2001 – 2004

NSW Tobacco Action Plan

NSW HEALTH DEPARTMENT

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Executive summary

Tobacco smoking is the single greatest preventable cause of death in Australia, particularly from cardiovascular disease, cancer and chronic obstructive pulmonary disease. There is also increasing evidence of harm to adults and children from exposure to Environmental Tobacco Smoke (ETS) in homes, workplaces and enclosed public places.

The *NSW Tobacco Action Plan 2001-2004* sets out the Government's commitment to the prevention and reduction of tobacco related harm in New South Wales.

The *Plan* aims to build on the successes of the NSW Tobacco and Health Strategy 1995-1999. It will continue to provide strategic direction for the implementation of a comprehensive range of tobacco control initiatives to reduce tobacco related harm in NSW. The *Plan* has also been developed in response to the National Tobacco Strategy 1999–2000/03, which sets out a coordinated response for tobacco control by all jurisdictions in Australia.

In line with the key strategy areas of the National Tobacco Strategy, the focus areas of this *Plan* are:

- Community awareness and education
- Smoking cessation
- Availability and supply of tobacco products
- Marketing and promotion of tobacco products
- Tobacco product regulation
- Exposure to environmental tobacco smoke.

Priority population groups within the *Plan* are children, young people, Aboriginal and Torres Strait Islander people, non-English speaking background communities with high smoking rates and people with mental illness.

The *Plan* describes milestones for achievement for the years 2001 and 2002. After this, achievements will be reviewed and future directions and priorities determined for the remaining life of the *Plan*.

The successful implementation of this *Plan* is dependent on collaboration with key stakeholders.

Coordinating and monitoring the implementation is the role of the NSW Health Department.

1 Why a NSW tobacco action plan?

1. Introduction

Tobacco smoking is the greatest single cause of premature death in Australia and is a leading preventable cause of morbidity[1]. As a result, leading international, national and state governments and health agencies have facilitated tobacco control policies and initiatives to address this issue and reduce the harm associated with tobacco use.

Evidence of the harm associated with exposure to tobacco smoke, and particularly by children and young people, has accumulated since the early 1970s[2]. Leading medical, health and research organisations have produced documents to support the need for governments throughout the world to develop policies, legislation and action plans to protect their communities from environmental tobacco smoke exposure.

The purpose of the *NSW Tobacco Action Plan 2001–2004* is to provide the strategic direction for the implementation of a range of tobacco control initiatives to reduce tobacco related harm in New South Wales.

2. International tobacco control strategies and initiatives

Numerous expert advisory groups have developed tobacco control policies over the past three decades and these include the World Health Organisation, the International Union Against Cancer and the United States' Surgeon General.

In July 1998, the World Health Organisation established the Tobacco Free Initiative to coordinate an improved global strategic response to tobacco as an important public health issue. The long-term mission of global strategic control is to reduce smoking prevalence and tobacco consumption in all countries and among all groups and thereby reduce the burden of disease caused by tobacco[3].

In support of this mission, some of the goals of the Tobacco Free Initiative are to:

- galvanise global support for evidence-based tobacco control policies and actions
- build new and strengthen existing partnerships for action
- mobilise adequate resources to support action
- integrate tobacco into the broader agenda of health and development
- facilitate the development of an effective Framework Convention for Tobacco Control and related protocols.

3. National tobacco control strategies and initiatives

National Tobacco Strategy

A National Tobacco Strategy 1999–2002/03[4] has been developed in response to calls from the World Health Assembly for the implementation of comprehensive tobacco control strategies and to provide Australia with a commitment to a comprehensive approach to tobacco control in the future. As well, the National Tobacco Strategy recognises that future successful action in tobacco control hinges upon coordinated and comprehensive national action. It provides a guide for jurisdictions in Australia to identify and respond to their needs and priorities.

The National Tobacco Strategy has the following goal:

- To improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms.

The National Tobacco Strategy has the following objectives:

- prevent the uptake of tobacco use in non smokers, especially children and young people
- reduce the number of users of tobacco products
- reduce the exposure of users to the harmful health consequences of tobacco products
- reduce exposure to tobacco smoke.

The National Tobacco Strategy identifies six key strategy areas, namely:

1. strengthening community action
2. promoting cessation of tobacco use
3. reducing availability and supply of tobacco products
4. reducing tobacco promotion
5. regulating tobacco products
6. reducing exposure to environmental tobacco smoke.

The National Tobacco Strategy provides a framework against which NSW can benchmark its own tobacco control activity, collaborate with other jurisdictions and contribute to a coordinated and comprehensive national action on tobacco.

4. Previous NSW tobacco control strategies and initiatives

In May 1995, the NSW Tobacco and Health Strategy 1995–1999[5] was introduced. The overall goal of the Strategy was to improve the health of the people of New South Wales by eliminating or reducing their exposure to tobacco in all its forms.

The Strategy focused on four key issues:

1. marketing of tobacco products
2. availability of tobacco products
3. passive smoking
4. smoking cessation.

Major achievements under this Strategy were:

- introduction of mandatory proof of age for the sale of tobacco in 1996
- introduction of a comprehensive sales to minors program, with compliance monitoring
- more than 125 successful prosecutions for sales to minors, with more than 90% of these since 1995
- review in 1995-96 of the Tobacco Advertising Prohibition Act 1991, with the introduction of tougher tobacco advertising laws under the Public Health Amendment (Tobacco Advertising) Act 1997 and Public Health (Tobacco) Regulation 1999
- review of the Business Franchising Licensing (Tobacco) Act 1987 in 1996 (although this system was subsequently disbanded in 1997 following a High Court decision)
- introduction of a per stick calculation of tobacco taxation in 1999, resulting in an increase in the price of cigarettes
- NSW support for the very successful National Tobacco Campaign, including media buys, development of resources, grants to Area Health Services and extra funding for the Quitline.

5. Tobacco control and public health

Healthy People 2005 – New Directions in Public Health in NSW

The scope of this *Plan* conforms to the Government's document Healthy People 2005 – New Directions in Public Health in NSW[6]. The comprehensive public health plan has the vision of *'Better health for all people in NSW through effective public health action to maintain, protect and promote health'*. To achieve this vision the document sets out five public health principles:

1. Population focus

- aims to improve the health of the community

2. Focus on prevention, promotion and early intervention

- tackles the things that can add years to life and quality life to years

3. Work in partnership

- works with local communities and other agencies (see Working in partnership, right)

4. Reduce health inequalities

- works to reduce the differences in health between sections of the community

5. Effective and sustainable action

- uses the best scientific information about approaches – what works and what doesn't
- uses the best mix of approaches to get the best value for money invested

To achieve this vision the document also describes a comprehensive framework for action, which is divided into three main streams of new health improvement initiatives:

1. healthier people
2. healthier places
3. reducing health inequalities

Working in partnership

Most health challenges confronting the community have their origins in socio-economic conditions, the social or physical environment or human behaviours. Accordingly, they are multifaceted and complex. The public health system cannot tackle them effectively without the formation of partnerships through a 'whole of government' approach. Such partnerships include, but are by no means restricted to:

- Area Health Services (especially Drug and Alcohol, Public Health Units and Health Promotion Units)
- Commonwealth Government
- Other NSW Government Agencies (Attorneys General, Gaming and Racing, Environmental Protection Agency, Department of Education and Training, Police, Corrective Services, Juvenile Justice)
- Local Government Authorities
- Non Government Organisations
- Aboriginal Health and Medical Research Council
- Aboriginal Health Partnership
- Multicultural Health Communication Service
- General Practitioners (medical)
- General Practitioners (dental)
- Pharmacists
- Professional associations
- University organisations
- Industry and Business
- Media.

6. Implementation of the NSW Tobacco Action Plan 2001-2004

The NSW Department of Health will undertake the coordinating role for the implementation and monitoring of the *NSW Tobacco Action Plan*. This will involve ongoing consultation with Area Health Services and other key organisations.

As part of the implementation of the *NSW Tobacco Action Plan*, Area Health Services will be expected to report on the following initiatives:

- development of Area Tobacco Action Plans
- designation of appropriate funds for the implementation of Area Tobacco Action Plans.

There are many organisations with relevant experience, expertise and community and professional links who have an interest in the *Plan*. The extent and nature of the involvement of stakeholders in each issue will vary. The document identifies key stakeholders involved in the implementation of strategies for each of the key issues. However, these lists are not exhaustive and should be viewed only as a guide.

2 Extent of tobacco related harm in NSW

1. Morbidity and mortality associated with tobacco use

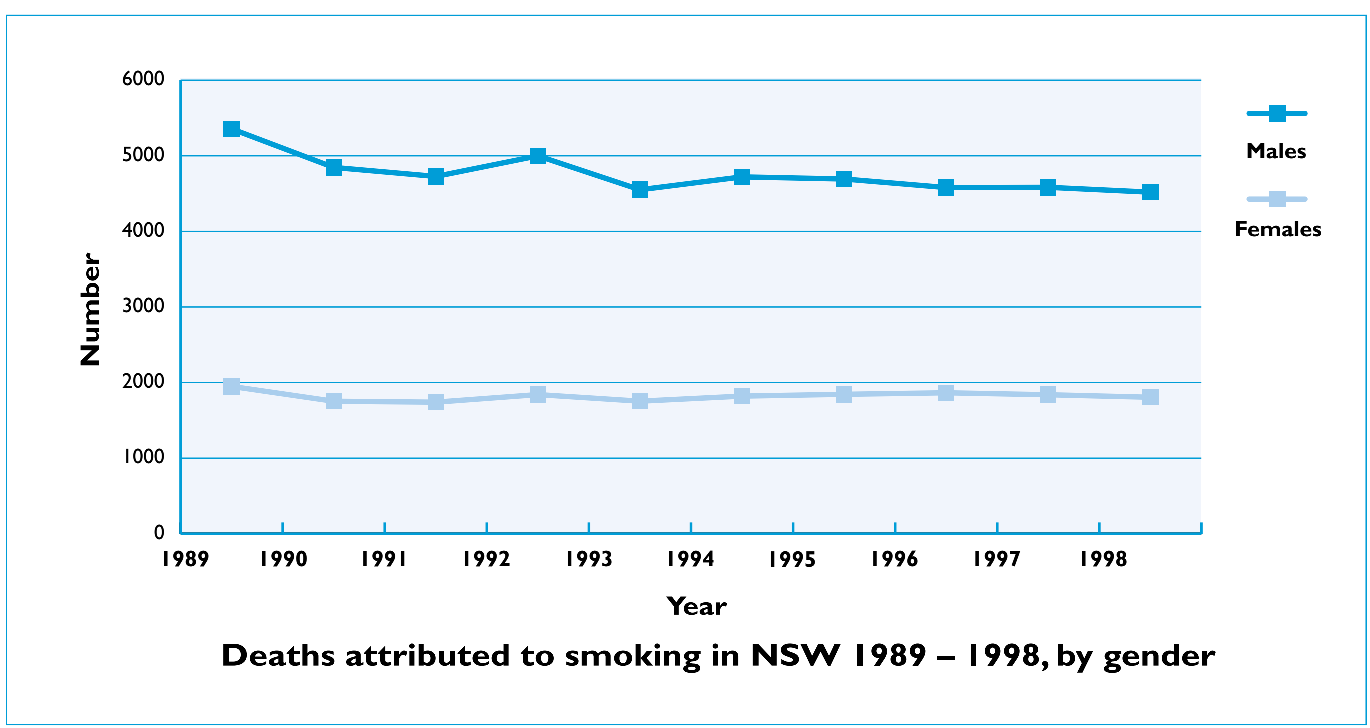
Tobacco smoking is estimated to kill approximately half of its long-term users[7]. It is a leading preventable cause of morbidity and premature mortality, particularly from cardiovascular disease, cancer and chronic obstructive pulmonary disease (COPD).

Mortality

In 1998, 19,000 Australians are estimated to have died from tobacco-related illnesses[8]. There were 6,551 tobacco related deaths in New South Wales in 1995[9]. In Australia, cigarette smoking causes around 40% of deaths of men and 20% of deaths of women before the age of 65 years. This includes 7,200 deaths from cardiovascular disease and 6,600 from cancer. Smoking is the cause of 30% of all cancers and 25% of heart disease[10]. Tobacco is also identified as the highest contributor of mortality and morbidity in the 35 years and over age groups. It is estimated that 50% of smokers will die prematurely due to their tobacco smoking[11].

From 1989/90 to 1997/98, New South Wales saw an overall decrease in the rate of deaths attributable to smoking, from 124 to 91 per 100,000 population. These figures conceal substantial differences between men and women. In 1989/90, smoking killed 217 men per 100,000 population but only 59 women. By 1997/98, these figures had decreased to 151 men per 100,000 and 46 women. Thus the overall death rate attributable to smoking among men has declined in this time by around 30%, while among women it has declined by 22%[12].

Between the mid 1970s and 1996, deaths from lung cancer rose by 94% in women and fell by 23% in men[13].



Deaths attributed to smoking in NSW 1989 – 1998, by gender

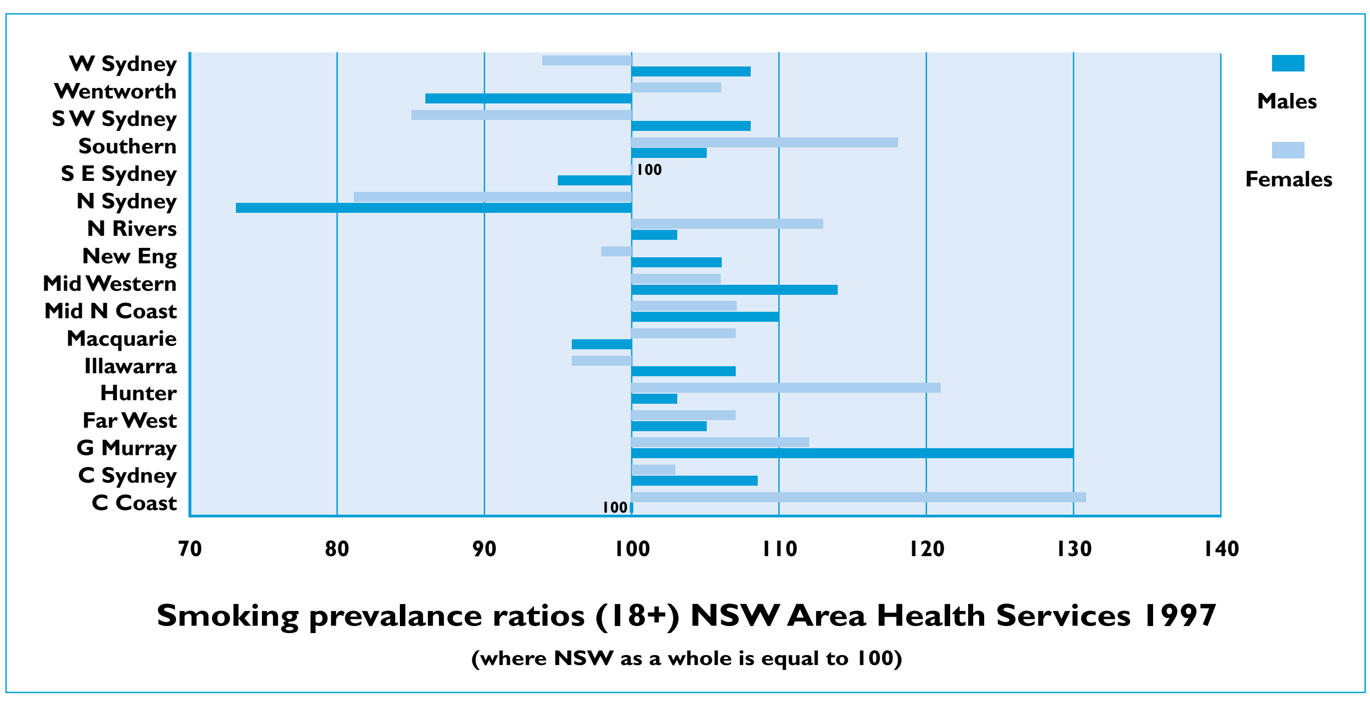
Source. The Health of the People of NSW – Report of the Chief Health Officer, 2000

Morbidity

In the Chief Health Officer's 2000 Report, NSW tobacco related hospital separations were quantified using aetological fractions for conditions caused by active cigarette smoking. These included various cancers (lung, oesophageal, oropharyngeal and cervical), cardiovascular diseases, chronic airways limitation, peptic ulcer, low birth weight and prematurity[14].

In NSW in 1997, the age-adjusted hospital separation rates for tobacco related conditions were 1127.8 per 100 000 for males and 514.1 per 100 000 for females, with nearly 54 000 hospital episodes[15].

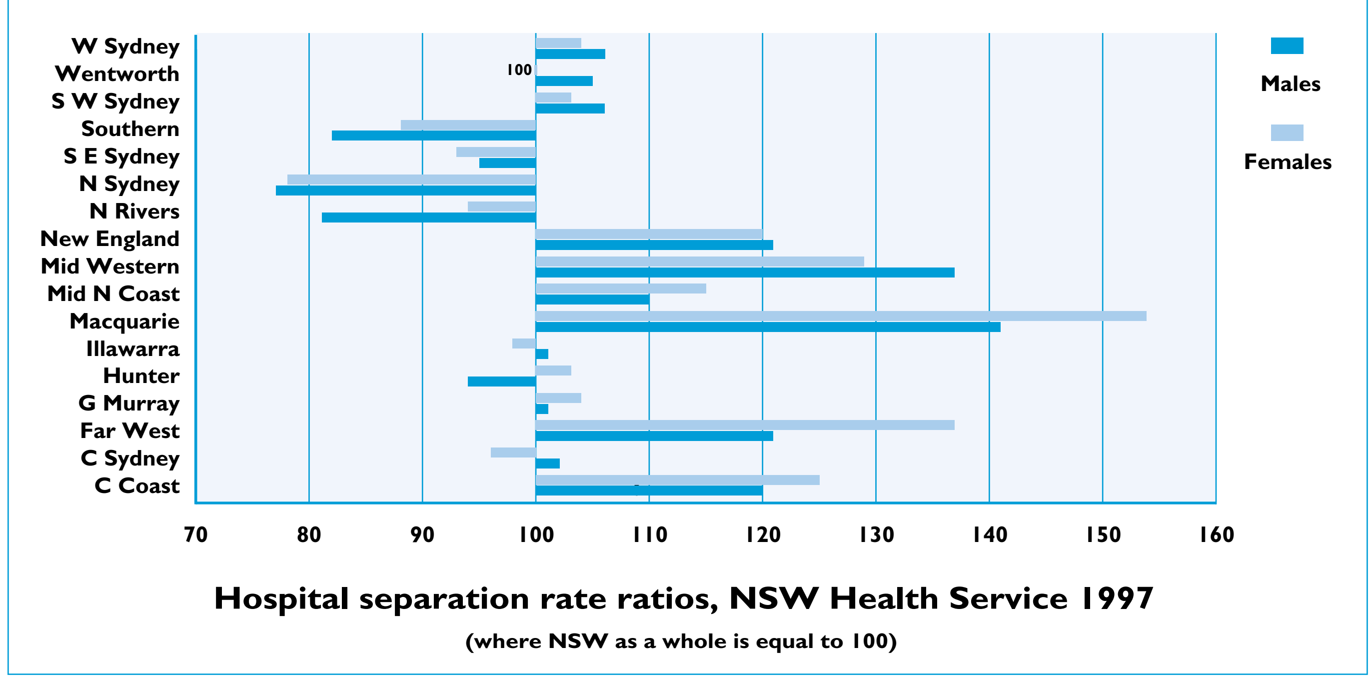
Age-adjusted smoking prevalence rates (where NSW as a whole is equal to 100) for each Area Health Service and age-adjusted hospital separation rates for tobacco related conditions, are provided in the graphs below.



Smoking prevalance ratios (18+) NSW Area Health Services 1997

(where NSW as a whole is equal to 100)

Source. NSW Health Survey 1997



Hospital separation rate ratios, NSW Health Service 1997

(where NSW as a whole is equal to 100)

Source. Area Health Service Health Status Profiles

Burden of disease

Tobacco is the risk factor associated with the greatest burden of disease in Australia. In 1996, it was responsible for about 9.7% (227,000) of Disability Adjusted Life Years (DALYs) – about 12% of the total burden of disease and injury in males and 7% in females.

Most of the burden of tobacco is found in lung cancer, chronic obstructive pulmonary disease (COPD) and ischaemic heart disease. Together they comprise almost 72% of the attributable burden of tobacco smoking and account for almost 7% of DALYs[16].

2. Annual cost of tobacco use

In 1992, it was estimated that the annual economic cost of tobacco use in Australia was $12.736 billion.

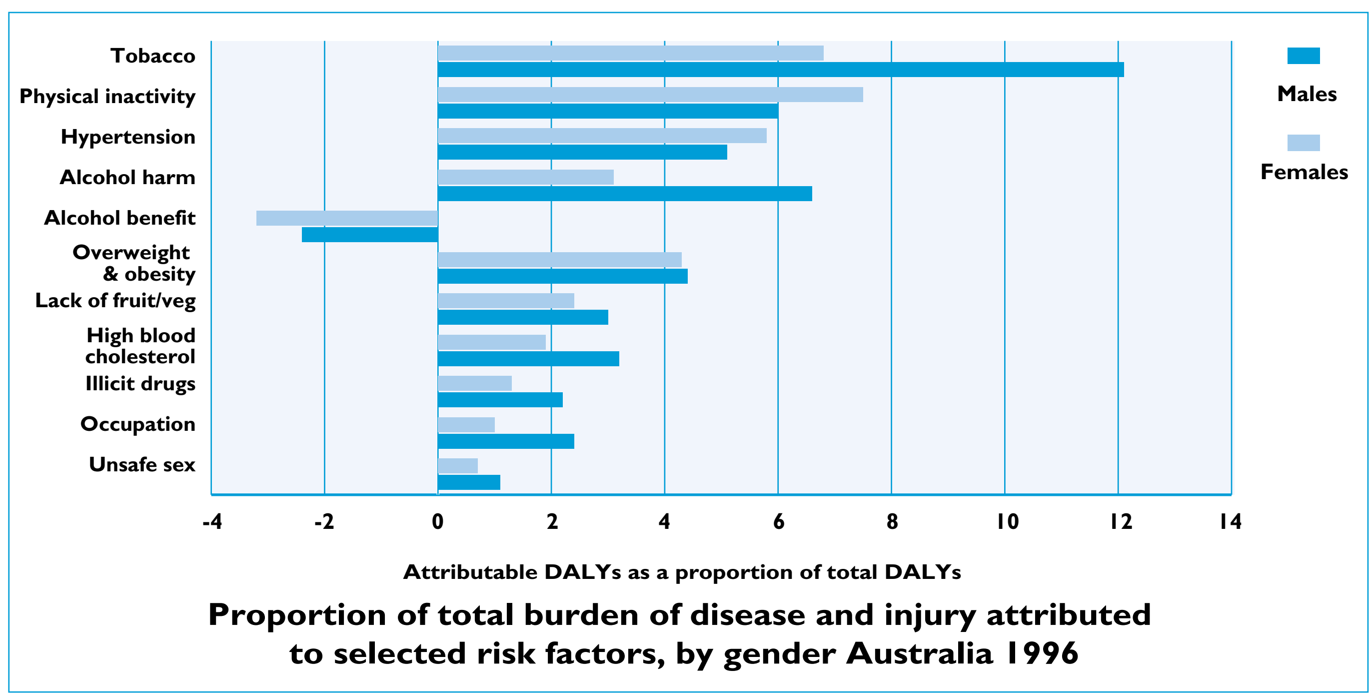
This constitutes tangible costs, which were:

- paid and unpaid production costs (lost productivity) less consumption benefits
- health care, including medical services, hospital bed days and nursing home bed days (taking into account costs and savings)
- resources used in addictive consumption (resources used in the production of abused drugs).

And intangible costs, which were:

- lost consumption of the deceased
- value of loss of life to the deceased.

In proportion to these national costs it was estimated that the annual economic cost of tobacco use for NSW was $4.340 billion[17].



