

Framework for  
Reducing Smoking Initiation  
in Aotearoa-New Zealand

HSC  
(Health Sponsorship Council)

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- Helen Darling: Researcher, University of Otago
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For further information about the Framework please contact Tane Cassidy, HSC.

## EXECUTIVE SUMMARY

This *Framework for Reducing Smoking Initiation* proposes a comprehensive suite of interventions and initiatives to reduce smoking initiation in Aotearoa-New Zealand. The Framework has been developed for use by health providers, health funders, policy makers and researchers.

The Framework is based on evidence from the *Reducing Smoking Initiation Literature Review* (HSC, 2005) and informed by key stakeholders within the tobacco control and related areas in New Zealand.

The Framework supports Objective One of *Clearing the Smoke* (Ministry of Health, 2004) the Ministry of Health's five year tobacco control strategy: to prevent smoking initiation. The Framework also supports the Ministry of Social Development's strategic document, *Opportunities for All New Zealanders 2004* (Ministry of Social Development, 2004) in which reducing tobacco use is identified as a critical area *requiring sustained interagency attention over the next three to five years*.

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

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

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

This suggests the need for a nationally coordinated approach to reducing smoking initiation that is responsive to local, cultural, age and gender specific contexts. Furthermore, cross sector and intersectoral collaboration is crucial to maximising effectiveness of both local and national strategies.

The Framework identifies the need for a youth development approach when developing and implementing strategies aimed at young people<sup>1</sup>.

Obtaining information is critical to the development and implementation of effective strategies and a research plan will, therefore, be developed to complement this Framework.

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<sup>1</sup> The youth development approach is set out in the *Youth Development Strategy Aotearoa 2002*. Wellington: Ministry of Youth Development.

## **1. BACKGROUND – DEVELOPMENT OF THE FRAMEWORK**

### **1.1 Purpose of the *Framework for Reducing Smoking Initiation***

The purpose of this document is to provide a framework for government and non-government agencies working in the area of tobacco control to develop a coordinated and comprehensive approach to reducing smoking initiation.

A cross-sector and inter-sectoral approach, facilitated by strong local and national collaboration will enable coordinated responses to the specific requirements of priority groups. The need for greater coordination and collaboration in order to enhance the effectiveness of current and proposed interventions has been noted in both the Ministry of Health's five-year tobacco control strategy, *Clearing the Smoke* and *The New Zealand Cancer Control Strategy: Action Plan 2005 – 2010* (see pages 15 and 16).

The strategies set out in this document aim to provide a framework to improve the coordination of tobacco control interventions and address health inequalities, where tobacco use is a contributing factor, particularly in relation to the priority groups identified.

### **1.2 Context - Smoking and tobacco control**

Each year in New Zealand it is estimated that between 4,300 and 4,700 people die from smoking-related illnesses (Ministry of Health, 2002c). Such illnesses, and the associated suffering and premature deaths caused by smoking, are preventable. Accordingly, both government and non-government organisations have employed multiple approaches to reduce smoking prevalence in order to improve health outcomes, enhance people's wellbeing, address health inequalities, and reduce the financial burden of tobacco use.

A decline in general smoking prevalence over the past 30 years has been attributed to the combined approach to tobacco control. However, the decline has recently slowed and in the mid to late 1990s there was a rise in the prevalence of young people smoking, especially among young Māori women (Ministry of Health, 2002a).

#### ***Tobacco control measures***

The Ministry of Health and non-government agencies have taken actions to reduce tobacco-related harm, through the use of campaigns, programmes, policy and legislation. In the Ministry of Health's five-year tobacco control strategy (Ministry of Health, 2004) five areas requiring continued attention are identified. Preventing smoking initiation is the first of these.

The actions considered by the Ministry of Health to prevent smoking initiation include:

- increasing tobacco taxation
- targeted mass media campaigns
- tobacco industry regulations
- health promotion
- enforcement of current law.

The *Framework for Reducing Smoking Initiation* supports these actions and adds value with a focus on enhancing factors that protect against smoking initiation and identifying young people as a priority group for the Framework.

The Framework includes strategies not generally considered the primary responsibility of the health sector, for example, developing life skills and ensuring opportunities for appropriate and meaningful participation by young people in their communities. However, the progression from the *preparatory stage* to that of *regular smoker* (Ling P & Glantz S, 2002)<sup>2</sup> occurs within complex social, economic, cultural and political environments. For this reason, the strategies set down in the Framework require actions from Government and non-government agencies, within and beyond the ambit of conventional tobacco control.

### **1.3 Smoking initiation**

The transition from being a non-smoker to becoming an addicted smoker is viewed as a process rather than a singular event. This process is generally seen as occurring over five stages - preparatory, trying, experimental, regular, and finally the addicted/dependent smoker<sup>2</sup> (Ling P & Glantz S, 2002). For those who become addicted smokers, progression through these stages is seen to occur over a two-to-three-year period, regardless of age.

Research shows that the longer the onset of smoking is delayed, the less likely a person is to become a daily smoker (US Surgeon General, 1994). Initiation to smoking usually occurs during pre-adolescence, with daily smoking behaviours typically established before the end of adolescence (NFO CM Research, 2001a 2001b; Stanton W, et al, 1989; US Surgeon General, 1994). To reduce smoking prevalence, tobacco control efforts need to address the three stages prior to regular smoking.

### **1.4 Development of the *Framework for Reducing Smoking Initiation***

In 2004, the HSC was contracted by the Ministry of Health to undertake a literature review on youth smoking initiation (HSC, 2005) and, using the review as a basis, to develop a national framework to reduce smoking initiation in New Zealand. A review committee made up of individuals with expertise in youth tobacco control

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<sup>2</sup> The first, preparatory, stage is where prospective smokers form attitudes and beliefs about the utility of smoking and advertising. The second, trying, stage is characterised by the person smoking a few cigarettes. The third stage is experimental where the person smokes repeatedly but irregularly. During the fourth, regular, stage the person moves into regular use of cigarettes, where they are smoking at least weekly, across a variety of situations and personal interactions. The final, addicted/dependent, stage is the move to become a dependent or addicted smoker; at this point the person has developed the physiological need for nicotine (Ling P & Glantz S, 2002).

was convened to assist in the development of both the literature review and the Framework (see Appendix A for a full list of review committee members).

The review committee, having established the parameters of the literature review, also provided expert opinion on how the literature review and other relevant issues should be translated into the national Framework.

During the development of the national Framework, input was also sought from young people, Māori, Pacific peoples, government and non-government agencies, and experts in the field of tobacco control. The purpose of the engagement was to:

- test proposed initiatives with those who would be involved in their implementation
- receive input to inform the development of an implementation plan
- secure support and commitment to the *Framework for Reducing Smoking Initiation* and future implementation.

A full list of those groups, agencies and individuals consulted in relation to the Framework is included in Appendix B.

## **1.5 The literature review**

The *Reducing Smoking Initiation Literature Review* carried out by the HSC (HSC, 2005) examined relevant national and international evidence and identified risk and protective factors relating to smoking initiation and interventions aimed at reducing smoking initiation. Evidence from the literature review informed the selection of initiatives. The findings of the review are summarised below under the *Strategies to reduce the incidence of smoking initiation* section (see page 21).

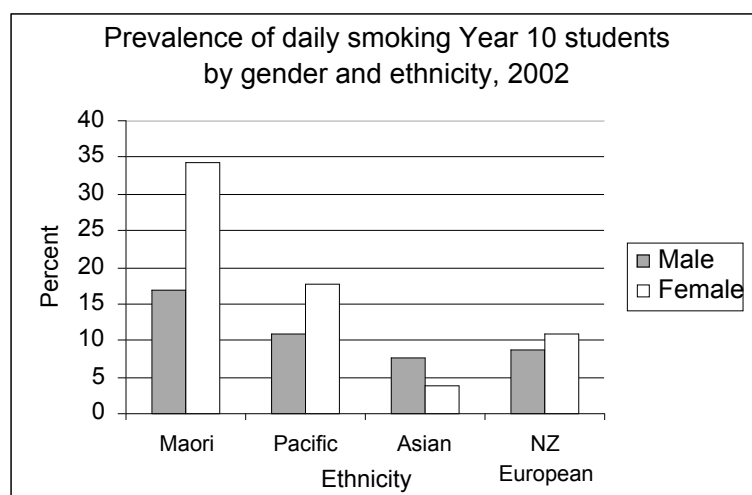
## **1.6 Youth smoking in New Zealand**

The decrease in adult smoking prevalence that has occurred in New Zealand over the past 30 years has slowed during the past decade. This slowing of progress was accompanied by an increase in the smoking rates of 14 and 15 year old students during the 1990s that affected both sexes, all regions, and all ethnic and socio-economic groups. However, the results of the 2002 ASH Survey, reported by the Ministry of Health, suggest that daily, weekly and monthly smoking rates of 14 and 15 year olds have declined since 1999 (Ministry of Health, 2003a).

### ***Smoking among ethnic groups***

Results from the 2002 Youth Lifestyle Survey (YLS) (Darling H, Reeder A, & Waa A, 2004)<sup>3</sup> and 2002 ASH survey<sup>4</sup> indicated that 33 to 34 percent of year 10 Māori females and 17 percent of year 10 Māori males, were daily smokers.

**Figure 1. Prevalence of daily smoking among Year 10 students**



Source: Tobacco Facts, Public Health Intelligence: Occasional Report No. 2. 2003, Ministry of Health: Wellington

### ***Smoking by sex***

The decline in smoking rates appears to have been greater for young males, with daily smoking among females consistently higher than males over the past decade. New Zealand studies of young people aged 14 to 16 consistently show a smoking rate for females of around five percent higher than for males.

