports activities to:

- promote health and wellbeing and encourage healthy lifestyles
- prevent disease, illness, and injury
- enable environments that support health and wellbeing and healthy lifestyles
- reduce personal, social, and economic harm.

Action on Smoking and Health (ASH)

Action on Smoking and Health (ASH) New Zealand (www.ash.org.nz) is a registered charity dedicated to eliminating the death and disease caused by tobacco.



ASH advocates and campaigns for evidence-based national action that contributes towards reducing tobacco-related illness and death, especially among Māori and the Pacific populations, due to high smoking inequalities. The ultimate aim will be a Aotearoa/New Zealand that is tobacco free. The country will be free from the demand for and supply of tobacco products. ASH is committed to the goal of smokefree Aotearoa/New Zealand by 2025.

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

Quitline

Funded by the Ministry of Health, Quitline is an incorporated charitable trust that was established in 1998.



Quitline is committed to helping all New Zealanders quit smoking, with a focus on Maori, Pacific Peoples and pregnant women. Its free services are available via **telephone, online** and **text**.

Clients who register with Quitline are placed on a three month programme and receive ongoing follow-up support.

Phone – 0800 778 778

- Open Monday – Friday (8am – 9.30pm) and Sunday (10am – 7.30pm) Quitline's phone-line offers non-judgmental advice and support to quit smoking.
- Quitline advisors work with clients to create a quit smoking plan and help them understand their smoking addiction. Clients are helped to identify the reasons why they smoke and come up with new ways to cope and beat cravings.
- Clients are sent a Quit Pack with helpful information including The Quit Book and other resources suited to the client's needs.

Online – www.quit.org.nz

- Quitline's website offers clients support 24/7. Clients who register get their own login and a personalised page. They can also select a Maori or Pacific design theme.
- Clients' personalised pages display real-time 'Quit Stats' to show how much money they've saved and how many cigarettes they haven't smoked since they quit. There are prompts for clients to create their own Quit Plan.
- Clients can share their story on the Quit Blog, a popular forum that connects people with others on the quitting journey. The blog community has more than 30,000 registered users and many clients find the peer support invaluable.
- Clients can opt to receive Quit Tip emails with messages and advice to help them stay strong on the quitting journey.

Text – Text QUIT to 3111

- Txt2Quit is an automated free text service designed to support a client through the quitting journey.
- Clients can opt to receive texts in English or Te Reo Maori.
- Texts are sent regularly for three months.
- Clients can text Quitline if they have any questions and an advisor will call them back.

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. Up until the ceasing of MoH funding in 2010, the main role undertaken was to advocate evidence-based positions on tobacco-related issues at a local, national and international level.



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 among 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 in 1995 to advocate for a tobacco free New Zealand. It is a coalition of over 50 non-government organisations with the purpose of being a united voice for action toward the Smokefree 2025 Goal. The Smokefree Coalition encourages collaboration between its members and also provides networking and communications services for the national tobacco control sector:



- a fortnightly electronic newsletter – Tobacco Control Update (www.sfc.org.nz/tcu/index.php) – you can subscribe by contacting admin@sfc.org.nz
- an online nationwide tobacco control directory- Smokefree Contacts (www.smokefreecontacts.org.nz/) – to get listed contact admin@sfc.org.nz
- a website focused upon the Coalition’s events and social movement priorities, including links to all members’ websites, the Tobacco Control Update Archive, tobacco control conferences here in New Zealand, and more
- a Twitter feed (@Smokefreeby2020)
- one-on-one or team consultation on Smokefree policy development, submission writing, media and public relations, and aligning local strategy with the National Smokefree Working Group’s National Action Plan.

Tala Pasifika

The National Pacific Tobacco Control Service (www.talapasifika.org.nz) was launched in November 2009 to provide Pacific peoples with a voice to provide input and advice into policy development processes and to enhance Pacific leadership on tobacco issues.