Proportion of total burden of disease and injury attributed to selected risk factors, by gender Australia 1996

Source. Mathers et al (1999) The burden of disease and injury in Australia

3. The prevalence and nature of tobacco use in NSW

3.1 Prevalence of tobacco use by adults

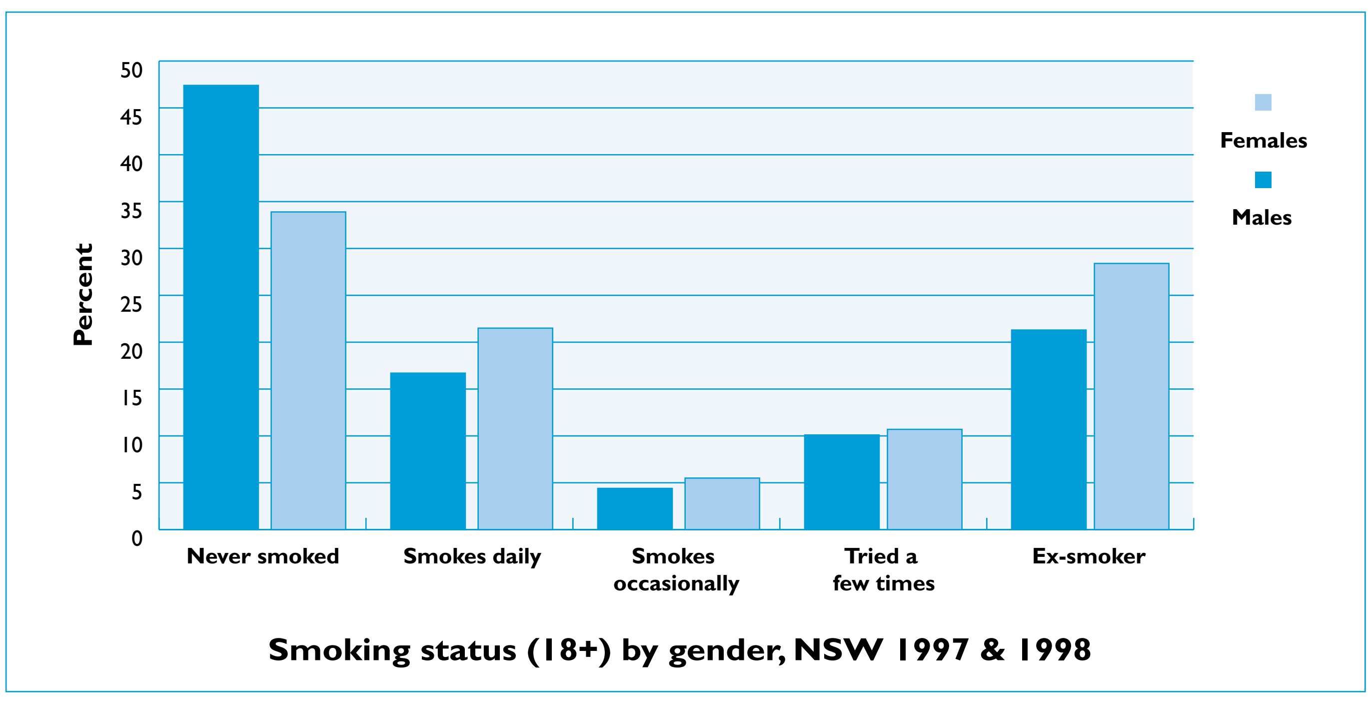
The NSW Health Survey 1997 and 1998[18] reported that current smoking rates were 27% for males and 21.1% for females. The Survey also found that current smoking was highest in the 25–34 year age group for males (35.3%) and the 18–24 year age group for females (31.4%) and that after these peaks, smoking rates decline with age. Males were more likely than females to report being current smokers in all age groups.

The following was also revealed regarding persons aged 18 years and over:

- 21% of males and 17% of females smoke daily
- 6% of males and 4% of females smoke occasionally
- 28% of males and 21% of females are ex-smokers
- 34% of males and 47% of females have never smoked.

3.2 Prevalence of tobacco use by young people

In 1996, for the first time, the Cancer Council's Secondary Students' Alcohol and Smoking Survey and the NSW Department of Health Survey of Drug Use by NSW Secondary Students were combined into one survey. Together they formed the NSW component of the national 1996 Australian School Students' Alcohol and Drugs Survey (ASSAD). The ASSAD Survey[19] estimated that in NSW, more than 30,000 (21%) female students and about 25,000 (19%) male students aged 12–17 had smoked in the last week (current smokers), and that the most vulnerable period for becoming a smoker was prior to 15 years, particularly for females.



Smoking status (18+) by gender, NSW 1997 & 1998

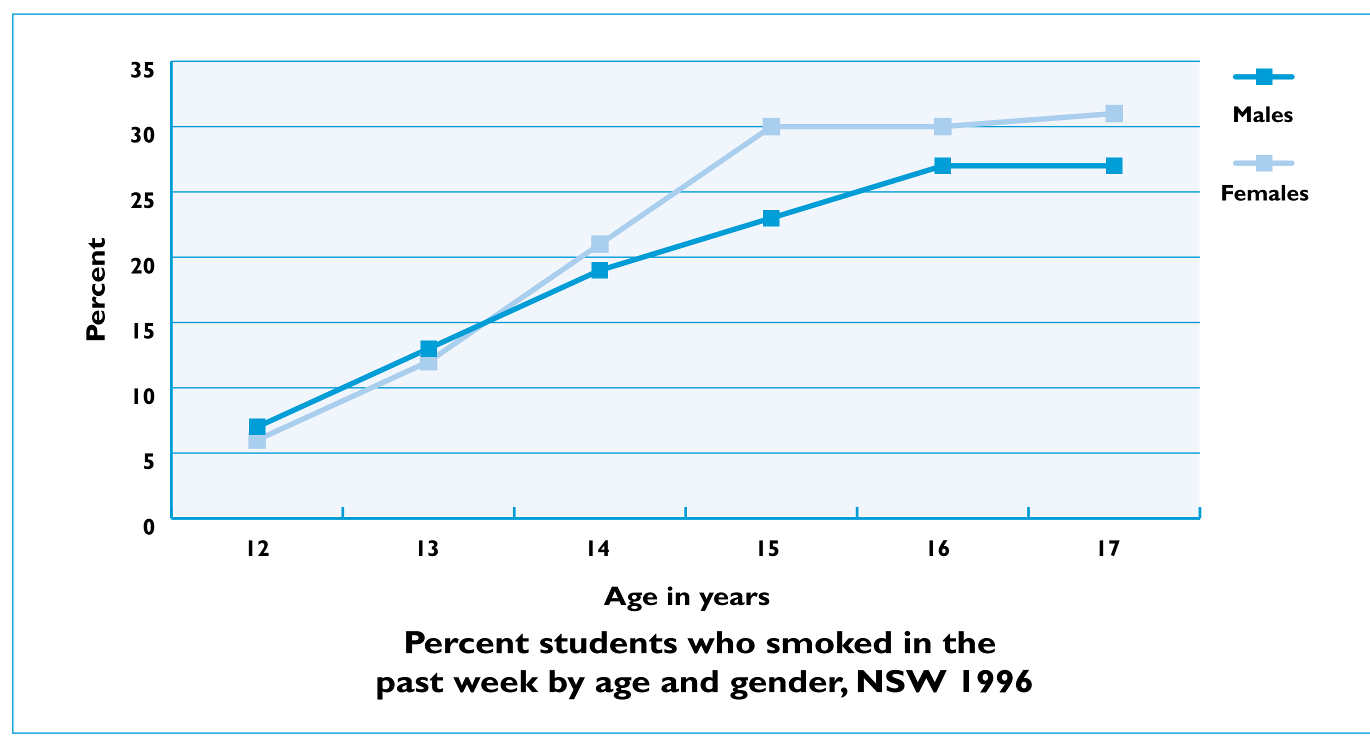
Source. ASSAD Survey (1996)

Nationally, smoking appears to have stabilised at around 16% for 12–15 year olds and 30% for 16–17 year olds, while the lowest prevalence for smoking in both these age groups was reached in 1990[20].

The results of the NSW Department of Health series of four triennial surveys of NSW secondary school students' drug use between 1983–1992 were compared to those of the 1996 ASSAD Survey.
For male students of any age group, there was very little difference between the 1992 and 1996 results. The findings for female students were similar. The prevalence of smoking at ages 15, 16 and 17 was considerably greater in 1983 than for any subsequent survey. The 1996 results were similar to those for 1992 and the increase between 1989 and 1992 (5%) appeared to have stabilised[21].

The 1996 ASSAD Survey report also stated that for both male and female students, there were more non-smokers in 1996 than in 1992. However, by the age of 17 years, there were less male non-smokers reported in 1996 (49%) than in 1992 (60%) and similar rates for 1992 and 1996 were reported for females (42%)[22].

The 1996 NSW Health Survey of Drug Use by Primary School Students[23] found that 18.5% of Year 5 and Year 6 students had tried smoking, compared with 24.8% in 1993[24]. Research conducted nationally in 1994 suggests that this age bracket is the period in which experimentation with smoking behaviours occurs[25].



Percent students who smoked in the past week by age and gender, NSW 1996

Source. Schofield WN, Lovelace KS, McKenzie JE, Burns L (1998) Self Reported Tobacco and Alcohol Use Among NSW Secondary School Students' Alcohol and Drugs Survey. NSW Cancer Council and NSW Health Dept Sydney.

3 Goal, objectives, focus areas, milestones and priorities of the NSW Tobacco Action Plan 2001–2004

1. Goal

The overall goal of the *NSW Tobacco Action Plan 2001–2004* is to improve the health of the people of New South Wales by eliminating or reducing their exposure to tobacco in all its forms.

2. Action Plan objectives

In accordance with the above goal, this *Action Plan* has the following broad objectives:

- prevent the uptake of tobacco use in non-smokers, especially children and young people
- reduce the number of users of tobacco products
- reduce exposure to tobacco smoke
- decrease the number of deaths and level of disease caused by smoking
- decrease the economic cost of tobacco-related illness.

3. Focus areas

In line with the key strategy areas of the National Tobacco Strategy 1999–2002/03, all strategies within this *Plan* are grouped into the following six focus areas:

1. Community awareness and education
2. Smoking cessation
3. Availability and supply of tobacco products
4. Marketing and promotion of tobacco
5. Tobacco product regulation
6. Exposure to environmental tobacco smoke

4. Milestones

Development of this *Plan* has led to the successful introduction of a number of key strategies in 2000. These achievements, outlined in table 1, provide a firm basis for the ongoing success of the *Plan*.

Table 1. Achievements for 2000

Focus Area	Strategies
1	Public Education Campaigns conducted (1.1.1)
1	NSW Tobacco Control Network established (1.2.4)
1	Pilot project in schools undertaken (1.3.9)
2	Quitline service continued (2.1.1)
3	Tobacco sales to minors program continued (3.1.1, 3.1.2)
3	Enforcement of tobacco related legislation enhanced (3.1.3)
3	Public Health Act 1991 reviewed (3.1.7)
4	Tobacco advertising legislation implemented (4.1.1, 4.1.2)
1, 4	Education and training conducted (1.2.1, 4.1.4)
6	Smoke free public places legislation introduced and implemented (6.1.1)
6	NSW Health Smoke Free Workplace Policy commenced implementation (6.3.1)
6	Strategies to address exposure to environmental tobacco smoke in children developed and implemented (6.4.1)

Tables 2 and 3 feature a suggested time frame for strategies to be addressed in the years 2001 and 2002. At the end of 2002, a review of achievements will be conducted to advise directions for the remaining life of the *Plan*.

Table 2. Strategies 2001

Focus Area	Strategies
1	Public Education Campaigns conducted (1.1.1)
1	NSW Tobacco Control Network continued (1.2.4)
2	Quitline service continued and enhanced (2.1.1, 2.1.2)
1, 2	Appropriate strategies developed to reduce tobacco related harm to Aboriginal & Torres Strait Islander people (1.5.4, 2.2.1, 2.2.2)
1, 2	Appropriate strategies developed to reduce tobacco related harm to NESB groups with high smoking rates (1.5.4, 2.2.1, 2.2.2)
2	Appropriate strategies developed to reduce tobacco related harm to people living with a mental illness (2.3.4)
2	Strategies developed and implemented to improve services and resources available for those smokers seeking assistance to quit (2.1–2.5)
3	Tobacco sales to minors program continued (3.1.1, 3.1.2)
3	Enhanced enforcement of tobacco related legislation continued (3.1.3)
3	Policies and procedures for enforcing Section 59 of the Public Health Act, 1991 reviewed and updated (3.1.5)
3	Options for retailer licensing system reviewed (3.1.8)
4	Enforcement of tobacco advertising legislation continued (4.1.1)
1, 2, 4	Education and training conducted (1.2.1, 1.2.2, 1.2.3, 1.3.3, 2.3.2, 4.1.4)
6	Enforcement of smoke free public places legislation continued (6.1.1)
6	Implementation of the NSW Health Smoke Free Workplace Policy continued (6.3.1, 6.3.2)
6	Strategies to address exposure to environmental tobacco smoke in children developed and implemented (6.4.1)

Table 3. Strategies 2002

Focus Area	Strategies
1	Public Education Campaigns conducted (1.1.1)
1	NSW Tobacco Control Network continued (1.2.4)
2	Enhanced Quitline Service continued (2.1.1, 2.1.2)
3	Tobacco sales to minors program continued (3.1.1, 3.1.2)
3	Enhanced enforcement of tobacco related legislation continued (3.1.3)
3	Introduction of preferred retailer licensing system investigated (3.1.9)
4	Enforcement of tobacco advertising legislation continued (4.1.1)
1, 2, 4	Education and training conducted (1.2.1, 1.2.2, 1.2.3, 1.3.3, 2.3.2, 4.1.4)
5	Framework/model developed for the regulation of tobacco and nicotine products in collaboration with the Federal Government (5.1.1)
6	Enforcement of smoke free public places legislation continued (6.1.1)
6	Implementation of the NSW Health Smoke Free Workplace Policy continued and review conducted (6.3.1, 6.3.2)
	Review conducted of the first years of NSW Tobacco Action Plan 2001-2004
	Milestones developed for the remainder of the life of the Plan

5. Priorities

Strategies for achieving the goal and objectives are located in section four. Under each focus area, the strategies are listed in order of priority.

5.1 Reducing smoking prevalence

Reducing the number of people who use tobacco will result in reduced tobacco related death and disease (and associated health costs) among both the users and others who are exposed to their tobacco smoke. The major target of this strategy therefore, is to reduce smoking prevalence in NSW.

The recent National Tobacco Campaign reduced smoking prevalence by an estimated 1.4% from June to December 1997. With adequate funding, an annual reduction of 1% in the proportion of adult smokers could be considered a key indication of the success of a focussed anti-smoking campaign[26].

Reducing smoking prevalence

Rationale:

- *Reducing smoking prevalence in the general community will reduce death, disease and associated health costs*

Priority strategies to reduce tobacco related harm:

1. Reduce the harm associated with tobacco use through public education (1.1).
2. Ensure the continuation of effective Quitline services (2.1.1, 2.1.2).
3. Enhance the education of health professionals in relation to key tobacco issues and smoking cessation interventions (1.2.1, 1.2.2, 1.2.3, 2.3.2).
4. Implement legislation to address smoking in enclosed public places (6.1.1).

5.2 Target groups

The *NSW Tobacco Action Plan 2001–2004* recognises the importance of developing specific strategies to target a range of priority population groups. The following groups have been identified in response to their higher prevalence of smoking and their greater susceptibility to tobacco related illness.

- children
- young people
- Aboriginal and Torres Strait Islander populations
- non-English speaking background communities with high smoking rates
- people with mental illness.

Strategies targeting these priority groups are included in each of the focus areas outlined in section four. The section following summarises the strategies that aim to meet the specific needs of these groups. Relevant strategies in section four are referenced in parentheses.

5.2.1 Children

The World Health Organisation (WHO) has reported that exposure to environmental tobacco smoke (ETS) leads to a wide range of adverse health effects in children. Children whose mothers smoke have 70% more respiratory problems and the prevalence is 30% higher if the father smokes[27].

The 1995 National Drug Strategy Household Survey estimated that approximately 1.7 million children aged 0-7 years were potentially exposed to tobacco smoke in the home[28].

The NHMRC (1997)[29] has concluded that passive smoking:

- is associated with an increased risk of sudden infant death.
- contributes to the symptoms of asthma in 46,500 Australian children each year.
- causes lower respiratory illness in more than 16,000 Australian children each year.
- results in a 60% increase in the chance that a child will develop lower respiratory illnesses such as croup, bronchitis, bronchiolotis and pneumonia during the first 18 months of life.
- is associated with an increased risk of glue ear (otitis media) in children, which is a common cause of hospital admission in early childhood and may result in long term problems.

One quarter of cases of low birth weight are attributable to maternal smoking during pregnancy,[30] adding to the costs of neonatal services.

The Australia Institute of Health and Welfare reported that respiratory conditions like asthma were the main causes for hospitalisations of children in Australia[31]. It also stated that in 1995, 16% of children under 15 years were reported to suffer from long term asthma.

Children are put at further risk because their parents' smoking increases the likelihood that they themselves will take up smoking[32].

Children

Rationale for prioritising this group:

- *Social justice – protecting those who cannot protect themselves from tobacco related harm.*

Priority strategies to reduce tobacco related harm among this group:

1. Address exposure to environmental tobacco smoke (ETS) in the home (6.4.1–6.4.3).
2. Enhance training in tobacco issues for people who work with children and young people (1.3.3).
3. Conduct public education campaigns with an ETS focus (1.1.3).
4. Promote positive non-smoking role models (1.3.9).

5.2.2 Young people

Research indicates that initiation into smoking behaviour is well established before the end of the teenage years. Surveys of smokers show that approximately 90% begin using tobacco by the age of 20 years[33].

It is also known that the earlier the onset of smoking, the earlier the risk of smoking related disease and the higher this risk is likely to become in a smoker's lifetime[34]. Similarly, the age of onset of smoking is an important predictor of success in quitting. The younger a person is when they start to smoke the less likely it is that they will ever cease[35].

On average, smokers who begin smoking in adolescence and continue to smoke regularly have a 50% chance of dying from tobacco. Half of these will die in middle age, before the age of 70 years, losing around 22 years of normal life expectancy[36].

Throughout Australia, youth smoking rates are causing increasing concern. Research has confirmed that the decline in adolescent smoking seen in the late 1980s has stopped. This is not unique to Australia and reflects trends in other western countries[37]. In NSW, smoking rates among male and female students appear to have stabilised, and there is evidence of a continuing trend for more females to take up smoking than males[38].

Discouraging young people from starting to use tobacco will impact on future tobacco related death and disease. Results of the Review by the US Surgeon General (1994) suggest that a coordinated, multi-component campaign involving policy changes, taxation, mass media and behavioural education can effectively reduce the onset of tobacco use among adolescents[39].

Young people

Rationale for prioritising this group:

- *Discouraging uptake of smoking to prevent long term addiction*
- *Reducing tobacco related disease and death*

Priority strategies to reduce tobacco related harm among this group:

1. Conduct public education campaigns targeting young people (1.3.1).
2. Provide telephone line support for young and potential smokers (1.3.2).
3. Implement effective sales to minors legislation (3.1.1–3.1.7).
4. Enhance training in tobacco issues for people who work with young people (1.3.3).
5. Address exposure to environmental tobacco smoke (ETS) in the home (6.4.1–6.4.3).
6. Implement effective tobacco advertising legislation (4.1).
7. Implement legislation to address smoking in enclosed public places (6.1.1).

5.2.3 Aboriginal and Torres Strait Islander populations

It is well documented that indigenous people have the poorest health in Australia. The following problems all occur more frequently among indigenous populations:

- stillbirths
- low birth weight
- infant mortality
- probability of dying between 20 and 54 years of age
- diabetes mellitus
- hospital separations
- myocardial infarction
- respiratory disease[40]

The National Drug Strategy Household Survey (1994)[41] revealed that more than half of Aboriginal and Torres Strait Islander adults were smokers compared to less than one-third of the non-Aboriginal adult population. In New South Wales, the NSW Health Survey 1997 & 1998 found the current smoking rate among indigenous people aged between 18 and 24 was 58%, compared with 33% in the same age group among non-indigenous people. Across all age groups (18+), the current smoking rate among indigenous people in NSW was 42%, compared with a rate of 24% for non-indigenous people[42].

This trend is more pronounced in rural areas. A survey carried out in Orana and Far Western New South Wales among the Aboriginal and non-Aboriginal people of Wilcannia in 1989[43] found that 75.8% of Aboriginal males and 68.7% of Aboriginal females aged 20-69 were current smokers compared to 40% of the non-Aboriginal population. A survey carried out in rural Victoria[44] compared smoking rates of Aboriginal and non-Aboriginal people living in two separate towns. The study found that 73.8% of Aborigines aged 13-54 were current smokers, compared with only 24.1% of non-Aborigines in the same age group.

Aboriginal and Torres Strait Islander populations

Rationale for prioritising this group:

- *High smoking rates*

Priority strategies to reduce tobacco related harm among this group:

1. Increase awareness of the harms associated with tobacco use and ETS (1.1.1–1.1.3, 1.3.10, 1.5.4, 6.4.2, 6.4.3).
2. Provide training in tobacco issues for people who work with Aboriginal people (1.2.1, 1.2.2, 2.3.2, 2.5.1).
3. Provide appropriate cessation services (2.2.1, 2.2.2).
4. Improve awareness of and access to appropriate cessation services (2.1.5, 2.1.6, 2.4.1).

5.2.4 Non-English speaking communities with high smoking rates

Smoking rates among non-English speaking background (NESB) communities vary from well below the NSW average (especially among females) to rates of around 44% among Vietnamese males and 43% among Lebanese males[45].

NESB communities with high smoking rates

Rationale for prioritising this group:

- *High smoking rates*

Priority strategies to reduce tobacco related harm among this group:

1. Increase awareness of the harms associated with tobacco use and ETS (1.1.1–1.1.3, 1.5.4, 6.4.2, 6.4.3).
2. Provide training in tobacco issues for people who work with NESB communities with high smoking rates (1.2.1, 1.2.2, 2.3.2, 2.5.1)
3. Provide appropriate cessation services (2.2.1, 2.2.2).
4. Improve awareness of and access to appropriate cessation services (2.1.5, 2.1.6, 2.4.1).

5.2.5 People with mental illness

There is a high proportion of smokers among people with mental illness. High prevalence rates have been reported for people with depression and anxiety disorders. On average, smoking is three times more prevalent among people with schizophrenia, than among the general population[46].

Smokers are more likely to have both depressive symptoms and depressive disorders. Although depression may not bring about the initiation of smoking, people with these conditions are more likely to progress to more regular use. Depressed smokers may also have more difficulty quitting. Generalist smoking cessation services are often uninformed and ill equipped to deal with some of the special issues faced by people with mental illness[47].

Research in this area has been limited and has focussed on the biological interaction of smoking and mental illness rather than the psychological and social issues involved. Nicotine is known to have some beneficial effect on some mental illness (schizophrenia) and issues such as self medication must be understood in promoting less health-damaging coping strategies.

People with mental illness

Rationale for prioritising this group:

- *High smoking rates*

Priority strategies to reduce tobacco related harm among this group:

1. Develop, implement and evaluate appropriate strategies to reduce tobacco related harm for people with mental illness in the health system. Strategies could include:
   - formation of a reference group including mental health physicians and other relevant stakeholders to oversee appropriate strategies
   - professional development of staff in treatment and cessation protocols
   - improving access to cessation pharmacotherapies (2.2.4).

4 Strategies for implementation

A note about timeframes

It must be stressed that the timeframes provided for the strategies on the following pages are in many cases merely suggested timeframes for commencement of the strategies. The different priorities of organisations will also dictate which strategies are addressed at what time. Strategies seen as ongoing are represented by the presence of arrows in the following year. Strategies that must occur in each of the three years are highlighted at the front of the *Plan* under 'Milestones'.

Focus Area 1 Community awareness and education

1. Definition

This focus area is intended to incorporate those strategies that influence and affect the community's awareness of the health effects of tobacco use.

2. Outcomes

Outcomes to be achieved for priority groups and the general population are:

- an increase in community awareness of the health effects of tobacco use
- a reduction in the proportion of the population who smoke on a regular basis
- an increase in the proportion of the population who have never smoked regularly.

3. Supporting evidence

The provision of information to the public and targeted groups is of vital importance in raising community awareness of tobacco control issues and the health effects of tobacco use. Public education and information programs form the core of a comprehensive tobacco control program and are described in a broad body of literature.

Information campaigns can:

- raise public awareness about smoking and health
- persuade smokers to give up smoking
- influence non-smokers to remain non-smokers
- create awareness that smoking is neither a normal nor a majority behaviour[48].