Reported smoking rates (Scragg R, et al., 2002) for Year 10 female students indicated that :

- Māori students were 2.7 times more likely to smoke daily than New Zealand European students
- Pacific students were 1.5 times more likely to smoke daily than New Zealand European students
- 18 percent of Pacific students were smoking daily in 2002
- Asian students were about half as likely to smoke as New Zealand European students.

Reported smoking rates (Scragg R, et al., 2002) for Year 10 male students indicated that:

<sup>3</sup> The New Zealand Youth Lifestyle Survey is a biennial survey that uses multi-stage cluster sampling and aims to recruit 2,500 Year 10 and 1,000 Year 12 students. Data from the study is reported in 'Tobacco use among Year 10 and 12 students in New Zealand' 2004. Darling, Reeder, & Waa.

<sup>4</sup> [www.ash.org.nz/pdf/Smoking/Youth/ASH2002Survey.pdf](http://www.ash.org.nz/pdf/Smoking/Youth/ASH2002Survey.pdf).

- Māori students were 1.9 times more likely to smoke than New Zealand European students
- Pacific students were 1.4 times more likely to smoke than New Zealand European students
- 11 percent of Pacific students were smoking daily in 2002
- Asian students were 0.78 times as likely to smoke than New Zealand European students.

### ***Smoking by age and school year***

Students who were daily smokers by Years 10 and 12 were more likely to have tried smoking at younger ages. This was particularly so for Māori daily smokers. For example, 30 percent of Māori males and 19 percent of Māori females reported trying their first cigarette at seven years of age or younger. This compares to 17 percent of non-Māori males and eight percent of non Māori females (Darling, unpublished).

### ***Smoking by socio-economic position***

Students who came from lower decile schools or who identified as Māori were more likely to try smoking at earlier ages compared with students from higher decile schools or who identified as New Zealand European.

Male and female students at schools with the lowest school deciles reported higher daily smoking rates than students at schools with higher deciles. Students in low decile schools (deciles 1 to 3) reported 17 percent daily smoking in comparison to 12 percent in middle decile schools (4 to 6) and 11 percent in high decile schools (7 to 10) (Darling H, Reeder A, & Waa A, 2004).

## **1.7 Priority groups**

There are common factors relating to smoking initiation across all ethnic, sex, and socio-economic groups in New Zealand and internationally. However, research shows that associations of varying strengths exist between particular demographic groups and smoking initiation. The evidence identifies indigenous peoples as having higher rates of smoking than other groups. Within this group, females are more likely to smoke than males. Across all ethnic and sex groupings, those with lower socio-economic position have higher rates of tobacco use (HSC, 2005).

The evidence suggests that smoking initiation in New Zealand occurs at ages as young as seven and on into adulthood (Darling H, Reeder A, & Waa A, 2004). The strategies in this Framework are inclusive of these age groups. However, a focus on reducing smoking initiation in the intermediate and secondary school population is clearly supported by the literature.

## *Young people*

Smoking uptake usually occurs during adolescence, while the vast majority of smoking-related deaths occur in middle-aged and elderly people. The longer the onset of smoking is delayed, the less likely a person is to become addicted (US Surgeon General, 1994). Young people who smoke may become addicted before reaching adulthood, making them less able to quit smoking and more likely to have a tobacco-related health problem.

Smoking experimentation remains a consistent characteristic of adolescence and as a young person moves through this period the likelihood of smoking increases (McCool J, Cameron L, Petrie K, et al., 2003). Tobacco use among adolescents is a critical indicator not only of the initiation of tobacco use but of future trends in tobacco addiction and tobacco-related disease in adults (HSC, 2005). To further reduce smoking prevalence, tobacco control efforts need to address smoking initiation among young people. Therefore, young people are identified as the primary priority group for the Framework. This group can be divided into pre-adolescents (most of whom have not yet tried tobacco) and early adolescents (a key time when young people start to become regular tobacco users).

The review committee has identified the further priority groups for this *Framework for Reducing Smoking Initiation*, based on the literature review and expert opinion, to be:

- Māori
- Pacific peoples
- females
- young people attending low decile schools.

There are specific issues particular to each group. These issues relate to risk and protective factors identified in the literature review, and have been taken into account in the development of this Framework. The issues are described in the table below.

**Table 1: Priority groups and special issues particular to them**

<b>Priority Group</b>	<b>Specific issues</b>
Māori	<ul style="list-style-type: none"><li>• <i>Treaty of Waitangi</i> – Under article two of the Māori version of the Treaty Māori can be seen as having the right to determine their own destiny. In relation to the Framework Māori are seen as a priority group as they have a right to deliver interventions to address Māori youth smoking. Related to this, the government is seen as having obligations of ensuring that interventions are delivered with Māori as partners and as participants in programme development, delivery, and as users. Also, where disparities are known to exist (see below) the Government is obliged to protect the health of Māori.</li><li>• <i>Inequalities</i> – Recognising Māori as a priority group in the</li></ul>

	<p><i>Framework for Reducing Smoking Initiation</i> is consistent with <i>Reducing Inequalities in Health</i> (Ministry of Health, 2002a). Tobacco use is a significant contributing factor to poorer health outcomes in Māori compared with non-Māori. This is reflected in the higher Māori rates of lung cancer, heart disease, SIDS, respiratory infections, glue ear, meningococcal disease and diabetes (Apārangi Tautoko Auahi Kore, 2003). Māori lung cancer morbidity rates are currently three times higher than non-Māori rates (Ministry of Health, 2005).</p> <ul style="list-style-type: none"> <li>- <i>Smoking disparity</i>: Evidence shows that young Māori females have particularly high rates of smoking (Ministry of Health, 2003c).</li> <li>- <i>Socio-economic</i>: The economic cost burden on Māori from purchasing tobacco and the cost of tobacco-related absenteeism, premature death and illness is likely to be particularly severe for Māori given higher rates of use (Apārangi Tautoko Auahi Kore, 2003).</li> <li>- <i>Trends</i>: Prevalence of smoking among Māori has not reduced at similar rates to non-Māori over recent years. The Māori smoking rate remains more than double the smoking rate for non-Māori (Ministry of Health, 2003c).</li> <li>• <i>Absolute health burden</i> – Māori represent a significant proportion of the New Zealand population. This proportion is expected to increase over the next 20 years. As Māori have high smoking rates this means that smoking-related illnesses among Māori are likely to place a significant burden on the health system compared with other ethnic groups.</li> </ul>
Pacific peoples	<ul style="list-style-type: none"> <li>• <i>Inequalities</i> – Recognising Pacific peoples as priority group(s) in the <i>Framework for Reducing Smoking Initiation</i> is consistent with <i>Reducing Inequalities in Health</i> (Ministry of Health, 2002a). <ul style="list-style-type: none"> <li>- <i>Smoking disparity</i>: Pacific peoples have higher overall smoking rates compared with those of European descent. This difference is largely due to higher smoking rates for Pacific men and young Pacific peoples (aged 14-15) than the same European groups (Ministry of Health, 2004).</li> <li>- <i>Socio-economic</i>: Pacific peoples are over represented in lower paid jobs and are more represented in the most deprived decile rating than both Māori and European ethnic groups. The financial burden from tobacco-related absenteeism, premature death and illness is also particularly problematic for Pacific peoples (Ministry of Health, 2004).</li> <li>- <i>Disparity in use of health services</i>: Barriers to Pacific peoples accessing health services exist around language, transport, affordability and cultural responsiveness</li> </ul> </li> </ul>

	<p>(Ministry of Health, 2002b).</p> <p>– <i>Trends</i>: Pacific peoples have a much younger age structure than the total population: 39 percent of all Pacific peoples were under the age of 15 in 2001 Census<sup>5</sup>.</p>
Females	<ul style="list-style-type: none"> <li>• <i>Smoking disparity</i> – In New Zealand for ages 15-24 years, smoking has persistently been more prevalent among females than males. For ages 25-34 years, male and female smoking prevalence has been similar, and for ages 35 years and over, smoking has generally been more prevalent among males (Ministry of Health, 2003c).</li> <li>• <i>Protection of infants</i> – There are health risks to infants and children exposed to second-hand smoke. Health risks to infants are also associated with women smoking during pregnancy – maternal smoking is a preventable risk to children dying of SIDS (Ministry of Health, 2003c).</li> <li>• <i>Unique risk factors</i> – Research indicates that women and girls may use tobacco products as a response to issues around self-image with regard to weight control and a response to depression (HSC, 2005).</li> <li>• <i>Trends</i> – As the cohort of females with high proportion of smokers grows older it is likely that smoking will become more prevalent among females than males (Ministry of Health, 2003c).</li> </ul>
Low-socio-economic position	<ul style="list-style-type: none"> <li>• <i>Smoking disparity</i> – There is substantial evidence in New Zealand that adults in lower socio-economic groups have higher smoking rates (Ministry of Health, 2003b). Furthermore, non-smoking adults in lower socio-economic groups appear to suffer from increased exposure to second-hand smoke (Ministry of Health, 2004).</li> <li>• <i>Health inequality</i> – Adverse health outcomes related to tobacco-related disease is greatest among New Zealanders in lower socio-economic groups. These socio-economic factors are prevalent throughout life and across generations (Ministry of Health, 2003b). Thus, health in middle and old age depends on past circumstances as well as present ones. The health effects of economic disadvantage accumulate over time.</li> <li>• <i>Absolute health burden</i> – Health outcomes are influenced by socio-economic factors negatively compounded by high rates of smoking among lower socio-economic groups.</li> </ul>

## 1.8 Risk and protective factors relating to smoking initiation

Like many health behaviours, smoking is not necessarily entirely determined by individual choice. Smoking behaviour can be influenced by factors external to the individual. That is, smoking behaviour occurs within a social context. This context can be the individual's immediate environment, the families and communities in which they live or the wider society in which they live. Risk and protective factors can be observed that are specific to each of these levels and at a

<sup>5</sup> Source: Statistics New Zealand [www.stats.govt.nz](http://www.stats.govt.nz).

general level have been referred to as the determinants of health (Ministry of Health, 1997).