There are five key principles which guide the work that they do:

- community Leadership
- advocacy
- responsiveness
- partnership
- evidence based.

Cancer Society of New Zealand

As the largest single preventable cause of cancer, tobacco control is a key area of work for the Cancer Society. We are committed to promoting a smoke free New Zealand through continued policy advocacy and innovative programmes. New Zealand has benefited from a comprehensive mix of interventions. However, much more needs to be done to control new types of marketing, the way tobacco is sold and the action of the tobacco industry. There is the National Tobacco Control Advisor who is located at the National office (www.cantobacco.org.nz/contact-us) in Wellington and also regional health promoters.



CANTOBACCO (www.cantobacco.org.nz) is the Society's campaign that aims to Protect Our Children through the following policies:

- banning retail display
- replacing brand imagery with plain packaging and graphic warnings
- making all locations where young people are present smokefree
- empowering parents and caregivers to be smokefree to protect their children from becoming smokers.

The Cancer Society is committed to, and will lead towards, a Smokefree Aotearoa in 2025.

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.

Tobacco Control Research Tūranga

The Tūranga is a multi-disciplinary network of researchers from across New Zealand led by Associate Professor Chris Bullen (National Institute of Health Innovation) and Dr Marewa Glover (Centre for Tobacco Control Research) of the University of Auckland. In 2010, the

Ministry of Health and Health Research Council of New Zealand formed the Reducing Tobacco-related Harm Research Partnership and in 2011 they awarded \$5 million to the University of Auckland to establish the New Zealand Tobacco Control Research Tūranga.

The Tūranga objectives are to:

- provide scientific and strategic direction to ensure that research meets policymakers and healthcare providers' need for evidence supporting policy and programme changes to bring about a rapid halving of smoking prevalence
- commission tobacco control research
- establish effective processes for knowledge transfer and exchange (KTE) with relevant policymakers, healthcare funders and providers, the tobacco control community, the public and other stakeholders
- ensure priority populations, in particular Māori and Pacific peoples, are represented and engaged at all levels of the Tūranga
- provide a platform for tobacco control research projects to attract funding from sources other than that allocated for the Tūranga
- support tobacco control research workforce development, particularly to build Māori and Pacific capacity.

Aspire 2025

ASPIRE2025 is a partnership between



major New Zealand research groups carrying out research to help achieve the Government's goal of a tobacco-free Aotearoa by 2025. It launched in July 2011.

ASPIRE2025 brings together leading tobacco-free researchers and health service groups in New Zealand and strengthens existing collaborations. ASPIRE2025 was awarded the status of a University of Otago Research Theme in November 2011.

Our areas of research encompass all the main aspects of tobacco control activity including smoking cessation support, policy and regulatory research, smoking among young people, smokefree communications, Maori health and tobacco use, Pasifika tobacco use, and research capacity development. We will use a translational approach that links the findings from clinical trials, experimental and observational studies, and qualitative approaches with end-users of research, to ensure our work contributes directly to reductions in smoking prevalence.

We will continue to expand our New Zealand and international collaborations and to work with groups that contribute to research design, study recruitment and research end-usage. We look forward to hosting hui, seminars and conferences that bring together the best researchers in tobacco control to debate and address this pivotal health priority.

www.aspire2025.org.nz

Te Ara Hā Ora

Hapai Te Hauora Tapui, Māori Public Health, in partnership with ASH deliver the National Māori Tobacco Control Service – “Te Ara Hā Ora – pathways to the breath of life”. The purpose of the service is to support Māori to take action to eliminate tobacco from Māori communities in order to reach Smokefree Aotearoa 2025. To achieve this goal Te Ara Hā Ora grows local, regional and national leadership, strengthens communication and enhances collaboration across the country. Te Ara Hā Ora is also dedicated to ensuring that Māori are strongly represented in local, regional and national tobacco control initiatives, especially in regards to policy development opportunities.