Such campaigns can also be useful in informing the public about new legislation, and for helping to create a climate of opinion about such issues.

Public education programs utilising broad mass media approaches have reported significant results in terms of impact on smoking prevalence as well as positive effects on different population groups[49, 50]. Combinations of advertising, community education, the provision of services and professional information and training are important for achieving the desired campaign results.

A reduction of 1% per annum in the proportion of adult smokers could be considered a key indication of the success of a cessation focussed anti-smoking campaign[51].

New South Wales has been a leading voice in the development of tobacco control public education activities in Australia. The first large-scale public education program in Australia (Quit. for life Campaign) was initiated by the NSW Department of Health in 1983. This saw the introduction of the 'Sponge' campaign, the evaluation of which concluded that anti-smoking public education campaigns had a significant downward effect on smoking rates. An immediate drop of more than 2% in male and female smoking prevalence was found. Thereafter, the campaign continued its efforts and intensified its activities in schools, organisations and the community and maintained regular advertising schedules on television, radio and in print. The evaluation and monitoring studies of the campaign reported an annual decline of about 1.5% particularly among males[52, 53]. Prior to these campaign initiatives there had been no observable trend in changes in smoking rates.

More recently, the success of the National Tobacco Campaign, 'Every cigarette is doing you damage', has confirmed the efficacy of undertaking campaigns which combine public education with supporting local activity. This campaign has evoked reactions from smokers at a level unsurpassed by any previous Australian anti-smoking campaign (with the possible exception of the 1983 Sponge advertisement). It has reached more than 80% of the target group and, most encouraging of all, has led to a drop in smoking prevalence of 1.8%[54].

4. Role of the NSW Quit Campaign

The NSW Tobacco and Health Strategy 1995-1999 identified the NSW Quit Campaign as a key organisation for the delivery of public education initiatives, and under the Tobacco Action Plan this role is maintained.

The NSW Quit Campaign provides NSW Health with a framework for using mass communication strategies in the areas of:

- promoting and assisting cessation of tobacco use
- maintaining the non-smoking status of young people
- reducing the exposure of environmental tobacco smoke in the community.

The NSW Quit Campaign will achieve its aims by undertaking responsibility for the planning, development, implementation and evaluation of specific public education strategies consistent with the National Tobacco Strategy 1999–2002/3 and this document.

5. Strategies for implementation

The following table outlines objectives, strategies and partnerships for addressing tobacco related harm in this focus area.

Focus Area 1	Community awareness and education		
2000	**2001**	**2002**	**Partners**
1.1 Increase the level of public awareness of the harm associated with tobacco use and tobacco smoke			
Develop and implement a comprehensive public education strategy to support the National Tobacco Campaign with supporting resources for specific target groups (1.1.1) Ensure that the public education strategies are complemented by strategies to address the cultural and ethnic diversity of the community where appropriate (1.1.2)	→	→	NSW Department of Health, NSW Quit Campaign, Alcohol and Other Drugs Information Service (ADIS), Area Health Services, Aboriginal Health Partnership, NSW Multicultural Health Communication Service
	Develop and implement a comprehensive public education strategy to support National or State campaigns with an environmental tobacco smoke (ETS) component or focus (1.1.3)	→	NSW Dept of Health, NSW Quit Campaign, Area Health Services
1.2 Increase the level of awareness of the harm associated with tobacco use and tobacco smoke among workers in the tobacco control field			
Enhance education and training for Area Health Service professionals in relation to key tobacco issues (1.2.1)	→	→	NSW Dept of Health, Area Health Services, professional organisations, tertiary institutions, Non-Government Organisations (NGOs), Aboriginal Health Partnership, Aboriginal Health and Medical Research Council (AHMRC), Corrective Services
	Enhance education and training for non-Area Health Service health professionals in relation to key tobacco issues (1.2.2)	→	NSW Dept of Health, Area Health Services, professional organisations, tertiary institutions, NGOs, Aboriginal Health Partnership, AHMRC
	Convene State-based forums on relevant tobacco control issues (1.2.3)	→	NSW Dept of Health, NSW Quit Campaign, NGOs, Area Health Services
Establish a tobacco control network in NSW (1.2.4)			NSW Dept of Health, NSW Quit Campaign, NGOs, Area Health Services
Enhance coordination of planning for events in the tobacco calendar between key stakeholders to maximise the reach and effectiveness of messages (1.2.5)	→	→	NSW Dept of Health, NSW Quit Campaign, NGOs, Area Health Services

Focus Area 1	Community awareness and education		
2000	**2001**	**2002**	**Partners**
1.3 Increase the level of young people's awareness of the harm associated with tobacco use. Decrease the desirability to young people of taking up and continuing smoking. Increase the effectiveness of programs aimed at the prevention of tobacco use by young people.			
	Develop and implement a comprehensive public education strategy to support National or State campaigns targeting young people and parents (1.3.1)	→	NSW Dept of Health, ADIS, NGOs, Area Health Services
	Investigate the feasibility of establishing a telephone service to address youth smoking issues and aimed at young and potential smokers and parents (1.3.2)		NSW Dept of Health, ADIS, NGOs, Area Health Services
	Provide education and training in tobacco issues for people who work with young people (1.3.3)	→	NSW Dept of Health, NSW Department of Education and Training (DET), private and independent schools, Area Health Services, NGOs
Encourage comprehensive tobacco education programs in primary and secondary schools, incorporating current evidence regarding smoking facts and child behaviour (1.3.4)	→	→	DET, private and independent schools, NSW Dept of Health
		Support tobacco education programs in primary and secondary schools with complementary community strategies (1.3.5)	DET, private and independent schools, NSW Dept of Health, Area Health Service, NGOs
		Monitor research into the area of school-based tobacco education and supporting programs (1.3.6)	DET, private and independent schools, NSW Dept of Health, Area Health Service, NGOs
		Implement strategies to raise awareness on tobacco issues at TAFE institutions (1.3.7)	DET, NSW Dept of Health
		Develop community based tobacco control initiatives targeting young people outside the school system (1.3.8)	NSW Dept of Health, Area Health Services, NGOs, Juvenile Justice
Undertake a pilot project in schools in relation to the promotion of positive non-smoking role models (1.3.9)			NSW Dept of Health, DET, Area Health Services
Develop and implement strategies to address tobacco related harm among Aboriginal young people (1.3.10)	→		NSW Dept of Health, Aboriginal Health Partnership, AHMIRC, Area Health Services

Focus Area 1	Community awareness and education		
2000	**2001**	**2002**	**Partners**
1.4 Maintain the provision of effective resources available to the community on the health effects of tobacco use			
Continue the development of resources in support of public education campaigns including those that target priority groups (1.4.1)	→	→	NSW Dept of Health, NSW Quit Campaign, Area Health Services, ADIS, Multicultural Health Communication Service
Ensure the ongoing evaluation of the effectiveness of resources (1.4.2)			NSW Dept of Health, Area Health Services
1.5 Increase the accessibility of information regarding the health effects of smoking			
	Review dissemination strategies for the distribution of resources on the health effects of tobacco use (1.5.1)		NSW Dept of Health, NSW Quit Campaign, Area Health Services
Investigate the feasibility of promoting resources through other mediums eg: Internet and implement accordingly (1.5.2)	→	→	NSW Dept of Health, NSW Quit Campaign, Area Health Services, ADIS
	Ensure that resources and information are available in accessible formats and mediums to special needs groups within the community eg: developmentally delayed, low literacy, visually impaired etc (1.5.3)	→	NSW Dept of Health, NSW Quit Campaign, Area Health Services, ADIS, Corrective Services, Juvenile Justice
	Ensure that resources and information are available in accessible formats and methods to particular target groups eg: ATSI communities and NESB communities with high smoking rates (1.5.4)	→	NSW Dept of Health, NSW Quit Campaign, Aboriginal Health Service, Area Health Services, ADIS
1.6 Increase community understanding and support for tobacco legislation			
Conduct information campaigns about issues pertaining to existing or planned tobacco legislation (1.6.1)	→	→	NSW Dept of Health, NSW Quit Campaign, Area Health Services, ADIS

Focus Area 2 | Smoking cessation

1. Definition

This focus area is intended to incorporate those strategies that promote smoking cessation interventions and opportunities, aimed at current smokers.

2. Outcomes

Outcomes to be achieved for priority groups and the general population are:

- a reduction in the proportion of the population who smoke on a regular basis
- an increase in the proportion of smokers who are taking definite action to stop smoking
- an increase in the proportion of smokers who successfully cease smoking
- an increase in the awareness within the community of the benefits of smoking cessation
- an increase in the number of quit attempts by smokers
- an increase in the range and number of health and other professionals with the information, skills and resources required to help smokers in the community to quit smoking
- an increase in the accessibility of information and smoking cessation resources and services for the community and in particular, low–income earners, Aboriginal and Torres Strait Islander people and persons of non-English speaking backgrounds
- maintenance of the non-smoking status of non-smokers, including those who have recently quit.

3. Supporting evidence

Smoking cessation has major and immediate health benefits for men and women of all ages and a significant impact on the health and well being of our community. These benefits include[55]:

- former smokers live longer than continuing smokers.
- smoking cessation decreases the risk of lung cancer, other cancers, heart attack, stroke and chronic lung disease.
- women who stop smoking before pregnancy or during the first three to four months of pregnancy reduce the risk of a having a low birth weight baby to the level of risk among women who have never smoked.

Research also indicates that quitting at any age increases life expectancy, provided that quitting takes place prior to the development of cancer or other serious disease. Those who quit smoking before the age of 35 have a life expectancy that is not significantly different from non-smokers. Even those who stop between ages 65 and 74 experience age-specific mortality rates beyond age 75 years that are lower than those who continue to smoke[56].

Research also demonstrates that the majority of smokers want to quit. In Australia around 80% of smokers have made attempts to quit[57]. 1998 figures from the NSW Health Survey indicated that around 50% of male and female current smokers were planning on quitting in the next six months[58]. Successful cessation may take a number of attempts[59].

It has been suggested that the behavioural process of smoking cessation has four steps[60].

1. **Pre-contemplation**
   The smoker is not considering quitting.
2. **Contemplation**
   The smoker is aware of benefits of quitting, but is ambivalent about quitting and does not act.
3. **Action phase**
   The smoker is actively engaged in attempts to cease smoking.
4. **Maintenance**
   The smoker has achieved smoking cessation. During this stage the smoker may relapse and return to an earlier stage.

The Health Promotion Survey 1994[61] also found that 43% of smokers had made at least one quit attempt in the previous twelve months and that 18–29 year olds were most likely to have attempted to quit (47%). The Survey also highlighted that quit attempts were much higher and likely to be successful among women with two or more children.

Tobacco dependence shows many features of a chronic disease and the majority of smokers cycle through multiple periods of relapse and remission[62].

A body of international evidence now recommends that:

- clinicians and health care delivery systems institutionalise the consistent identification, documentation and treatment of every tobacco user.
- smokers willing to quit be provided with treatments identified as effective.
- smokers unwilling to quit be provided with a brief intervention designed to increase their motivation to quit.
- pharmacotherapies for smoking cessation should be used with all smokers attempting to quit (except where contraindicated).
- Treatments involving person to person contact (including pro-active telephone counselling) are consistently effective and their effectiveness increases with intensity (eg: minutes of contact)
- Tobacco dependence treatments are both clinically effective and cost effective relative to other medical and disease prevention interventions[63].

Pharmacotherapies

A range of medical products have been found to double the success rate of smokers who are trying to quit[63].

Nicotine replacement therapies (including patch, gum and inhaler) have been rescheduled to allow for over the counter sales at pharmacies and removal of advertising restrictions. It has been argued that this has resulted in dramatically increased quit attempt activity[64].

Bupropion hydrochloride (Zyban), is the first non-nicotine prescription-only medication approved for smoking cessation in Australia. It was launched in November 1999 and listed on the Pharmaceutical Benefits Scheme (PBS) in February 2000.

4. Strategies for implementation

The following table outlines objectives, strategies and partnerships for addressing tobacco related harm in this focus area.

Focus Area 2	**Smoking Cessation**		
2000	**2001**	**2002**	**Partners**
2.1 Ensure that smokers have a range of options to assist them to quit smoking			
Continue the Quitline service with appropriate resources for specific target groups (2.1.1)	→	→	NSW Dept of Health, NSW Quit Campaign, Area Health Services, ADIS
	Incorporate a call back facility into the Quitline service (2.1.2)	→	NSW Dept of Health, NSW Quit Campaign, ADIS
	Identify and promote evidence-based practice models of smoking cessation interventions (2.1.3)	→	NSW Dept of Health, research organisations, Area Health Services, NGOs, private health providers
	Ensure that a range of evidence-based practice smoking cessation interventions are provided throughout NSW (2.1.4)	→	NSW Dept of Health, Area Health Services, NGOs, private health providers
	Ensure the continual update of information about the provision of public and private cessation services throughout NSW (2.1.5)	→	NSW Dept of Health, NSW Quit Campaign, ADIS, Area Health Services, NGOs, private health providers
	Provide information to the public about the availability of these interventions (2.1.6)	→	NSW Dept of Health, Area Health Services, NGOs, private health providers, ADIS, AHMRC
	Monitor the effectiveness of one on one interventions for highly addicted smokers and the use of pharmacotherapies (2.1.7)	→	NSW Dept of Health, research organisations, NGOs, Area Health Services
Ensure the adequate availability of cessation services when running public education strategies and initiatives, including staffing of the Quitline (2.1.8)		→	NSW Dept of Health, NSW Quit Campaign, ADIS

Focus Area 2	Smoking Cessation		
2000	**2001**	**2002**	**Partners**
2.2 Increase the accessibility and appropriateness of smoking cessation services for priority target groups such as people from NESB, Aboriginal and Torres Strait Islander people, people with mental illness and young people			
	Develop and identify evidence-based models for cessation services for priority target groups such as people of NESB, ATSI communities and young people (2.2.1)	→	NSW Dept of Health, research organisations, Area Health Services, Multicultural Health Communication Service, AHMRC
	Ensure that appropriate cessation services are available for priority target groups, including coordinated resource development (2.2.2)	→	NSW Dept of Health, Area Health Services, Multicultural Health Communication Service, AHMRC
		Monitor research into alternative methods of addressing initiation into smoking in young people (2.2.3)	NSW Dept of Health, Area Health Services, NGOs
	Conduct research into appropriate strategies for reducing tobacco related harm among people with mental illness (2.2.4)	→	NSW Dept of Health, Area Health Services, NGOs
2.3 Increase the range and number of health professionals who have the skills, resources and organisational support to assist people to quit smoking			
	Explore and utilise mechanisms to involve health professionals and allied health workers in the delivery of evidence-based practice smoking cessation interventions and programs (2.3.1)	→	NSW Dept of Health, research organisations, Area Health Services, NGOs, professional bodies
	Provide information and training in evidence-based smoking cessation interventions to professionals such as GPs, dentists, pharmacists, nurses, midwives, drug and alcohol staff, youth workers, multicultural health workers, Aboriginal health workers, mental health workers, cardiologists, respiratory and stroke physicians and allied health professionals (2.3.2)	→	NSW Dept of Health, Universities and colleges, professional bodies, Area Health Services
		Expand the number of modules on tobacco issues and cessation approaches in undergraduate and graduate health related and teacher training courses (2.3.3)	NSW Dept of Health, universities and colleges

Focus Area 2	Smoking Cessation		
2000	**2001**	**2002**	**Partners**
2.3 Increase the range and number of health professionals who have the skills, resources and organisational support to assist people to quit smoking (cont.)			
		Ensure modules include skills development for those working with the targeted population groups (2.3.4)	NSW Dept of Health, universities and colleges
	Implement organisational strategies to support health service staff in the provision of brief advice (2.3.5)	→	NSW Dept of Health, Area Health Services
	Develop and implement systems for identifying smoking inpatients and the provision of appropriate interventions (2.3.6)	→	NSW Dept of Health, Area Health Services
Ensure that Quit kits are being upgraded to include current and relevant information (2.3.7)		→	NSW Dept of Health, NSW Quit Campaign
Ensure that health services have access to sufficient Quit kits to support the implementation of the NSW Health Smoke Free Workplace Policy (2.3.8)	→	→	NSW Dept of Health, NSW Quit Campaign
	Disseminate and publicise research and evidence-based practice in cessation (2.3.9)	→	NSW Dept of Health, NGOs, Area Health Services
2.4 Increase the incentives for smokers to quit smoking			
	Obtain information on barriers to smokers accessing quit smoking interventions eg: cost and availability (2.4.1)		NSW Dept of Health, NGOs, Area Health Services
	Develop strategies for improving the access of low income earners to cessation pharmacotherapies (2.4.2)	→	NSW Dept of Health, NGOs, Commonwealth Dept of Health and Aged Care
	Examine the cost effective provision of cessation pharmacotherapies to inpatients (2.4.3)	→	NSW Dept of Health, Area Health Services, pharmaceutical companies, private health care providers
		Encourage insurance companies to introduce lower premiums for non-smokers (2.4.4)	NSW Dept of Health, NGOs
		Encourage private health funds to cover smoking cessation services and techniques (2.4.5)	NSW Dept of Health, NGOs

Focus Area 2	Smoking Cessation		
2000	**2001**	**2002**	**Partners**
2.5 Decrease intra-uterine exposure to maternal active and passive smoking. Decrease infants' exposure to tobacco smoke			
	Disseminate evidence-based practice guidelines and training materials regarding smoking and pregnancy for relevant professionals in both English and community languages (2.5.1)	→	NSW Dept of Health, NGOs, Area Health Services, professional bodies, Multicultural Health Communication Services
	Develop strategies to promote smoking cessation among pregnant women/their partners and new parents (2.5.2)	→	NSW Dept of Health, NSW Quit Campaign, Area Health Services, NGOs
	Identify barriers preventing pregnant smokers and their partners accessing smoking cessation services and resources and develop strategies to address these (2.5.3)	→	NSW Dept of Health, Area Health Services

Focus Area 3 Availability and supply of tobacco products

1. Definition

This focus area is intended to incorporate those strategies that affect the availability and supply of tobacco products in the community.

2. Outcomes

Outcomes to be achieved for priority groups and the general population are:

- a reduction in the availability of tobacco products to the general community
- a reduction in the availability of tobacco products to young people
- a reduction in the supply of tobacco products to young people.

3. Supporting evidence

Tobacco is a legal product that has been freely available for much longer than its detrimental health effects have been known. However, the ready availability of tobacco products to young people and the general community is of concern.

Availability of tobacco products is influenced by a number of factors including:

- the price and affordability of tobacco products
- the distribution of tobacco products through retail outlets
- the accessibility of tobacco products to young people
- the supply of tobacco products to young people.

It can be seen that the availability of tobacco products relates to two concepts: **accessibility and affordability.**

Research demonstrates that access to tobacco products is an important factor in the uptake of smoking[65]. Self-reported data from the 1996 secondary school survey revealed that among 12 year old students who had smoked in the last week, almost 20% of males and 6% of females bought the last cigarette they smoked. At age 17, these figures rose to more than half of both males and females. For those young people who did not buy their own cigarettes, the most frequent source of obtaining them was from a friend[66].

Australian research confirms that programs of retailer education, enforcement of sales to minors legislation and well-publicised prosecutions do reduce selling rates[67]. In NSW, under section 59 of the Public Health Act 1991, it is an offence to sell tobacco to people under 18 years of age. NSW has had a comprehensive sales to minors program in place since 1996.

A localised example of the success of this program can be seen on the Central Coast. Prior to the commencement of the program, 31% of retailers sold to minors. Following several highly publicised prosecutions in that area, the number dropped to only 8%[68]. Ongoing efforts in this region resulted in 100% compliance with the law for the year 1998/99.

In 1998/1999 there was more enforcement and improved compliance with sales to minors legislation than previously recorded in NSW. More than 2700 store visits were made for the purpose of enforcing the legislation and on average 84% of retailers were found to comply with the legislation. In 1999/2000 2118 first visits were made to tobacco retailers and on average 82% of retailers complied with the legislation. These figures compare favourably to earlier studies, which indicated low rates of compliance with the legislation. For example, compliance rates in two areas of Sydney in 1994 and 1995 were as low as 48%[69] and 26%[70].

These results are also confirmed by international findings. For example, US intervention programs have shown that programs of merchant education, and the real threat of prosecution can lead to reductions in selling of up to 93%[71]. In California, a remarkable 96% compliance rate was achieved with education alone, but when officials made it clear that offending merchants would not be prosecuted, compliance fell to 11%[72].

Research also suggests that enforcing such legislation has a positive effect on rates of smoking among young people. Further to the experience on the Central Coast, results of a recent survey conducted there indicate that smoking rates among young people have decreased along with reduced sales to minors. The authors contend that this effect only occurs when a high level of retailer compliance (ie 90% and over) is achieved and maintained over a considerable time[73].

It is necessary to monitor the effectiveness of enforcement action and develop options for other mechanisms such as retailer registration. A system of retailer registration has the advantages of maintaining an up-to-date database of retailers while providing a source of revenue for enforcement.

Another influence on smoking behaviour is the cost of tobacco products. It is argued that price is a powerful determinant in an individual's decision to smoke. Price sensitive consumers will respond to increases in the price of cigarettes by either quitting or lowering their consumption[74]. Research shows that in general terms, a 10% price increase will, on average, reduce tobacco consumption by between 3 and 6%[75]. The relationship between price and consumption is even more pronounced for children and young people where a 10% increase will, on average, reduce demand by 14%[76].

It has been argued that reducing the affordability of tobacco products may have undesired outcomes for some groups within the community who have high rates of smoking combined with low income levels, who may continue to smoke. On the other hand, two studies[77, 78] (one from the UK, one from the US) have indicated that lower income groups are more responsive to price increases of cigarettes than higher income groups. That is, in these studies, as cigarettes became less affordable to lower income groups, consumption in these groups decreased, whereas in the higher income groups, such price increases had little or no effect.

4. Strategies for implementation

The following table outlines objectives, strategies and partnerships for addressing tobacco related harm in this focus area.

Focus Area 3 Availability and supply of tobacco products

2000	2001	2002	Partners
3.1 Decrease the availability of tobacco to young people through a decrease in illegal sales of tobacco			
Enforce section 59 of the Public Health Act 1991, including the sale of herbal cigarettes to under 18s (3.1.1)			NSW Dept of Health, Area Health Services
Monitor compliance with section 59 of the Public Health Act 1991 (minimum of 10% of tobacco retailers in each Area Health Service) and disseminate reports (3.1.2)			NSW Dept of Health, Area Health Services
Establish a Tobacco Legislation Compliance Group to ensure strategic enforcement of the Public Health Act 1991 and other tobacco-related laws administered by the NSW Department of Health (3.1.3)			NSW Dept of Health, Area Health Services
	Review the effectiveness of the sales to minors program on smoking rates and smoking behaviour (3.1.4)		NSW Dept of Health, Area Health Services, NGOs
	Review policies and procedures for enforcement of the Act (3.1.5)		NSW Dept of Health, Area Health Services
Encourage the involvement of Police and Local Government Authorities in enforcement of sales to minors legislation (3.1.6)			NSW Dept of Health, Area Health Services, Police, Local Government Authorities (LGAs)
Support the review of the Public Health Act 1991 to identify areas where it can be strengthened with specific consideration to be given to the following: • introducing restrictions to require sellers of tobacco to be 18 years of age • introducing third party supply offences • introducing infringement notices (3.1.7)			NSW Dept of Health, Area Health Services
	Review options for retailer licensing systems (3.1.8)		NSW Dept of Health, Area Health Services
		Introduction of preferred retailer licensing system investigated (3.1.9)	NSW Dept of Health

Focus Area 3	Availability and supply of tobacco products		
2000	**2001**	**2002**	**Partners**
3.2 Decrease the availability of tobacco to young people through an increase in retailer awareness, public awareness and public support for the legislation			
Continue to educate retailers about the law and provide s59 notices (3.2.1)	→	→	NSW Dept of Health, Area Health Services
Continue to publicise prosecutions to increase retailer and public awareness and support for the sales to minors program (3.2.2)	→	→	NSW Dept of Health, Area Health Services
	Monitor public awareness and support for the law (3.2.3)		NSW Dept of Health, Area Health Services
	Encourage the inclusion in school drug education of issues surrounding the sale of tobacco products to young people (3.2.4)	→	NSW Dept of Health, DET, private and independent schools, NSW Office of the Board of Studies
3.3 Decrease the availability of tobacco to young people through a decrease in supply of tobacco products			
	Continue to identify areas where young people access tobacco products and develop strategies to reduce availability in these areas (3.3.1)		NSW Dept of Health, Area Health Services, NGOs
3.4 Decrease the availability of tobacco through price increases			
		Monitor the effectiveness of tobacco price increases on consumption levels in NSW (3.4.1)	NSW Dept of Health, Area Health Services, NGOs
		Support the Commonwealth in the introduction of further progressive and deterrent price increases (3.4.2)	NSW Dept of Health, Area Health Services, NGOs
Investigate tax avoidance by retailers selling 'chop-chop' tobacco without paying tobacco excise (3.4.3)			NSW Dept of Health, Area Health Services, Australian Customs Service

Focus Area 4	Marketing and promotion of tobacco products

1. Definition

This focus area is intended to incorporate those strategies that restrict the marketing, placement and promotion of tobacco use, tobacco products, and tobacco brands in the community.