Risk factors are those experiences and characteristics that increase the probability that one will smoke, and protective factors are those that reduce that probability.

A review of the evidence in the *Reducing Smoking Initiation Literature Review* (HSC, 2005) suggests there are many risk factors associated with why young people take up smoking. They are compounding, overlapping and cumulative. These are to do with a young person's accessibility to tobacco products, social norms and how society treats young people.

Conversely, the evidence also indicates that there are a number of factors that protect against smoking initiation. These factors also operate at different levels in society and are compounding, overlapping and cumulative. They are developed through interactions within and between whānau/family, school, peer and other social environments (HSC, 2005).

General levels within society at which risk and protective factors can influence tobacco use include:

- 1. Population:** Population factors are those that exist in society in general and have an influence on individual behaviour. They can include social factors and prejudices, economic policy and health legislation. Population level factors can impact on youth in general or specific groups among youth. They are also often inter-linked in complex ways.
- 2. Community:** Community factors include the nature and dynamics of social environments in which youth participate: at school, at work, within the community and with peers.
- 3. Whānau/family:** Whānau/family factors include parental/family smoking behaviour, attitudes to smoking within the whānau/family, the nature of association and dynamics within the whānau/family and the physical environment in which the whānau/family live.
- 4. Individual or personal:** Individual/personal factors are those relating to self-esteem and self-concept, personal resources, resiliency, developmental assets, attitudes and beliefs, participation in other risk behaviours and the way in which stress and the pressures of life are coped with.

Evidence shows that the most prominent modifiable risk factors for smoking initiation are peer smoking, family environment, the nature of access to tobacco products, low self-esteem, and participation in risk-taking behaviours. The most prominent protective factors across all cohorts include doing well within the school environment, participation in community or sports clubs, spiritual connectedness and family connectedness.

Available evidence on the cumulative and overlapping nature of risk and protective factors indicates the need for a comprehensive approach to any framework that aims to reduce smoking initiation. Evidence suggests there are a number of key elements with which to enhance the effectiveness of interventions. Interventions must:

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

## **1.9 Areas identified for further investigation**

During the course of developing the Framework, a number of modifiable risk factors were identified. However, two important areas have not been included in the Framework. These two key areas are disparities in the social and economic determinants of health and the regulating of tobacco product content. They have not been included due to the selection of interventions being limited by the principles set out on page 21 of this Framework, or because it was not possible to identify practical and effective interventions at this stage that could be implemented as part of the Framework.

It is likely that interventions in both these areas could potentially have a significant impact on smoking uptake. It is proposed that they receive further consideration during future reviews of the Framework. The areas should also be considered as important research issues for the related research and evaluation plan (currently being developed).

### ***Tobacco product content and the potential for future regulations***

Concerns have been expressed by the World Health Organization (WHO, 2000) and others regarding additives and compounds in tobacco products and their potential to ease progression to long-term smoking. These include compounds that may impact on the addictiveness and palatability of tobacco products, or that reduce irritation of the throat or allow for easier absorption of smoke or nicotine.

The New Zealand Ministry of Health has initiated work looking at the long-term regulation of tobacco products, including giving consideration to regulations on the permitted content of tobacco products. The review committee considered this an area for careful consideration and review, given the potential for such modifications to either ease, or discourage, transition to regular smoking by young people.

### ***Determinants of health***

Significant health inequalities exist between various groups within New Zealand, particularly affecting Māori, Pacific and lower socio-economic groups. Various models have been developed to explain the causes of health inequalities. Typically these models place individual health behaviours in the context of:

- social and community influences

- living and working conditions
- gender and culture
- socio-economic and environmental conditions.

(Ministry of Health, 2002a)

Evidence suggests that those groups most affected by health inequalities are also more likely to have higher rates of smoking. Smoking is an intermediary and structural cause of health inequalities. The former through the direct health impacts of smoking and the latter through the loss in income among those addicted to smoking due to the direct and indirect cost of tobacco use.

Woodward and Kawachi (2000) suggest that inequitable access to the social and economic determinants of health affect and limit health behaviour-related choices. They advocate for a social justice approach whereby a just society is seen as one where all citizens have equitable access to these determinants.

The National Advisory Committee on Health and Disability (1998) has suggested that key determinants include access to adequate housing, adequate income, appropriate education and employment. As social and economic determinants typically lie outside the health arena, careful consideration is required to determine the most effective and appropriate way for those working within tobacco control to engage these areas. This may include the establishment of intersectoral groups or the provision of support for agencies implementing interventions in these areas. Assisting community organisations in their work to support communities with health and social issues is another possibility.

Addressing social and economic determinants must be considered within the context of other approaches to reducing health inequalities, including directly reducing smoking disparities among priority groups.

The challenge is to identify the areas where tobacco control could most practically and effectively influence health determinants, given available resources.

## 2. GOALS AND OBJECTIVES

Reducing smoking initiation in Aotearoa New Zealand is about:

- promoting a smokefree lifestyle in New Zealand
- valuing our young people and providing them with positive opportunities
- reducing health inequalities, especially for Māori and Pacific peoples
- building safe, healthy communities, and enhancing wellbeing.

### 2.1 Goal of the *Framework for Reducing Smoking Initiation*

There is one primary, overarching goal for the Framework:

*Reduce the incidence of New Zealanders becoming addicted smokers.*

A reduction in the incidence of smoking will be evident through a reduction over time in the percentage of people becoming addicted smokers.

### 2.2 Objectives

There are four primary objectives associated with the *Framework for Reducing Smoking Initiation*.

- Develop personal skills: resisting tobacco use.
- Affordability and access: reducing the affordability and access by youth to tobacco products.
- Denormalise tobacco use: reducing prevalence of attitudes and behaviours that reinforce the use of tobacco products in New Zealand.
- Positive identity development: strengthen associations with key social environmental factors that contribute to the formation of self-identities.

A further objective cuts across the other objectives and is seen as a crucial addition to the others.

- Improve support for coordinated monitoring, surveillance and evaluation of smoking initiation and interventions to address initiation.

### 2.3 Risk factors and sub-objectives

Associated with each of the objectives are a series of sub-objectives that aim to address the risk factors as identified by research literature.

Risk Factors	Sub-objectives for the Health Sector in New Zealand
<ul style="list-style-type: none"> <li>• Low self-esteem and the nature of self-concept held by some youth.</li> <li>• The way in which stress is dealt with by youth as well as a range of associated mental health issues.</li> <li>• The participation in other risk behaviours, including the excessive use of alcohol and use of illicit drugs.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop personal skills – resisting tobacco use:               <ul style="list-style-type: none"> <li>– develop skills which support young people to be able to refuse tobacco</li> <li>– develop social skills of young people.</li> </ul> </li> </ul>

Risk Factors	Sub-objectives for the Health Sector in New Zealand
<ul style="list-style-type: none"> <li>• The affordability of tobacco products.</li> <li>• The continuing availability of tobacco products through illegal underage sales or through commercial sources such as the internet.</li> <li>• The availability of tobacco products through social sources (family, peers, older teens, strangers).</li> </ul>	<ul style="list-style-type: none"> <li>• Affordability and access – reducing the affordability and access of youth to tobacco products:               <ul style="list-style-type: none"> <li>– reduce affordability of tobacco products</li> <li>– eliminate sales of tobacco to youth from retail outlets</li> <li>– reduce social supply of tobacco products to young people.</li> </ul> </li> </ul>

Risk Factors	Sub-objectives for the Health Sector in New Zealand
<ul style="list-style-type: none"> <li>• The promotion of smoking culture through depictions of tobacco use on TV, in films, in magazines and on the internet.</li> <li>• The continuation of tobacco industry advertising through intentional or incidental product placement in films or TV, in international magazines and on the internet.</li> <li>• The existence of incorrect assumptions within the community, within families and by smoking youth, regarding the prevalence of tobacco use within society.</li> <li>• The beliefs held by youth on the continued acceptability of tobacco use: as reflected by the visibility of smoking in public places; as demonstrated by the smoking behaviour of peers, parents and others in the community; as supported by the positive attitudes to tobacco use by others.</li> </ul>	<ul style="list-style-type: none"> <li>• Denormalise tobacco use – reducing prevalence of attitudes and behaviours that reinforce the use of tobacco products in New Zealand: <ul style="list-style-type: none"> <li>– reduce depictions of tobacco use in media (film, television, print, internet)</li> <li>– reduce intentional and unintentional tobacco brand promotion in media</li> <li>– support smoking cessation among parents and caregivers</li> <li>– develop anti-tobacco attitudes among young people</li> <li>– increase the number of smokefree settings in the community (settings where smoking is banned in all indoor and outdoor spaces without exception)</li> <li>– reduce perceived prevalence of tobacco use among peers.</li> </ul> </li> </ul>

Risk Factors	Sub-objectives for the Health Sector in New Zealand
<ul style="list-style-type: none"> <li>• Vulnerable intra and intergenerational communication networks.</li> <li>• The nature of association and the dynamics of interaction with parents, other members of the family and other adults.</li> <li>• The nature and dynamics of social environments in which youth participate: ie at school, work and others within the community.</li> </ul>	<ul style="list-style-type: none"> <li>• Positive identity development – strengthen associations with key social environmental factors that contribute to the formation of self-identities exclusive of tobacco use: <ul style="list-style-type: none"> <li>– strengthen family functioning</li> <li>– increasing youth participation in community projects and events</li> <li>– encouraging schools to be more responsive to youth needs.</li> </ul> </li> </ul>

## 2.4 Relationship with other plans and strategies

The *Framework for Reducing Smoking Initiation* is complementary to other government and non-government initiatives relating to tobacco control, reducing inequalities, capacity building, youth development and health promotion. These include:

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

*Clearing the Smoke* is a five-year plan for tobacco control in New Zealand (2004-2009) that aims to:

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

The plan identifies adolescents and young adults as key target groups for reducing smoking initiation interventions and supports employing combined approaches to meet this objective.

