June 2003

A FIVE YEAR TOBACCO ACTION PLAN

2003 - 2008

Investing for Health

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Index

Investing for Health

INTRODUCTION

INTRODUCTION

1. The Programme for Government includes a commitment to develop a strategy to tackle, on a cross-departmental basis, the harm caused by smoking, focusing on preventing young people from taking up smoking, helping smokers to quit, and addressing the issue of passive smoking in the workplace. The *Investing for Health* Strategy, which outlines the approach to improving health and well-being and reducing health inequalities, also identifies tackling smoking as a priority.

2. In March 2001, the then Minister of Health, Social Services and Public Safety, Bairbre de Brún, as Chair of the Ministerial Group on Public Health representing all departments here, established an inter-sectoral Working Group:
"To develop and oversee the implementation of a comprehensive action plan to tackle tobacco use within specified timescales."
Membership of the Working Group is set out in **Annex 4**.

3. The Working Group developed 'A Five Year Tobacco Action Plan', which was issued for public consultation in August 2002. Almost 4,000 copies of the Plan were distributed and it was also available via the Department of Health, Social Services and Public Safety website. Ninety-three responses were received. Overall there was broad support for the content of the Action Plan. A summary of responses is available on the DHSSPS website:
www.dhsspsni.gov.uk/publications/2003/tobaccoplanresponses.pdf

Content of Plan

4. This 5 year Action Plan, which builds upon *"Smoking Kills - A White Paper on Tobacco"*, published in 1998, provides a framework for collaborative working across Government departments, the statutory and voluntary sectors, as well as with business and in local communities. It does not aim to provide a comprehensive analysis of the complex issues surrounding the use of tobacco. Rather, it seeks to combine an overview of the background, scale and nature of the problem with a comprehensive programme of action to reduce the harm caused by tobacco use.

Structure of Plan

5 **Chapter 1** explains the rationale behind the Plan. The remainder of the document is structured in line with the objectives set out in **Chapter 2**. **Chapter 3** outlines action to prevent smoking; **Chapter 4** sets out action to help smokers quit; **Chapter 5** addresses measures to protect non-smokers; **Chapter 6** summarises the action to be taken, by whom and the timescale; and **Chapter 7** examines the roles and responsibilities of the key players and also covers issues such as research and resources. In addition, **Annex 1** looks at International and European measures; **Annex 2** outlines good practice in smoking cessation; **Annex 3** addresses equality implications; **Annex 4** sets out membership of the Working Group; and **Annex 5** lists details of useful contacts.

Equality, Targeting Social Need and Human Rights

6. Section 75 of the Northern Ireland Act 1998 requires public authorities in carrying out their functions to promote equality of opportunity between persons of different religious belief, political opinion, racial group, marital status, sexual orientation, gender, disability and persons with dependants or without. The DHSSPS,

together with its associated bodies, conducted a 2-stage joint consultation exercise on the equality implications of all their policies between December 2000 and June 2001. The Tobacco Action Plan was identified as a new policy requiring Equality Impact Assessment (EQIA). This formed part of the consultation exercise and is included at Annex 3.

7. The New Targeting Social Need (New TSN) policy aims to tackle poverty and exclusion by targeting the efforts and available resources of public agencies towards the people, groups and areas objectively defined as being in greatest social need. New TSN includes a special focus on tackling the problems of unemployment, but also targets inequalities in health, housing, education and other policy areas. Tobacco is a major cause of health inequalities (see paragraphs 1.4 - 1.6). The Tobacco Action Plan was therefore included in the DHSSPS New TSN Action Plan 2002-2003. Subsequent New TSN Action Plans will monitor and report progress of actions set out in the Action Plan to minimise the harm caused by tobacco use to those in the lower socio-economic group categories.

8. The Human Rights Act 1998 came fully into force in October 2000. It provides additional focus and emphasis to the rights and freedoms of individuals guaranteed under the European Convention on Human Rights. There are some 18 Convention rights and protocols which range from the Right to Life and the Right to Respect for Private and Family Life to the Right to Education. The Act requires legislation, wherever enacted, to be interpreted as far as possible in a way which is compatible with the Convention rights; makes it unlawful for a public authority to act incompatibly with the Convention rights; and, if it does, allows a case to be brought in a court or tribunal against the authority. DHSSPS will ensure that the Tobacco Action Plan is compatible with the Human Rights Act.

9. An overview of the comments received on the equality and human rights implications of the Plan is contained in the overall summary of responses received (see paragraph 3).

TOBACCO ACTION PLAN
EXECUTIVE SUMMARY

TOBACCO ACTION PLAN: EXECUTIVE SUMMARY

Chapter 1: Why we need this Action Plan

Smoking claims between 2,700 and 3,000 lives here each year. It is the single greatest preventable cause of premature death and avoidable illness. It also harms people who do not smoke and babies in the womb.

Smoking is a major risk factor for coronary heart disease, strokes and other diseases of the circulatory system, which kill two in every five men and women here. These diseases are also important causes of disability. A lifetime non-smoker is 60% less likely than a current smoker to have coronary heart disease and 30% less likely to suffer a stroke.

Chapter 2: Aim of the Plan

The overall aim is to create a tobacco-free society.

The key objectives are: -

- preventing people from starting to smoke;
- helping smokers to quit; and
- protecting non-smokers from tobacco smoke.

Improving the health of all our people and reducing health inequalities is a key element of the Programme for Government and is the main aim of the *Investing for Health* Strategy. The factors that can cause poor health and inequalities are complex. Smoking, more than any other identifiable factor, contributes to the gap in healthy life expectancy between those most in need, and those most advantaged. Therefore it will be particularly important to target the socially disadvantaged.

Although the Plan is aimed at the population as a whole, three target groups have been identified:

- children and young people;
- disadvantaged adults who smoke; and
- pregnant women who smoke.

Chapter 3: Prevention

Preventing people, particularly children and young people, from starting to use tobacco will require a range of measures in four key areas: -

- raising awareness about the effects of tobacco smoke on smokers' and non-smokers' health through: -

  i) public information; and
  ii) education;

- banning the advertising and promotion of tobacco products;

- enforcing existing legislation on sales of tobacco to children; and

- the widespread adoption of smoke-free policies in workplaces and in places frequented by the general public.

Chapter 4: Helping Smokers to Quit

Two-thirds of smokers say they want to quit yet, despite increasing publicity about smoking related ill-health, many continue to smoke. Of the two-thirds who want to stop smoking, about one-third will try to stop in any one year. Giving up is not easy because nicotine is highly addictive and repeated quit attempts may be required before total abstinence is achieved.

Professional advice and support are essential to help smokers quit. Without such help, only about 2% of middle-aged smokers are successful each year. In particular, young people, disadvantaged adults, and pregnant women, will require a range of services tailored to meet their specific needs. The needs of other disadvantaged groups

such as those from an ethnic minority background, or with a disability, also need to be addressed. Cessation methods used with the general adult population should be modified as necessary with the aim of meeting such needs.

The range of effective interventions available to motivate and support those attempting to quit includes: -

- local and regional media campaigns;
- brief advice delivered by health and social care professionals including doctors, dentists, nurses and pharmacists as well as by allied health professionals;
- specialist services offering advice and intensive support; and
- other support, such as telephone helplines, self-help manuals, pharmaceutical industry.

Chapter 5: Protecting non-smokers from tobacco smoke

Nicotine is highly addictive and it will take many years to achieve the overall aim of a tobacco-free society. In the meantime, the protection of the general public, particularly children, from tobacco smoke must remain a key element of any tobacco control policy. This requires partnership working and measures to promote smoke-free environments.

Tobacco smoke is a particular issue in the workplace as it can aggravate certain diseases such as asthma and chronic bronchitis and can cause discomfort to the eyes, nose, throat and chest.

It is recognised that there may be particular issues to be addressed in introducing smoking bans in hotels, pubs and other places of entertainment. Nevertheless, the wishes of customers (and employees) who do not smoke should be respected. The introduction of no smoking policies in some public places is a welcome development but needs to become standard practice.

Occupational health services in both the private and statutory sectors have an important role to play in promoting a non-smoking environment. A key indicator of progress towards the ultimate goal of a tobacco-free society will be widespread acceptance that the provision of facilities for smokers can only be viewed as a short-term measure leading ultimately to smoke-free premises.

Chapter 6: Action

Prevention

Further development of public information campaigns.

CCEA Curriculum Review to highlight the need to promote awareness of the dangers of smoking.

Legislation banning tobacco advertising.

Local councils to pursue a pro-active approach to enforcement activity.

Support

To promote the provision of smoking cessation services in a variety of settings.

To further develop sustainable specialist smoking cessation services.

To promote training and support in smoking cessation.

Protection

To promote the widespread adoption of no smoking policies in the workplace.

To finalise proposals for an Approved Code of Practice on Passive Smoking at Work.

CHAPTER 1:
WHY WE NEED THIS ACTION PLAN

Chapter 1:
WHY WE NEED THIS ACTION PLAN

Introduction

1.1 Tobacco was introduced to Europe at the end of the sixteenth century. Smoking spread rapidly and was for a time regarded as having medicinal value. However, cigarette smoking as a mass habit is a 20th century phenomenon. So too is smoking as a mass killer.

1.2 In the early part of the 20th century, it was acceptable for men, but not women, to smoke. Since the 1920s, women have been smoking in increasing numbers and the tobacco industry has actively encouraged smoking by both men and women. It was not until the 1950s that the dangers of smoking were publicised, leading to a reduction in smoking prevalence. Smoking among men reached its peak shortly after the Second World War, but among women, the peak came during the 1960s.[1]

The Problem

1.3 A survey of 11-16 year olds here found that 35% of pupils (38% girls and 33% boys) have smoked tobacco with most smoking for the first time at age 12. 13.5% reported having smoked in 2000.[2] Continuous Household Surveys, which biennially include questions about smoking, show that: -

- in 2000/01, adult smoking prevalence was 27% (26% males and 28% females);
- between 1983 and 2000/01: -
  - the proportion of men who smoke has fallen from 39% in 1983 to 26%. This trend has not been matched among women (29% - 28%);
  - the proportion of 20-34 year olds who smoke has fallen from 42% to 32%. The decrease has been particularly marked among men (from 44% to 29%); in comparison to women (40% to 34%); and
  - the proportion of 16-19 year old women who smoke has increased from 19% to 27%.