Contact: Zoe.hawke@hapai.co.nz

The Asthma Foundation

The Asthma Foundation (www.asthmafoundation.org.nz) is New Zealand's sector authority on asthma and other respiratory illnesses. They advocate to government and raise



awareness of respiratory illnesses, fund research for better treatments and educate on best practice. They provide resources on their website and support affiliated asthma societies and trusts in providing education, support and advice.

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)

The Public Health Association of New Zealand (PHA) is a voluntary organisation taking a leading role in promoting public health and influencing public policy through submissions, seminars, speaking engagements, the annual conference and a communications and media strategy.

Their goal is to improve the health of all New Zealanders by progressively strengthening the organised efforts of society by being an informed collaborative and strong advocate for public health.



Local

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.

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.

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

Cancer Society of New Zealand (www.cancernz.org.nz/Society/Divisions/)

Heart Foundation <http://www.heartfoundation.org.nz/our-work/our-locations>

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)

Primary health organisations (PHOs) are funded by DHBs to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO. The majority of primary health care services have traditionally been provided by GPs and practice nurses. (<http://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations>)

PHOs are one vehicle through which the Government's primary health care objectives

(articulated through Better, Sooner, More Convenient Primary Health Care) are implemented in local communities. As at December 2011, there are 31 PHOs that vary widely in size and structure although all are not-for-profit organisations.

PHOs are expected that their general practices provide better help for smokers to quit as part of the Health Target for primary care. The target is for health professionals to provide brief advice and offer smoking cessation support to 90% of enrolled patients who smoke and have a medical appointment with their GP or practice nurse. Target results are monitored through the PHO Performance Programme and reported on a quarterly basis.
(<http://www.health.govt.nz/new-zealand-health-system/health-targets/2011-12-health-targets/health-targets-better-help-smokers-quit>)



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. Make contact with the key players listed above at both national and local level.

The following newsletters, networks and websites will also help to keep you in touch with colleagues and up to date with the latest topics, issues and research.

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.

The Smokefree2025 network

The Smokefree2025 network is an email list service for professional communication regarding tobacco control policy, health promotion, research, evaluation and news information. To ensure a secured and conducive environment for discussion, only subscribing members are allowed to post to the network. Members must also be legitimate tobacco control stakeholders. Applicants to the network will be subject to a referee check.

To subscribe, send an email to the network administrator Esther U (eu@ash.org.nz) or ashnz@ash.org.nz. Please also include the names, positions and emails 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 smokefree2025@smokefreenz.org.nz.

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).

Smokefree contacts map

This map, on the Smokefree Coalition website, (www.smokefreecontacts.org.nz) lists every organisation dedicated to helping New Zealand become free from tobacco. You can select contacts either by region or by sector field (cessation, health promotion, research/training or enforcement). You can filter the contacts for all Maori and Pacific services only. Alternatively, you can select the broad overview of all government and non-government agencies identified as working in some way in tobacco control.

For the sector, this service is helpful for anyone building a database of services and contact information. It is also useful to anyone from one region, looking for counterparts to network with in other regions.

For the public, this service can help people find cessation providers in their region. It is helpful for anyone interested in becoming involved in tobacco control work or looking for someone in their community to talk to.

Smokefree.org.nz

A general smokefree portal provided by HPA (www.smokefree.co.nz) with four main sections – Being Smokefree, Helping others, Getting involved, Info and Tools. There are also links to other smokefree websites such as:

- [Auahi Kore](http://www.auahikore.org.nz) (www.auahikore.org.nz)
- [Smokefree schools](http://www.smokefreeschools.org.nz) (www.smokefreeschools.org.nz)
- [Kura Auahi Kore](http://www.kuraauahikore.org.nz) (www.kuraauahikore.org.nz)

There is also information on current projects such as [World Smokefree Day](http://www.worldsmokefreeday.org.nz) (www.worldsmokefreeday.org.nz) and past campaigns, [Second-hand smoke](http://www.secondhandsmoke.org.nz) (www.secondhandsmoke.org.nz) and [Face The Facts](http://smokefree.org.nz/face-facts) (smokefree.org.nz/face-facts).