- ***National Māori Tobacco Control Strategy 2003 (ATAK, 2003)***

This Strategy, prepared by ATAK, sets three objectives by which to meet the goal of *improving Māori wellness by reducing, then eliminating, smoking-related morbidity and mortality*. These objectives are encouraging smoking cessation, reducing exposure to second-hand smoke, and reducing the uptake of tobacco use by Māori. Four key strategies are identified to meet these objectives: legislative and regulatory processes; health promotion activities; cessation programmes; supporting and strengthening Māori tobacco control research.

- ***Pacific Peoples Tobacco Control Action Plan 2004 (Pacific Tobacco Control Interim Group, 2004)***

The *Pacific Peoples Tobacco Control Action Plan* identifies six priority areas for action. These areas are:

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

- ***A Tobacco Control Research Strategy for New Zealand (The Tobacco Control Research Strategy Steering Group, 2003)***

The strategy identifies several priority areas for tobacco control research and criteria for assessing tobacco control research proposals. The strategy also provides for the establishment of a steering group to guide the implementation of the Strategy and to promote coordinated and enhanced tobacco control research.

- ***Framework Convention on Tobacco Control (World Health Organization, 2003)***

New Zealand ratified the WHO Framework Convention on Tobacco Control (FCTC) and has progressed tobacco control measures to advance compliance with the FCTC. The FCTC's objectives include protecting present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels. The guiding principles of the FCTC include taking measures to prevent smoking initiation, and developing comprehensive multisectoral measures and responses to reduce consumption of all tobacco products.

- ***Review of the evidence for major tobacco control interventions (Wilson, 2003)***

The material in this document was part of a larger paper produced in late 2002 to inform the discussion around the development of the Ministry of Health's five-year plan for tobacco control. The document includes evidence from New Zealand-specific research, where this has been published, and considers the potential relevance of the international evidence for the New Zealand setting.

- ***National Drug Policy (Ministry of Health, 1998)***

The National Drug Policy provides the framework for minimising harm from alcohol, illicit drugs and tobacco. Priority actions include enabling New Zealanders to increase their control over and improve their health by limiting the harms and hazards of tobacco and alcohol use and reducing the prevalence of tobacco smoking and exposure to second-hand smoke. The Policy is currently under review by the Ministry of Health.

- ***The New Zealand Cancer Control Strategy: Action Plan 2005 – 2010 (Ministry of Health, 2005)***

*The New Zealand Cancer Control Strategy Action Plan 2005 – 2010* provides a high-level framework for reducing the incidence and impact of cancer in New Zealand. Goal One of the Action Plan is to *Reduce the incidence of cancer through primary prevention*. This includes the objective to *Reduce the numbers of people who develop cancers due to tobacco use and second-hand smoke*. The plan also aims to reduce the rate of young people taking up smoking, especially groups with higher rates of smoking. Improved leadership

and coordination of tobacco control programmes at a national and regional level is also an objective.

- ***New Zealand Health Strategy (Ministry of Health, 2000)***

Reducing smoking is an identified population health objective for the Ministry of Health and district health boards in the short to medium term. The *New Zealand Health Strategy* identifies the link between smoking and other priority health areas. These are:

- reduce the incidence and impact of cancer
- reduce the incidence and impact of cardiovascular disease
- reduce the incidence and impact of diabetes
- improve nutrition
- increase the level of physical activity
- reduce obesity
- reduce rates of suicide and suicide attempts
- minimise harm caused by alcohol and illicit and other drug use to individuals and the community
- improve oral health.

- ***Achieving Health for all People: Whakatutuki te Oranga Hauora mo nga Tangata Katoa (Ministry of Health, 2003)***

*Achieving Health for all People* is the public health sector's response to the New Zealand Health Strategy. The three overarching goals are to:

- improve the overall health status of the New Zealand population
- improve the health status of Māori
- reduce inequalities in health.

- ***Treaty of Waitangi***

The Treaty of Waitangi is the founding document of New Zealand. It provides a framework of rights and responsibilities, and articulates a relationship between Māori and the Crown. The principles of participation, partnership and active participation are integral to progressing all aspects of Māori health and the provision of services in all areas, including initiatives aimed at reducing smoking initiation.

- ***Reducing Inequalities in Health (Ministry of Health, 2002)***

*Reducing Inequalities in Health* proposes principles to be applied to all health sector activities to ensure they help to overcome health inequalities. The principles include:

- dealing with the social, economic, cultural, and historical factors that cause health inequalities
- targeting material, psychosocial and behavioural factors
- undertaking specific actions within health and disability services
- minimising the impact of disability and illness on socio-economic position.

The Strategy sets out best practice principles which include an explicit commitment to implementing Treaty of Waitangi principles – participation, partnership and active protection.

- ***He Korowai Oranga - Māori Health Strategy (Ministry of Health, 2001)***

He Korowai Oranga (The Māori Health Strategy) sets the direction for Māori health development. The aim of the strategy is whānau ora: Māori families supported to achieve maximum health and wellbeing. Smoking has been identified as one of the Māori health priorities which the district health boards and the Ministry of Health will progress.

- ***Pacific Health and Disability Action Plan (Ministry of Health, 2002)***

The *Pacific Health and Disability Action Plan* sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples. *Promoting Pacific healthy lifestyles and wellbeing* is identified as a priority and includes the need to:

- explore the development of a Pacific Quitline and smoking cessation programmes
- encourage smokefree Pacific environments
- improve linkages between Pacific communities and statutory and non-statutory agencies to ensure co-ordinated and integrated planning for minimising alcohol and drug related harm
- improve the availability and delivery of services in the areas of gambling, smoking, alcohol and drugs.

- ***Opportunities for All New Zealanders 2004 (Ministry of Social Development, 2004)***

*Opportunities for All New Zealanders* sets out the Government programme for tackling disadvantage and improving equality of opportunity. It is based on the findings of *The Social Report (Ministry of Social Development 2004a)* and identifies tobacco control as one of the five priority issues to be addressed by government agencies over the next three to five years.

- ***Youth Development Strategy Aotearoa (Ministry of Youth Development, 2002)***

The *Youth Development Strategy* provides a tool for public sector agencies, individuals, groups and organisations working with young people and on youth issues to develop policy advice and initiatives (such as programmes and services) relating to those aged within the 12 to 24 years age group. It outlines six principles for youth development, all of which have been highlighted in the *Reducing Smoking Initiation Literature Review* (HSC 2005) as components of protective factors against smoking initiation in young people. Government has committed to employing these principles in the development and implementation of programmes for young people. These principles are:

- youth development is shaped by the ‘big picture’
- youth development is about young people being connected
- youth development is based on a consistent strengths-based approach
- youth development happens through quality relationships
- youth development is triggered when young people fully participate
- youth development needs good information.