Table 1: Cigarette smoking among people aged 16 and over

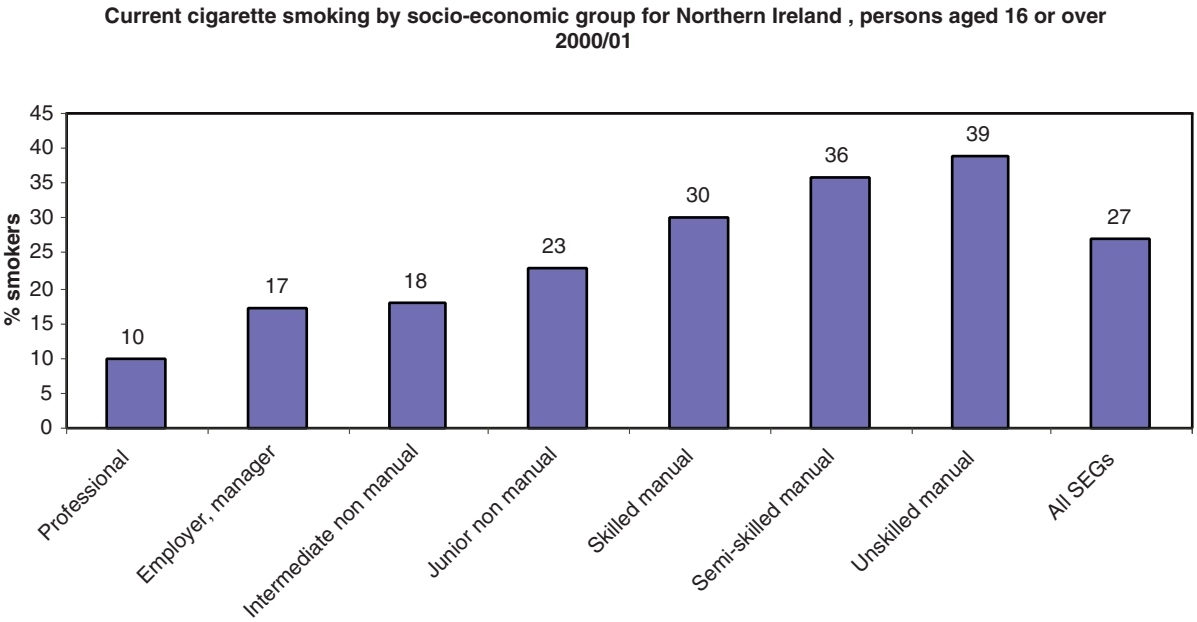
Percentages										
Gender	1983	1984	1986	1988	1990-91	1992-93	1994-95	1996-97	1998-99	2000-01
Males	39	36	35	34	33	31	29	31	28	26
Females	29	29	31	30	31	29	27	27	29	28
All persons	33	33	33	32	32	30	28	29	29	27

Source: Continuous Household Survey, Northern Ireland Statistics and Research Agency

Smoking & Inequalities

1.4 Tobacco is a major cause of health inequalities and is the principal cause of the gap in life expectancy between rich and poor.[3, 4] Although smoking rates among adults have fallen over the last 15 years, this has not occurred to the same extent in lower socio-economic groups **[Figure 1]**. Children in lower socio-economic groups also suffer greater exposure to environmental tobacco smoke and its consequences.[5, 6]

Figure 1



1.5 A survey among civil servants in 2000 [7] provided further evidence of the social gradient that exists both in relation to smoking prevalence and the number of cigarettes smoked, with prevalence highest among junior and industrial grades.

1.6 Research carried out in 2000 [8] shows that 35% of mothers here smoked before pregnancy with 22% continuing to smoke during pregnancy of whom 17% were classified as professional (Social Class 1) and 28% were classified as unskilled manual (Social Class V)

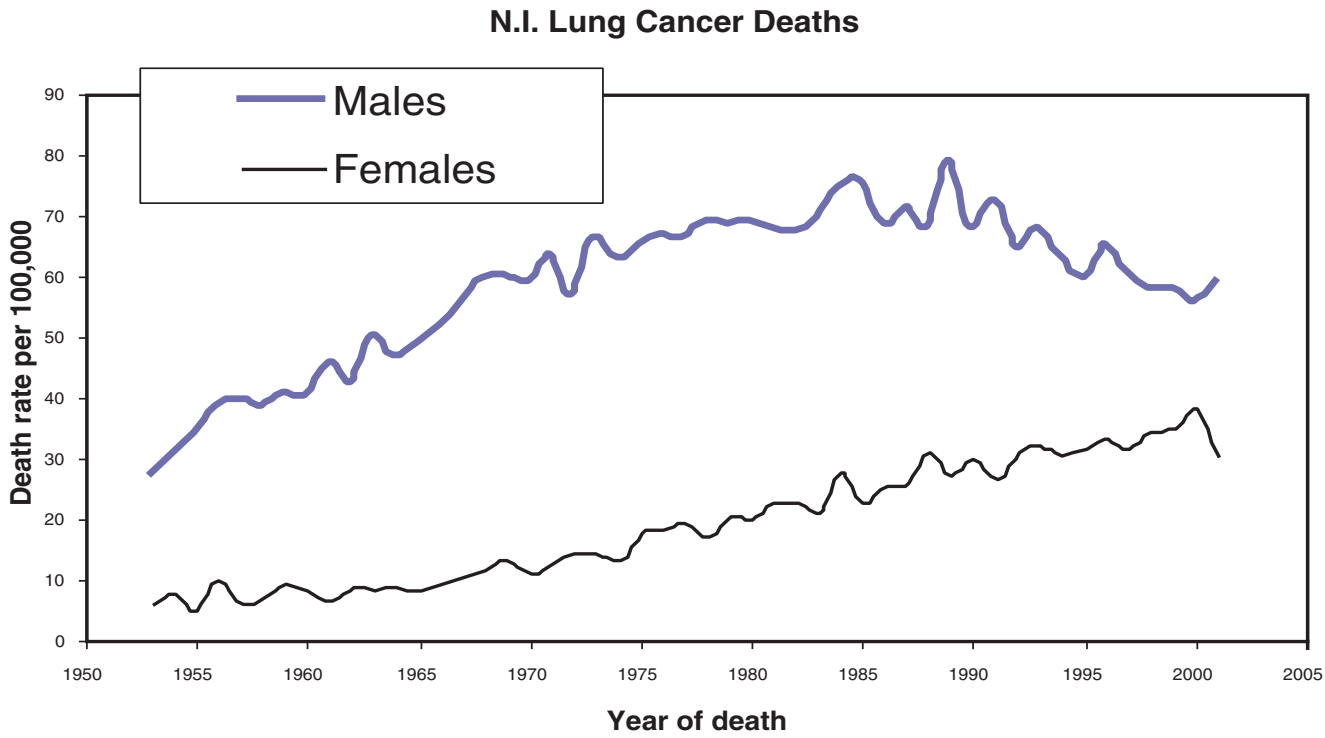
Death and illness

1.7 Smoking claims between 2,700 and 3,000 lives here each year. It is the single greatest preventable cause of premature death and avoidable illness. It also harms people who do not smoke and babies in the womb. Smoking is responsible for almost one in three of all cancer deaths and 84% of all lung cancer deaths.[9]

1.8 Lung cancer kills around 800 people here each year - more than 2 people every day.

It is the most common cause of cancer death in men. In women, the impact of smoking can already be seen in the increasing number of lung cancer deaths **[Figure 2]**. NI Cancer Registry data show that more women now die of lung cancer than of breast cancer.[10]

Figure 2



Source: NI Cancer Registry

1.9 As well as lung cancer, smoking can cause death by cancer of the mouth, larynx, oesophagus, bladder, kidney, stomach and pancreas. It is also linked to many other serious conditions including chronic obstructive lung disease (eg. bronchitis,[9] asthma) and brittle bone disease (osteoporosis).[11]

1.10 Smoking is a major risk factor for coronary heart disease, strokes and other diseases of the circulatory system, which kill two in every five men and women here. These diseases are also important causes of disability. A lifetime non-smoker is 60% less likely than a current smoker to have coronary heart disease and 30% less likely to suffer a stroke.[6]

1.11 Smoking is a critical women's health issue as it not only adversely affects the health of women but also that of the unborn child. Smoking in pregnancy is associated with many problems both for the foetus and newly born baby including miscarriage, placenta damage, pre-term delivery, low birthweight, perinatal death and sudden infant death syndrome.[6, 12]

Environmental Tobacco Smoke (ETS)

1.12 Exposure to ETS is a cause of lung cancer and, in those with long-term exposure, the increased risk is in the order of 20-30%.[6]

The World Health Organisation has stated that tobacco smoke is a real and substantial threat to child health.[5]

1.13 The greatest exposure to ETS is likely to occur in the child's own home from the smoking habits of parents and siblings. Smoking in the presence of infants and children is a cause of serious respiratory illness and asthmatic attacks. Sudden infant death syndrome, the main cause of post-neonatal death in the first year of life, is associated with exposure to ETS.[6]

Economic Costs of Smoking

1.14 The cost of smoking is high in terms of people's health. It is also high in other ways. In her 2000 Annual Report, the Chief Medical Officer estimated that the annual in-patient care costs to the Health Service was over £22m. 1.5m working days are lost each year due to smoking-related illness and the total economic cost is estimated at a staggering £3.1billion.[13]

Recent Developments

1.15 Smoking is a serious public health problem. That is why the Programme for Government and the public health strategy *Investing for Health*, include a commitment to produce a comprehensive Action Plan. The evidence outlined in this Plan demonstrates that tobacco has a major adverse impact on people's lives and on the health service.

1.16 Action at International and European levels to tackle smoking includes: -

- the World Health Organisation Tobacco Free Initiative;
- a new European Union Directive which addresses the manufacture, presentation and sale of tobacco products; and
- a new European Union Directive banning advertising and sponsorship.

1.17 In the South of Ireland, the Public Health (Tobacco) Act 2002 introduces comprehensive measures relating to the control, sale and marketing of tobacco products and establishes the Office of Tobacco Control.

1.18 **Annex 1** contains more detailed information about the measures outlined in paragraphs 1.16 - 1.17.