2. Outcomes

Outcomes to be achieved for priority groups and the general population are:

- a reduction in the marketing and advertising of tobacco products and tobacco brands
- a reduction in the promotion of tobacco products and tobacco brands
- a reduction in the marketing, advertising and promotion of tobacco use and consumption
- a reduction in the placement of tobacco products within the community.

3. Supporting evidence

As outlined previously, tobacco use is the leading cause of preventable death in Australia. Initiatives intended to restrict the marketing, placement and promotion of tobacco use are integral to a comprehensive tobacco control strategy.

The US Surgeon General has noted seven ways in which tobacco advertising and promotion could increase tobacco consumption[79]:

1. Advertising and promotion could encourage children or young adults to experiment with tobacco products and initiate regular use.
2. Advertising and promotion could increase tobacco users' daily consumption.
3. Advertising and promotion could reduce current tobacco users' motivation to quit.
4. Advertising and promotion could encourage former smokers to resume smoking.
5. Media dependence on advertising revenues from the tobacco companies may discourage full and open discussion of the hazards of tobacco use.
6. Financial dependence of organisations receiving tobacco company sponsorship may silence political opposition to measures designed to control advertising and promotion.
7. The ubiquity and familiarity of tobacco advertising and promotion may create an environment in which tobacco use is seen as not only acceptable but likely to be without hazard.

While it is difficult to determine the exact influence of tobacco product promotion on tobacco consumption, a report by the British Department of Health reviewed a broad body of published studies on the effects of tobacco advertising and concluded that "the preponderance of positive results showing an increase in consumption in response to advertising points to the conclusion that advertising does have a positive effect on consumption"[80].

In relation to the effect that tobacco product promotion has on children, it has been determined that children observe and recall cigarette advertising and promotions and that it has a greater impact on young people than on adults[81].

Research also demonstrates that children and young people's views of tobacco advertising shape their pattern of future uptake[82]. Advertising also serves as a reinforcing factor in smoking among young people[83].

4. Strategies for implementation

The following table outlines objectives, strategies and partnerships for addressing tobacco related harm in this focus area.

Focus Area 4 Marketing and promotion of tobacco products

2000	2001	2002	Partners
4.1 Reduce the exposure of the public to tobacco products through the removal of tobacco advertising and the placement of restrictions on the display of tobacco products			
Enforce compliance with the Public Health Act 1991 and the Public Health (Tobacco) Regulation 1999 (4.1.1)	→	→	NSW Dept of Health, Area Health Services
Disseminate information to retailers about the legislation (4.1.2)	→	→	NSW Dept of Health, Area Health Services
Develop appropriate training and reference materials and photographs to assist in the enforcement of the legislation (4.1.3)	→	→	NSW Dept of Health, Area Health Services
Provide training for Environmental Health Officers and other authorised officers in the enforcement of the Public Health Act 1991 and other tobacco-related laws administered by the NSW Department of Health (4.1.4)	→	→	NSW Dept of Health, Area Health Services
	Extend authorisation and training for other (non Health EHO) personnel to enforce tobacco advertising legislation (4.1.5)	→	NSW Dept of Health, Area Health Services, LGAs, Police
Research retailer compliance with the legislation and measure the effectiveness of the legislation (4.1.6)	→	→	NSW Dept of Health, Area Health Services
Monitor and document attempts by tobacco suppliers to circumvent the law and the intent of the law through display, product lines and packaging (4.1.7)	→	→	NSW Dept of Health, Area Health Services
		4.1.8 – After 2002*	NSW Dept of Health
4.2 Reduce the exposure of the public to tobacco products by eliminating tobacco sponsorship			
Enforce NSW legislation in relation to tobacco company sponsorship of sporting and cultural events (4.2.1)	→	→	NSW Dept of Health, Area Health Services

*After 2002. Review the Regulations in the twelve months prior to 1 September 2004 in accordance with the Subordinate Legislation Act 1989 (4.1.9)

Focus Area 5 — Tobacco product regulation

1. Definition

This focus area is intended to incorporate those strategies that affect the regulation of the contents of tobacco products and other nicotine delivery systems.

2. Outcomes

Outcomes to be achieved for priority groups and the general population are:

- improved regulation of tobacco products
- an increase in consumer and community knowledge about the contents and ingredients, nicotine levels, additives and poisons found in tobacco products and tobacco smoke
- an increase in the utilisation of Nicotine Replacement Therapies to encompass harm reduction approaches.

3. Supporting evidence

Due to its nicotine content, tobacco is highly addictive. However, unlike alcohol and other drugs including nicotine in other forms, tobacco is subject to few restrictions on sales and the formulation of the constituents of cigarettes is largely at the discretion of the manufacturers.

Given the highly addictive nature of nicotine and the extensive harm that tobacco causes in our community, there is an opportunity to improve the regulation of tobacco products to include the disclosure of contents, ingredients, levels of nicotine, additives and poisons found in tobacco products and tobacco smoke. Such regulations would provide further information to consumers of tobacco products.

In addition, there has been an emerging trend towards incorporating some harm reduction strategies within the tobacco control framework, namely to reduce disease through product regulation. In this instance, 'product' refers to both traditional tobacco products such as cigarettes and cigars, and alternative nicotine delivery systems. It is argued that product regulation might include modifications that would make cigarettes less harmful and/or potentially less addictive. It may also provide products that act as replacements for cigarettes, ie products that would deliver nicotine in a manner that was satisfying to the user but without so many of the dangerous by-products[84].

In addition to the use of nicotine replacement therapies in promoting smoking cessation and assisting smokers to completely abstain from smoking, there is an argument for the use of nicotine replacement therapies in assisting smokers to reduce tobacco consumption or to temporarily abstain from smoking[85].

4. Strategies for implementation

The following table outlines objectives, strategies and partnerships for addressing tobacco related harm in this focus area.

Focus Area 5	Tobacco product regulation		
2000	**2001**	**2002**	**Partners**
5.1 Improve the regulation of tobacco products			
		Develop a framework/model for the regulation of tobacco and nicotine products in collaboration with the Federal Government. Such a framework could include: • Requiring tobacco companies to disclose contents, ingredients, nicotine levels, additives and poisons found in tobacco and tobacco smoke • Labelling/health warnings on packages • Taxation • The illicit tobacco trade • Regulation of contents, ingredients, nicotine levels, additives and poisons found in tobacco. (5.1.1)	NSW Dept of Health, Area Health Services, NGOs
5.2 Increase the knowledge of the government, tobacco consumers and the general public about the contents of tobacco products			
		Undertake education initiatives aimed at ensuring the community is aware of all the contents of tobacco smoke and their effects (5.2.1)	NSW Dept of Health, NSW Quit Campaign, Area Health Services, NGOs
5.3 Increase the knowledge of consumers in relation to 'low tar' cigarettes			
		Provide advice to consumers on the real effects of utilising low tar cigarettes (5.3.1)	NSW Dept of Health, NGOs, ADIS
5.4 Increase the utilisation of NRT			
	Monitor research into alternate deliveries of nicotine (5.4.1)	→	NSW Dept of Health, NGOs
	Undertake research examining the medium and long term impact of NRT on cigarette consumption and quit rates (5.4.2)	→	NSW Dept of Health, NGOs, pharmaceutical companies, research organisations
	Identify barriers to the utilisation of NRT and other pharmacological methods in the reduction of tobacco use (as distinct from cessation of tobacco use) (5.4.3)	→	NSW Dept of Health, NGOs, pharmaceutical companies, research organisations

Focus Area 6 Exposure to environmental tobacco smoke

1. Definition

This focus area is intended to incorporate those strategies that affect the community's exposure to environmental tobacco smoke (ETS) and the awareness of the health effects of passive smoke.

2. Outcomes

Outcomes to be achieved for priority groups and the general population are:

- a reduction in the exposure of the community to environmental tobacco smoke in workplaces, enclosed public places and crowded outdoor places
- a reduction in the exposure of children and young people to environmental tobacco smoke in enclosed public places and in the home and its settings (including private transport).

3. Supporting evidence

Since the early 1970s, medical and environmental health journals have published numerous articles presenting evidence on the health effects of ETS. Several major medical research agencies and leading health organisations including Australia's National Health and Medical Research Council (NHMRC), the United States Environmental Protection Agency, the US Surgeon General and the Independent Scientific Committee on Smoking and Health from the United Kingdom have reviewed this evidence to draw conclusions on the health effects of ETS exposure[86].

Specific mention of the risks of ETS exposure for the community has also been made in the policy statements of a range of health and medical organisations, National and State Government committees and non-government health charities within New South Wales and nationally.

The growing evidence about environmental tobacco smoke and the harm it causes in the community has prompted a range of legislative and policy developments for enclosed public places, transport, workplaces and crowded outdoor spaces. Restrictions on the times and places in which smoking may occur, whether enforced by laws and regulations or by community social norms, all reduce the exposure of non-smokers to environmental tobacco smoke. In Australia, there has been a growing trend towards restricting smoking in various venues and locations. This has been effected either through legislation or the voluntary adoption of smoking restriction policies in response to community demands and occupational health and safety issues. The venues include workplaces, shopping centres, restaurants, hotels, bars, clubs and sporting venues. As well, many householders have voluntarily adopted initiatives to ensure their homes are smoke-free.

Of particular concern is the effect that ETS exposure has on young children. The World Health Organisation (WHO) reported in 1999 that ETS exposure leads to a wide range of adverse health effects on children. Children whose mothers smoke have 70% more respiratory problems and the prevalence is 30% higher if the father smokes[89]. The 1995 National Drug Strategy Household Survey estimated that approximately 1.7 million children aged 0-7 years were potentially exposed to tobacco smoke in the home[90].

The NHMRC (1997)[91] has concluded that passive smoking is associated with an increased risk of sudden infant death; contributes to the symptoms of asthma in 46,500 Australian children each year; causes lower respiratory illness in more than 16,000 Australian children each year; results in a 60% increase in the chance that a child will develop lower respiratory illnesses such as croup, bronchitis, bronchiolitis and pneumonia during the first 18 months of life and is associated with an increased risk of glue ear (otitis media) in children, which is a common cause of hospital admission in early childhood and may result in problems over the long term. Children are put further at risk because smoking by their parents increases the likelihood that they themselves will in time take up smoking.

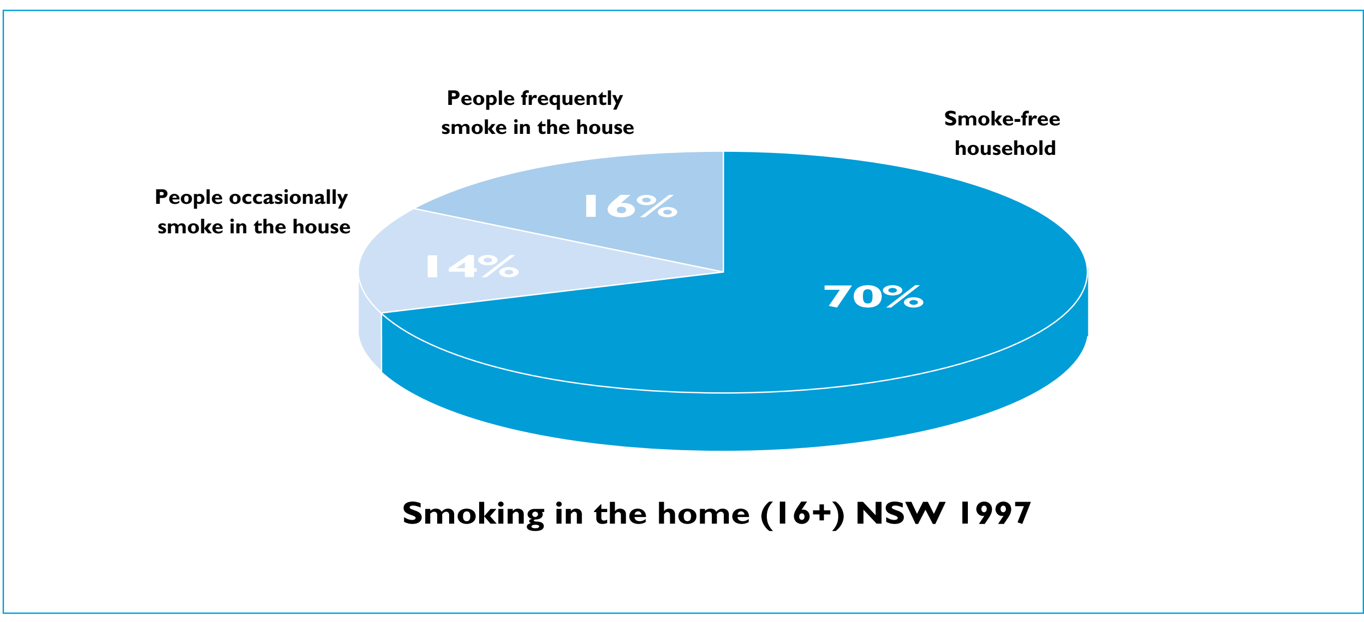
The Australia Institute of Health and Welfare reported that respiratory conditions such as asthma were the main causes for hospitalisations of children in Australia[92]. It also stated that in 1995, 16% of children under the age of 15 were reported to suffer from long-term asthma.

The 1994 NSW Health Promotion Survey found that the presence of children appears to be a factor in smoking and ex–smoking rates for women. The Survey found that:

- smoking rates were lower among women with children
- attempts to quit were much higher among women with children
- women with two or more young children (aged less than five years) were most likely to have tried to quit and succeeded and showed substantially higher rates of ex-smoking
- the smoking rates for males were less influenced by the presence of children in the house[93].

4. Strategies for implementation

The following table outlines objectives, strategies and partnerships for addressing tobacco related harm in this focus area.



Smoking in the home (16+) NSW 1997

Source. NSW Health Survey 1997

Focus Area 6	**Exposure to environmental tobacco smoke**		
2000	**2001**	**2002**	**Partners**
6.1 Increase the number of enclosed public places and outdoor venues that are smoke free			
Implement legislative controls on exposure to environmental tobacco smoke (ETS) in enclosed public places (6.1.1)	→	→	NSW Dept of Health, Area Health Services, NGOs
Encourage smoke free outdoor venues including sporting venues (6.1.2)	→	→	NSW Dept of Health, Area Health Services, NGOs
Promote the adoption of smoke free entertainment venues (6.1.3)	→	→	NSW Dept of Health, Area Health Services, NGOs
		Consider options to reduce exposure to environmental tobacco smoke (ETS) in crowded outdoor places (6.1.4)	NSW Dept of Health, Area Health Services, NGOs
6.2 Increase the number of workplaces that are smoke free			
Enforce the Occupational Health and Safety Act 1983 in relation to passive smoking in the workplace (6.2.1)	→	→	WorkCover Authority
Monitor compliance with the Occupational Health and Safety Act 1983 (6.2.2)	→	→	WorkCover Authority
Disseminate information about evidence-based models for introducing smoke free workplaces (especially small businesses and the hospitality industry) (6.2.3)	→	→	WorkCover Authority, NSW Dept of Health, Area Health Services, NGOs
		Undertake research in relation to the number and type of employees and visitors still exposed to ETS in the workplace (6.2.4)	NSW Dept of Health, Area Health Services, NGOs

Focus Area 6	Exposure to environmental tobacco smoke		
2000	**2001**	**2002**	**Partners**
6.3 Reduce the number of staff, patients and community members exposed to ETS when in contact with NSW Health facilities			
Implement the NSW Health Smoke Free Workplace Policy (6.3.1)	→	→	NSW Dept of Health, Area Health Services
	Review the NSW Health Smoke Free Workplace Policy including the implementation of an evaluation framework (6.3.2)	→	NSW Dept of Health, Area Health Services
Provide support and assistance for NSW Health workers who want to quit, including counselling and access to pharmacotherapy (6.3.3)			NSW Dept of Health, Area Health Services
6.4 Increase the number of households that are smoke free. Increase the number of people who do not smoke around children			
Develop and implement strategies to address exposure to ETS in children (6.4.1)	→		NSW Dept of Health, NGOs, Area Health Services
	Develop strategies to increase awareness of the health risks associated with passive smoking and strategies to reduce exposure in the home, with messages and mediums targeting priority groups, pregnant women/their partners and parents of young children (6.4.2)	→	NSW Dept of Health, NSW Quit Campaign, Area Health Services, Aboriginal Health Partnership, Multicultural Health Communication Service, NGOs including SIDA and Asthma Foundation
	Provide groups who work with children with information on assessing and providing advice on exposure to tobacco smoke in the home (6.4.3)	→	DET, NSW Dept of Health, children's advocacy groups, NGOs, Area Health Services

5 Relationship with National Tobacco Strategy and national priorities

1. Introduction

As outlined previously, the National Tobacco Strategy 1999–2002/03 provides a framework against which New South Wales can benchmark its own tobacco control activity, collaborate with other jurisdictions and contribute to a coordinated and comprehensive national action on tobacco.

It is intended that the *NSW Tobacco Action Plan 2001–2004* will fulfil the obligations of New South Wales to contribute to the implementation of the National Tobacco Strategy 1999–2002/03. Features of the National Strategy and the New South Wales response are summarised below:

	National Strategy	NSW Response
Goal	Improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms	Improve the health of the people of New South Wales by eliminating or reducing their exposure to tobacco in all its forms
Objectives	Prevent the uptake of tobacco use in non-smokers, especially children and young people	Prevent the uptake of tobacco use in non-smokers, especially children and young people
	Reduce the number of users of tobacco products	Reduce the number of users of tobacco products
	Reduce the exposure of users to the harmful health consequences of tobacco products	Decrease the number of deaths and level of disease caused by smoking Decrease the economic cost of tobacco-related illness
	Reduce exposure to tobacco smoke	Reduce exposure to tobacco smoke
Key strategy areas / key focus areas	Strengthening community action	Community awareness and education
	Promoting cessation of tobacco use	Smoking cessation
	Reducing availability and supply of tobacco	Availability and supply of tobacco products
	Reducing tobacco promotion	Marketing and promotion of tobacco products
	Regulating tobacco	Tobacco product regulation
	Reducing exposure to environmental tobacco smoke	Exposure to environmental tobacco smoke
Targeted population groups	Aboriginal and Torres Strait Islander people	Aboriginal and Torres Strait Islander people
	Children and young people under 18 years of age children	Children Young people
	Pregnant women and their partners	Incorporated within key focus areas
	People with mental illness	People with mental illness
	People from culturally and linguistically diverse backgrounds	Non-English speaking background communities with high smoking rates
	Low income earners	Incorporated within key focus areas

2. Reporting requirements

It is proposed that the Commonwealth and each State and Territory Government report annually on the National Tobacco Strategy to the Intergovernmental Committee on Drugs (IGCD). Reports will be made against an agreed set of criteria and performance indicators. Whilst the exact nature of the criteria is yet to be developed, it is envisaged that New South Wales will provide performance information against the *NSW Tobacco Action Plan 2001–2004*. The NSW Department of Health will be responsible for coordinating this response.

6 Monitoring and evaluation

1. Baseline data for the NSW Tobacco Action Plan 2001–2004

The broad objectives of the *Tobacco Action Plan 2001–2004* are to:

- prevent the uptake of tobacco use in non smokers, especially children and young people.
- reduce the number of users of tobacco products.
- reduce exposure to tobacco smoke.
- decrease the number of deaths and level of disease caused by smoking.
- decrease the economic cost of tobacco-related illness.

The strategies of the *Plan* are designed to meet these objectives, by addressing the 'strategic objectives' included in Section 4.

In the table that follows, the strategic objectives are linked to the broad objectives to highlight where baselines for these objectives exist and where work is needed to establish baselines. Below is a key to understanding the table and the baseline data.

Strategic objectives in…	…Means
Normal print	An indicator, or partial indicator is available for this objective and these can be found as numbered in the following pages.
Italics	No baseline is available and this area will require preliminary research to establish a baseline with further research to follow.
<u>Underlined</u>	No baseline is available, but it can be assumed that the implementation of the strategy will itself generate reportable results in this area. The need for research is less pressing.

Sources for graphical data are included after the baseline data.

A. Prevent the uptake of tobacco use in non smokers, especially children and young people			
Awareness of harms	**Prevalence**	**Availability & marketing**	**Regulation**
Increase the level of public awareness of the harm associated with tobacco use and tobacco smoke (1.1) *Increase the level of awareness of the harm associated with tobacco use and tobacco smoke among workers in the tobacco control field (1.2)* *Increase the level of young people's awareness of the harm associated with tobacco use (1.3)* *Maintain the provision of effective resources available to the community on the health effects of tobacco use (1.4)* *Increase the accessibility of information regarding the health effects of smoking (1.5)*	Decrease intra-uterine exposure to maternal active and passive smoking (2.5) *Decrease the desirability to young people of taking up and continuing smoking (1.3)* *Increase the effectiveness of programs aimed at the prevention of tobacco use by young people (1.3)*	Decrease the availability of tobacco to young people through a decrease in illegal sales of tobacco (3.1) Decrease the availability of tobacco to young people through a decrease in supply of tobacco products (3.3) *Decrease the availability of tobacco to young people through an increase in retailer awareness, public awareness and public support for the legislation (3.2)* *Decrease the availability of tobacco through increases in the price of tobacco (3.4)* *Increase community understanding and support for tobacco legislation (1.6)* Reduce the exposure of the public to tobacco products through the removal of tobacco advertising and the placement of restrictions on the display of tobacco products (4.1) Reduce the exposure of the public to tobacco products by eliminating tobacco sponsorship (4.2)	Improve the regulation of tobacco products (5.1) *Increase the knowledge that the government, tobacco consumers and the general public have about the contents of tobacco smoke (5.2)* *Increase the knowledge that consumers have in relation to 'low tar' cigarettes (5.3)*
1. Illnesses caused by smoking	4. Adult prevalence 18+	14. National source of last cig bought	
2. ATSI knowledge of risks	5. Prevalence ratios AHSs 18+	15. Students who bought last cig	
3. Level of agreement with statements	6. Students 12-17	16. Students' source of last cig not bought	
	7. Students' self description	17. Compliance rates sales to minors	
	8. Students never smoked		
	9. Indigenous smoking status		
	10. NESB prevalence		
	11. Mothers who smoked during pregnancy		
	12. by number of cigs smoked, second half of pregnancy		
	13. NESB mothers		

B. Reduce the number of users of tobacco products		
Cessation	**Use of NRT**	**Cessation services**
Increase the incentives for smokers to quit smoking (2.4	Increase the utilisation of pharmacotherapy (5.4)	*Ensure that smokers have a range of options to assist them to quit smoking (2.1)* *Increase the accessibility and appropriateness of smoking cessation services for priority target groups such as people from NESB, Aboriginal and Torres Strait Islander people, people with mental illness and young people (2.2)* *Increase the range and number of health professionals who have the skills, resources and organisational support to assist people to quit smoking (2.3)*
1. Intention to quit smoking	2. Sales volume of pharmacotherapy 3. Survey of quitters 4. NTC survey of smokers & quitters	5. 1997 DoH survey data

C. Reduce exposure to tobacco smoke		
Awareness of harms	**Home**	**Work/public places**
Increase the level of public awareness of the harm associated with tobacco use and tobacco smoke	Decrease infants' exposure to tobacco smoke (2.5) Increase the number of households that are smoke free (6.4) Increase the number of people who do not smoke around children (6.4)	Increase community understanding and support for tobacco legislation (1.6) Increase the number of workplaces that are smoke free (6.2) *Increase the number of enclosed public places and outdoor venues that are smoke free* Reduce the number of staff, patients and the community exposed to ETS when in contact with nsw health facilities (6.3)
1. Level of agreement with statement	3. Smoking in the home 16+	4. Workplace smoking restrictions 16+
2. ATSI knowledge of risks		5. ….by sex
		6. ….by workplace size
		7. Attitude to smoking in cafes/ restaurants 18+
		8. ….hotels, bars, pubs 18+
		9. ….registered clubs 18+

D. Decrease the number of deaths and level of disease caused by smoking E. Decrease the economic cost of tobacco related illness		
Deaths	**Disease**	**Cost**
1. Deaths	2. Hospital separations 3. Burden of disease	*Estimates based on PAR (Population Attributable Risk) – to be confirmed*

A. Prevent the uptake of tobacco use in non-smokers, especially children and young people

A1. Smokers and recent quitters

Smokers and recent quitters (within the last year) were asked the following general questions:

- In your opinion, are there any illnesses caused by smoking?
- In your opinion, are there any forms of damage to the body caused by smoking?