- ***Youth Health: A Guide to Action 2002 (Ministry of Health, 2002)***

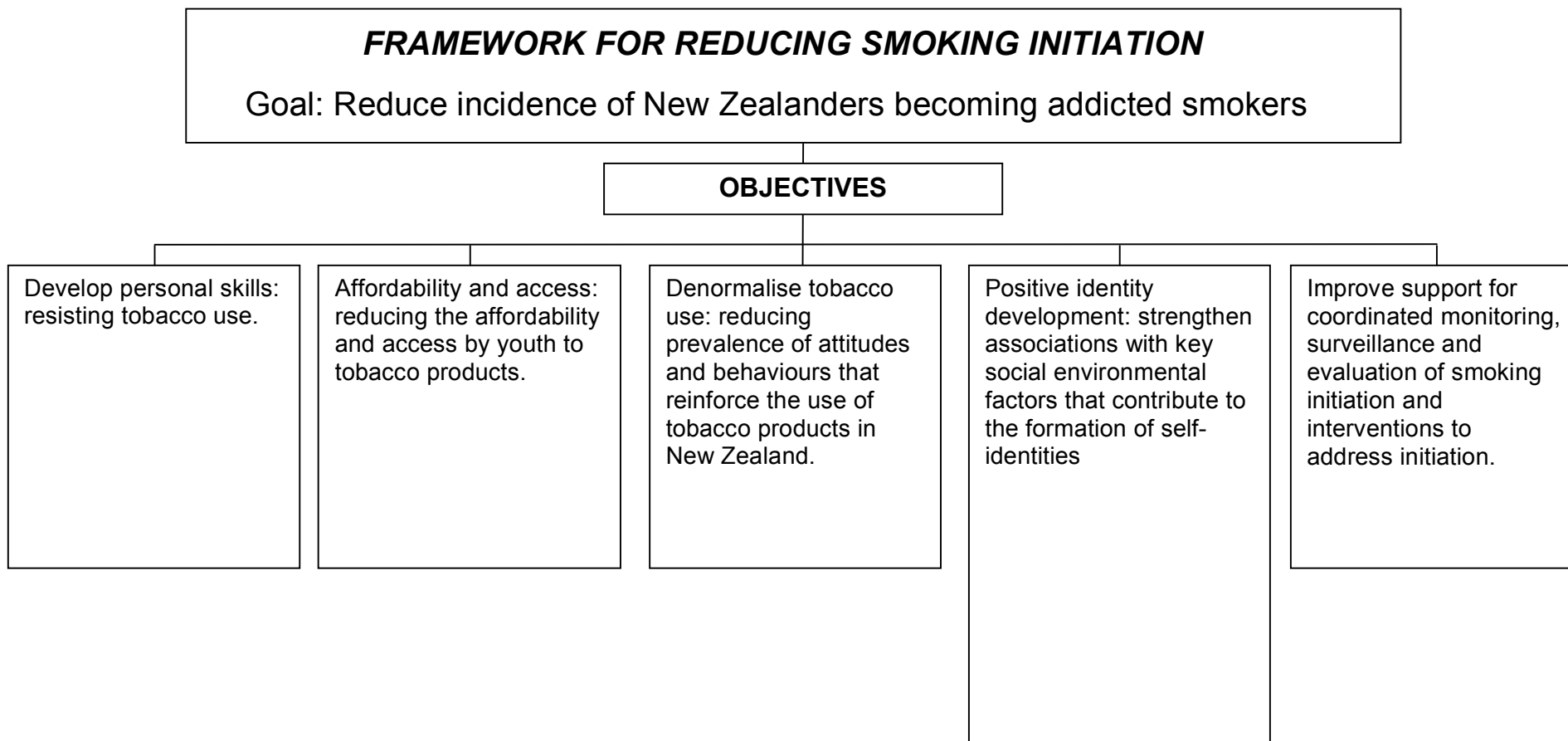
*Youth Health: A Guide to Action* proposes a shift toward a youth-focused and youth-knowledgeable approach to the provision of physical and mental health services to young people. It emphasises the need to gather better information about factors that affect young people’s health and about ‘what works’ for young people. Goal three of the plan sets out actions to reduce smoking. These are:

- integrate effective current drug and alcohol health education programmes into the Health and Physical Education Curriculum
- take comprehensive, evidence-based measures to prevent the uptake of smoking by young people
- use policy, regulatory and legislative measures to discourage smoking, and to minimise the harm associated with alcohol and illicit drug use
- promote the most successful smokefree initiatives and share the good news stories.

- ***Public Health Service Handbook (Ministry of Health, 2004)***

The *Public Health Service Handbook*, prepared by the Ministry of Health, outlines the tobacco control services funded by the Ministry of Health and provided by public health providers.

**Diagram 1. Goal and Objectives of *Framework for Reducing Smoking Initiation***



### 3. STRATEGIES TO REDUCE THE INCIDENCE OF SMOKING INITIATION

This *Framework for Reducing Smoking Initiation* identifies a comprehensive suite of strategies that should be implemented within programmes to reduce smoking uptake. The initiatives are designed to be implemented in a range of settings and at a range of levels (ie, population, community, family and individual). The initiatives are designed to be consistent with, and complementary to, existing Government and non-government strategies.

Many of the initiatives set out in the Framework comprise enhancements of current activities being carried out by government and non-government agencies. However, clear new areas of action have emerged as a result of the literature review (HSC, 2005) and engagement with key stakeholders during the development of the Framework.

The strategies set out in the following tables (pages 24 to 36) are supported by evidence from the literature review. They reflect the need to reduce risk factors and enhance protective factors. They also recognise the social, cultural, and economic context within which smoking initiation occurs. Initiatives must reach beyond supply control and demand reduction tobacco control measures and include capacity-building programmes for families, communities and young people.

Aside from usual tobacco control initiatives, therefore, there is a need to include; assisting families to develop good communication skills, progressing schools as places where young people feel a sense of place and belonging, and actively promoting and supporting young people's involvement in their communities.

A key to the success of these strategies will be in identifying the appropriate mix of strategies to be implemented concurrently and consecutively, while remaining responsive to local needs and the requirements of national initiatives.

#### 3.1 Principles used to select and prioritise initiatives

A set of guiding principles were used to select interventions aimed at reducing smoking initiation. These principles were employed because they were identified as being strongly evidence based, practical, effective and consistent with other tobacco control and broader initiatives. They are also consistent with the principles within *Clearing the Smoke 2004-2009*.

The principles employed to determine and prioritise the interventions and initiatives in this Framework are as follows.

- Evidence based: the Framework is evidence based and appropriate to New Zealand-specific environments.
- Effectiveness: the Framework has potential to influence smoking initiation among key target groups.
- Equity (fairness): the Framework seeks to reduce disparities in health outcomes.
- Advancing Māori health: the Framework will address disparity in Māori health outcomes.
- Consistency: the Framework is consistent and complementary with other policy, programmes and initiatives.

- Plausible benefit: the Framework will include evidence from other areas of health.
- Appropriate use of targeting: the Framework will maximise the benefits of targeted interventions and minimise potential adverse effects.
- Ethical considerations: The Framework will acknowledge the ethical issues raised by tobacco use and initiatives, for example, tobacco taxation.

### 3.2 Priority strategies

Evidence from the literature review suggests that coordination of concurrent and successive strategies is a major factor in the success of interventions to reduce smoking initiation, due to the interrelated, compounding and complex nature of risk and protective factors. Therefore, prioritising the strategies set out on pages 24 to 36 requires coordination involving stakeholders at all levels of intervention (i.e. population, community, family and individual) and between government and non-government agencies and groups.

A national coordination function to assist in the development of complementary, timely, and appropriate national and local initiatives will have significant impact on reducing the incidence of people becoming addicted smokers.

The literature review process has identified the following strategies as priorities to reduce smoking initiation. The development of a comprehensive implementation plan, engaging all key stakeholders, will determine the most effective mix of strategies at the national, regional and local level.

### 3.3 Strategies and rationale

#### *Objective 1. Develop personal skills: resisting tobacco use*

Strategy Objectives	
<p><b>1.1 Develop skills which support young people to be able to refuse tobacco.</b></p> <p><b>1.2 Develop social skills of young people.</b></p>	
1.1 Develop skills which support young people to be able to refuse tobacco	
1.1.1 Implement school-based refusal skills programme as part of a wider life skills programme.	A: Implement relevant aspects of programme at primary, intermediate and secondary school level. B: Refusal skills aspect of programme to include information and activities designed to develop anti-tobacco use activities, skills to refuse tobacco and confidence in ability to refuse tobacco.
1.1.2 Ensure messages utilised in refusal skills programme are consistent with other anti-tobacco campaigns, in particular those targeting youth attitudes.	A: Develop any resources in collaboration with agencies involved in anti-tobacco mass communications campaigns.
1.2 Develop life skills of young people	
1.2.1 Implement school-based life skills programme.	A: Programme to include social skills (communication, problem solving, decision making, self-management), stress-management, coping with anxiety, problem solving skills,

	<p>smoking refusal skills.</p> <p>B: Ensure programme is relevant to other aspects of school activities (eg, enhancing learning environment).</p>
<p>1.2.2 Support relevant initiatives promoted by the Ministries of Health, Education and Youth Development.</p>	<p>A: Support implementation of the Student Well-being Approach promoted by the Ministry of Education<sup>6</sup>.</p> <p>B: Support implementation of the Health Promoting Schools Programme promoted by the Ministry of Health<sup>7</sup>.</p> <p>C: Ensure that the life skills programme proposed under 1.2.1 is consistent with and supports the initiatives discussed in 1.2.2A and 1.2.2B.</p>

### *Developing skills to resist tobacco use*

The most appropriate setting to implement most of the strategies identified above has been suggested as schools. While evidence on the effectiveness of school-based programmes is mixed it was difficult to identify any other settings where programmes to develop resistance skills could be practically implemented. In addition, it is intended that such skills programmes would be implemented within an integrated and comprehensive school based anti-tobacco programme.

The provision of information to youth in relation to smoking or attempts to teach resiliency skills to resist initiation have long been approaches adopted within tobacco control although recent evaluations have raised questions as to the efficacy of past works due to the lack of rigour in planning or evaluation.

A stocktake of existing or planned interventions for teaching resiliency skills is necessary. Funding agencies should be targeted to ensure that minimum planning and evaluation standards are in place.

Evaluations of school-based interventions have highlighted the difficulty in determining the strength of the elements associated with programmes in reducing smoking initiation/occurrence and suggest further rigorous evaluation and data collection is required. Research suggests that programmes focusing on student characteristics such as social, gender or cultural groups, or targeting programmes aimed at high-risk groups, may also be more effective.

Research has shown that there is a difference between the sexes as to the type of skills utilised to resist tobacco initiation and with respect to the type of information provided in teaching these skills. These differences should be understood and catered for when interventions are designed. In addition, it is likely there are also differences between ethnic groupings. In identifying suitable interventions, groups and agencies worked through should have suitable geographic spread, with a focus on lower decile areas. In addition, ethnic and cultural groups (iwi/hapu, Pacific and other groups) and settings (marae, churches) should be utilised. Female and male youth organisations should also be identified and targeted.

<sup>6</sup> The Student Well-being Approach includes delivering programmes in schools which focus on enhancing students' personal identities, building relationships, examining the choices and consequences of drug use and addressing stereotypes and discrimination: [www.tki.org.nz/governance/prf\\_learn/health\\_e.pdf](http://www.tki.org.nz/governance/prf_learn/health_e.pdf)

<sup>7</sup> About Health Promoting Schools [www.cpublichealth.co.nz/files/HES0007.pdf](http://www.cpublichealth.co.nz/files/HES0007.pdf).

