



ACHIEVING SMOKEFREE AOTEAROA BY 2025

Engagement with stakeholders – summary report

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INTRODUCTION

Hāpai te Hauora led a stakeholder engagement process to provide expert and practitioner input into developing the Achieving a Smokefree Aotearoa Project (ASAP) action plan.

The purpose was to engage with stakeholders, particularly Māori and Pacific tobacco control experts and community leaders, to find out their priorities and preferences for the action plan. Hāpai te Hauora was selected to lead the engagement process because of its expertise, cultural competence, and Māori and Pacific networks.

Engagement process

The engagement sought input on the ASAP's interpretation of the 2025 goal, a set of priority interventions, and the detail of the draft action plan content. It was a focused process of engagement, rather than a full consultation with the entire tobacco control sector.

The process took place in January to May 2017, comprising three phases of stakeholder engagement:

1. **Initial engagement** to help shape the definition of the Smokefree Aotearoa 2025 goal (January-February)
2. **Second engagement** to help prioritise potential policy options that stakeholders considered would be most effective and feasible in achieving the 2025 goal, based on an initial set of six key intervention areas (March-April)
3. **Final engagement** to provide input and advice on the objectives and actions in an initial draft action plan to achieve a Smokefree Aotearoa by 2025. This aimed to seek input to help improve the action plan (May).

The engagement used face-to-face hui (meetings) to gather information, supplemented by two teleconferences, written feedback from one group hui and one survey.

In each phase of the engagement, the ASAP team provided background documents to Hāpai te Hauora for adapting and distributing to stakeholders before the discussion groups (attached as appendices 1-3).

Recruitment and data collection

Hāpai te Hauora staff used a list of current stakeholders to identify potential groups for the stakeholder engagement. The staff then invited potential participants to attend a face-to-face engagement meeting in their region.

All group chairpersons were emailed and phoned to introduce the project, share information and invite them to take part. If they were willing, Hāpai te Hauora discussed and agreed a suitable date to meet.

In phase 1, Hāpai te Hauora were organising an inaugural national teleconference of regional smokefree coalition leaders at the same time, and used this forum to engage with stakeholders.

The final engagement round involved group discussions in late May with organisations to provide input and advice on objectives and actions in a draft action plan to achieve Smokefree Aotearoa 2025. Compared with the first two rounds, recruitment was more challenging because the timing coincided with World Smokefree Day on 31 May.

Participants in the engagement process

The following three tables summarise the location and number of participants for each phase of the engagement. Many of the participants took part as official representatives of their organisation or wider coalitions. Some groups and individuals were consulted in two or three of the engagement rounds, while others attended only one engagement meeting.

Consulted stakeholders comprised:

- a) tobacco control sector experts and practitioners
- b) iwi leaders, kaumatua and leaders of various Pacific ethnic groups.

The recruitment process emphasised Māori to reflect the ASAP's top priority of addressing Māori smoking, Te Tiriti o Waitangi obligations, and high Māori smoking prevalence. Pacific involvement was also important, because of the high rates of smoking among Pacific peoples in Aotearoa New Zealand.

The engagement included a mix of urban and rural stakeholders from the North and South Islands. Participants were tobacco control experts, practitioners and cultural leaders, rather than wider community members (i.e. the public).

Participant roles

The table gives a breakdown of the number of stakeholders and their organisational roles across the hui and teleconferences during the three phases of the engagement. Most stakeholders were health staff or managers (DHB or Regional Public Health) or health professionals. The next most common roles were NGO staff or managers, iwi or Māori health providers, and cultural leaders.

Role	Number of participants #
Cultural leader	13
Iwi / Māori health provider	15
Stop smoking practitioner	8
Health professional	24
Researcher / academic	2
DHB or Regional Public Health staff (e.g. manager, advisor, health promoter)	38
Business sector	1
NGO (e.g. team leader, senior advisor, health promoter)	18
PHO manager or staff	7
Government agency	1
Smokefree Coalition Coordinator	4
Smokefree Coalition member	1
Health administration	1
Other (designer, student on placement)	2
	135

The table shows #135 in total – but some participants have been counted more than once if they attended more than one round of the engagement process. In total, an estimated 100 individuals took part in the engagement process.

Participant locations

The number of participants and location of meetings, for each phase of the engagement process, is summarised in the following three tables.

Participants in phase 1 engagement:

Location	Organisation/network	Type of engagement	Number of participants
Northland	Northland group	Face-to-face hui	6
Auckland	Pacific Network Fono	Face-to-face hui	6
Auckland	Whānau Whānui	Face-to-face hui	6
Wellington	Waka Tupeka Kore Hui	Face-to-face hui	7
Wellington	Wellington Smokefree Coalition	Face-to-face hui	16
National	National Regional District Health Board Hui	Teleconference	6
Total participants			37

Phase 1 stakeholders included leaders in the tobacco control and health sector, leaders in Māori and Pacific communities, and several leaders in Māori and Pacific research and academia.