1.19 Since the publication of *"Smoking Kills"*, the 4 UK Health Departments have been examining how best to reconcile the document's aims with work already underway to tackle smoking. These have included measures ranging from legislation banning tobacco advertising to better enforcement and promoting greater awareness of the issues. In addition, as an incentive to reduce smoking, the UK has set cigarette tax at a high level and now has one of the highest levels of duty on cigarettes in the world.

1.20 This high price policy and other action to prevent people smoking is being undermined by the availability of cut-price cigarettes through smuggling. For example, young people and adults from lower socio-economic groups would normally be expected to have less disposable income and may benefit disproportionately from the availability of cheap cigarettes. In 2000, Customs and Excise published the "Tackling Tobacco Smuggling" strategy and, in 2001/02, seized almost 2.6 billion cigarettes in the UK, making a total of more than 5 billion illicit cigarettes seized in the first two years of the strategy. During 2001/02, Customs

also stopped the growth in tobacco smuggling for the first time in ten years.

1.21 In taking forward this Action Plan, it will be important for the Implementation Group to work closely with local Customs and Excise officials to maximise co-operation and ensure that cigarette smuggling does not undermine the overall strategy.

1.22 While these measures go some way towards tackling the problem, the death and illness caused by smoking demand a more comprehensive programme of action.

Key Points

- **35% of 11-16 year olds report having smoked, with most smoking for the first time at age 12.**
- **Tobacco is a major cause of health inequalities.**
- **Smoking claims between 2,700 and 3,000 lives here each year.**
- **Lung cancer kills some 800 people here every year - 84% due to smoking.**
- **Smoking in pregnancy causes ill-health to both mother and baby.**
- **ETS causes a 20-30% increase in lung cancer risk.**
- **ETS is a real threat to the health of children and babies.**
- **1.5m working days are lost each year due to smoking related illness.**

CHAPTER 2:
AIM OF ACTION PLAN

Chapter 2:
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Overall aim: To create a tobacco-free society

Introduction

2.1 Because nicotine is highly addictive, it will take time to achieve the ultimate goal of a tobacco-free society. It is therefore recognised that this 5 year Plan represents only the first phase of a long-term strategy to tackle the harm caused by tobacco. There are no easy solutions but experience from Europe and in other countries, such as Australia and America, shows that substantial improvement is possible with an integrated, co-ordinated approach, which includes educational, clinical, regulatory, economic and social measures.

Objectives

2.2 The key objectives are: -

- preventing people from starting to smoke;
- helping smokers to quit; and
- protecting non-smokers from tobacco smoke.

2.3 These objectives will be met through integrated and effective approaches including: -

- education programmes and information strategies to prevent and discourage tobacco use, particularly by children and young people, and actions to build on the change in public attitudes;
- regulatory and voluntary controls on a range of issues including advertising and promotion, access to tobacco, and clean air policies; and
- interventions to help smokers overcome their addiction.

Values and Principles

2.4 This document adopts the values and principles set out in *"Investing for Health"*. These include: -

- health as a fundamental human right;
- actively pursuing equality of opportunity and the promotion of social inclusion;
- reducing social inequalities;
- focusing public policies towards improving health and well-being;
- encouraging community involvement in improving health; and
- partnership working.

Priorities

2.5 Reducing smoking will save lives and reduce disability. The vast majority of adult smokers started smoking in childhood and the addictive nature of nicotine means that, without help, they are likely to do so for the rest of their lives. Therefore, a priority must be to prevent children and young people from smoking and to protect them from the effects of Environmental Tobacco Smoke.

2.6 Improving the health of all our people and reducing health inequalities is the main aim of the *Investing for Health* Strategy. The factors that can cause poor health and inequalities are complex. Smoking, more

than any other identifiable factor, contributes to the gap in healthy life expectancy between those most in need, and those most advantaged. [3, 4] Therefore it will be particularly important to target the socially disadvantaged.

2.7 It is also important to address the issue of smoking among adults, including pregnant women, not least because of parents' influence on children's smoking habits and the need to protect the unborn and newly born from the direct and indirect effects of tobacco smoke.

Target Groups

2.8 While this Plan is aimed at the population as a whole, three key target groups have been identified as requiring particular action. These are:

- children and young people;
- disadvantaged adults who smoke; and
- pregnant women who smoke.

Targets

2.9 The following targets have been set: -

- to increase the proportion of 11-16 year old children who do not smoke from 86.5% in 2000 to 89% by 2006; *
- to increase the proportion of pregnant women who do not smoke from 78% in 2000 to 82% in 2005;
- to increase the proportion of adults who do not smoke from 73% in 2000/01 to 75% in 2006/07; and
- to increase the proportion of non-smokers in manual groups from 65% in 2000/01 to 69% in 2006/07.

***The Young Persons' Behaviour and Attitudes Survey 2000 found that the rate of smoking among 11-16 year old girls was 16% compared to 24% in 1997/98 (Health Behaviour of School Children Survey). The Continuous Household Survey found that smoking among 16-19 year old females was 27% in 2000/01 compared to 19% in 1983. It should, however, be noted that the 2000/01 figure was based on a small sample size (143). The priority in the short to medium term must therefore be to build on the reduction in girls' smoking and to reverse the trend among young women.**

As a first step, the aim will be to bring smoking levels among 11-16 year old girls broadly into line with that of boys - currently 11.7%.

CHAPTER 3:
PREVENTION

Chapter 3:
PREVENTION

Introduction

3.1 Preventing people, particularly children and young people, from starting to use tobacco will require co-ordinated activity involving a partnership approach with the statutory, voluntary, community and private sectors. It requires a range of measures in four key areas: -

- raising awareness about the effects of tobacco smoke on smokers' and non-smokers' health through: -

  i) public information; and

  ii) education;

- banning the advertising and promotion of tobacco products;

- enforcing existing legislation on sales of tobacco to children; and

- the widespread adoption of smoke-free policies in workplaces and in places frequented by the general public.

As the adoption of smoke-free policies also serves to protect the public it is addressed in **Chapter 5**.

Raising Awareness

3.2 It is important to develop sustained public information and education campaigns to raise awareness of the issues involved, such as the health risks to smokers and non-smokers and to counter the promotional activities of the tobacco industry. Various initiatives to highlight the dangers of tobacco use have been undertaken by health and education professionals, voluntary organisations and others over a number of years.

3.3 These included public information campaigns and lifestyle education programmes in schools, primarily aimed at preventing the young from adopting the habit. However, such initiatives have largely operated in isolation rather than as part of a co-ordinated, comprehensive approach to reducing the harm caused by smoking. Over the past decade, other countries - most notably Australia and America - have achieved dramatic results through a sustained, hard-hitting approach to public information campaigns, as part of an integrated approach to tackling tobacco use.

Public Information

3.4 Since 1999, the Health Promotion Agency has been developing a public information campaign on tobacco. The first two phases of the campaign targeted young people and comprised television advertisements, a magazine distributed to all second and third year pupils and an interactive website. The most recent phases, aimed at adult smokers, included television advertisements which also promoted a telephone helpline service.

3.5 Other successful measures aimed at raising awareness and preventing children from taking up the habit have been running for some years. These include two Ulster Cancer Foundation initiatives - Teenagers Against Smoking (TASK) and the Smokebusters' Club. TASK is a peer-led approach to empower and support adolescents in considering tobacco issues and to help them develop their own campaigns and education programmes. The Smokebusters' Club encourages 9-12 year olds to reject smoking. An evaluation of the Club by the University of Ulster showed Smokebusters to be effective in changing attitudes and behaviour.

Education

3.6 The education sector, from primary through to tertiary education, makes an important contribution towards reducing smoking levels among young people.

3.7 In schools, the science programme of study requires pupils, at successive key stages, to be taught about the harmful effects of tobacco, including the impact on body functions. Personal, social and health education lessons also provide opportunities to consider self-image and personal development. The specific aim with regard to tobacco is to reduce pupils' vulnerability and enhance their self-esteem, knowledge and decision-making skills in order to equip them with the confidence to resist the attractiveness of smoking as portrayed in the media and by the industry.

3.8 Another effective way of promoting no smoking and reducing smoking levels is through the health promoting schools concept. This combines health education and the wider school environment to ensure that all aspects of school life support the positive health messages being explored in the classroom setting. To do this effectively requires school staff, Boards of Governors and other relevant agencies to work together in a planned way.

3.9 In Further Education Colleges, many students gain information about healthy living through learning programmes such as health and social care, science, childhood studies and leisure. Further Education colleges have put in place policies on a range of lifestyle matters based on guidelines issued by the Department for Employment and Learning.

3.10 The higher education institutions also actively promote a healthy lifestyle among the student population. While some students will address health issues, including smoking, as part of their learning programmes, health promotion activities are primarily extra curricular and are delivered by the Institutions' student welfare staff in conjunction with Student Union welfare officers.

3.11 The Youth Service is also well placed to promote healthy lifestyles. Health promotion is seen as an important element of the youth work curriculum and new guidelines have been published. Youth workers are adept at building relationships with young people and helping them to make informed choices. They are encouraged by initiatives such as the Western Education and Library Board's Health Promoting Youth Awards. In addition, the Ulster Cancer Foundation and the Health Promotion Agency have produced guidance to assist youth workers address smoking matters with young people.

Tobacco Advertising

3.12 Advertising and promotion by the tobacco industry was one of the reasons regularly put forward to explain why smoking continued, despite widespread knowledge about the health risks to smokers and non-smokers alike.

3.13 The Tobacco Advertising and Promotion Act 2002 extends to the whole of the UK. The advertising of tobacco products on billboards and in newspapers and magazines has been banned since 14 February 2003. All new tobacco-related sponsorship

agreements have also been banned since that date. Existing sponsorship agreements must end on 30 July 2003 apart from "exceptional global events" which have until 31 July 2005 to find alternative sponsors. Advertising at "point of sale" and brandsharing regulations are due to be introduced at a later date. Brandsharing, or brandstretching as it is sometimes known, is a form of indirect advertising involving the use of tobacco branding on non-tobacco products or services, or vice versa. These important developments will remove a major obstacle to the work of health professionals and others in tackling smoking.