**Objective 2. Affordability and access: Reducing affordability and access of youth to tobacco products**

Strategy Objectives
<p><b>2.1 Reduce social supply of tobacco products to young people.</b></p> <p><b>2.2 Reduce affordability of tobacco products.</b></p> <p><b>2.3 Eliminate sales of tobacco to youth from retail outlets.</b></p>

2.1 Reduce social supply of tobacco products to young people	
2.1.1 Reduce access to tobacco products at home.	<p>A: Encourage parents who smoke not to leave tobacco where it is accessible to children.</p> <p>B: Encourage parents and siblings not to supply tobacco to children.</p> <p>C: Support parental/caregiver smoking cessation.</p>
2.1.2 Improve effectiveness of Smoke-free Environments Act ban on supply of tobacco to youth in public places.	<p>A: Inform general public of ban and its rationale.</p> <p>B: Enforce legislation as appropriate.</p>

2.2 Reduce affordability of tobacco products	
2.2.1 Implement a taxation regime that provides a significant disincentive for experimental smokers to purchase tobacco.	<p>A: Provide advice to the Government on the desirable level and frequency of taxation increases, including risk management.</p> <p>B: Utilise the taxation regime as part of a communication plan.</p>
2.2.2 Support parents and caregivers to assist their children to make healthy consumer choices.	<p>A: Develop resources to assist parents and caregivers to assist their children to develop healthy spending patterns.</p> <p>B: Develop resources to inform parents of the means by which young people access tobacco products.</p>

2.3 Eliminate sales of tobacco to youth from retail outlets	
2.3.1 Improve enforcement of the Smoke-free Environments Act ban on sales of tobacco to minors.	<p>A: Increase perceived threat of being prosecuted if selling tobacco to minors.</p> <p>B: Increase controlled purchase operations activities.</p> <p>C: Increase resources to prosecute retailers caught selling to minors.</p>
2.3.2 Further strengthen the Smoke-free Environments Act.	<p>A: Ban tobacco display at point of sale.</p> <p>B: Ban the sale of confectionary in the shape of tobacco products.</p> <p>C: Advocate amending the Act with the purpose of further restricting or banning the display of tobacco products in retail outlets.</p>

### *Affordability*

The two primary areas identified within the literature associated with limiting access to tobacco products by altering their affordability relate to price increases of the product through taxation and the level of disposable income available to young people. Reducing affordability is primarily seen as a strategy to reduce progression from early initiation to regular and addicted smoking among early adolescents. This is based on the rationale that pre-adolescents are unlikely to be able to purchase tobacco and that early adolescence is often a time when transition from experimental to regular smoking occurs requiring greater access to consistent, reliable and sufficient quantities of tobacco.

### *Increasing taxation on tobacco products*

Reducing the affordability of tobacco products by price increases has been identified as one of the most important and effective single tobacco control interventions. Youth appear particularly sensitive to price increases. Chaloupka and Pacula (1999) estimated that youth are up to three times more sensitive to increases in price compared with adults.

The literature review identified increased taxation as being particularly effective in preventing initiation as youth were considered to be more responsive than adults to changes in cigarette prices.

Article 6<sup>8</sup> of the WHO *Framework Convention on Tobacco Control* (FCTC) also recognises tobacco tax increases as a key component within tobacco control programmes, particularly with regard to young people.

Any taxation increase (beyond annual inflation adjustments) should ideally be set at a level that achieves substantive results and is justifiable to the public. Taxation increases are among the most controversial tobacco control interventions from the perspective of the tobacco and retail industries, and the public and, therefore, the need to manage risks and clearly communicate the objective of the intervention is necessary. The association

<sup>8</sup> Article 6: *Price and tax measures to reduce the demand for tobacco* 1. The Parties recognize that price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons: [www.who.int/tobacco/framework/download/en/](http://www.who.int/tobacco/framework/download/en/).

of the tax increase with reducing youth tobacco initiation could be stressed as a priority legitimisation.

### *Pocket money and disposable income*

Recent research findings in New Zealand have indicated that the amounts of pocket money or disposable income provided to, or earned by, young people, in association with other parental behaviours, are primary determinants of the elevated smoking prevalence. The *Framework for Reducing Smoking Initiation* envisages a need to communicate to parents the links between pocket money and smoking initiation. However, parents would also need information on how pocket money can be provided at a level and in a way that it does not encourage smoking initiation.

The question arises as to whether levels of pocket money/disposable income affects demographic groups differently and whether it contributes to the different smoking prevalence of the priority groups identified for this Framework. There is also a need to understand where pocket money/disposable income fits within the wider family dynamic and to ensure that it is not compartmentalised as an issue divorced from other associated factors.

### *Access and legislative regulation*

Access laws are important in shaping community norms around tobacco. They are a clear statement that smoking by under-aged youth is not acceptable. Enforcement is needed to demonstrate how seriously the State rejects the illegal supply of tobacco products. This is not to suggest that it is expected that full compliance as a result of enforcement will end supply. It is recognised internationally that in order to be most effective, bans on sales must occur within a suite of other tobacco control interventions.

Legislative interventions are aimed at restricting supply. The strategy associated with this sub-objective focuses on existing regulation that seeks to prevent the sale and supply of tobacco products to those aged under 18 years of age.

Available research identifies two important issues associated with existing regulation of access to tobacco products. Firstly, the enforcement regime is a key aspect of ending illegal sales of tobacco products to people under the age of 18. Secondly, in those places where there has been active enforcement, there is uncertainty as to whether there is an actual link in reducing tobacco consumption, as social sources of tobacco products become more important.

Other strategies relating to access (such as the role of young people in retail outlets and the potential of the internet as a source for tobacco products), have been proposed in light of specific research results that have highlighted these problems.

Thought could also be given as to how far regulation can be used to restrict non-commercial supply to under-aged youth. While the social source issue will be tackled through awareness-raising techniques, the existing law makes such supply an offence in public places and consideration should be given as to whether there is a practical and effective way to enforce this regulation. Consideration of overseas jurisdictions may assist.

### *Access via social sources*

The importance of social sources (parents, family, friends) as a supply for tobacco products has been demonstrated by international evidence in jurisdictions that have strong youth access laws and good enforcement. Although supply to those under 18 years of age is illegal, the enforcement of such regulation is difficult in practice. Instead, other means need to be devised to counter social source supply.

Different avenues of social sources are important at various stages of adolescent smoking development. Social sources are especially important for those initiating cigarette smoking. Sources include parents who have either bought cigarettes for their children or had their cigarettes stolen by their children. Friends were also a primary source of cigarettes for new smokers especially in the experimentation stage. Another important source for young adolescents was asking strangers to buy them tobacco.

### ***Objective 3. Denormalising the use of tobacco***

Strategy Objectives
<b>3.1 Increase the number of smokefree settings in the community (settings where smoking is banned in all indoor and outdoor spaces without exception).</b>
<b>3.2 Reduce smoking among parents and caregivers.</b>
<b>3.3 Develop anti-tobacco attitudes among young people.</b>
<b>3.4 Reduce depictions of tobacco use and tobacco brand promotion in the media.</b>
<b>3.5 Reduce access (Objective 2: Affordability and Access).</b>

3.1 Increase the number of smokefree settings in the community (settings where smoking is banned in all indoor and outdoor spaces without exception)	
3.1.1 Increase the number of parents and caregivers of children implementing and enforcing strategies to make indoor and outdoor areas of the home smokefree.	<p>A: Motivate parents/caregivers to ban smoking inside and outside their homes.</p> <p>B: Increase knowledge of strategies to make homes and cars smokefree.</p> <p>C: Strengthen support for parents and caregivers implementing and enforcing smokefree home and car strategies.</p> <p>D: Increase smoking cessation among parents and caregivers who smoke.</p>
3.1.2 Support schools to promote smokefree messages.	<p>A: Encourage the Ministry of Education and schools to provide curriculum-based teaching on critical analysis of industry activity, health impacts and healthy lifestyles.</p> <p>B: Support schools to develop comprehensive tobacco control programmes.</p>
3.1.3 Increase the number of smokefree marae.	<p>A: Promote legislation where appropriate.</p> <p>B: Mobilise with local Māori identities and communities to make their marae Auahi Kore.</p> <p>C: Provide incentives for marae to become Auahi Kore.</p> <p>D: Provide marae with Auahi Kore resources.</p>
3.1.4 Increase the number of smokefree areas covered by local and regional councils.	<p>A: Raise community awareness regarding smoking in front of children and role modeling.</p> <p>B: Identify playgrounds that could become smokefree.</p> <p>C: Work with local councils to pass regulations requiring more areas to be smokefree.</p> <p>D: Implement appropriate monitoring and enforcement strategy.</p> <p>E: Reduce smoking in public spaces outside of hospitality venues and other workplaces.</p>
3.1.5 Increase the number of smokefree sports settings.	<p>A: Work in the sport areas that at risk youth frequent to develop smokefree policies.</p> <p>B: Enforce smokefree workplaces legislation.</p> <p>C: Advocate the need for tobacco control to sporting code decision makers.</p> <p>D: Provide incentives to sporting codes to become smokefree.</p>
3.1.6 Increase the number of smokefree workplaces.	<p>A: Provide cessation programmes for workers.</p> <p>B: Promote benefits of smokefree workplaces to employers (increases productivity, healthier workforce).</p> <p>C: Provide strategies to employers and employees on how to make their workplaces smokefree.</p>