Globalink

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

[Globalink](http://www.globalink.org/) (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.

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. Research in New Zealand around tobacco control happens regularly and assists to:

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

Different data sets in use

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

- New Zealand Health Survey (NZHS)
- New Zealand Youth Tobacco Monitor (NZYTM)
- Census.

The NZHS is managed and disseminated by the Ministry of Health. The survey covers a wide range of health topics, such as tobacco smoking, vegetable intake and access to health services. For most topics in the NZHS, the survey is the best source of information at a population level. The NZHS was conducted in 1991/92, 1996/97, 2001/02 and 2006/7. From July 2011, the NZHS adopted a new methodology and has been in continuous operation since then. The survey has a core component (which includes questions on tobacco use), as well as a module component. A 'Tobacco Use' module was in field the first time in 2012/13 and included a wide range of questions about smoking and quitting.

The key point of difference between the NZHS and the Census is the definition of *current smoker*. A regular smoker as measured by the Census essentially measures daily smoking only, while both the NZHS and NZTUS combine daily and non-daily smokers into a 'current smoker' classification.⁸¹ The advantage of the NZHS is that it produces separate estimates for daily and non-daily smokers, whereas the Census cannot.

The NZYTM comprises three surveys - The Youth Insights Survey (YIS), the ASH Year 10 Snapshot, and the Global Youth Tobacco Survey (GYTS). The HPA's Youth Insights Survey is a biennial survey of Year 10 students. The YIS collects in-depth information on tobacco-related knowledge, attitudes and behaviour, exposure to second-hand smoke and role modelling of smoking behaviour, as well as a wide range of information on youth culture and lifestyles. It monitors the broad spectrum of risk and protective factors that relate to smoking uptake among young people. The ASH Year 10 Snapshot Survey is an annual census of Year 10 students' smoking prevalence. It is developed collaboratively by ASH and HPA, with HPA taking a project management role. The Global Youth Tobacco Survey is a biennial survey of students aged 13 to 15 years, which ran in 2006, 2008 and 2010 alongside the Youth Insights Survey. The GYTS was developed by the World Health Organization and Centers for Disease Control to track tobacco use among youth across countries using a common methodology and core questions.

⁸¹ 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.

There are also other surveys that assess New Zealanders' smoking-related attitudes and behaviours, such as the HPA's Health and Lifestyles Survey (HLS) and the Ministry of Health's New Zealand Smoking Monitor (NZSM) (managed by the HPA). Information on these surveys can be found [here](http://www.hpa.org.nz/research-library) (<http://www.hpa.org.nz/research-library>)



Prevalence and trends

At a glance

- Fewer than one in five (18%) people aged 15 years and over (adults) were current smokers in 2011/12. The rate of adult daily smoking was 17% in 2011/12 and this rate has fallen consistently since 1996/97 when one quarter (25%) of adults smoked daily.⁸²
- Among youth aged 15 to 17 years, 6% were current smokers in 2011/12⁸³.
- Māori (41%) and Pacific peoples (26%) were more likely to be current smokers compared with the total population aged 15 year and over.⁸⁴
- People living in the most deprived neighbourhoods (28%) were more likely to be smokers than people living in the least deprived areas quintile (11%).⁷⁷
- 4% of 14 to 15-year-olds were daily smokers in 2012, compared with 12% in 2002 and 16% in 1999. Although the rate in 2012 was unchanged from 2011, there was a significant drop in daily smoking between 2010 (6%) and 2011 (4%).⁸⁵

⁸² Ministry of Health. 2012. *The Health of New Zealand Adults 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

⁸³ *ibid*

⁸⁴ *ibid*

⁸⁵ Action on Smoking and Health. 2013. *National ASH Year 10 Snapshot Survey 1999-2012 Fact Sheet 1: Youth Smoking in New Zealand*. Auckland: Action on Smoking and Health. URL: <http://www.ash.org.nz/wp-content/uploads/2013/04/Factsheet-1-2012-Youth-smoking-in-NZ.pdf>. Retrieved on 17 June 2013

Key documents

Current tobacco control documents

Smokefree Aotearoa 2025 local, regional and national action plans.