3.14 Direct TV advertising of tobacco products has been banned since 1965. Successive Governments have, since 1982, entered into voluntary agreements with the tobacco industry aimed at controlling other forms of tobacco advertising and promotion. However, there is little evidence that such agreements have worked.

3.15 Children are particularly vulnerable to advertising. Research in England [14] demonstrates a high level of awareness of tobacco advertising with half of all young people believing that they have seen a cigarette advert on television in the previous six months. This is despite the fact that it was banned in the mid-sixties and suggests that tobacco sponsorship of televised events has a similar impact to direct TV advertising.

Restricting Sales to Children

3.16 In their formative years, children are exposed to a range of influences which may impact on their future behaviour. The vast majority of adult smokers - around 82% - adopted the habit in their early teens.[15]

3.17 Existing legislation [16, 17, 18] seeks to make it more difficult for children to obtain tobacco products thus helping to delay, and ideally prevent, adoption of the smoking habit. These restrictions include prohibiting the sale of tobacco products to children under sixteen and the publication of warning statements as well as enforcement measures.

3.18 Enforcement of the legislation falls to local councils' Environmental Health/Enforcement Officers. A recent snapshot survey on enforcement activity among the 26 district councils found that, while all 17 respondents considered a programme of enforcement action annually, only two councils accorded a high priority to enforcement activity. Key reasons given for not undertaking a programme of action were lack of resources and low priority. Between 1998 and 2000, only one council had initiated proceedings.

What more needs to be done

3.19 Public attitudes towards tobacco use are changing and it will be essential to build on this to prevent people, particularly children, starting to smoke. This is central to achieving the overall aim of creating a tobacco-free society. When attitudes change, behavioural change is likely to follow. Therefore tobacco must become less acceptable, less accessible and less desirable, thereby influencing current and potential future tobacco users, particularly children and young people. This will only be achieved through time using a range of measures including education and legislation.

3.20 Preventive action has, to date, mainly focused on children and this should

continue through the further development of sustained public information and education initiatives. It will be important to promote greater awareness of the harm caused by tobacco. One way of achieving this is by maintaining a flow of information to the media and by encouraging journalists to give a higher profile to the issue. This can be done by, for example, regular media briefings, the promotion of appropriate anti-smoking events, press releases and interviews with spokespersons.

3.21 The education sector, from primary through to tertiary, should continue to use every opportunity to work with other statutory organisations and the voluntary sector to prevent children and young people smoking. This could include, for example, the further roll-out of the health promoting schools concept, peer-led approaches and projects such as the Further Education Curriculum Development project which has the potential to improve students' knowledge of key health related issues, including smoking.

3.22 The current review of the curriculum by the Northern Ireland Council for the Curriculum Examinations and Assessment provides an excellent opportunity to ensure that children and young people develop personal development skills which include issues surrounding social and health education, citizenship and employability.

3.23 The majority of retailers are responsible and try to comply with the legislation restricting sales to children. However, many encounter difficulty in establishing the age of young people. Another problem area is the purchase of cigarettes by over 16s for those under age, a practice which clearly undermines the existing legislation. In August 2001, legislation was introduced in the South of Ireland prohibiting the sale of tobacco products to those under the age of 18 (previously 16).

3.24 Despite restrictions on sales, surveys consistently identify a high prevalence of smoking among children. This provides compelling evidence that more needs to be done to prevent them obtaining cigarettes. The adoption of a *"When in doubt - don't sell"* policy by **all** retailers would be a useful starting point. In this respect, the *"buyyoungdieyoung"* smoking and under 16s' project run by the Western Health and Social Services Board and the Western Group Environmental Health Services represents an example of good practice.

3.25 The *"When in doubt- don't sell"* policy is recognised as a key principle in a tobacco enforcement protocol published in September 2000 by the Department of Health and the Department of Trade and Industry in London. The protocol is, in effect, a best practice code which aims to reduce under-age sales by encouraging local authorities in England and Wales to adopt a tough line with shopkeepers who flout the law. While it is recognised that such action would not, of itself, eradicate children's smoking, it would undoubtedly complement other action to tackle the problem.

3.26 Vending machines can provide a relatively easy source of access to cigarettes for children. In crowded spaces, such as pubs, it is not always easy for staff to detect children using such machines. If children are to be protected, it is essential that vending machines are sited in a supervised area and that staff closely monitor their

use. The National Association of Cigarette Machine Operators (NACMO) has attempted to address the accessibility of vending machines by issuing a code to its members defining the siting arrangements which they should follow.

Summary of Action

- **Further development of sustained public information campaigns.**
- **Rolling out of the health promoting schools concept.**
- **Promotion of written policies on smoking in schools, colleges and the youth service.**
- **The Curriculum Review to reflect the need to promote awareness of the dangers of smoking.**
- **Legislation banning tobacco advertising.**
- **Promotion of training for environmental health officers on illegal tobacco activity and enforcement procedures.**
- **Proposals to be brought forward requiring an annual programme of enforcement action.**
- **Recent legislative changes in the South of Ireland to be monitored.**
- **Adoption of an enforcement protocol.**
- **Placement of tobacco vending machines to comply with the NACMO Code.**
- **Prohibition of tobacco vending machines from council and other public sector facilities.**
- **Councils, or groups of councils, to nominate an individual to co-ordinate anti-tobacco activity.**

CHAPTER 4:
HELPING SMOKERS TO QUIT

Chapter 4:
HELPING SMOKERS TO QUIT

Introduction

4.1 Two-thirds of smokers say they want to quit yet, despite increasing publicity about smoking related ill-health, many continue to smoke. Of the two-thirds who want to stop smoking, about one-third will try to stop in any one year.[19] Giving up is not easy because nicotine is highly addictive and repeated quit attempts may be required before total abstinence is achieved.

4.2 Giving up smoking has immediate and longer-term effects.[20] Therefore, the provision of advice and cessation support services to smokers who want to quit must be key elements of a comprehensive programme of action as part of an overall strategy which also includes public information campaigns, education programmes, regulatory change and clinical and community based initiatives.

Priority Groups

4.3 Professional advice and support are essential to help smokers quit. Without such help, only about 2% of middle-aged smokers are successful each year.[19] In particular, young people, disadvantaged adults, and pregnant women, will require a range of services tailored to meet their specific needs. The needs of other disadvantaged groups such as those from an ethnic minority background, or with a disability, also need to be addressed. Cessation methods used with the general adult population should be modified as necessary with the aim of meeting such needs.

Young people

4.4 Young people continue to smoke in significant numbers and many will become addicted. Cessation services for young people under 16 who wish to quit is an issue which cannot be ignored. The provision of cessation training for all of those working with young people including teachers, youth workers and peer leaders is therefore very important. Smoking prevention and cessation interventions are necessary in a range of settings, including schools and youth organisations. Less conventional settings, such as residential homes and young offenders' centres, should also be considered. These should be co-ordinated with other community-based initiatives, media campaigns and parental activities which seek to influence the smoking activities of children and young adults.

Disadvantaged Adults

4.5 For some adults, smoking can be a coping mechanism and many, particularly those in the lower socio-economic groups, find it very difficult to give up. For this group in particular, the dangers of "roll your own" cigarettes need to be highlighted in view of the relatively high content of harmful substances. Innovative approaches to the provision of cessation services may therefore be required, involving use of the community sector and additional action to promote self-esteem.

Pregnant women

4.6 The majority of pregnant women and young mothers are in regular contact with a wide range of health and social care professionals. This provides an ideal opportunity for all those who are involved in providing ante and post-natal care to raise the issue of smoking, including the

risk posed by Environmental Tobacco Smoke (ETS), and to offer advice and general support including referral to a specialist cessation service, where appropriate. Counselling from a smoking cessation specialist, together with written support materials, have been shown to be effective in aiding cessation among pregnant women.

4.7 Families, the education sector, employers, the voluntary and community sectors and the wider community also have an important role to play in helping and supporting smokers who want to quit. For example, schools and the workplace are well placed to provide smoking cessation support.