93% of respondents answered 'yes' to one or both of these questions (Australia, Nov 1997)[94].

A2. Aboriginal and Torres Strait Islander people

Respondents generally underestimated the risks associated with tobacco.

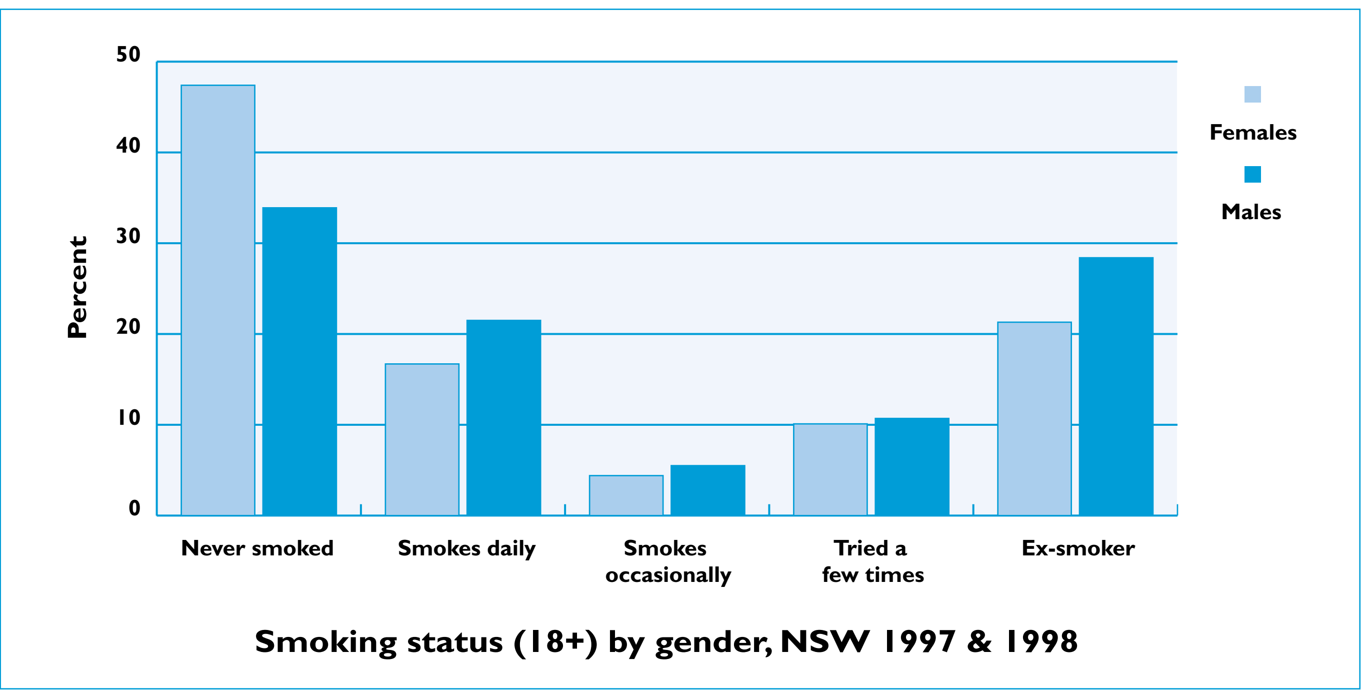
5% did not think smoking could damage their health, and 31% thought that a pack or more a day could be safely smoked. Current smokers and heavier drinkers were more prevalent among those who held these misconceptions[95].

A3. The awareness of the health effects of smoking – smokers and recent quitters

Level of agreement with opinion statements about smoking and health – Australia, November 1997

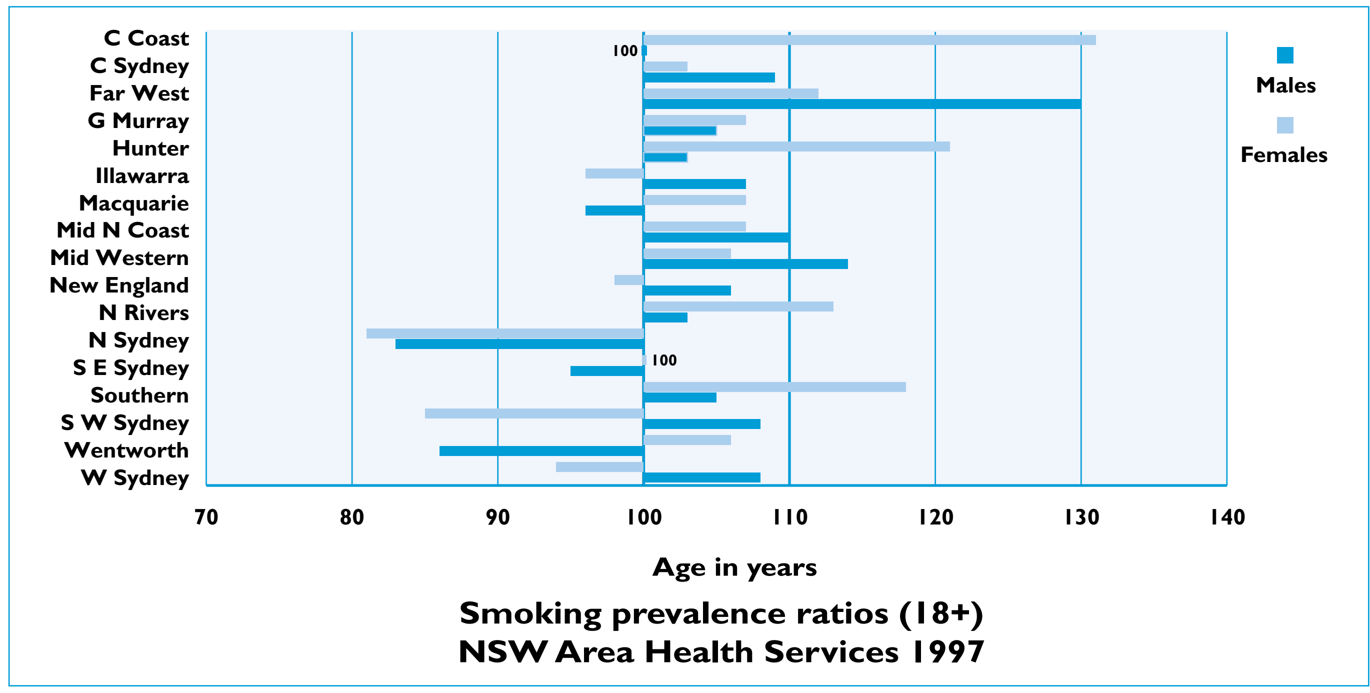
Opinion statements	Percent agreement – smokers and recent quitters (within the last year)
Smoking causes lung cancer	87
Smoking causes heart disease	84
Smoking causes emphysema	86

Source. Australia's National Tobacco Campaign – Evaluation report vol. one

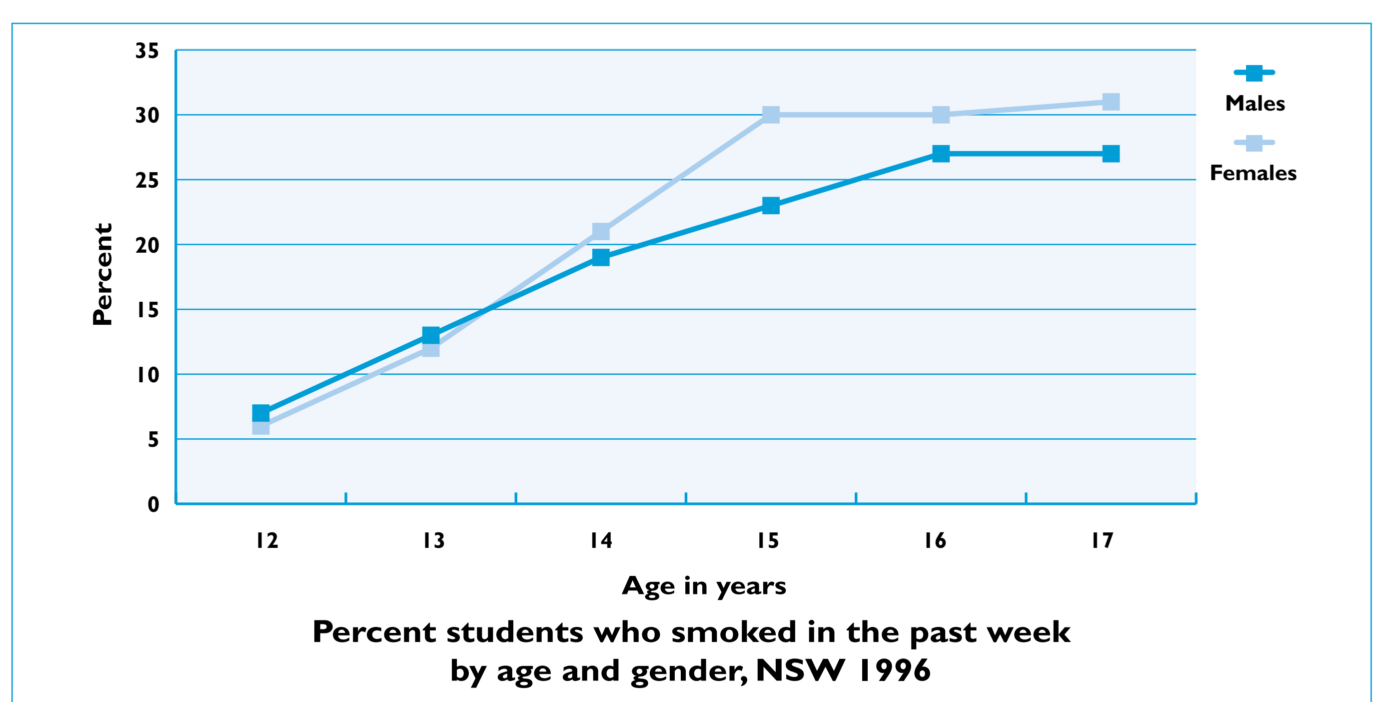


Smoking status (18+) by gender, NSW 1997 & 1998

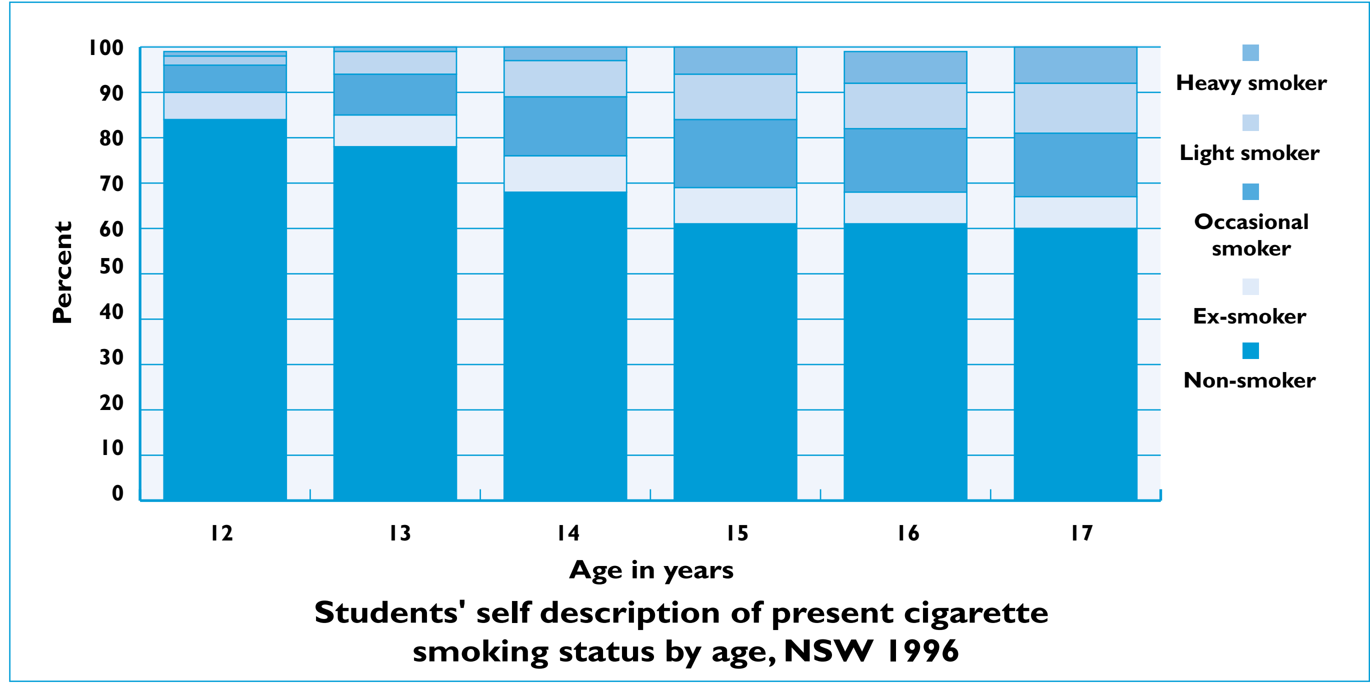
A4 Source. NSW Health Survey (1997)



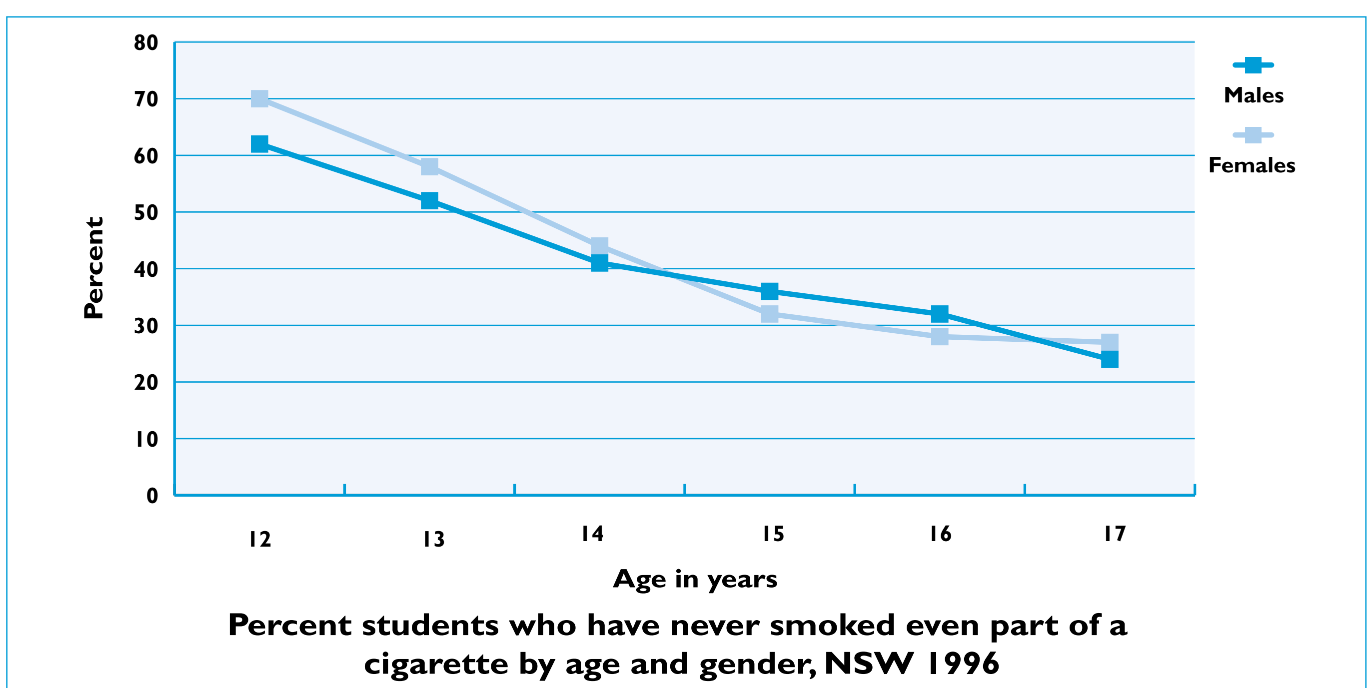
A5 Source. NSW Health Survey (1997)



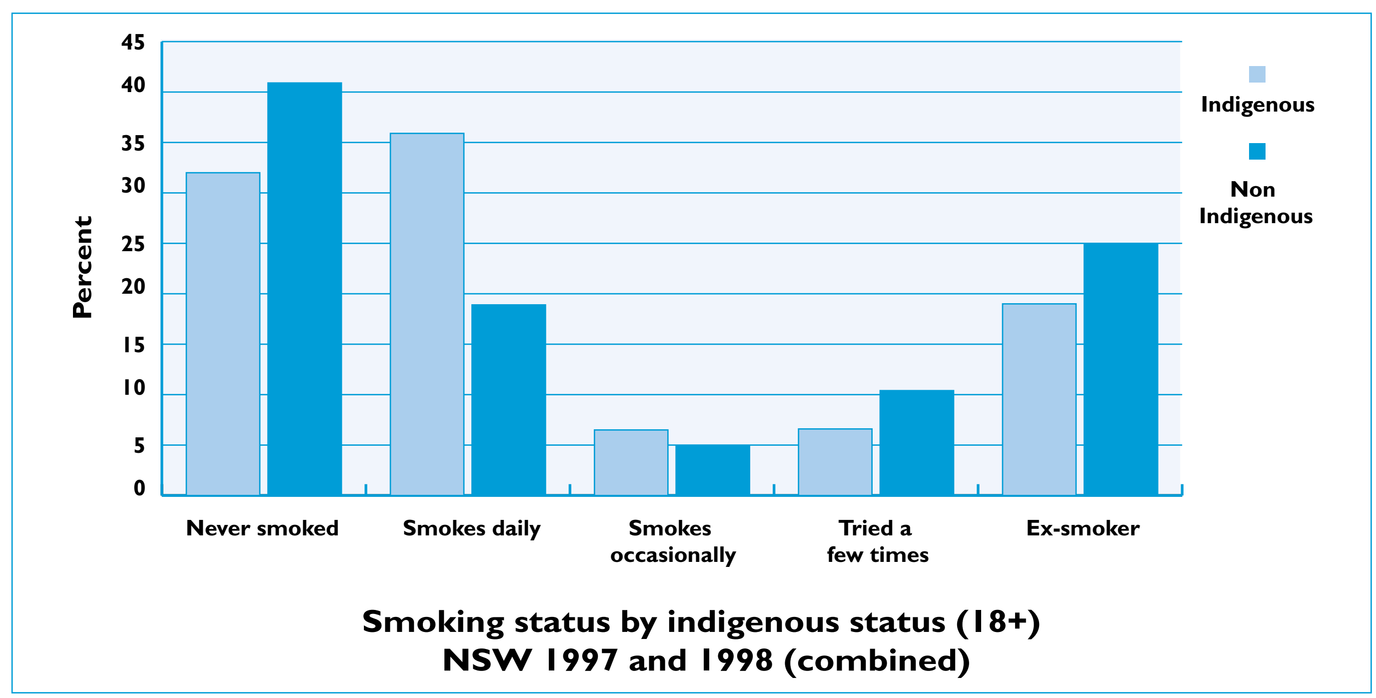
A6 Source. ASSAD Survey (1996)



A7 Source. ASSAD Survey (1996)

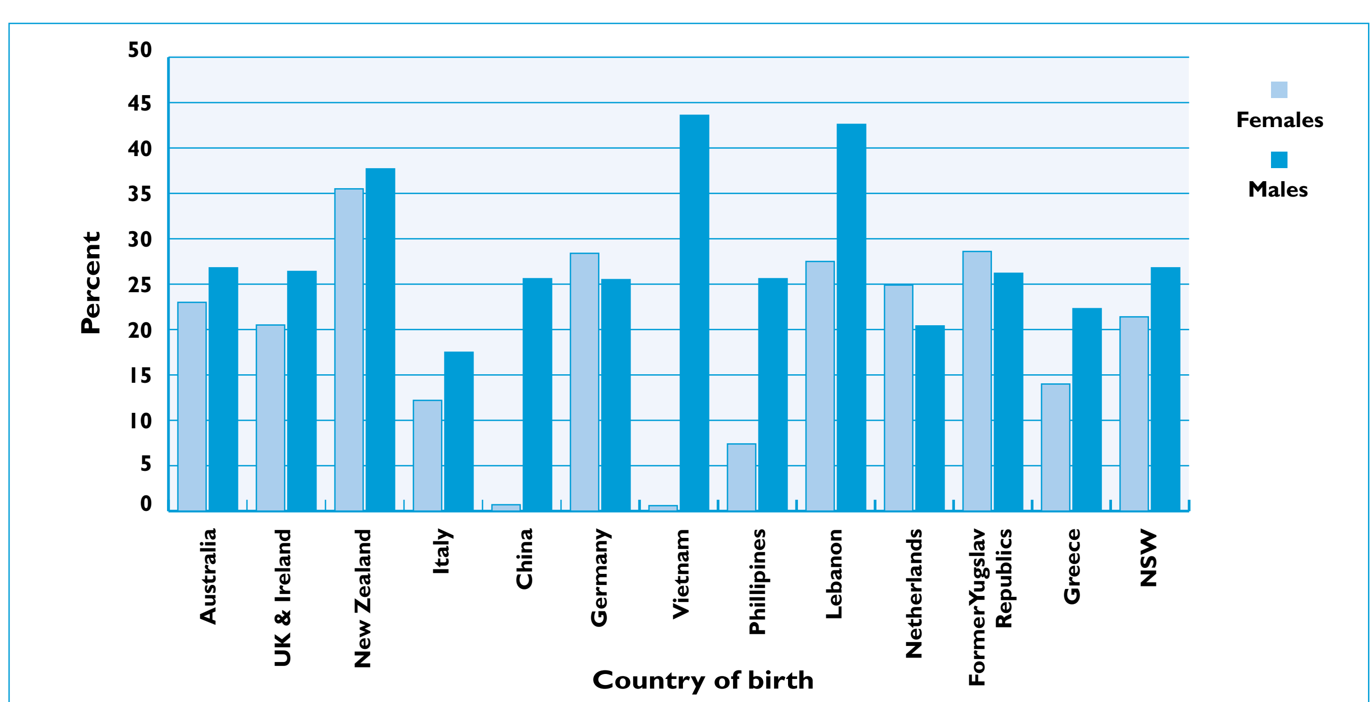


A8 Source. ASSAD Survey (1996)