Māori Affairs Select Committee Inquiry

The Māori Affairs Select Committee report and the Government's response can be found [here](#).

Tobacco Trends

This [website](http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/tobacco-data-and-stats?mega=Health%20statistics&title=Tobacco) page (www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/tobacco-data-and-stats?mega=Health%20statistics&title=Tobacco) provides an overview of current smoking and tobacco consumption among New Zealanders over time.

Other useful tobacco control documents

Pacific Peoples Tobacco Control Action Plan

The main aim of this [document](http://www.cancernz.org.nz/Uploads/Pacific_Peoples_Action_Plan.pdf) (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](http://www.health.govt.nz/publication/implementing-abc-approach-smoking-cessation-framework-and-work-programme) (www.health.govt.nz/publication/implementing-abc-approach-smoking-cessation-framework-and-work-programme). 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](http://www.moh.govt.nz/moh.nsf/indexmh/nz-smoking-cessation-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](http://www.smokefreeschools.org.nz/sites/all/files/RSI_Framework_Final-4.pdf) (www.smokefreeschools.org.nz/sites/all/files/RSI_Framework_Final-4.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 [2009-2012 Strategy](http://www.auahikore.org.nz/sites/default/files/TCR-STRATEGY-20090903-1.pdf) (www.auahikore.org.nz/sites/default/files/TCR-STRATEGY-20090903-1.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](http://www.allenandclarke.co.nz/Tobacco_Strategy_Book.pdf) (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.

Smokefree legislation

Smoke-free Environments Act 1990

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

Smoke-free Environments Regulations 2007

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

Other important health documents

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.

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.

Whanau Ora

Whānau Ora is an inclusive interagency approach to providing health and social services to build the capacity of all New Zealand families in need. It empowers whānau as a whole rather than focusing separately on individual family members and their problems. Learn more from the Te Puni Kokiri [website](http://www.tpk.govt.nz/en/in-focus/whanau-ora) (www.tpk.govt.nz/en/in-focus/whanau-ora)

Framework Convention on Tobacco Control

What is the Framework Convention on Tobacco Control (FCTC)?⁸⁶

The FCTC is a legally binding treaty that 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 September 2010, 183 participants had signed the Treaty and 168 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% (but ideally 50% 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-government organisations (NGOs) and other members of civil society in support of stronger tobacco control.

⁸⁶ 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 29 November, 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 that 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 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](http://www.fctc.org) , (www.fctc.org).

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

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

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 HPA has many years of experience in sponsorships and partnerships and it may be worth calling the tobacco control 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 Schools⁸⁷ (www.hps.tki.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

While school nurses can be encouraged to become quitcard providers and other quit support is available, this request is an opportunity to encourage the adoption of a comprehensive school approach to smoking. The Smokefree/Auahikore Schools website can support you and them through this process.

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 that 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). More than 50 different tobacco control resources can be ordered 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/notebook/nbbooks.nsf/0/0B5B192B40AADA0CC256BDC00080279). 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.

⁸⁷ 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.

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 that tells you where you are going and helps identify where you have come from.

You may want to use the [smokefree toolkit](http://www.smokefreetoolkit.org.nz/project-planner) (www.smokefreetoolkit.org.nz/project-planner) to help you develop your project plan.

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 that 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 permitted 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? These are three to five easy to remember lines to get your point across in no frills terms. 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?
- Don't make up facts and figures. If you're not certain, simply say that you'll have to look in to it. Make sure you follow up with an email or phone call when you've got the information to hand.

For further information about getting media coverage, see your organisation's communications manager.