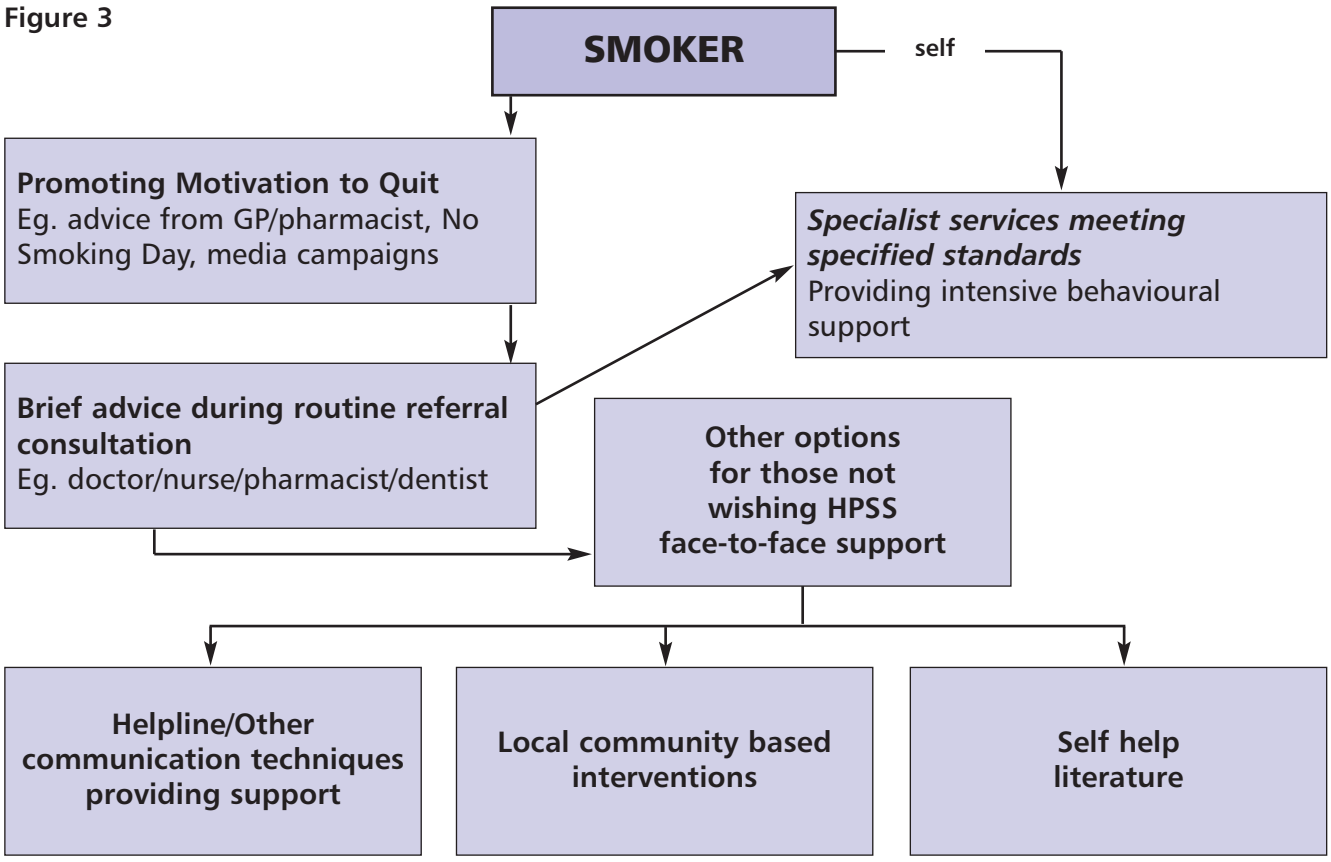
Interventions

4.8 The range of effective interventions available to motivate and support those attempting to quit includes: -

- local and regional media campaigns;
- brief advice delivered by health and social care professionals including doctors, dentists, nurses and pharmacists as well as by allied health professionals;
- specialist services offering advice and intensive support; and
- other support, such as telephone helplines, self help manuals, pharmaceutical industry.

These are illustrated in **Figure 3** below.

Figure 3



Adapted from ASH "Smoking Cessation Services -Implementing the NHS plan"

4.9 **Brief advice**[21, 22] involves health and social care professionals taking the opportunity to give advice during the course of a routine consultation, including advice on medicines to aid the quit attempt, and is of 3-5 minutes duration. **Specialist services**[21, 22] involve intensive support with the use of products such as Nicotine Replacement Therapy (NRT) and bupropion and are particularly important for highly dependent smokers.[19] More detail on brief and specialist advice is contained in **Annex 2**.

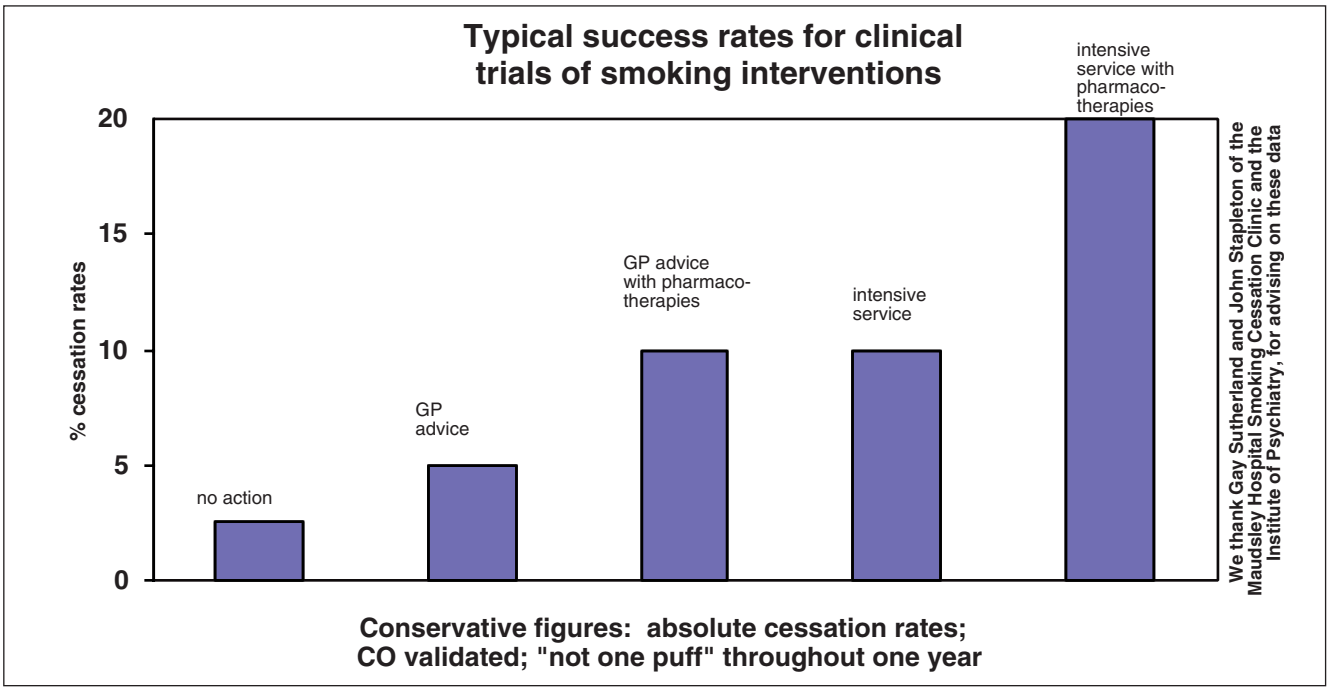
4.10 Most people who successfully quit make several attempts before they actually succeed. Clinical trials and experience from elsewhere have demonstrated that behavioural support, combined with medicines to aid the quit attempt, can enable 20-25% of smokers to remain abstinent at one year post-treatment.[22] Brief advice, together with pharmacotherapies can produce cessation rates of 5-10% **[Figure 4]**.

Giving help to smokers who want to stop is both effective and cost effective.[19] Therefore, it is important to have in place a structured and sustained approach to the development of smoking cessation services. A Regional Training Framework, setting out agreed minimum standards has been distributed to a wide range of interests. It is also available on the DHSSPS website at www.dhsspsni.gov.uk/publications/2003/smoking_cessation.pdf. Given the proven effectiveness of smoking cessation services it will be important for HPSS Managers to accord a high priority to the release of staff for training purposes and refresher courses.

Service Development

4.11 Much work is currently underway to develop and promote smoking cessation initiatives. Since 1999/00, additional funding, including New Opportunities funding, has been made available to enable Health and Social Services Boards to provide advice and dedicated support, in a

Figure 4



Source: The Case for Commissioning Smoking Cessation Services [19]

range of settings, for those who wish to quit. These settings include Health Action Zones, health centres, the voluntary sector, community pharmacies, GP and dental practices. Multi-agency Tobacco Control Groups have also been established to take this work forward.

4.12 These initiatives have been complemented by the public information campaign developed by the Health Promotion Agency. The most recent phases of the campaign highlighted the dangers of smoking and directed smokers to smoking cessation services. Voluntary organisations such as the Ulster Cancer Foundation and the Chest, Heart and Stroke Association also provide a range of services including support, information and advice.

What more needs to be done

4.13 Opportunistic interventions and cessation services have been developing over the last few years. However, a comprehensive approach, with a much greater focus on motivating smokers to quit and the provision of local advice and support in a variety of accessible settings, including the workplace, is essential to the success of the Action Plan. The Northern Ireland Civil Service (NICS) and the Health & Personal Social Services, as two of the largest employers here, are well placed to give a lead in this area. The NICS Workforce Health Survey 2000[7] found that, in common with the population as a whole, over two thirds of civil servants who smoke would like to give up.

4.14 The NICS is fully committed to its Workplace Health Improvement Programme which was further informed by the publication of the Workforce Health Survey. The programme addresses smoking issues and the introduction of smoking cessation support services for interested staff. Smoking cessation co-ordinators have been appointed in each Health and Social Services Board area and they will have a key role in ensuring the development of effective cessation services across the HPSS.

4.15 *Investing for Health* highlights the role of local communities in reducing health inequalities through the provision of services, information and support within their own localities. Training and support must be available to ensure that they are in a position to identify needs and make an effective contribution towards helping smokers quit. Account also needs to be taken of the need for services to be tailored to meet the differing needs of the target groups - disadvantaged adults, children and young people and pregnant women. Consideration must also be given to other groups including people with disabilities, those from an ethnic minority background and those from the rural community.

4.16 The provision of NRT and bupropion is an integral part of smoking cessation initiatives. It is important to recognise that, in addition to current prescribing arrangements, doctors, dentists, nurses, pharmacists and other health care professionals have major roles in offering advice on these products and, where appropriate, in assisting patients gain access to smoking cessation services. In addition, local collaboration and agreement on the use of Patient Group Directions has the potential for enhanced use of NRT as has the future extension of nurse prescribing. *"Improving Local Access to Smoking Cessation Therapies by using Patient Group Directions"* is available on the Royal Pharmaceutical Society of Great Britain

website: www.rpsgb.org.uk/patientcare/ The development of policies on the use of NRT in pregnancy and during breastfeeding is necessary at local level for those women who cannot otherwise stop smoking.[6]

4.17 The most recent phases of the public information campaign targeted adult smokers by highlighting the damage caused by smoking. If the 350,000 adult smokers here are to be persuaded to quit, it will be important to build on the public information campaign, to take specific steps to raise awareness about the dangers to mother and child during pregnancy - including messages aimed at women hoping to become pregnant- and also about the harmful effects of ETS. Key messages will need to be innovative and tailored to meet the needs of the respective audiences.

4.18 The most recent advertising campaign ran from 7 January to 31 March 2003 and included a dedicated telephone helpline service commissioned by the Department of Health, Social Services and Public Safety. During this period, 3,725 interactive calls were processed. While a detailed analysis of the calls is not yet available, it is already clear from this and earlier campaigns that a demand exists for this type of service. DHSSPS will continue to work closely with the Health Promotion Agency and others to ensure that services for smokers wishing to quit are effectively promoted as part of the overall public information campaign.