3.2 Reduce smoking among parents and primary caregivers	
3.2.1 Support parents and caregivers to quit smoking.	<p>A: Develop cessation campaign for parents and caregivers. This could include incorporating cessation messages within a smokefree homes campaign.</p> <p>B: Increase accessibility and reduce barriers to cessation services for parents and caregivers.</p> <p>C: Create supportive smokefree environments (see strategy objective 3.4).</p>

3.3 Develop anti-tobacco attitudes among young people	
3.3.1 Deliver campaign to increase negative attitudes towards tobacco use and/or the tobacco industry.	<p>A: Develop paid and unpaid media advertisements.</p> <p>B: Develop an effective forum to engage and mobilise youth.</p> <p>C: Integrate the campaign with other community based activities.</p>
3.3.2 Encourage parents to promote anti-tobacco messages to their children.	<p>A: Support parents of preteens who are less involved with their children to become more involved.</p> <p>B: Develop anti-smoking attitudes among parents.</p> <p>C: Provide strategies to parents on how to communicate anti-tobacco attitudes to their children.</p>
3.3.3 Support schools to develop media studies programmes critiquing tobacco industry activities and aiming to develop anti-tobacco industry sentiments.	<p>A: Develop resources for media studies topics with the Ministry of Health.</p> <p>B: Promote media studies courses focusing on the negative impacts of the tobacco industry on society.</p> <p>C: Encourage the Ministry of Education and schools to develop comprehensive tobacco control programmes.</p>
3.3.4 Support schools to develop programmes for health and physical activity studies that aim to develop anti-tobacco use sentiments.	<p>A: Develop resources for media studies topics with the Ministry of Health and the Ministry of Education.</p> <p>B: Promote health and physical activity studies courses focusing on health impacts of tobacco use.</p> <p>C: Encourage the Ministry of Education and schools to develop comprehensive tobacco control programmes.</p>
3.3.5 Increase the number of positive smokefree role models.	<p>A: Implement a smokefree role models campaign.</p>

3.4 Reduce depictions of tobacco use and tobacco brand promotion in the media	
3.4.1 Reduce depictions of tobacco use in media produced within New Zealand.	<p>A: Enforce the Smoke-free Environments Act where applicable.</p> <p>B: Promote alternatives to depictions of unnecessary tobacco use.</p> <p>C: Consider providing funding incentives to discourage unnecessary tobacco depictions (eg, for state-funded channels).</p> <p>D: Increase awareness within the media industry of impacts on youth smoking.</p> <p>E: Promote smokefree environments within industry.</p>
3.4.2 Reduce accessibility of international media depicting tobacco use to young people.	<p>A: Support international movements that aim to reduce unnecessary depictions of tobacco use in media.</p> <p>B: Consider counter advertising prior to films depicting tobacco use.</p>
3.4.3 Reduce intentional and unintentional tobacco brand promotion in New Zealand.	<p>A: Enforce the Smoke-free Environments Act, where applicable.</p> <p>B: Strengthen the Smoke-free Environments Act to include international promotions (eg, sports exemptions).</p> <p>C: Provide funding incentives to discourage unnecessary tobacco promotion.</p> <p>D: Increase awareness within film industry of impacts on youth smoking.</p> <p>E: Promote smokefree environments within the media industry.</p>
3.4.4 Reduce accessibility of international media promoting tobacco products.	<p>A: Promote the use of higher age censor ratings in media that unnecessarily promote the use of tobacco.</p> <p>B: Support international movements that aim to eliminate promotion of tobacco products.</p>
3.4.5 Monitor the tobacco industry in New Zealand.	<p>A: Monitor and document industry activities in New Zealand.</p> <p>B: Consider legal action where the tobacco industry may have engaged in misleading promotional activity (e.g. package labeling).</p> <p>C: Amend legislation to require fuller information disclosure.</p>

**3.5 Reducing access: See Objective 2, Affordability and access**

### *The depiction of tobacco use*

Exposure to images of tobacco consumption can promote assumptions held by young people that the prevalence of tobacco use in adults and adolescents is greater than it actually is. Exposure to smoking behaviour in movies and television shapes normative beliefs about smoking, self-identification processes and learned expectations. There are also a number of other media that present positive images to youth of tobacco use.

Research consistently shows that such imagery of tobacco use is highly pervasive and typically glamorised. As a result, the literature demonstrates that adolescent perceptions of the prevalence of smoking in society tend to be inflated.

Within the context of the public funding and broadcasting that exists within New Zealand, there are a number of opportunities to engage with the local film and TV industry to reduce depictions of tobacco use. The international context, however, provides a greater challenge. Steps can, however, be taken to deal with a pervasive and not easily controllable risk. Of these, the international literature has suggested that a change in rating would make a large difference to the number of films which depict tobacco use that are seen by young adolescents and children. Policy work would be required to further develop this proposal.

Research has shown that there is a difference between the sexes and their reaction to the depiction of tobacco use in various media. When planning responses these differences should be taken into account.

The potential of the internet as a health promotion tool and for encouraging youth smoking has been raised in recent literature. Both aspects require further investigation.

Accurate information needs to be provided to youth on tobacco use within New Zealand. An awareness or publicity campaign could run as a component of other strategies seeking to engage with youth over tobacco issues.

### *Brand promotion*

Tobacco industry advertising and sponsorship is banned in New Zealand. Nevertheless, some residual marketing still occurs (eg, on packets, imported magazines, on the internet and on television – the latter in the form of motor racing and possibly product placement).

All of these media provide potential sites for the promotion of a culture that normalises tobacco use. A relationship between adolescent exposure to cigarette advertising in international magazines and brand identification among smoking youth has been demonstrated by research. Glantz, Kacrik and McCulloch note that despite declining tobacco use and increasing public understanding of the dangers of smoking, the depiction of tobacco use in movies has returned to levels observed in 1950, when smoking was nearly twice as prevalent in reality as it was in 2000 (Glantz, Kacrik & McCulloch, 2004). On the internet, sites devoted to smoking culture and lifestyle, anti-smoking youth chat rooms and teen smoking clubs exist.

International literature that assesses the impact of tobacco industry advertising on youth occurs in a tobacco control environment that is dissimilar to New Zealand (the Smoke-free Environments Act (1990) banned tobacco advertising in New Zealand). In addition, normative values may vary greatly from overseas jurisdictions that have been studied. Research in this area is, therefore, important. Furthermore, the research and the resulting interventions should be sensitive to any variations in the way that priority populations identified for the *Framework for Reducing Smoking Initiation* engage with and react to advertising.

### *Visibility and acceptability of tobacco use*

Research has suggested that smoking in public may lead to beliefs among adolescents of a higher prevalence and acceptability of tobacco use in society than actually exists. Also, young people may acquire the behaviour of smoking through observational learning. The achievement of legislated smokefree indoor environments has led to an increased level of smoking in outdoor public places increasing the visibility of tobacco use. The following strategy focuses on the physical environment to lower the visibility and acceptability of tobacco use.

Although the recent amendments to the smokefree legislation require indoor public environments to be smokefree, it is important to focus compliance on those environments in which youth are likely to be present. The early achievement of such compliance would encourage similar action within other private indoor environments not covered by the legislation.

Settings that are youth-focused and whose communities of interest include those youth seen as being among the priority groups for the *Framework for Reducing Smoking Initiation* should be especially targeted for action and an effort made to devise ways to effectively communicate the need to implement smoking restrictions. Social marketing techniques aimed at community groups could be used to highlight responsibilities under smokefree environments legislation. In addition, low-cost or free health promotion material could be produced for the use of community groups to achieve smokefree environments in their buildings and generally promote this to their communities of interest.

In relation to discouraging smoking in outdoor public spaces and developing smokefree outdoor public spaces, a formal structure and programme of health sector consultation with territorial local authorities with clear objectives and milestones could be developed. The extent that this issue has been considered in overseas jurisdictions could be investigated. Territorial local authorities in which priority groups predominate should be worked with closely and the requirements of those groups should be considered.

One of the most important types of private indoor environments not covered by the legislation is family homes and other family environments. One possible action is through the use of regulation but this would have to be carefully investigated and non-legal interventions are probably more realistic.

Aside from regulation, other means to achieve smokefree family environments should be explored. Liaison with international agencies would ascertain what steps were being taken overseas. A comprehensive approach to the provision of information on the creation of smokefree environments within family settings complete with clear

objectives and milestones and an evaluation component to ascertain effectiveness is suggested. Any information compiled to promote smokefree environments within family settings would need to be sufficiently flexible to cater for differing socio-economic, sex and ethnic variables.

Cessation initiatives for adults could include messages providing awareness of how family environments impact on youth smoking. Any parenting programmes supported to reduce smoking initiation should use techniques known to be effective. Special attention needs to be paid to the differing concepts associated with parental roles across different cultures and the initiative adapted as necessary (e.g. to other primary caregivers where suitable).

***Objective 4. Positive identity development: strengthen associations with key social environmental factors that contribute to the formation of self-identities***

These broad issues are generally outside the usual realm of tobacco control. However, they are within the realm of the health sector’s influence and are factors associated with protecting against smoking initiation. Initiatives in this section are evident in other government strategies, plans, policy and programmes. The importance of noting them here is that the literature review identified key factors that protect young people against smoking initiation. These include young people having the skills and opportunity to communicate, participate, engage with and have a sense of belonging in the social environments in which they live, learn, work and play.