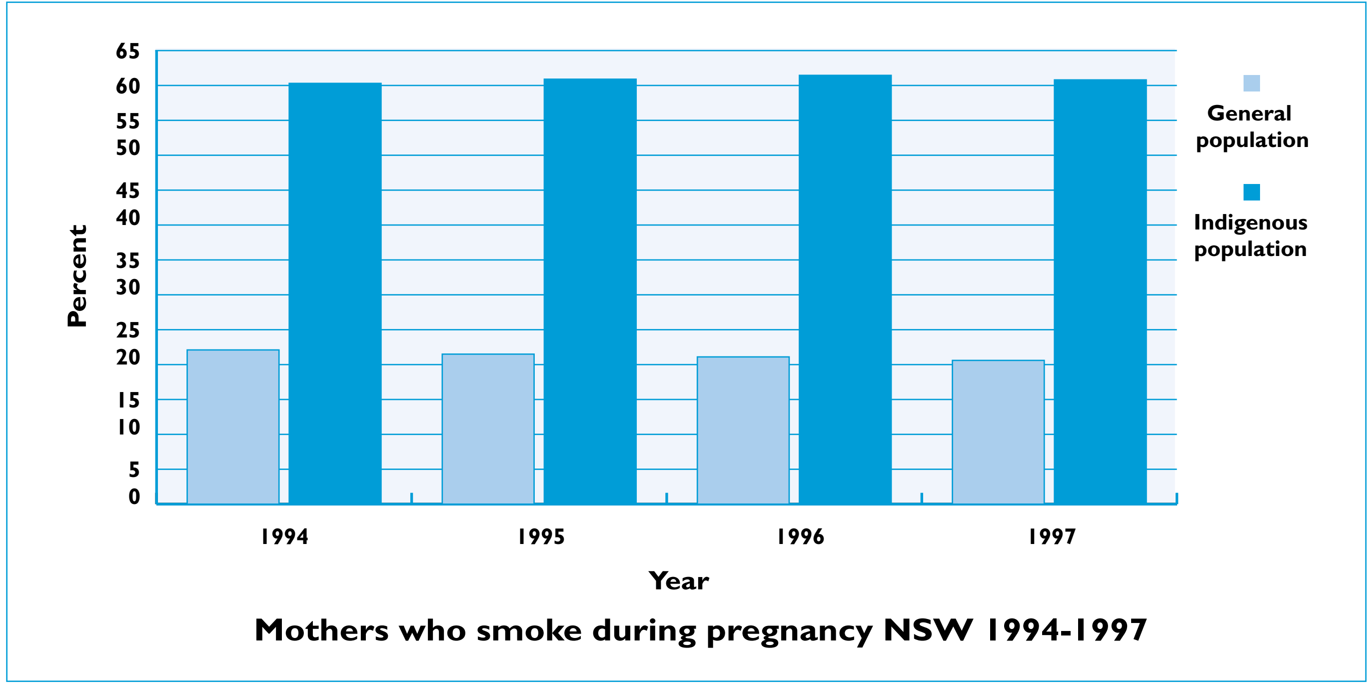


Smoking status by indigenous status (18+) NSW 1997 and 1998 (combined)

A9 Source. NSW Health Survey (1997 & 98)

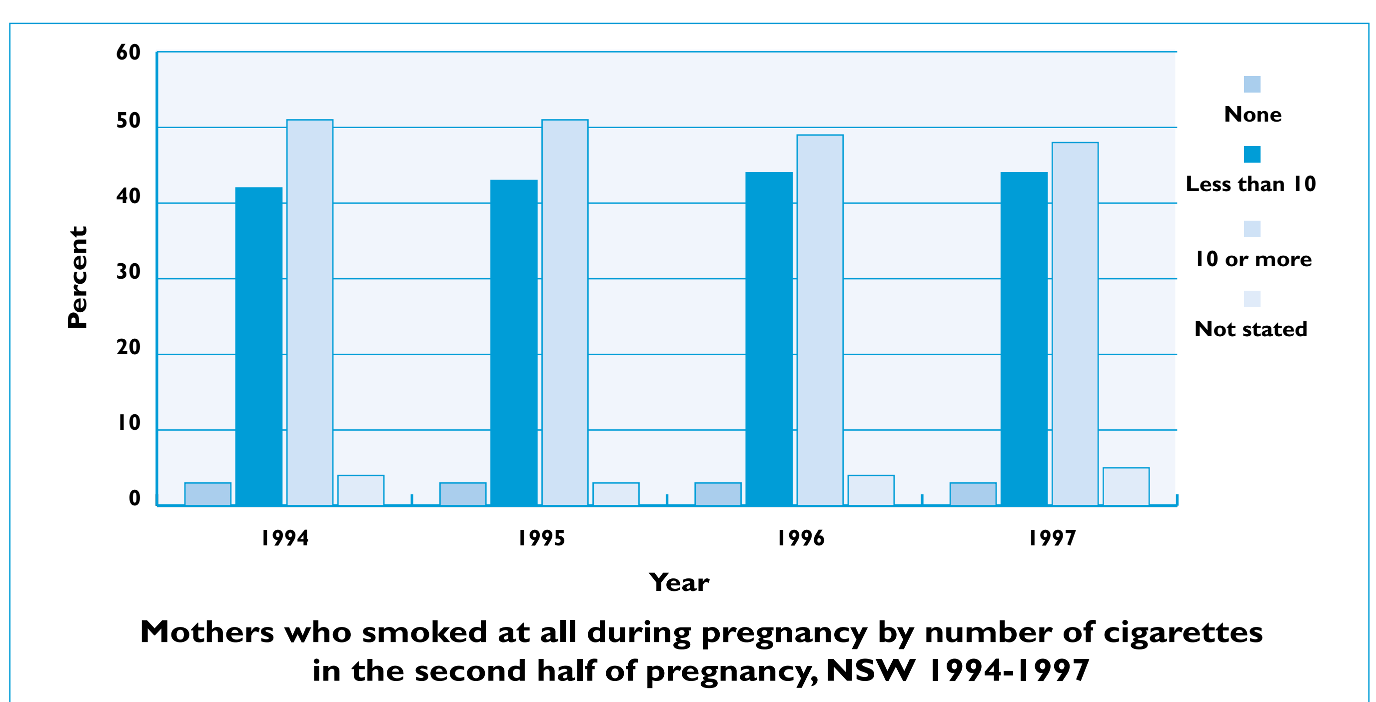


A10 Source. NSW Health Survey (1997 & 98)



Mothers who smoke during pregnancy NSW 1994-1997

A11 Source. NSW Mothers and Babies Report (1999)



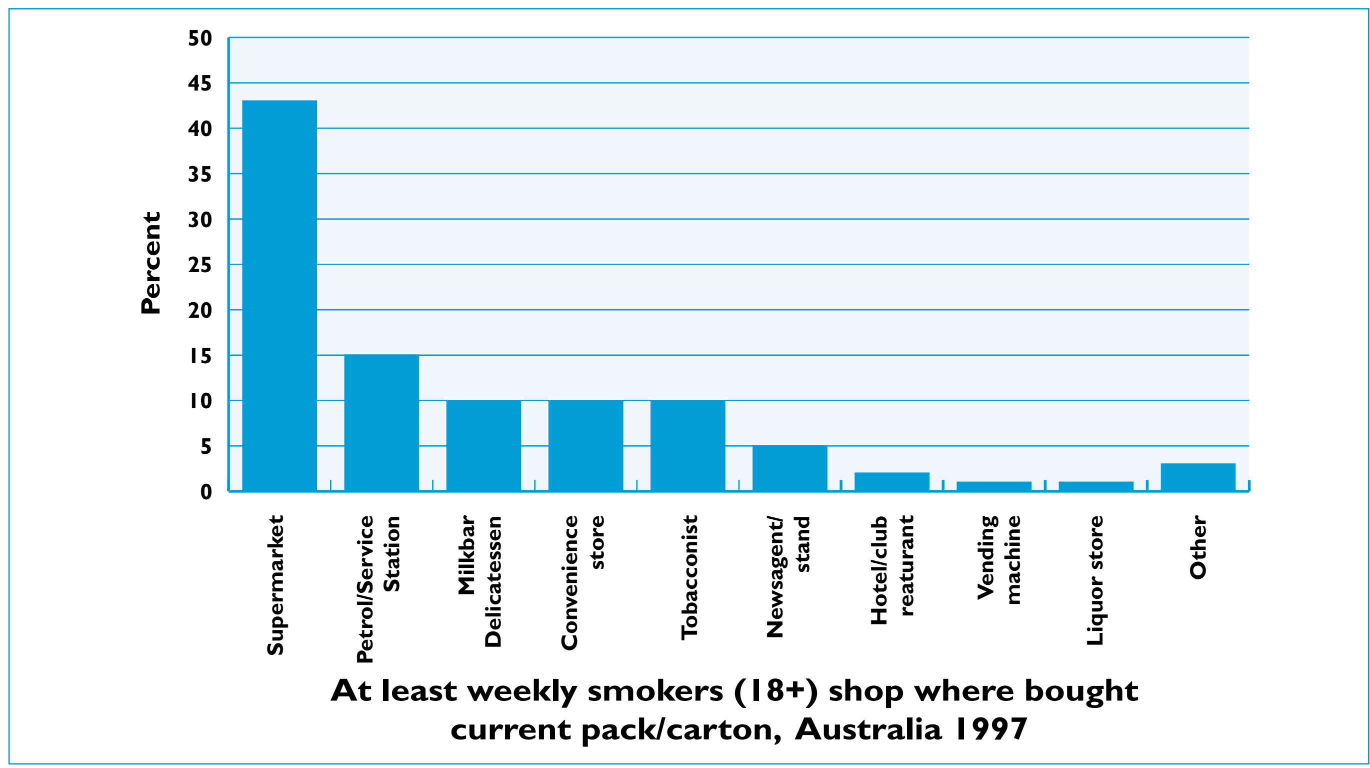
Mothers who smoked at all during pregnancy by number of cigarettes in the second half of pregnancy, NSW 1994-1997

A12 Source. NSW Mothers and Babies Report (1999)

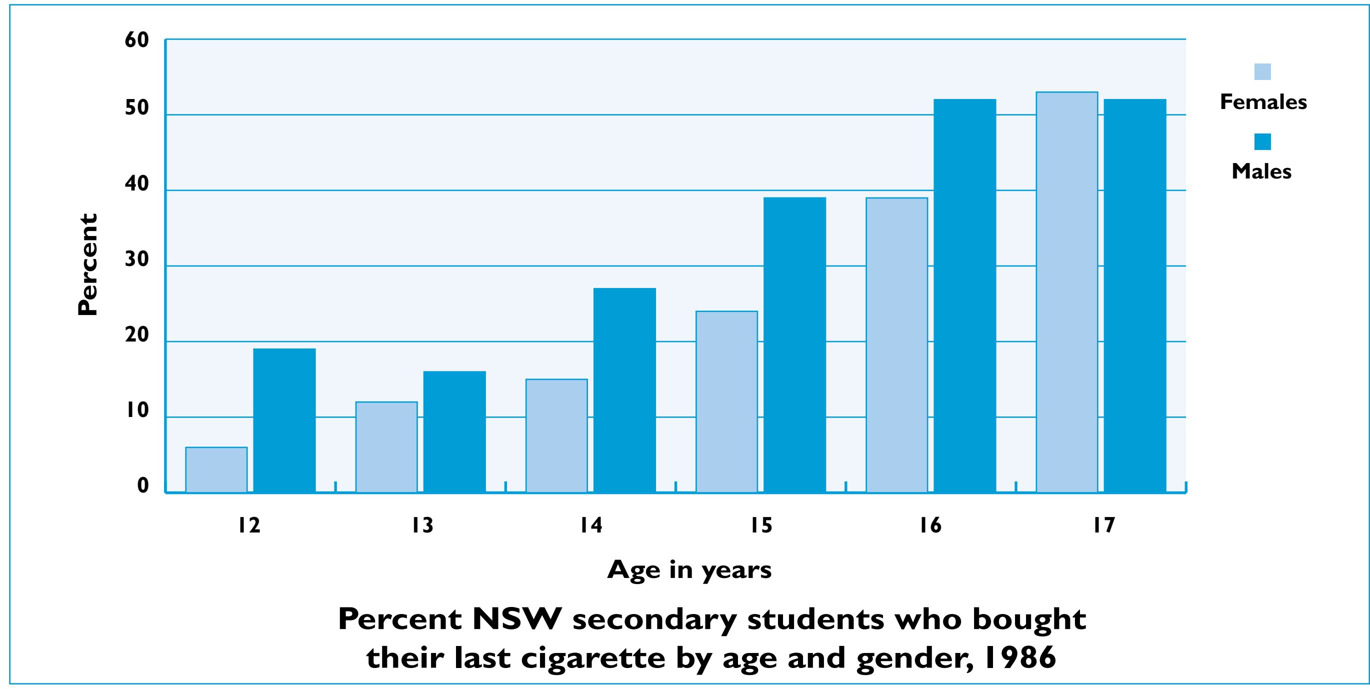
A13. NESB mothers

In 1997, smoking at any time during pregnancy was far more common among mothers born in English speaking countries than mothers born in non-English speaking countries. About one in four mothers born in English speaking countries smoked at some time during pregnancy, compared with one in six or fewer mothers born in non-English speaking countries.

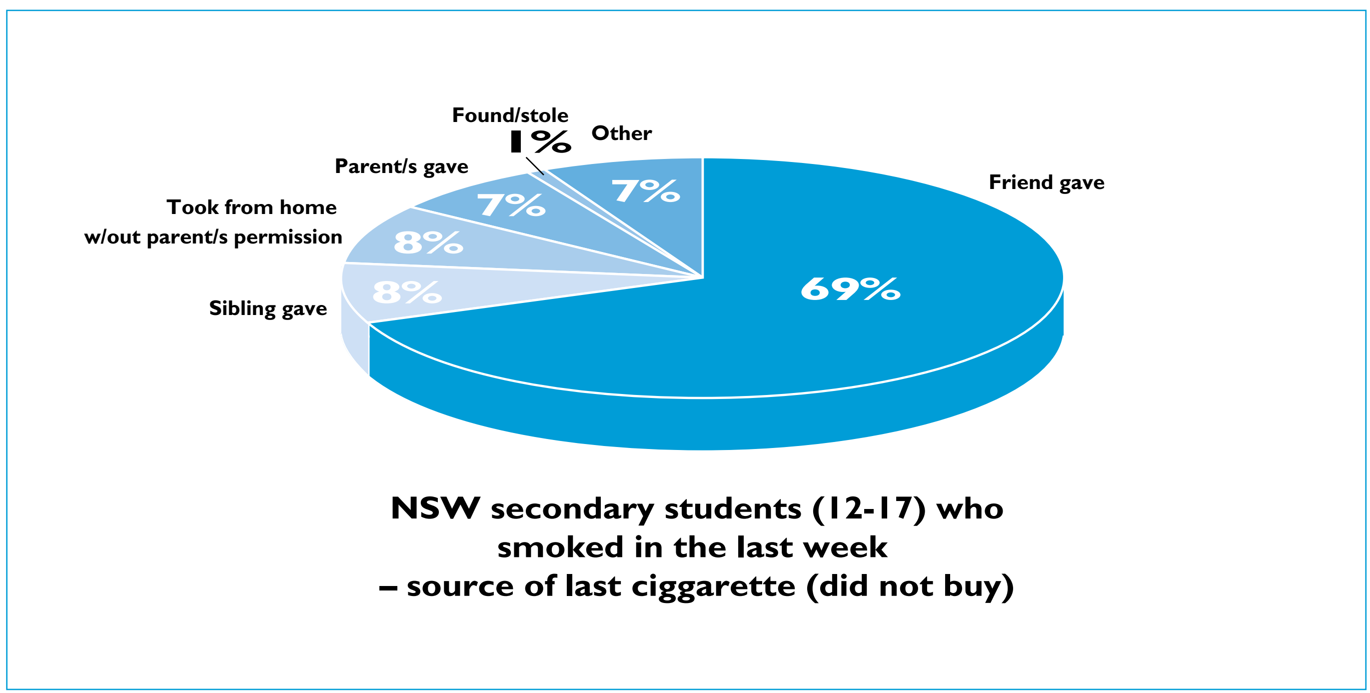
Smoking in the second half of pregnancy poses the greatest risk to the health of both mother and baby and was also more common in mothers born in English speaking countries than in mothers born in non-English speaking countries.



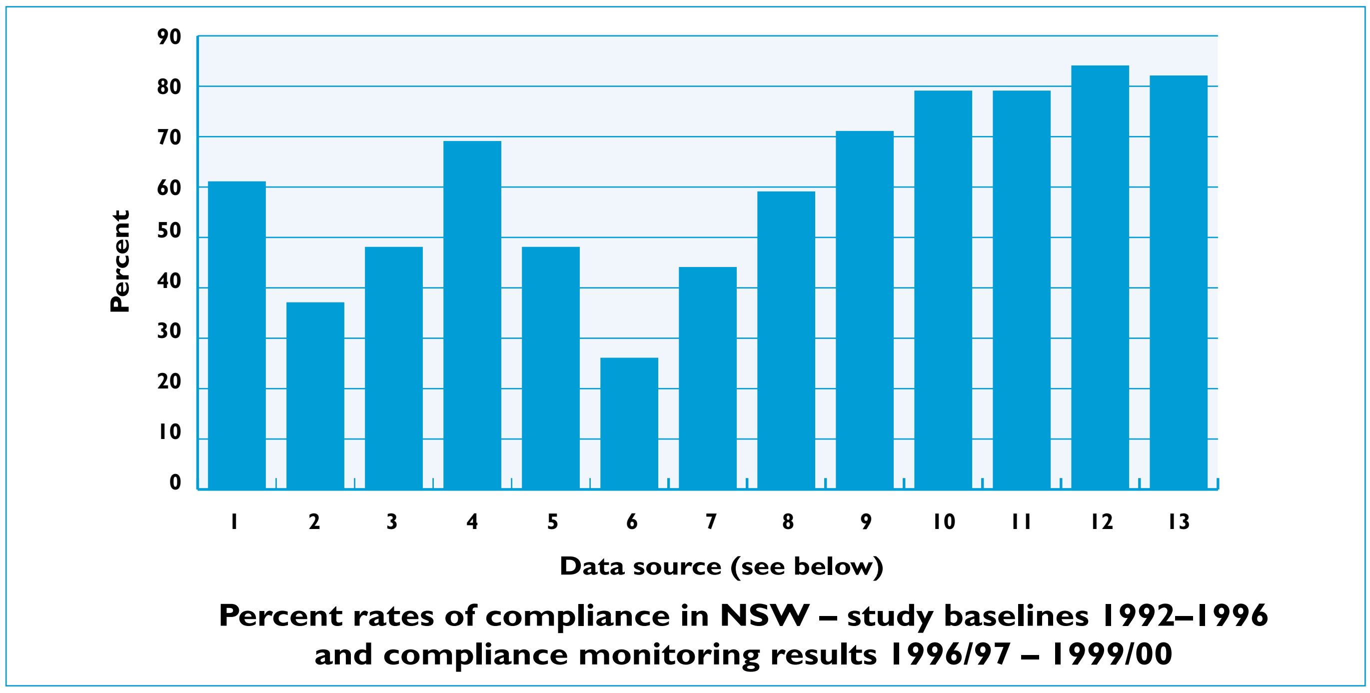
A14 Source. Australia's National Tobacco Campaign – Evaluation Report Vol.one



A15 Source. ASSAD Survey (1996)



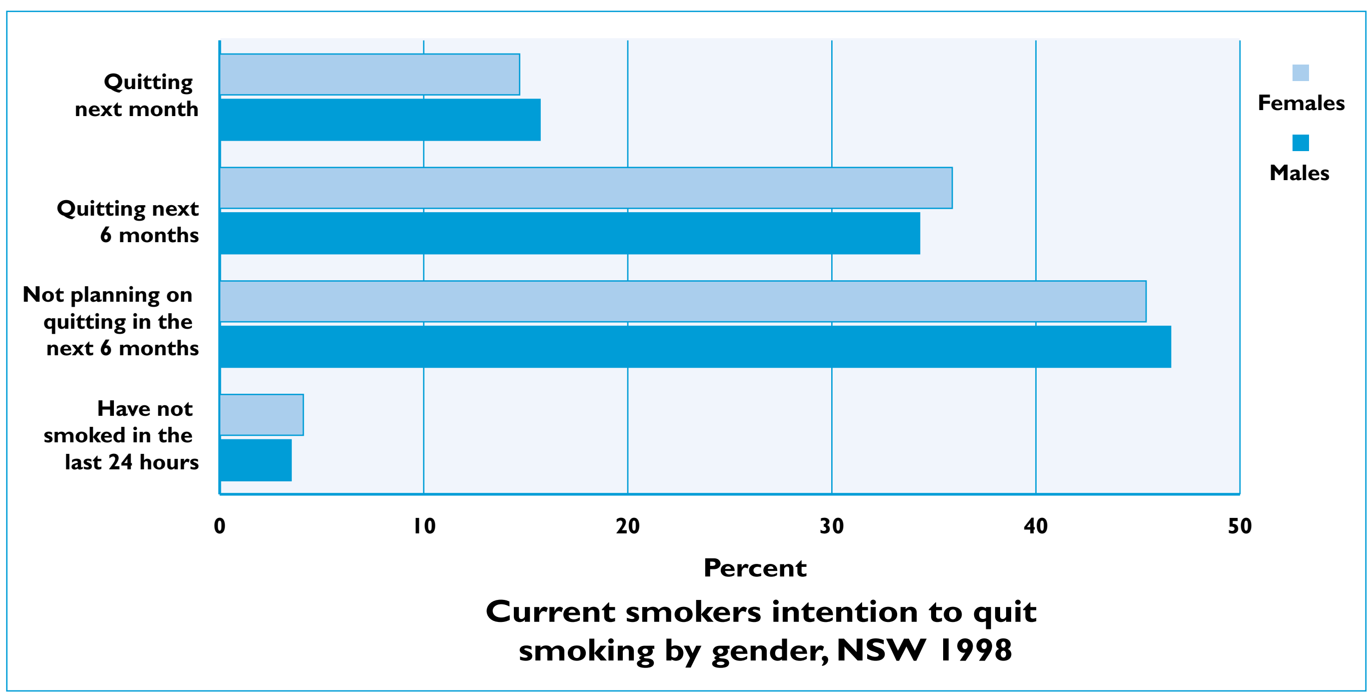
A16 Source. ASSAD Survey (1996)



A17 Various sources, incl DoH data

1. Chapman et al (1992)
2. Andrews et al (1992)
3. Illawarra (1994)
4. Central Coast (1994)
5. Manly (1994)
6. Marrickville (1995)
7. Central Sydney (1996)
8. South Eastern Sydney (1996)
9. South Western Sydney (1996)
10. NSW average compliance rate 1996/97
11. NSW average compliance rate 1997/98
12. NSW average compliance rate 1998/99
13. NSW average compliance rate 1999/00

B. Reduce the number of users of tobacco products



B1 Source. NSW Health Survey (1998

B2

"The sales volume of NRT has approximately doubled over the two year period (from Jan 1997 to Feb 1999, nationally) from little over 70,000 units per month to around 160,000 units in early 1999"[96].

B3

A survey in Jan-Feb 1999 of 'committed quitters' (defined as planning to quit in the next month, currently trying to quit, or quit within the last month) in two Australian capital cities revealed the following results on NRT usage:

NRT Usage	% of committed quitters
Ever used NRT gum	24
Ever used NRT patch	29
Would try gum next time quitting	10
Would try patches next time quitting	38

Source. Advertising of Nicotine Replacement Therapy: has it promoted more smoking cessation?

B4. NRT

A survey of smokers and recent quitters (defined as within the last year) featured a question on getting help to quit. Two surveys were conducted, before and after the *National Tobacco Campaign*, and it was revealed that in the six months prior to May 1997, 7% of this group had used nicotine gum or patches, and in the six months prior to November 1997, 10% had used nicotine gum or patches[97].

B5

In 1997, a survey on smoking cessation services was sent to the 17 Area Health Services, and 15 responded.

- All of these had smoking cessation services within their Area.
- In the two years prior to 1997, staff training in providing cessation services had occurred in 12 Areas. Staff in 8 Areas reported providing such training.

Groups targeted by the training included nurses, Aboriginal health workers, GPs, D&A workers and midwives.