Summary of Action

- **Promotion of smoking cessation services in a variety of settings, including the workplace.**
- **Development of specialist services in primary and secondary care.**
- **Promotion of education and training on brief advice in undergraduate and postgraduate education for health and social care professionals.**
- **Promotion of training and support on smoking cessation for teachers, youth workers and peer leaders.**
- **Training and support on smoking cessation to be made available to those working in community settings.**
- **Regional Training Framework to be adopted.**
- **Public information campaign to include the promotion of services for smokers wishing to quit.**

CHAPTER 5:
PROTECTING NON-SMOKERS FROM TOBACCO SMOKE

Chapter 5:
PROTECTING NON-SMOKERS FROM TOBACCO SMOKE

Introduction

5.1 Nicotine is highly addictive and it will take many years to achieve the overall aim of a tobacco-free society. In the meantime, the protection of the general public, particularly children, from tobacco smoke must remain a key element of any tobacco control policy. This requires partnership working and measures to promote smoke-free environments. The voluntary sector has made an important contribution to the promotion of smoke-free policies, the widespread adoption of which, as stated in **Chapter 3**, will also help prevent tobacco use.

Promoting Smoke-Free Environments

5.2 Smoking is legal. However, adult non-smokers and children - who are particularly vulnerable - are entitled to protection from Environmental Tobacco Smoke (ETS). The increasing evidence about the risks associated with ETS is outlined in **Chapter 1**. It is important that smokers and non-smokers are aware of these risks and that adequate safeguards are in place. **The views of those who wish to breath air free from tobacco smoke must take precedence over those of people who smoke**. Some protective measures are already in place, both non-legislative and legislative. These have been introduced to either protect the general public, or with the welfare of particular groups, such as employees, in mind.

The General Public

5.3 There are no specific legislative controls banning smoking in public places although some organisations have implemented no-smoking policies or taken steps to improve air quality. For example, Government departments, hospitals, theatres, cinemas and some shopping malls have adopted no smoking policies.

5.4 Public transport is widely used and has an important role to play in promoting a smoke-free environment. The airline industry has set an excellent example by introducing no smoking policies on all flights.

5.5 Action has also been taken under The Transport Act (Northern Ireland) 1967 and The Road Traffic (Northern Ireland) Order 1981 to tackle smoking on trains and buses. As far back as 1971, bye-laws were introduced banning smoking on trains and in railway stations. These bye-laws allow offenders to be prosecuted. In 1982 and 1994 respectively, Citybus and Ulsterbus introduced total no smoking policies on their vehicles. No smoking policies are also operational in three integrated bus/rail stations - Bangor, Craigavon and Eurobus.

Employees

5.6 Tobacco smoke is a particular issue in the workplace as it can aggravate certain diseases such as asthma and chronic bronchitis and can cause discomfort to the eyes, nose, throat and chest. Although there is no specific statutory duty on employers to ban smoking, the Health & Safety at Work (Northern Ireland) Order 1978 places a duty on employers to ensure, so far as is reasonably practicable, the health, safety and welfare at work of their employees and the health and safety of others who may be affected by their [employers'] work activities.

5.7 Regulations[23, 24] made under the 1978 Order may also impact on employers' responsibilities to protect their employees. Guidelines for employers were published in Britain by the Health and Safety Executive in 1988 (revised in 1992) and are fully recommended to employers here by the Health & Safety Executive (HSENI). They point out possible legal implications and recommend that all employers should have policies on smoking. Basic advice on formulating policies is included. The extent to which the 1978 Order affords protection from exposure to tobacco smoke has not been tested in the criminal courts.

5.8 In April 2000, HSENI also issued to interested parties here a consultative document produced in Britain containing proposals for an Approved Code of Practice (ACOP) on Passive Smoking at Work. HSENI sought views on the introduction of a similar document here. The draft ACOP recognised that employers have legal obligations under the legislation to protect the welfare of their employees in relation to exposure to tobacco smoke, and set out advice on how to meet those obligations. Although the proposals were the subject of widespread consultation, the Code has not been published in Britain or here.

5.9 The Health and Safety Executive in Britain is currently re-assessing the financial implications of its proposals with particular reference to small businesses. HSENI is to assess the implications of any major revision and to put forward proposals here.

What More Needs to be Done

5.10 It is recognised that there may be particular issues to be addressed in introducing smoking bans in hotels, pubs and other places of entertainment. Nevertheless, the wishes of customers (and employees) who do not smoke should be respected. The introduction of no smoking policies in some public places is a welcome development but needs to become standard practice. There are claims and counter claims about the impact on business of smoking bans in restaurants.

5.11 In the South of Ireland, research was carried out in 2001 to establish the general public's attitude to smoking and to the introduction of bans or restrictions on smoking in public places. Two key findings show that there is considerable support for all measures to control smoking and that this support is broad based, coming from smokers as well as non-smokers.[25] In January 2003, the Health Minister in the South announced plans to prohibit smoking in all workplaces with effect from the beginning of 2004. It will also be important to commission research to gauge the level of support here for action in this area.

5.12 Large employers such as the NICS and the Health and Personal Social Services are well placed to lead in the provision of smoke-free facilities. Both have introduced no smoking policies, some of which make provision for "smoking rooms". Occupational health services in both the private and statutory sectors have an important role to play in promoting a non-smoking environment. A key indicator of progress towards the ultimate goal of a tobacco-free society will be widespread acceptance that the provision of facilities for smokers can only be viewed as a short-term measure leading ultimately to smoke-free premises.

5.13 Government departments and their agencies can promote smoke-free environments through, for example, the conditions attached to the awarding of grants and the commissioning of services. An independent evaluation of current local initiatives introduced by hoteliers and licensees to improve indoor air quality will be necessary to measure effectiveness.

Summary of Action:

- **Promotion of no smoking policies.**
- **Proposals for Approved Code of Practice on Passive Smoking at Work to be finalised.**
- **Research to be commissioned on the extent of smoke-free facilities and public attitudes towards smoking.**
- **Policies on smoking to be built into commissioning arrangements with HPSS and other service providers.**

CHAPTER 6:
ACTION

CHAPTER 6:
ACTION

PREVENTION

Further development of public information campaigns taking account of issues such as target groups and issues such as Environmental Tobacco Smoke (ETS), legislation and enforcement.

Lead Organisations: Department of Health, Social Services and Public Safety (DHSSPS), Health Promotion Agency (HPA), Health and Social Services Boards & Trusts (HSS Boards & Trusts), voluntary & community sectors.

Target Date: Ongoing with delivery of key messages - reviewed annually

Further promotion and implementation of the Health Promoting Schools concept.

Lead Organisation: Health Education Liaison Group.

Target Date: Ongoing

Schools, Further Education Colleges and the Youth Sector to be encouraged to introduce and implement no smoking policies.

Lead Organisations: Department of Education (DE), Education & Library Boards (E&L Boards), Department for Employment & Learning.

Target Date: December 2003

The Curriculum Review to highlight the need to promote awareness of the dangers of smoking.

Lead Organisations: DE, E&L Boards, CCEA

Target Date: March 2004

The Tobacco Advertising and Promotion Act 2002.

Lead Organisation: DHSSPS.

Target Date: Provisions started to come into force from February 2003

To promote the inclusion of training on illegal tobacco activity and enforcement in undergraduate and postgraduate education for environmental health officers.

Lead Organisations: DHSSPS, professional training organisations and institutions, HPA.

Target Date: Ongoing

To bring forward proposals to amend Article 6 of the Children and Young Persons (Protection from Tobacco) (Northern Ireland) Order 1991 to place a statutory duty on councils to carry out an annual programme of enforcement action.

Lead Organisation: DHSSPS.

Target Date: March 2005

To monitor the impact in the South of Ireland of the recent legislative changes and, in particular, that prohibiting the sale of tobacco products to those under the age of 18.

Lead Organisation: DHSSPS.

Target Date: July 2004

To encourage councils to pursue a pro-active approach to enforcement by adopting a protocol similar to the enforcement protocol introduced in England and Wales.

Lead Organisations: DHSSPS, NI Local Government Association, local councils.

Target Date: March 2004

To work with local councils and others to ensure that the placement of tobacco vending machines complies with the NACMO Code.

Lead Organisations: DHSSPS, local councils.

Target Date: July 2004

To work with local councils and other public sector bodies to prohibit tobacco vending machines from their facilities.

Lead Organisations: All Government departments and local councils.

Target Date: September 2004

To encourage each council, or groups of councils, to nominate an individual to co-ordinate tobacco control activity and to liaise with counterparts in the South of Ireland on potential cross-border co-operation.

Lead Organisations: DHSSPS, local councils.

Target Date: March 2004

SUPPORT

To promote the provision of smoking cessation services in a variety of settings including schools, the workplace - including the NICS and the HPSS - and the community.

Lead Organisations: DHSSPS, HSS Boards & Trusts, E&L Boards, employers, voluntary, community and youth sectors, Local Health & Social Care Groups (LHSCGs).

Target Date: Ongoing

To further develop sustainable specialist smoking cessation services in primary and secondary care which are accessible to all smokers, including the three target groups, those from an ethnic minority background and those with a disability.

Lead Organisations: HSS Boards & Trusts, LHSCGs, the voluntary and community sectors.

Target Date: Ongoing

To promote the inclusion of training on brief advice in undergraduate and postgraduate education for doctors, nurses, health visitors, allied health professionals, pharmacists, dentists and social workers.

Lead Organisations: DHSSPS, professional training organisations and institutions.

Target Date: September 2004

To promote training and support in smoking cessation for teachers, youth workers and peer leaders.

Lead Organisations: E&L Boards.

Target Date: September 2004

Training and support in smoking cessation to be made available to those working within a community setting.

Lead Organisations: DHSSPS, HPA, HSS Boards & Trusts, voluntary and community sectors.

Target Date: October 2004

To ensure the incorporation of the Regional Training Framework into quality standards for the commissioning of services and to encourage its implementation.

Lead Organisations: HSS Boards.

Target Date: March 2004

To ensure that services for smokers wishing to quit are effectively promoted as part of the overall public information campaign.

Lead Organisation: DHSSPS.

Target Date: Ongoing - with delivery of key messages reviewed annually

PROTECTION

To work with Trades' Unions, employers' organisations, Chamber of Trade, Chamber of Commerce, local councils etc. to promote the adoption of no smoking policies in the workplace.

Lead Organisations: HPA, Department of Enterprise, Trade & Investment - Health & Safety Executive NI (HSENI).

Target Date: Ongoing

To finalise proposals for an Approved Code of Practice on Passive Smoking at Work.

Lead Organisation: HSENI.

Target Date: September 2003

To commission research on the extent of smoke-free facilities and public attitudes towards smoking and smoking prohibitions/restrictions.

Lead Organisations: DHSSPS, HPA, HSENI.