Strategy Objectives
<p><b>4.1 Strengthen family functioning.</b></p> <p><b>4.2 Increase youth participation in community projects and events.</b></p> <p><b>4.3 Encourage schools to become more responsive to youth needs.</b></p> <p><b>4.4 Reduce exposure to smoking behaviour in key social environments that influence the development of youth identity.</b></p>

4.1 Strengthen family functioning	
4.1.1 Support parents of preteens who are less involved with their children to become more involved.	<p>A: Improve parental/caregiver relationship quality with their children (eg, encourage parents to be more aware of their child’s life and to spend more time engaged in parent-child activities).</p> <p>B: Encourage parents to actively monitor what their children are doing in their spare time.</p> <p>C: Support parents to develop clear rules regarding acceptable behaviour (including substance use) and provide strategies to convey these rules to their children.</p>
4.1.2 Improve the social and economic position of families.	<p>A: Facilitate access to training programmes to up-skill parents.</p> <p>B: Improve housing of low-income families.</p> <p>C: Improve nutritional intake of low-income families.</p> <p>D: Facilitate family structures that are supportive of youth development.</p>

4.2 Increase youth participation in community projects and events	
4.2.1 Remove barriers to youth participation.	A: Removing financial disincentives. B: Removing unnecessary bureaucracy and technical jargon. C: Reducing time demands. D: Prioritising youth participation. E: Developing effective processes for working with young people. F: Ensuring events are culturally appropriate.
4.2.2 Employ a positive youth development approach as set out in the <i>Youth Development Strategy 2002</i> .	A: Ensuring a consistent strengths-based youth development approach. B: Developing skilled people to work with young people. C: Creating opportunities for young people to actively participate and engage. D: Building knowledge on youth development through information and research.
4.2.3 Projects/events.	A: Provide youth events that are relevant to youth.

4.3 Encouraging schools to become more responsive to youth needs.	
4.3.1 Involve the education sector to develop programmes and interventions that promote a sense of belonging, participation and ownership by students in their school community eg, Student Well Being Approach and Health Promoting Schools.	
4.3.2 Develop resources that can be used to demonstrate the means used by the media to influence young people's attitudes, behaviours etc using tobacco use as a means.	
4.3.3 Ensure low decile schools have adequate resources for providing protective factors against smoking initiation (achievement, participation, sense of belonging, etc).	
4.3.4 Support approaches that foster improved teacher-student connections and interactions.	

4.4 Reduce exposure to smoking behaviour in key social environments that influence the development of youth identity	
See sub-objective 3.1.	

### *Strengthening of families/whānau*

The role of family has been identified within the literature as important to counter the possibility of smoking initiation. The risk of children becoming smokers is reduced if parents cease smoking. Parental disapproval of smoking has been found to be a protective factor in smoking initiation. Positive parenting style and good communication within whānau/family environments were also noted as protective factors. Interventions associated with strengthening the family in many cases lie outside the health sector. Nevertheless, the sector has a role in communicating the importance of strong families in the reduction of smoking initiation.

A structured programme of consultation should be developed to keep the issue of strengthening families to the fore. There should be an attempt to evaluate the nature and extent of existing initiatives and identify gaps and areas for improvement. Reviews of initiatives in other jurisdictions should be considered. An ongoing evaluation of healthy family programmes should be maintained with special emphasis on researching the effect on youth tobacco initiation.

#### 4. IMPLEMENTATION OF THE FRAMEWORK

Further work is required to guide the implementation of this Framework.

A first step toward implementation will be to establish a national coordination function that would lead a facilitation process to ensure the successful implementation and ongoing coordination, evaluation and monitoring of the Framework. This would include coordination in areas other than initiation, such as cessation and enforcement. The need for national, regional and local coordination of tobacco control has been identified as an objective in the *Cancer Control Strategy 2005* and *Clearing the Smoke 2004*<sup>9</sup>. An existing body operating in the tobacco control area should take up the coordination function. It is envisaged that the national coordination function would take responsibility for the implementation of the Framework over a five-year timeframe.

The coordination function would facilitate the following.

- Promotion of the Framework within the tobacco control sector and others interested in or significant to the Framework eg, community and education providers; development and coordination requirements; development of a community-focused approach to tobacco control through increased workforce capacity.
- Development of an implementation plan based on stakeholder consultation that includes specification of specific programmes, timeframes for implementation and responsibilities.
- Development of a monitoring framework that includes:
  - research relating to priority groups
  - establishment, administration and coordination of evaluation and monitoring requirements
  - evaluation of coordination of the Framework at national and local levels
  - evaluation of strategies at national and local levels
  - rates of smoking initiation among priority groups
  - use of the principles of the Youth Development Strategy at all stages of developing, implementing and evaluating strategies focusing on young people
  - coordination of national and local networking, information collection and dissemination.
- implementation of other processes necessary to achieve the objectives of the Framework.

The second step toward the implementation of the *Framework for Reducing Smoking Initiation* is to ensure adequate and appropriate information is available with which to inform implementation. A research strategy relating to smoking initiation is under development.

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<sup>9</sup> *Cancer Control Strategy: Action Plan 2005*. Goal One, Objective eight: Improved leadership and co-ordination of the tobacco control programme at national and regional levels. *Clearing the Smoke 2004*. Objective five: Improve infrastructure support and co-ordination for tobacco control activities.

#### **4.1 Funding implications**

Key to the success of the *Framework for Reducing Smoking Initiation* is the provision of appropriate funding to develop resources, provide training, implement strategies, and to carry out rigorous monitoring and evaluation processes.

During 2002 alone, the retail value of tobacco sales to those aged 14–16 years was estimated to be in excess of \$18 million, with around \$12.5 million of this going to the Government as taxes (Darling et al., 2005). A tied tobacco tax would enable revenue gained from the sale of tobacco to be used for reducing smoking initiation strategies set out in this Framework.

As the Framework contains strategies across government sectors, such as health and education, funding may require coordination across agencies.

#### **4.2 Agency responsibilities**

The strategies set out in the Framework require implementation by both government and non-government agencies. The Ministry of Health will play a significant role in implementing the Framework. However, other government agencies, such as the Ministry of Education, will play key roles also. As noted above, further work is required to guide the implementation of this Framework. During the implementation phase the appropriate strategies, key agencies and supporting agencies will be identified. The Ministry of Health will have a key role in facilitating the progress of the *Framework for Reducing Smoking Initiation*.

#### **4.3 Research needs**

Research is required into the application of specific strategies to reduce smoking initiation for priority groups. There is a need to capture a greater understanding of the complex overlapping factors that influence young people's smoking behaviour. Given New Zealand's unique social and cultural environment and a lack of targeted research in this area it has not been possible, through the literature review or our initial engagement with the sector, to develop full and final recommendations on the best mix of initiatives for implementation in New Zealand. To aid in the implementation and future reviews of the Framework a research plan is expected to be completed by July 2005. This plan will include:

- research to identify risk and protective factors for uptake
- monitoring and surveillance requirements
- strategies to establish effective tobacco control programme evaluation processes.

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## **APPENDIX A: REVIEW COMMITTEE MEMBERSHIP AND PROJECT MANAGEMENT**

### **Members of the Reducing Smoking Initiation Review Committee:**

Shane Bradbrook	ATAK (Apārangi Tautoko Auahi Kore)
Helen Darling	University of Otago
Heidi Flaxman	HSC (Health Sponsorship Council)
Dr Judith McCool	University of Auckland
Melanie Nepe	Nga Miro Health Services
Vili Nosa	University of Auckland (replaced Luisa Falanitule)
Andrew Waa	HSC (Health Sponsorship Council)
Dr Nick Wilson	University of Otago

### **Project Management:**

Tane Cassidy	HSC (Health Sponsorship Council)
Lisa Docherty	ATAK (left to take up a new position at the end of 2004)
Belinda Hughes	Cancer Society of New Zealand (from November 2004)
Iain Potter	HSC (Health Sponsorship Council)
Leigh Sturgiss	Smokefree Coalition
Dale Wilson	Cancer Society of New Zealand (left to take up a new position in August 2004)

## APPENDIX B: ENGAGEMENT

Individuals, groups, government and non-government agencies were engaged in the development of the *Framework for Reducing Smoking Initiation*. This included Māori providers, young people, and others interested in reducing smoking initiation.

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- Heather Gifford
- Hutt Valley District Health Board
- Māori Health Directorate of the Ministry of Health
- Ministry of Education
- Ministry of Pacific Island Affairs
- Ministry of Social Development
- Ministry of Women's Affairs
- Ministry of Youth Development
- NZ Drug Foundation
- Office for the Children's Commissioner Young People's Reference Group
- Pacific Health, Public Health Directorate, Ministry of Health
- Dr Robert Scragg
- Smokefree Coalition
- Southern Smokefree Network Or Canterbury
- Canterbury, Westcoast and Nelson-Marlborough DHBs
- Te Hauroa O Turanganui A Kiwa
- Te Puni Kokiri
- T&T Consultants.

## **APPENDIX C: GLOSSARY**

Addicted/dependent	When a person becomes a dependent or addicted smoker.
Experimental stage (Stage 3)	Third Stage, where the person smokes repeatedly but irregularly.
Objective	Objectives describe what changes you want to bring about.
Preparatory stage (Stage 1)	First stage, where prospective smokers form attitudes and beliefs about the utility of smoking and advertising.
Regular smoker (Stage 4)	Fourth Stage, where the person moves into regular use of cigarettes.
Smoking initiation	The first three stages of the progression towards becoming an addicted smoker.
Sub-objective	What has to happen before the objective can be achieved.
Strategies	What you do in the programme, what the programme provides.
Trying stage (Stage 2)	Second Stage, characterised by the person smoking a few cigarettes.