C. Reduce exposure to tobacco smoke

C1. The awareness of the health effects of ETS – smokers and recent quitters

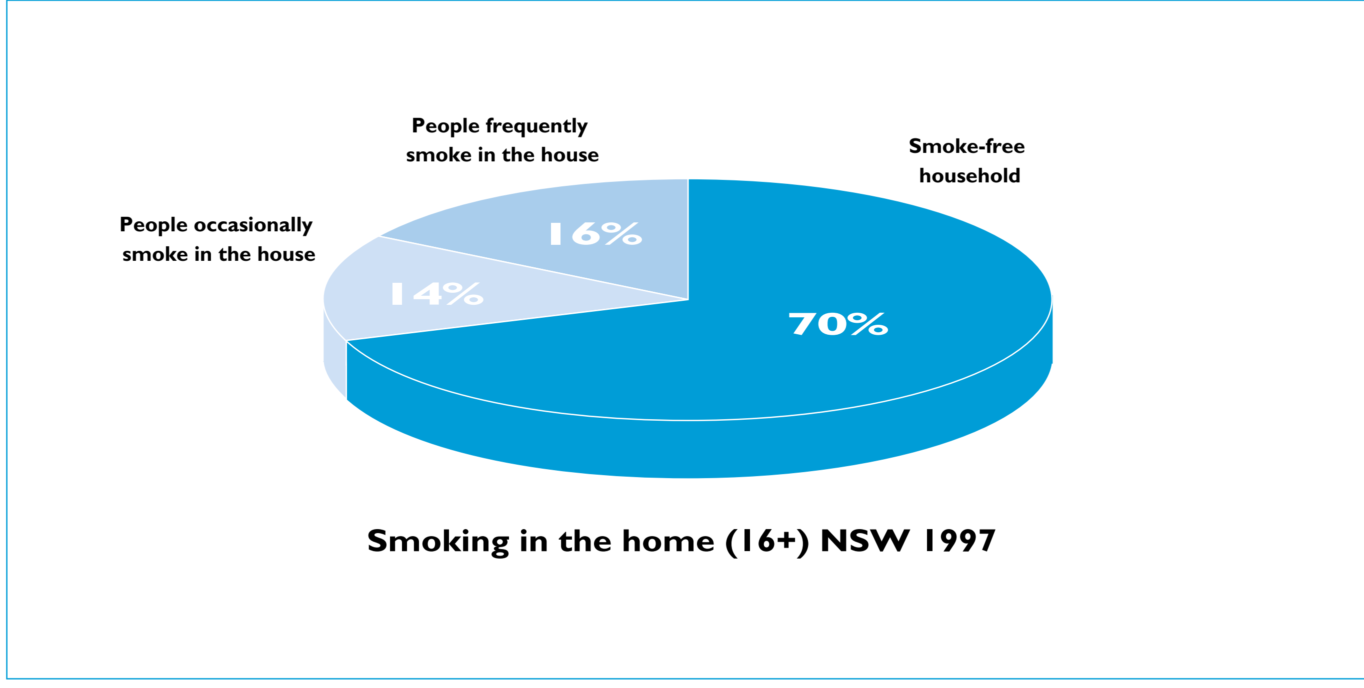
Level of agreement with opinion statements about smoking and health – Australia, November 1997

Opinion statements	% agreement
Your smoking can harm others	83

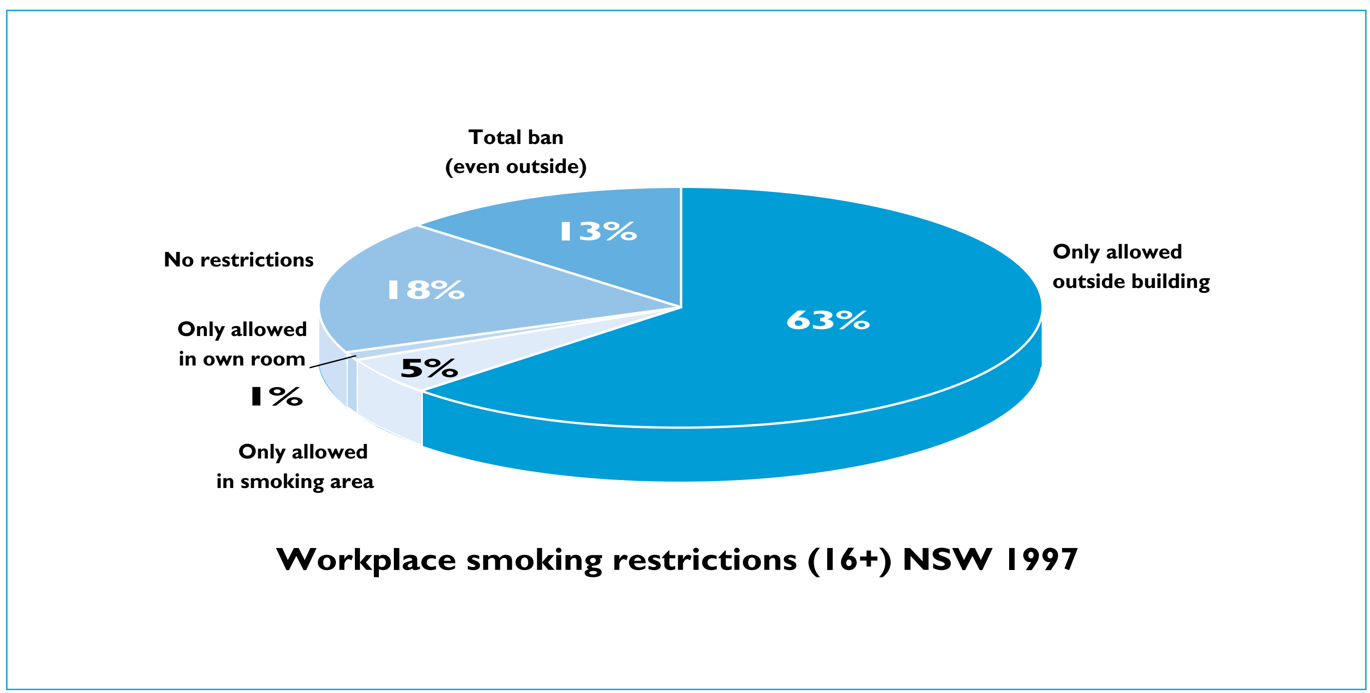
Source. Australia's National Tobacco Campaign – Evaluation Report Vol.one

C2. Aboriginal and Torres Strait Islander People – passive smoking

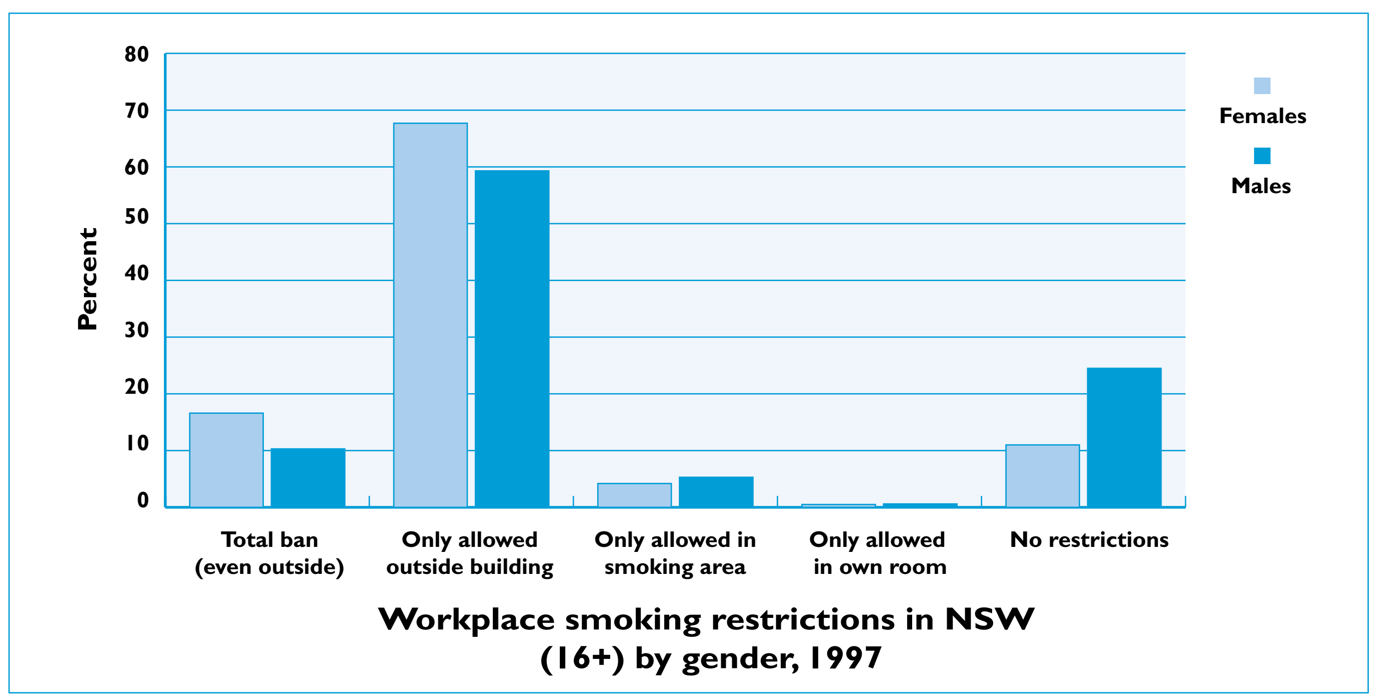
- There was some awareness of the risks of passive smoking, with 45% of respondents rating the risk to the health of a person living with a smoker to be high, 28% rating the risk as medium and 8% as low. 17% thought there was no risk
- Awareness of the risks of passive smoking was highest among women, younger persons and non-smokers[98].



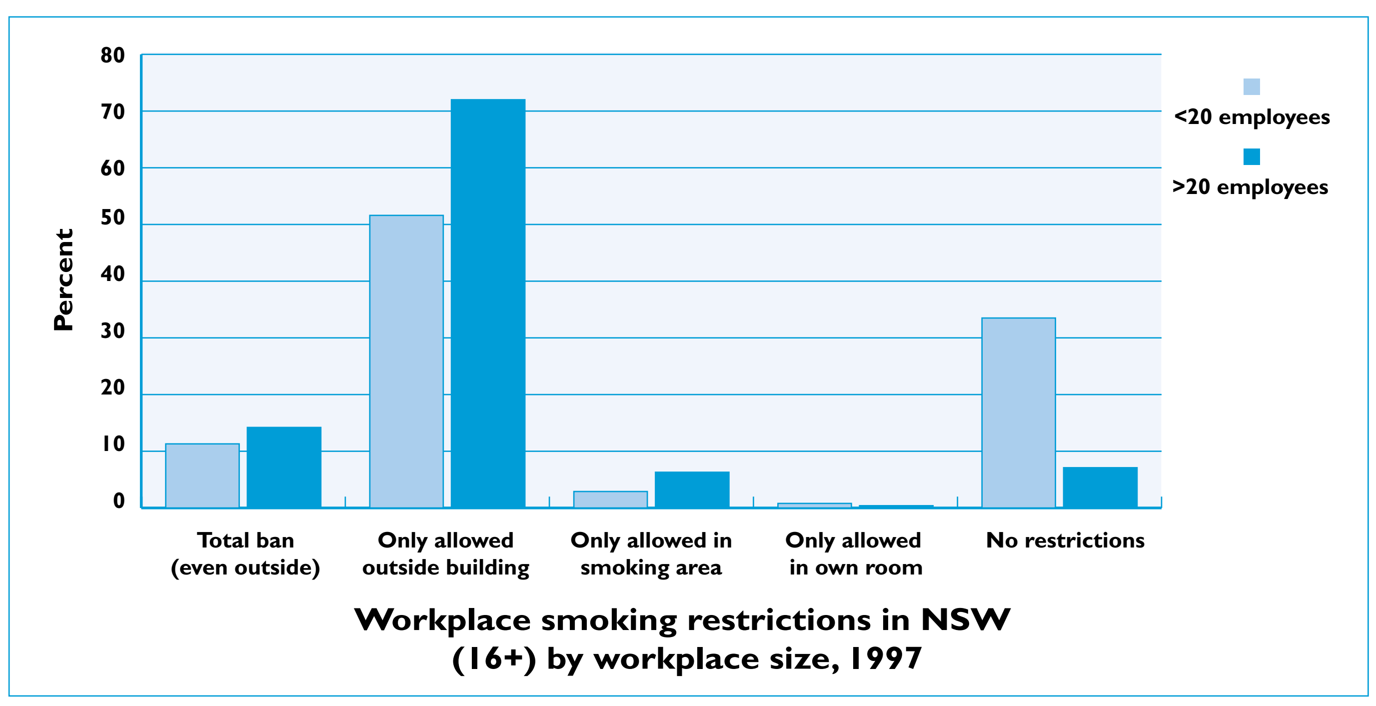
C3 Source. NSW Health Survey (1997)



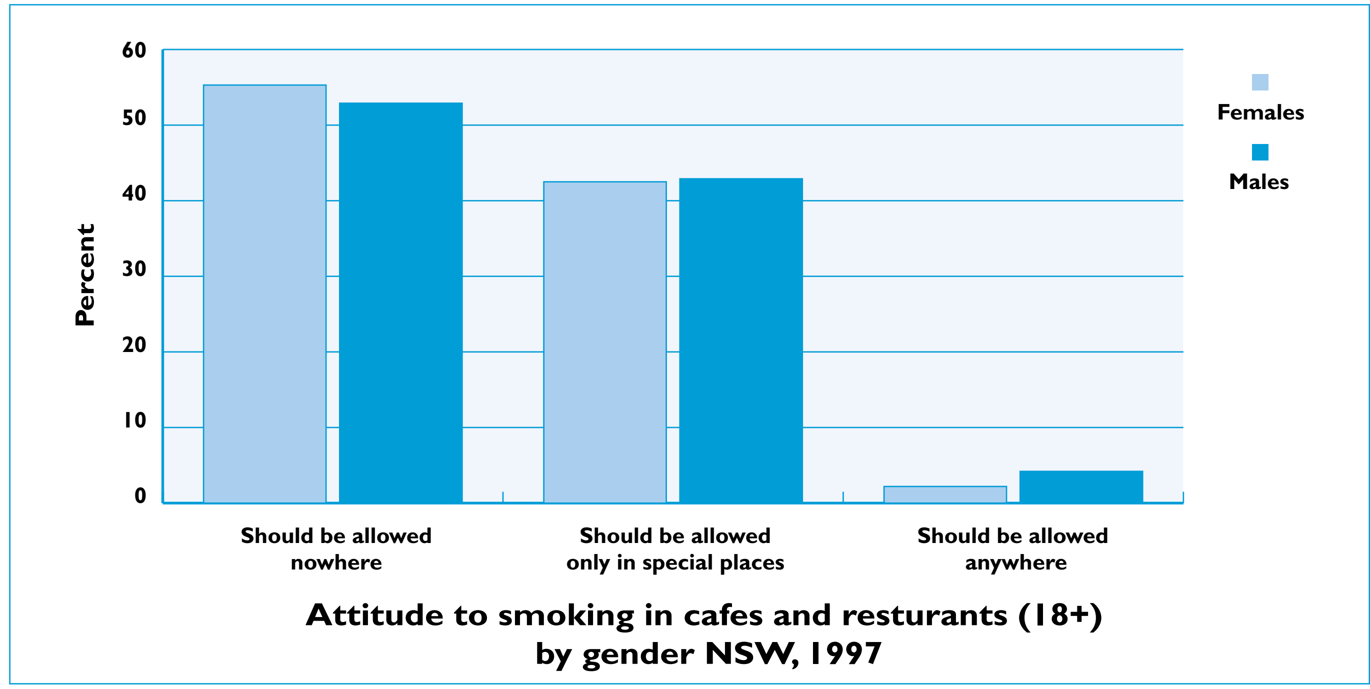
C4 Source. NSW Health Survey (1997)



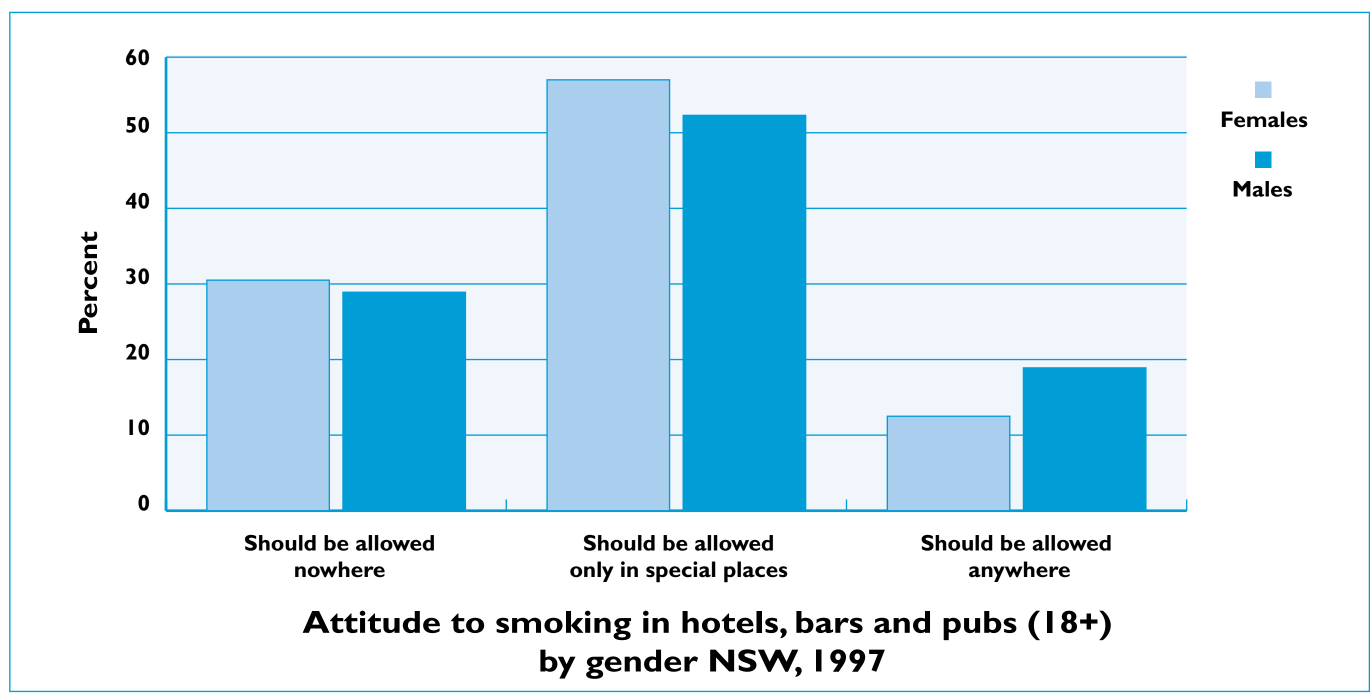
C5 Source. NSW Health Survey (1997)



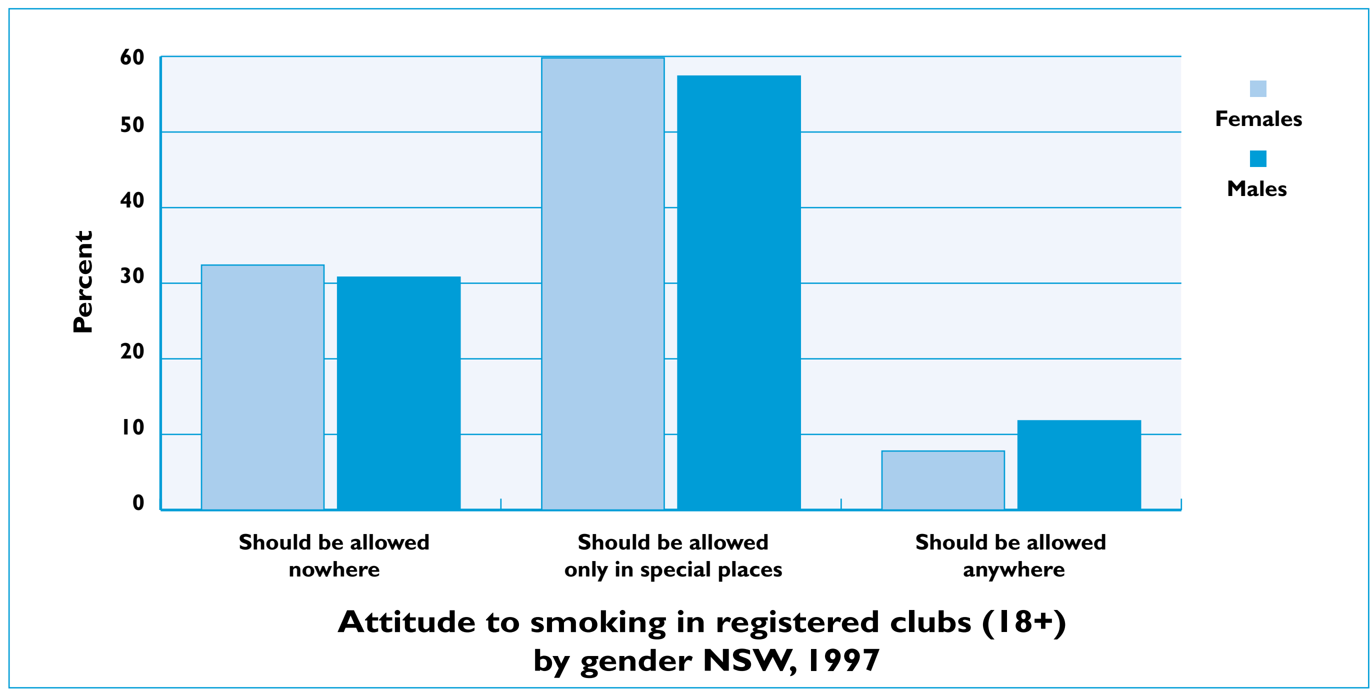
C6 Source. NSW Health Survey (1997)



C7 Source. NSW Health Survey (1997)



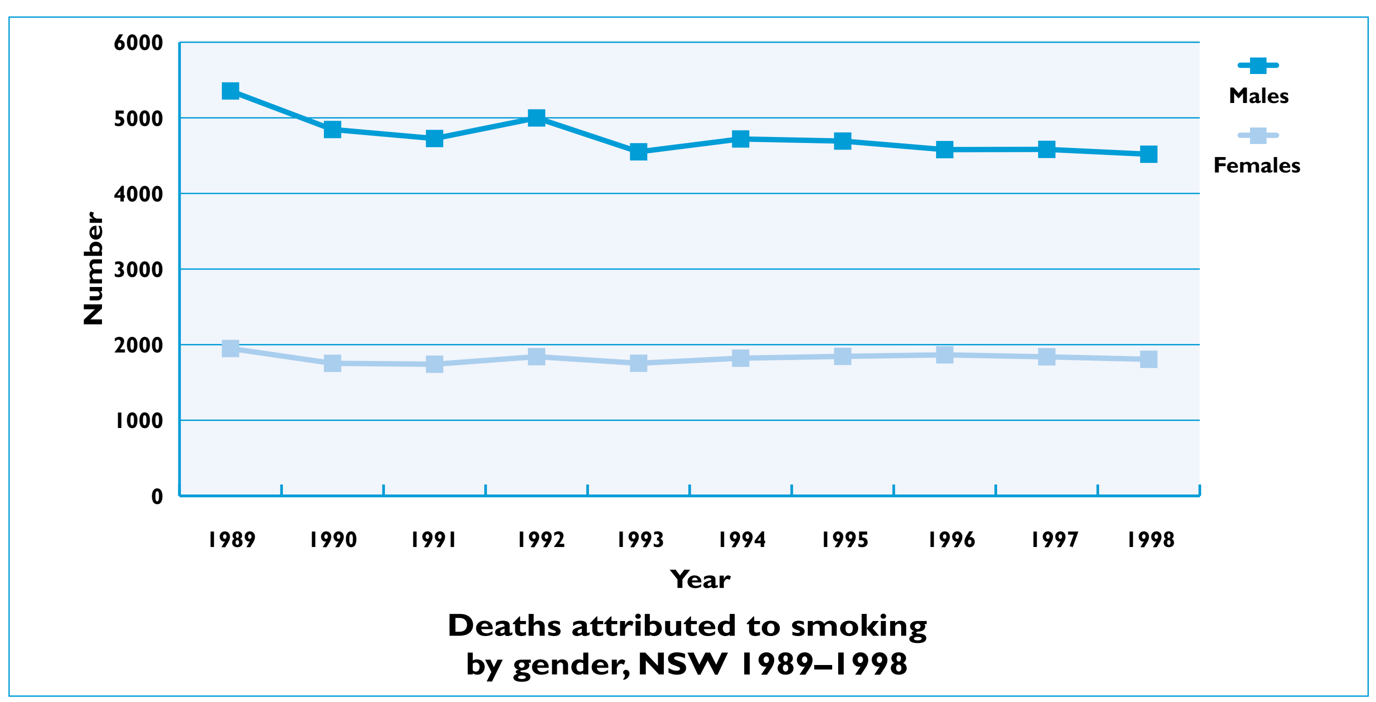
C8 Source. NSW Health Survey (1997)