Target Date: March 2004

Policies on smoking to be built into commissioning arrangements with HPSS and other providers and such policies to be evaluated.

Lead Organisations: HSS Boards.

Target Date: Ongoing

To work with the NICS, HPSS, local councils and others to promote the introduction of smoke-free policies.

Lead Organisations: All Government departments, HPA, HSS Boards & Trusts, local councils.

Target Date: September 2004

CHAPTER 7:

MAKING IT HAPPEN

Chapter 7:
MAKING IT HAPPEN

Introduction

7.1 It will take time and partnership working between Government departments, statutory, private, voluntary and community sectors to achieve the overall aim of the Action Plan. However, the three objectives identified in **Chapter 2**, if realised, will help to create a tobacco-free society. If these objectives are to be met, it is essential that structures are in place to oversee the programme of action. The Plan's success will also require sufficient resources and systematic arrangements for monitoring and accountability.

Managing the Plan

7.2 The Ministerial Group on Public Health (MGPH) will be responsible for the overall monitoring of the Action Plan. It will establish a multi-agency Implementation Group to oversee and drive forward the actions outlined in the Plan. The Group will be asked to set intermediate targets in areas such as behavioural change following public information campaigns and uptake of smoking cessation services. It will also report progress to the MGPH on an annual basis.

Research

7.3 The Implementation Group will wish to consider the need for additional research to help monitor and evaluate progress taking account of the need to draw comparisons with other countries. This could include research to increase our knowledge of the social and cultural factors that influence tobacco use, particularly among young girls, and also to ascertain the views of pregnant women who smoke. A number of existing surveys regularly monitor adult and young people's smoking activity. These include: the Continuous Household Survey which biennially includes questions on smoking; the Infant Feeding Survey; the Health & Social Wellbeing Survey and the Young Persons' Behaviour and Attitudes Survey.

Resources

7.4 The Department of Health, Social Services and Public Safety allocated over £4m between the 1999/00 and 2003/04 financial years for the development of public information campaigns and smoking cessation services. It will continue to support the further development of these services.

Tobacco Control: Roles and Responsibilities

7.5 The implementation of a Tobacco Action Plan requires input from a variety of organisations, agencies and individuals ranging from Government departments, Health and Personal Social Services and local councils, to employers, trades unions, the voluntary sector and local communities.

7.6 **The Department of Health, Social Services & Public Safety (DHSSPS)** - is responsible for the health and well-being of the population and therefore has a key role to play in delivering the aims of the Action Plan. It has specific responsibility for legislative provisions to ban tobacco advertising, commissioning public information campaigns and disseminating advice and guidance on smoking cessation services to the Health and Personal Social Services (HPSS). Through the Chief Environmental Health Officer, the Department has a role in promoting consistent and effective implementation of

the legislation, protocols and codes by local councils. In the longer term, DHSSPS will monitor the impact of the Action Plan on smoking levels among adults and young people.

7.7 **The Ministerial Group on Public Health (MGPH)** - comprises senior officials from all departments and is chaired by the DHSSPS Minister. It is responsible for co-ordinating and monitoring the implementation of the *Investing for Health* Strategy, including the Tobacco Action Plan. Departmental representatives on MGPH will be responsible for monitoring the progress of the bodies for which they are responsible.

7.8 **The HPSS** - has a key role in developing smoking prevention and support programmes. This involves collaboration between Health Boards, Trusts and primary care, as well as the voluntary and community sectors. In recognition of the multi-sectoral approach required to effect improvement in health, Boards are establishing Investing for Health Partnerships. These multi-sectoral partnerships will ensure that action to improve health is properly co-ordinated and that a long-term cross-sectoral plan is developed to improve the health and well-being of the population in line with the *Investing for Health* Strategy.

7.9 **The Health Promotion Agency** - has a regional responsibility for health promotion. It will work closely with DHSSPS, the HPSS and others in developing its contribution to tackling tobacco use.

7.10 **The Department of Education** - is responsible for securing the place of health education in schools and in the Youth Service. Health education is currently a statutory requirement of the curriculum under the science programme of study for all pupils up to age 16. The statutory curriculum is currently under review, and it is anticipated that the position of health education will be given greater focus in the revised curriculum, which will be implemented from September 2004. The Department will continue to ensure that young people receive specific education about the harmful effects of tobacco in the context of personal and social development.

7.11 **Education & Library Boards** - are responsible for ensuring the delivery of health education across all sectors from early years to post-16s and in the youth service from age 8 to age 25.

7.12 **The Department for Employment and Learning** - is responsible for promoting education insofar as it relates to further and higher education. This includes health education.

7.13 **The Health and Safety Executive** - is an Executive Non-Departmental Public Body, sponsored by the Department of Enterprise, Trade and Investment. It is the lead body responsible for the promotion and enforcement of health and safety at work standards.

7.14 **Local Councils** - are responsible for enforcement and education in respect of the illegal sale of tobacco products to those under 16. This involves investigating complaints, educating retailers about their responsibilities, bringing the role of councils to the attention of the general public and, where appropriate, instituting legal proceedings. Councils will also be responsible for enforcement of the Tobacco Advertising and Promotion Act 2002.

7.15 **Customs and Excise** - is responsible for preventing and detecting the illegal import of tobacco, the investigation of organisations and individuals engaged in tobacco smuggling and related activities, and their prosecution.

7.16 **Employers** - have an important role to play in protecting their employees from the dangers of tobacco smoke through the development of clearly defined smoking policies in the workplace.

7.17 **Trades' Unions** - have a responsibility to safeguard their members' interests through collaboration with employers regarding exposure to environmental tobacco smoke.

7.18 **The Voluntary Sector** - can do much to promote a change in the social climate towards smoking by, for example, highlighting the benefits to health and the financial implications of quitting. They can also help promote and provide cessation services. Organisations such as the Chest, Heart and Stroke Association and the Ulster Cancer Foundation have many years experience in this area and can offer practical help to those trying to quit.

7.19 **Communities** - Local communities have an important role to play in reducing health inequalities by providing services, support, information and advice within their own localities. This work needs to be built upon and arrangements put in place to maximise their support for those who wish to quit smoking. Family and friends can play an important role in supporting and encouraging individuals trying to quit, particularly through the difficult early days.

ANNEX 1:
INTERNATIONAL AND EUROPEAN MEASURES

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International

The World Health Organisation is committed to reducing global tobacco consumption. Its Tobacco Free Initiative aims to make tobacco-related issues a global concern and provide leadership to strengthen international anti-smoking action. A major component of this initiative is the development of an International Framework Convention on Tobacco Control (FCTC). The FCTC is intended to enable and encourage countries to strengthen their national tobacco strategies.

The FCTC lays down a comprehensive approach to tobacco control and includes proposals to reduce the demand for and supply of tobacco. Demand reduction measures include controls on tobacco advertising and labelling of tobacco products and provisions covering education, awareness and training. Supply reduction measures include requirements to reduce the availability and attractiveness of tobacco to young people as well as measures to tackle illicit trade in tobacco. There are also proposals covering surveillance, research and exchange of information as well as scientific, technical and legal co-operation. The FCTC was formally adopted in May 2003 at the World Health Assembly.

European

The European Parliament and Council published the text of EU Directive 2001/37/EC on the Manufacture, Presentation and Sale of Tobacco Products (the Labelling Directive) on 18th July 2001. UK-wide regulations to implement the Directive came into force on 31 December 2002 although some transitional periods are allowed. Among other things the Directive: -

- defines the maximum tar, nicotine and carbon monoxide yields of cigarettes;
- lays down requirements for additional and larger health warnings on all tobacco products;
- requires tobacco manufacturers to provide a wider range of information about the ingredients of tobacco products; and
- bans descriptions which suggest that a particular tobacco product is less harmful than other tobacco products.

An EU Directive banning tobacco advertising and sponsorship was annulled by the European Court of Justice in October 2000. The European Commission subsequently introduced new proposals for a Directive banning certain forms of advertising and sponsorship. This has been considered by the European Parliament and the Council and was formally adopted in March 2003. The Directive is designed to tackle cross border tobacco advertising. It covers four main areas - printed publications, internet, radio and tobacco sponsorship.

Ireland

A number of tobacco control measures already exist in the South, including:

- ban on smoking in a number of areas including schools, health care facilities, theatres, public offices, banks, building societies, hairdressers;
- ban on advertising in the printed media and sponsorship;

- high retail price strategy; and
- ban on the sale of tobacco products to persons under 18.

Furthermore, in January 2003, the Health Minister announced plans to prohibit smoking in all workplaces with effect from the beginning of 2004.

The Public Health (Tobacco) Act 2002 provides for comprehensive measures relating to the control, sale and marketing of tobacco products and the establishment of the Office of Tobacco Control. The Office will advise on tobacco measures and will monitor and co-ordinate their implementation.

ANNEX 2:
GOOD PRACTICE GUIDELINES FOR CESSATION SERVICES

ANNEX 2:
GOOD PRACTICE GUIDELINES FOR CESSATION SERVICES

Brief advice [21, 22]

Brief advice involves health care professionals, taking the opportunity to give advice during the course of routine consultation, whether or not the individual is seeking help to stop smoking. The purpose of the delivery of brief opportunistic advice is to trigger a quit attempt or to further motivate the individual to consider stopping smoking. This typically involves the 5 "A"s of:

- ***ask*** *- about current smoking status and record response;*
- ***advise*** *- on stopping;*
- ***assess*** *- motivation to stop and record outcome;*
- ***assist*** *- by providing information, including advice/prescription for Nicotine Replacement Therapy or Buproprion (Zyban) and referral to a specialist cessation service, where appropriate; and*
- ***arrange*** *- follow up, if appropriate.*

Brief advice is typically of 3-5 minutes duration and can result in about one to three out of a hundred smokers stopping for at least 6 months. This is in addition to those who might have stopped anyway. If all professionals, particularly those in primary care, ask about current smoking status and, where appropriate, gave advice on smoking cessation at least once a year, this would have significant population health gain.

Specialist cessation services [21, 22]

Specialist cessation services involve intensive support with the use of products such as NRT or Zyban.[19] It is estimated that specialist services will enable 20-25% of smokers to remain abstinent after one year. The development of specialist cessation services is particularly important for highly dependent smokers (disproportionately found in lower socio-economic groups), who are not able to stop following brief advice.

There is a need to develop sustainable specialist services, which are evidence based and meet quality standards. Much work is currently being undertaken at Board/Trust level and in primary care to develop these services. Key elements to success include:

i. the training of staff to deliver intensive support;

ii. the intensity of the support delivered;

iii. the dedicated time and resources to undertake it; and

iv. a consistent approach to quality standards and the monitoring of outcomes.

Minimum standards for a smoking cessation service

The following represents minimum standards for current and future development of smoking cessation, for brief advice and the development of specialist cessation services.

General

i. The use of evidence based guidelines.
ii. Advisers to receive appropriate training for their role, which meets standards outlined in the Regional Training Framework.

Brief advice

Delivery of brief advice and recording of outcome in accordance with locally developed protocols taking account of i and ii above.

Specialist Cessation Services

For specialist services, which could be delivered in a range of settings and may attract additional payments, the following minimum standards should be applied to current and future development of specialist services:

1. i and ii;

2. an initial consultation with the client of greater than 15 minutes duration, to include assessment of motivation and readiness to quit, agreement of quit date and assessment and advice on suitability of NRT/Bupropion;

3. completion of the Minimum Data Set as outlined in DHSSPS monitoring guidance;

4. proactive use of carbon monoxide monitoring;

5. the offer of structured weekly support for at least the first 4 weeks; and

6. follow up at 52 weeks following quit date. The initial contact could be telephone/letter, with those with continued abstinence coming in for carbon monoxide validation and further support.

ANNEX 3:
EQUALITY IMPACT ASSESSMENT

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EQUALITY IMPACT ASSSESSMENT

1. Introduction

Northern Ireland Act 1998

1.1 Section 75 of the Northern Ireland Act 1998 requires the Department of Health, Social Services and Public Safety (DHSSPS) in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity -

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

1.2 In addition, without prejudice to the above obligation, DHSSPS should also, in carrying out its functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

2. Aims of the Action Plan

2.1 Tobacco is the single greatest cause of premature death and avoidable illness. Chapter 1 of this Action Plan sets out the extent of the problem and the cost in terms of death, ill health and disability as well as the economic cost.

2.2 The Action Plan aims to tackle the harm caused by tobacco by creating an environment that promotes non-smoking, prevents young people from taking up smoking, encourages and supports smokers to quit, protects non-smokers from tobacco smoke and ensures effective enforcement.

2.3 Action to achieve the aims will include raising awareness of the dangers of tobacco smoke through public information campaigns, health education programmes, services to support those who wish to quit, promotion of smoke-free environments and enforcement of legislation. The policy will also address inequalities by targeting vulnerable groups:

- children and young people;
- disadvantaged adults; and
- pregnant women.

2.4 The Action Plan policy has been defined by DHSSPS. It will be implemented by DHSSPS in conjunction with other Government departments, statutory bodies and voluntary and community groups.

2.5 Implementation of the Action Plan should achieve a reduction in the number of smokers in the adult population, a reduction in the number of young people taking up smoking and greater awareness of the dangers of smoking. In the longer term the outcome should achieve a reduction in smoking related premature death, illness and disability.

3. Groups Affected by the Policy

3.1 The Action Plan will affect the health and wellbeing of both smokers and non-smokers. Of the groups outlined in paragraph 1.1, it is most likely to affect age, gender and religion.

4. Consideration of Available Data and Research

i. Source: Continuous Household Survey 2000-01

Prevalence - 27% of the population smoke, 26% of men and 28% of women smoke.

Prevalence of smoking among persons by Age/Gender

	Total	Male	Female
16 - 24	28%	25%	31%
25 -34	33%	30%	34%
35 -44	32%	32%	32%
45 -54	29%	29%	30%
55 -64	26%	24%	27%
65 -74	17%	18%	16%
75+	9%	10%	9%
All age groups	27%	26%	28%

Prevalence of smoking among persons by marital status

	Total	Male	Female
Single	31%	28%	33%
Married/Cohabiting	24%	23%	24%
Widowed	18%	21%	17%
Divorced/Seperated	48%	47%	49%
All groups	27%	26%	28%

Prevalence of smoking among persons by religion/gender

	Total	Male	Female
Catholic	33%	30%	34%
Protestant	23%	23%	23%
Other	13%	19%	0%
None	27%	30%	24%
Refused	26%	30%	23%
All groups	27%	26%	28%

Prevalence of smoking by religion and by socio-economic group

	Total	Catholic	Protestant
Professional/employer,manager	15%	17%	13%
Intermediate non-manual	19%	24%	16%
Junior non-manual	23%	29%	19%
Skilled manual	30%	37%	27%
Semi-skilled manual	36%	42%	31%
Unskilled manual	39%	40%	38%
No SEG, ref, etc, armed forces	28%	35%	21%
All groups	27%	33%	23%

No information on prevalence of smoking population by - political opinion/ disability/ racial group/with or without dependents

ii. Source: **Health & Wellbeing Survey 2001**

Number of cigarettes smoked:

Gender Men are almost twice as likely (19%) as women (10%) to smoke more than 25 cigarettes a day.

Environmental Tobacco Smoke (ETS):

Gender 52% of men and 45% of women were regularly exposed ETS.

Age Of 16-24 year olds, three quarters (76% of men and 74% of women) said they were exposed to ETS regularly. This declined to one fifth of those aged 75 and over (21% of men and 19% of women).

iii. Source **Young Persons' Behaviour & Attitudes Survey 2000**

Gender/age 35 % of pupils aged 11-16 have smoked tobacco.
24% of pupils smoke every day -13% boys and 12 % girls.

iv. Source **2000 Infant Feeding Survey**

35% of mothers smoked before pregnancy - 22% continued to smoke during pregnancy.

5. Assessment of Impact

5.1 The overall aim of the policy, which is to promote a tobacco-free society, will take time to achieve. Three key objectives have been set which when implemented will help to achieve the overall aim. Specific actions will focus on preventing people from starting to smoke, supporting those who wish to stop and protecting non-smokers from environmental tobacco smoke.

5.2 Consideration of the data in paragraph 4 indicates that:

- women aged 16-24 were over 3 times as likely to smoke cigarettes (31%) as those aged 75 or more (9%);
- men aged 16- 24 were 2½ times more likely to smoke cigarettes (25%) as those aged 75 or more (10%);
- in the under 35s there is a higher prevalence of smoking among women compared to men, with the greatest difference in the 16-24 age group;
- in women the highest prevalence is in the 25-34 age group but other evidence shows that the proportion of 16 -19 year old women is increasing;
- overall the greatest prevalence of smoking is among divorced or separated people with almost half smoking (48%) compared to one third of single people (31%) and one quarter (24%) married or cohabiting;
- single women are more likely to smoke than single men;
- overall almost one third of Catholics (33%) smoke compared to one quarter of Protestants (23%);
- Catholic women are more likely to smoke than Catholic men;
- smoking rates are higher in the lower socio-economic groups for both Catholics and Protestants although the proportion smoking in each socio-economic group is higher amongst Catholics than Protestants; and
- of those mothers who smoked before becoming pregnant, almost two thirds continued to do so during pregnancy.

This suggests, that of the categories listed in 1.1, the groups most likely to be affected by the Action Plan are age, gender and religion. The Plan will also impact on disabled people, as evidence from elsewhere suggests that smoking prevalence is high among people who have mental health problems. The 2001 Health and Wellbeing Survey also shows that respondents showing signs of a possible mental health problem were more likely to smoke cigarettes than respondents not showing such signs.

5.3 In developing the Action Plan, the Working Group recognised that smoking prevalence was either high or increasing among certain groups - adults in lower socio-economic groups and young women. It also recognised that children including the unborn need to be protected. The Action Plan therefore identifies three priority groups - children and young people, disadvantaged adults who smoke and pregnant women who smoke.

5.4 The specific actions contained in the Plan have been developed with the three target

groups in mind and it is the Department's view that they should not have an adverse impact on any of the groups. The actions should promote equality of opportunity by ensuring that education initiatives, public information campaigns and smoking cessation services are developed to take account of the specific needs of the particular groups, and that professionals and others working to reduce the harm caused by tobacco receive relevant training and skills and are aware of the particular needs of different groups.

6. Monitoring Impact of Policy

6.1 An Implementation Group is to be established to take forward the Action Plan. This Group will advise on a research programme and report progress on a annual basis to the Ministerial Group on Public Health. Surveys will be used to monitor progress.

ANNEX 4:
MEMBERSHIP OF WORKING GROUP

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MEMBERSHIP OF WORKING GROUP

NAME	ORGANISATION
Mrs Deirdre Kenny	Chair DHSSPS **[From April 2002]**
Dr Liz Mitchell	Chair DHSSPS **[From December 2001]**
Dr Bill Smith	Chair DHSSPS **[To December 2001]**
Mr Denis Barr	Health and Safety Executive
Ms Sharon Bleakley	Community Development and Health Network **[From December 2001]**
Dr Maura Briscoe	DHSSPS
Mr Alan Burke	Chief Environmental Health Officers' Group
Ms Lorna Coe	Department of Employment and Learning **[From September 2001]**
Dr Bernadette Cullen	Eastern Health and Social Services Board
Mr Kevin Devine	Department of Health and Children, Dublin
Mr Andrew Dougal	Northern Ireland Chest, Heart and Stroke Association
Dr Brian Gaffney	Health Promotion Agency for NI
Mrs Jane Graham	Health and Social Services Councils
Mr Martin McIlvenny	Customs and Excise
Mr Gerry McElwee	Ulster Cancer Foundation

NAME	ORGANISATION
Mr Seamus Magee	Community Development and Health Network **[To September 2001]**
Mr Owen Metcalfe	Institute of Public Health In Ireland
Mr Brian Morton	Department of Education **[From April 2002]**
Mrs Bridie Mullin	Western Education and Library Board
Mr Eamon Nugent	Department of Employment and Learning **[To July 2001]**
Ms Patricia Thomson	Department of Education **[To March 2002]**

Secretariat

Mrs Pat Osborne	DHSSPS
Mr Jim Gibson	DHSSPS
Mrs Heather Rainey	DHSSPS

ANNEX 5:
USEFUL CONTACTS

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USEFUL CONTACTS

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