Attitude to smoking in registered clubs (18+) by gender NSW, 1997

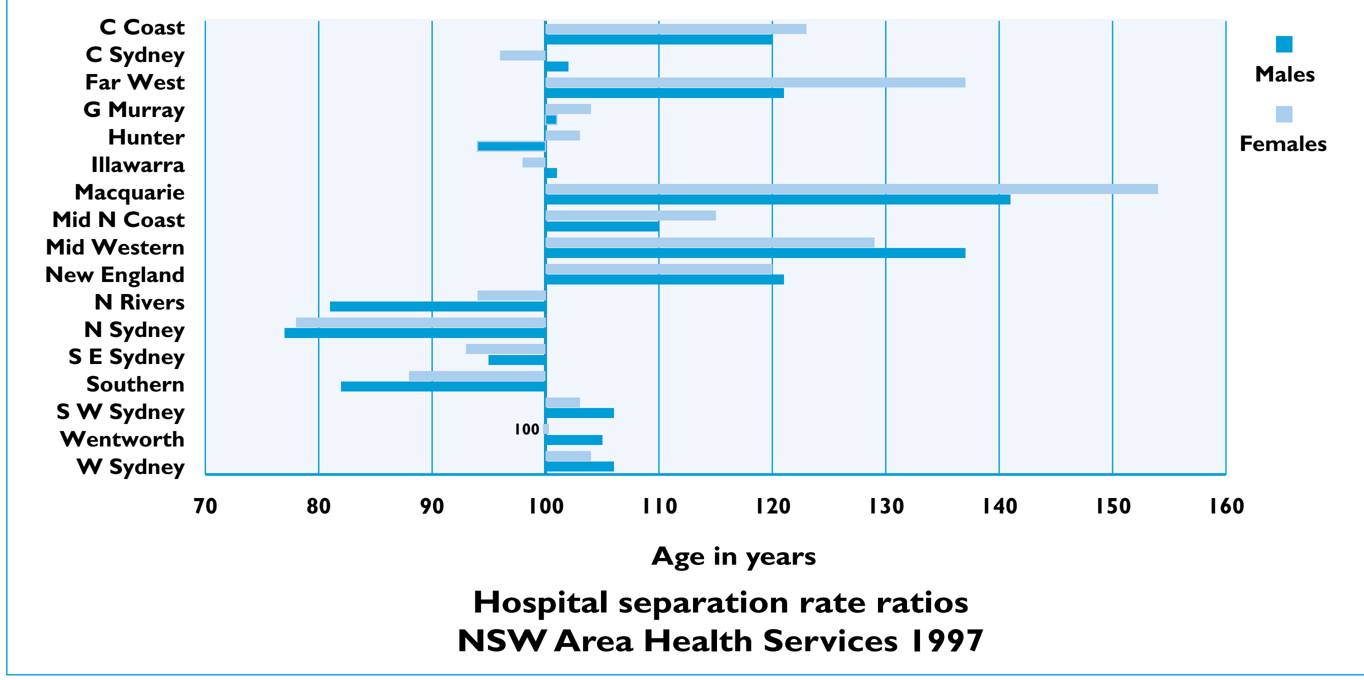
C9 Source. NSW Health Survey (1997)

D. Decrease the number of deaths and level of disease caused by smoking

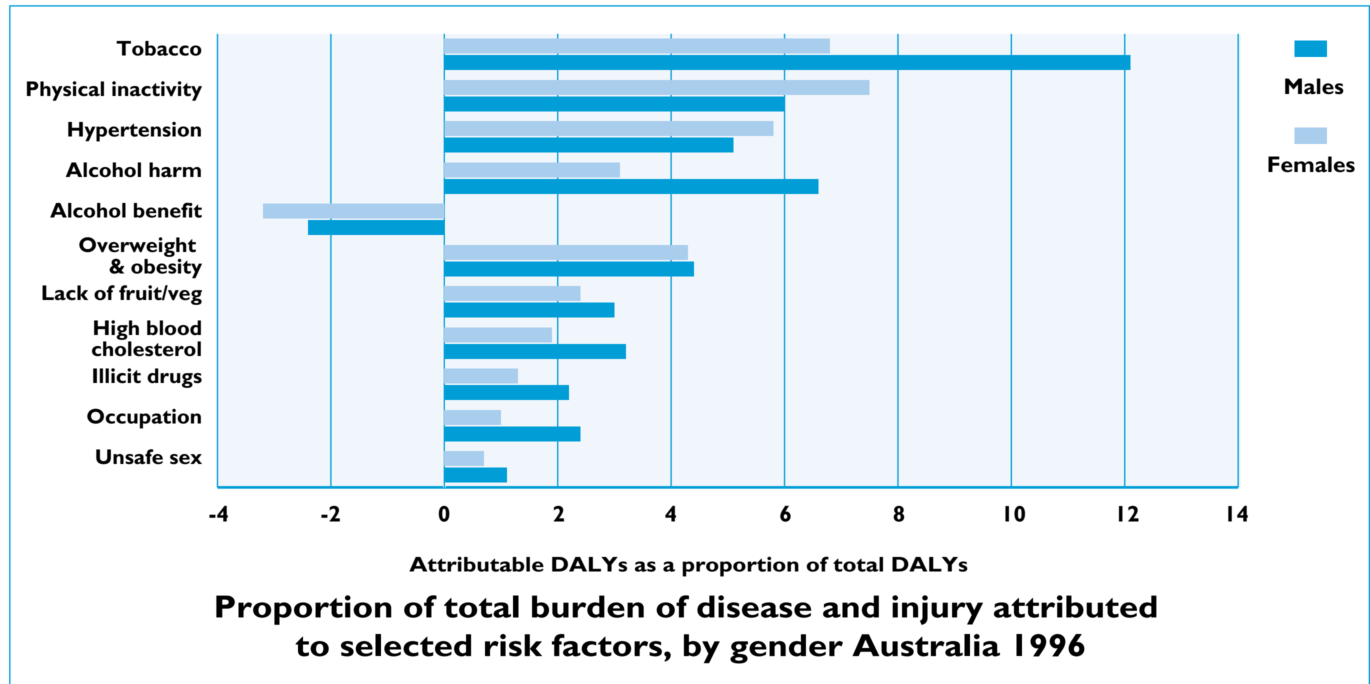


Deaths attributed to smoking by gender, NSW 1989–1998

D1 Source. The Health of the People of NSW – Report of the CHO, 2000



D2 Source. AHS Health Status Profiles



D3 Source. Mathers et al (1999) The burden of disease and injury in Australia

2. Monitoring, evaluation and future research

Monitoring

The NSW Department of Health requires Area Health Services to report annually on compliance monitoring for the tobacco sales to minors program. The Department keeps a central record of state wide compliance rates, prosecutions and fines.

At the time of writing, a scheme of monitoring compliance with all New South Wales tobacco related laws was being organised in consultation with the newly formed Tobacco Legislation Compliance Group.

Evaluation

Any policy, program or research funded by the Department must be evaluated. An evaluation component must be built into proposals and timeframes.

Future research

Research is required in many areas. Along with clarifying and measuring the strategic objectives covered in the preceding baseline data section, there is a need for basic research or pilot studies in a number of areas, particularly among priority groups including people with mental illness, Aboriginal and Torres Strait Islander people and young people.

It is expected that groups that have been or will be established, including the Tobacco Legislation Compliance Group and Tobacco Control Network, along with other existing networks, will facilitate the coordination of research and dissemination of results.

References

1 English DR, Holman CDJ, Milne EG et al. *The quantification of drug caused morbidity and mortality in Australia*. Commonwealth Department of Human Services and Health. Canberra: AGPS, 1995.

2 NSW Department of Health. *Passive smoking in the hospitality industry: options for control. Report of the NSW Passive Smoking Taskforce*. Sydney: NSW DoH, 1997.

3 World Health Organisation. *Tobacco Free Initiative*. 1998.http://www.who.org/inf-

4 Department of Health and Human Services. *National Tobacco Strategy 1999–2002/03: A framework for national action*. Canberra: AGPS, 1999.

5 NSW Department of Health. *NSW Tobacco and Health Strategy 1995–1999*. ISBN 0 7310 0696 8. State Health Publication Number 950064. Sydney: NSW DoH, 1995.

6 Public Health Division. *Healthy People 2005– New Directions for Public Health in NSW*. NSW Health Department: Sydney 2000.

7 Lopez PR, Boreham J et al. *Mortality from smoking in developed countries 1950-2000*. Oxford, ICRF and WHO. London: Oxford University Press, 1994.

8 Ridolfo, B & Stevenson, C. *The quantification of drug-caused morbidity and mortality in Australia, 1998*. AIHW cat no PHE 29 (Drug Statistics Series no 7). Canberra: Australian Institute of Health and Welfare (AIHW), 2001.

9 Williams P. *Progress of the national drug strategy: key national indicators*. Canberra: AGPS, 1997.

10 English DR, Holman CDJ, Milne MG et al. *The quantification of drug caused morbidity and mortality in Australia*. Commonwealth Department of Human Services and Health. Canberra: AGPS, 1995.

11 Peto R, Lopez A et al. *Health effects of tobacco use: Global estimates and projections*. Tobacco and Health 1995; 109–120.

12 Public Health Division. *The health of the people of New South Wales – Report of the Chief Health Officer, 2000*. NSW Health Department: Sydney, 2000

13 Coates M, Armstrong B. *Cancer in NSW Incidence and Mortality*. Sydney: Cancer Control Information Centre, NSW Cancer Council, June 1997.

14 Public Health Division. *The health of the people of New South Wales – Report of the Chief Health Officer*. NSW Health Department: Sydney 2000.

15 Public Health Division. *The health of the people of New South Wales – Report of the Chief Health Officer*. NSW Health Department: Sydney 2000.

16 Mathers C, Voss T & Stevenson C. *The burden of disease and injury in Australia*. Canberra: Australian Institute of Health and Welfare (AIHW), 1999.

17 Collins D, Lapsley H. The social costs of drug abuse in Australia in 1988 and 1992. *National Drug Strategy monograph series No.30*.Commonwealth Department of Human Services and Health. Canberra: AGPS, 1996.

18 Epidemiology and Surveillance Branch. *NSW Health Survey (HOIST)*. Sydney: NSW Dept of Health, online 2000.

19 Schofields WN, Lovelace KS, McKenzie JE, Burns L. Self Reported Tobacco and Alcohol Use Among Secondary School Students, *The 1996 Australian School Students' Alcohol and Drugs Survey*. Sydney: NSW Cancer Council and NSW DoH, 1998.

20 Commonwealth Department of Health and Aged Care. *National Tobacco Strategy 1999–2002/03: A framework for national action*. Canberra: Publications Production Unit, 1999.

21 Schofields WN, Lovelace KS, McKenzie JE, Burns L. Self reported tobacco and alcohol use among secondary school students, *The 1996 Australian School Students' Alcohol and Drugs Survey*. Sydney: NSW Cancer Council and NSW DoH, 1998.

22 Schofields WN, Lovelace KS, McKenzie JE, Burns L. Self reported tobacco and alcohol use among secondary school students, *The 1996 Australian School Students' Alcohol and Drugs Survey.* Sydney: NSW Cancer Council and NSW DoH, 1998.

23 Bowman J, Considine R, D'Este K, James E, Sanson-Fisher R. *Preliminary results of the 1996 survey of drug use by NSW primary school children.* NSW DoH and the Hunter Centre for Health Advancement, 1997.

24 Bauman A, Chen JC, Cooney A, Dobbinson S, Flaherty B. 1993 *Survey of drug use by NSW primary school children.* Sydney: NSW DoH, 1994.

25 NSW Drug & Alcohol Directorate.*1993 Survey of drug use by NSW primary school students.* Sydney: NSW DoH, 1994.

26 Commonwealth Department of Health and Aged Care. *National Tobacco Campaign 1999: Australia's National Tobacco Campaign evaluation report, Volume one: Every cigarette is doing you damage.* ISBN 064 39374 1999. Canberra: AGPS, 1999.

27 World Health Organisation. International Consultation on Environmental Tobacco Smoke (ETS) and Children. Division of Non Communicable Diseases. *Tobacco Free Initiative.* World Health Organisation, 1999. http://www.who.int/toh

28 Commonwealth Dept of Health and Family Services. *National Drug Strategy Household Survey 1995.* Canberra: AGPS, 1996.

29 National Health and Medical and Research Council. *The health effects of passive smoking.* Canberra: NHMRC, 1997.

30 English DR, Holman CDJ, Milne EG et al. *The quantification of drug caused morbidity and mortality in Australia.* Commonwealth Department of Human Services and Health. Canberra: AGPS, 1995.

31 Australian Institute of Health and Welfare (AIHW). *Report on Australia's children: their health and well-being, 1998.* National Drug Strategy Cat no Aus 10. Canberra: AIHW, 1999.

32 Rissel C, Hughes A. *A community-based approach to reduce youth tobacco use.* Final report to the NSW Dept of Health. (unpublished).

33 Australian Bureau of Statistics. *National Health Survey, Smoking 1989*–1990 Australia. Canberra: ABS, 1992.

34 US Department of Health and Human Services. *A report of the Surgeon General.* Dept of Health and Human Services Publication No PHS 82:50179. (Rockville, MD, : Public Health Service Office on Smoking and Health 1982.)

35 Bjartveit K, Foss OP, Gjervig T. in Armstrong B, deKlerk NH, Shean R, Dunn E and Dolin P. *Influence of Education and Advertising on the Uptake of Smoking by Children.* Med J Aust 1990; February; 152.

36 World Health Organisation. *Action on tobacco and health for 1995-1999.* Regional Office for Western Pacific. WHO,1995.

37 Hill D, White V, Letcher T. *Tobacco use among Australian secondary students in 1996.* Aust and N Z J Public Health 1999; 23: 3.

38 Schofields WN, Lovelace KS, McKenzie JE, Burns L. Self reported tobacco and alcohol use among secondary school students, *The 1996 Australian School Students' Alcohol and Drugs Survey.* Sydney: NSW Cancer Council and NSW DoH, 1998.

39 US Dept of Health and Human Services. *Preventing tobacco use among young people: A report of the US Surgeon General.* Public Health Service, Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Atlanta, Georgia: Dept of HHS, 1994.

40 Performance Management Division & Epidemiology and Surveillance Branch. *Interim National Performance Indicators and Targets for Aboriginal and Torres Strait Islander Health – NSW Report 1998.* Sydney: NSW Dept of Health, 1998.

41 Commonwealth Dept of Human Services and Health. *National Drug Strategy Household Survey – Urban Aboriginal and Torres Strait Islander supplement.* Canberra: AGPS, 1994.

42 Epidemiology and Surveillance Branch. *NSW Health Survey 1997 & 1998 Electronic Report*. Sydney: NSW Health Dept, 1999. [http://internal.health.nsw.gov.au/public-health/hs97]

43 Andrews B, Stephenson J. *Smoking and Health Report Orana and Far West Region*. Dubbo: Health Promotion Unit, Dubbo, 1993.

44 Guest CS, O'Dea K, Carlin JB, Larkins RG. *Smoking in Aborigines and persons of European descent in South eastern Australia: prevalence and associations with food habits, body fat distribution and cardiovascular risk factors*. Aust J Public Health, 1992; 16:397-402.

45 Epidemiology and Surveillance Branch. *NSW Health Survey (HOIST)*. NSW Health Department. Sydney: NSW DoH, 1999.

46 Jorm A F. *Association between smoking and mental disorders: results from an Australian National Prevalence Survey.* Aust and NZ J Public Health 1999; 23(3), 245-248.

47 Jorm A F. *Association between smoking and mental disorders: results from an Australian National Prevalence Survey*. Aust and N Z J Public Health 1999; 23(3), 245-248.

48 Gray NJ, Daube MM, editors. *Guidelines for smoking control.2nd ed*. UICC Technical Report Series, Volume 52. Geneva: UICC, 1980.

49 Saffer H, Chaloupka F et al. *Tobacco advertising: economic theory and international evidence.* Working Paper 6958. Cambridge, Massachusetts: The National Bureau of Economic Research, 1999. Online at www.papers.nber.org/papers/W6958

50 Pierce JP, Macaskill P, Hill D. *Long term effectiveness of mass media led anti smoking campaigns in Australia.* Aust J Public Health 1990 May; 80: 5.

51 Commonwealth Department of Health and Aged Care. *National Tobacco Campaign 1999: Australia's National Tobacco Campaign evaluation report, Volume one: Every cigarette is doing you damage.* ISBN 064 39374 1999. Canberra: AGPS, 1999.

52 Pierce JP, Dwyer T, Frape G, Chapman S et al. *Evaluation of the Sydney quit for life anti-smoking campaign part 1. Achievement of immediate goals.* Med J Aust 1986; 144:341-347.

53 Pierce J, Macaskill P, Hill D. *Long term effectiveness of mass media led anti-smoking campaigns in Australia.* Am J Public Health 1990; 80:565-9.

54 Commonwealth Department of Health and Aged Care. *National Tobacco Campaign 1999: Australia's National Tobacco Campaign evaluation report, Volume two: Every cigarette is doing you damage.* ISBN 064 2433 151. Canberra: AGPS, 2000.

55 US Department of Health and Human Services. The health benefits of smoking cessation. *A report of the US Surgeon General.* Rockville, Maryland: US Department of Health and Human Services, Public Health Service. Centres for Disease Control, Centre for Chronic Disease Prevention and Health Promotion. Office on Smoking and Health. DHHS Publication No 90-8416. 1990.

56 Doll R, Peto R, Wheatley K, Gray R, Sutherland I. *Mortality in relation to smoking: 40 years observations on male British doctors.* Br Med J 1994; 309:901-911.

57 Borland R, Hill D. Two month follow up on callers to a telephone quit smoking service. *Drug and Alcohol Review.* 1990; 9; 211-218.

58 Epidemiology and Surveillance Branch. *NSW Health Survey (HOIST).* NSW Health Department. Sydney: NSW DoH, 1999.

59 US Department of Health and Human Services. *The health benefits of smoking cessation. A report of the US Surgeon General.* Rockville, Maryland: US Department of Health and Human Services, Public Health Service. Centres for Disease Control, Centre for Chronic Disease Prevention and Health Promotion. Office on Smoking and Health. DHHS Publication No 90-8416. 1990.

60 Prochaska J, DiClemente C. As cited in the US Department of Health and Human Services. *The health benefits of smoking cessation. A report of the US Surgeon General.* Rockville, Maryland: US Department of Health and Human Services, Public Health Service. Centres for Disease Control, Centre for Chronic Disease Prevention and Health Promotion. Office on Smoking and Health. DHHS Publication No 90-8416. 1990.

61 NSW Department of Health(Health Promotion Branch). *1994 NSW Health Promotion Survey.* Sydney: NSW DoH, 1995.

[62] US Department of Health and Human Services. Public Health Service. *Treating Tobacco Use and Dependence*. June 2000 pg 5.

[63] US Department of Health and Human Services. Public Health Service. *Treating Tobacco Use and Dependence.* June 2000 pps 3–5.

[64] Borland R, Chapman S. *Advertising of nicotine replacement therapy: has it promoted more smoking cessation*. Sydney: Smithkline, Beecham Consumer Healthcare, 1999.

[65] US Department of Health and Human Services. *Preventing Tobacco Use Among Young People: A report of the US Surgeon General*. Public Health Service, Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. 1994 DHHS Publication.

[66] Schofields WN, Lovelace KS, McKenzie JE, Burns L. Self reported tobacco and alcohol use among secondary school students, *The 1996 Australian School Students' Alcohol and Drugs Survey*. Sydney: NSW Cancer Council and NSW DoH, 1998.

[67] Chapman S, King M, Markham P, Woodward S. *Effects of publicity and warning letters on illegal cigarette sale to minors following purchase attempts by 12–17 year old children*. Aust J Public Health 1994: vol 18, no 1.

[68] Health Promotion Unit, Central Coast Area Health Service. *Our smokers are getting younger – tobacco control for youth on the Central Coast*. (unpublished).

[69] Junck E, Humphries J, Rissel C. *Reducing tobacco sales to minors in Manly: 10 months follow-up*. Health Promotion J Aust 1997; 7: 1.

[70] Schoenmakers I, Nyhuis A, Rissel C, Chapman S. *The role of ethnicity in sales of cigarettes to minors*. Health Promotion J Aust 1997; 7:1.

[71] US Department of Health and Human Services. *Preventing tobacco use among young people: A report of the US Surgeon General*, Public Health Service, Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. 1994 DHHS Publication.

[72] Di Franza JR. *Active enforcement of minors access laws: A moral and ethical imperative.* Tobacco Control 1995; 4:5.

[73] Tutt D, Bauer L, Edwards C, Cook D. *Reducing adolescent smoking rates: Maintaining high retail compliance results in substantial improvements.* Health Promotion J Aust 2000;10 (1): 20-24.

[74] US Department of Health and Human Services. *Preventing tobacco use among young people: A report of the US Surgeon General*. Public Health Service, Centres for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. 1994 DHHS Publication.

[75] Anti Cancer Society and the National Heart Foundation of Australia. *Federal excise on tobacco; Tobacco tax solutions.* May 1998 Budget: A submission to the Australian parliament. Anti-Cancer Council of Victoria, November 1997.

[76] US Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General.* Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Centres for Disease Control, Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. DHHS Publication No (CDC) 89–8411.

[77] Townsend JL, Roderick P, Cooper J. *Cigarette smoking by socioeconomic group, sex and age: effects of price, income, and health publicity*. Br Med J 1994;309:923-926.

[78] Farrelly MC, Bray JW. Office on Smoking and Health. *Response to increases in cigarette prices by race/ethnicity, income and age groups – United States, 1976-1993*. MMWR Morb Mortal Wkly Rep 1998;47:605-609.

[79] US Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General.* Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Centres for Disease Control, Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. DHHS Publication No (CDC) 89–8411.

80 Department of Health; Economics and Operational Research Division. Effect of tobacco advertising on tobacco consumption: a discussion document reviewing the evidence. London: Department of Health, 1992.

81 Armstrong BK, de Klerk NH, Shean RE, Dunn DA, Dolin PJ. *Influence of education and advertising on the uptake of smoking by children*. Med J Aust 1990; 152: 117–124.

82 Vickers A. *Why cigarette advertising should be banned*. Br Med J 1992;304:1195-1196.

83 Armstrong BK, de Klerk NH, Shean RE, Dunn DA, Dolin PJ. *Influence of education and advertising on the uptake of smoking by children*. Med J Aust 1990;152:117–124.

84 Scollo M. *The future regulation in Australia of products delivering nicotine: deliberations, conclusions and recommendations following a one day symposium*. Melbourne:Victorian Smoking and Health Program, 1998. ISBN 1 875186 26 3.

85 Scollo M. *The future regulation in Australia of products delivering nicotine: deliberations, conclusions and recommendations following a one day symposium*. Melbourne:Victorian Smoking and Health Program, 1998. ISBN 1 875186 26 3.

86 NSW Department of Health. Passive smoking in the hospitality industry: Options for control. *Report of the NSW Passive Smoking Taskforce.* Sydney: NSW DoH, 1997.

87 NSW Department of Health, Drug and Alcohol Directorate. *NSW Drug Strategy 1993–1998.* Sydney: NSW DoH, 1993.

88 NSW Health Department. *NSW Tobacco and Health Strategy 1995–1999.* ISBN 0 7310 0696 8. State Health Publication Number 950064. Sydney: NSW DoH, 1995.

89 World Health Organisation. International Consultation on Environmental Tobacco Smoke (ETS) and Children. Division of Non Communicable Diseases. *Tobacco Free Initiative.* WHO, 1999. http://www.who.int/toh

90 Department of Health and Human Services. *National Tobacco Strategy 1999–2002/03: A Framework for National Action*. Canberra: AGPS, 1999.

91 National Health and Medical and Research Council. *The health effects of passive smoking.* Canberra: NHMRC, 1997.

92 Australian Institute of Health and Welfare (AIHW). *Report on Australia's children: their health and well-being.* Cat no Aus 10. National Drug Strategy. Canberra: AIHW, 1999.

93 NSW Department of Health (Health Promotion Branch). *NSW Health Promotion Survey*. Sydney: NSW DoH, 1995.

94 Commonwealth Dept of Health and Aged Care. Australia's National Tobacco Campaign. *Evaluation Report Volume one*. Canberra, 1999.

95 Commonwealth Dept of Human Services and Health. *National Drug Strategy Household Survey – Urban Aboriginal and Torres Strait Islander Supplement*. Canberra: AGPS, 1994.

96 Borland R, Chapman S. *Advertising of nicotine replacement therapy: has it promoted more smoking cessation*. Sydney: Smithkline, Beecham Consumer Healthcare, 1999.

97 Commonwealth Dept of Health and Aged Care. Australia's National Tobacco Campaign. *Evaluation Report Volume one.* Canberra, 1999.

98 Commonwealth Dept of Human Services and Health. *National Drug Strategy Household Survey – Urban Aboriginal and Torres Strait Islander Supplement*. Canberra: AGPS, 1994.