Participants in phase 2 engagement:

Location	Organisation/network	Type of engagement	Number of participants
Northland	Patu Pauahi representatives	Teleconference	2
West Auckland	Whānau Whānui Collective	Face-to-face hui	7
South Auckland	Pacific Health and Welfare representatives	Face-to-face hui	9
Central Auckland	Auckland Cancer Society	Face-to-face hui	3
Wellington	Takiri Mai Te Ata Steering Group	Face-to-face hui	9
Marlborough	Smokefree Coalition representatives	Face-to-face hui	7
Southern District (Smokefree Murihiku, Smokefree Otago and Smokefree Central Otago)			
Face-to-face hui			12
Total participants			49

In addition, 32 of the 49 participants in phase 2 completed a survey either at the close of the hui or afterwards using an online version. The surveys enabled more specific, detailed comment, compared with the group discussions. A survey can also allow individuals to more easily express views that differ from the majority group view.

Māori and Pacific peoples were strongly represented in the engagement hui. In phase 2, for example, two of the three Auckland groups were specific Māori or Pacific groups. One Māori engagement group was comprised of kaimahi working specifically with Māori whanau, hapu and iwi in the wider Auckland region covering Tainui, Waipareira and Ngāti Whātua rohe (territories). The second group, specific to Pacific peoples, included all Pacific NGO and non-NGO professionals based in all 3 DHB areas.

All of the phase 2 meetings were with tobacco control coalitions, mostly Smokefree, Māori or Pacific groups, except for one organisational meeting with the Auckland Cancer Society Division.

Participants in phase 3 engagement

Location	Organisation/network	Type of engagement	Number of participants
Auckland	Pacific Health Network	Face-to-face hui	6
Auckland	Hāpai te Hauora Whānau Whānui	Face-to-face hui	6
Wellington	Wellington Smokefree Sector Group/Coalition	Face-to-face hui	16
Wellington	Compass Health Māori and Population Health teams	Written feedback from a group hui	6
Total participants			34

Engagement based on cultural values and principles

Hāpai te Hauora used Māori Ora Māuri Ora values and principles to conduct the engagement with stakeholders. The values and principles used included: Manaaki / Matauranga / Tika / Pono / Aroha / Tautoko / Whenua / Tangihanga.

In practice this meant:

- All face-to-face meetings opened with karakia (opening prayer)
- Following Māori and Pacific tikanga (customs and traditional values), e.g. in the opening and conduct of meetings
- All meetings included mihi whakatau (introductions from everyone) and usually a more detailed update from Hāpai te Hauora on the process and timeframe of the ASAP.

Content of the engagement rounds

Phase 1 focused on a discussion about the nature of the Smokefree Aotearoa 2025 goal. Participants were provided with a suggested draft for the goal (see Appendix 1) and asked for their comments about the draft and how the goal should be worded.

Phase 2 involved a discussion about six intervention areas that were being considered for inclusion in the action plan. Participants were asked to comment on the importance of each of the six areas and to discuss the relative priority of a range of possible actions within each of the intervention areas (see Appendix 2).

In phase 3, participants were provided with an outline of the draft action plan (see Appendix 3), which was informed by the findings of the phase 2 consultation, and were asked to comment on the proposed intervention areas and specific actions.

The 8 draft objectives were: (not in priority order)

1. Increase the price of tobacco products
2. Reduce youth access to tobacco products
3. Reduce the supply of tobacco products
4. Make tobacco products less addictive and less appealing
5. Enhance and intensify mass media campaigns
6. Regulate to enable appropriate access to e-cigarettes and other potential cessation and harm reduction products
7. Enhance and target smoking cessation advice and support
8. Expand smokefree environments.

These were accompanied by various specific actions – see the full table in Appendix 3. In the phase 3 engagement meetings, stakeholders were asked various questions, including their views on the draft action plan as a whole, and whether they agreed with the eight priority areas in the draft plan. Questions also covered the detailed content in the draft plan, such as suggestions for improvement, and whether stakeholders agreed with the detailed options in each of the intervention areas.

In addition, two specific questions were asked. Firstly, stakeholders were asked to select whether retail reduction should occur with or without a licensing scheme, for example by requiring all existing tobacco retailers to transition out of selling tobacco by a specified date.

Secondly, stakeholders in phase 3 were asked whether they preferred increasing the minimum purchase age or introducing a tobacco-free generation policy.

Hāpai te Hauora staff recorded key points from the discussions at the hui and teleconferences. They summarised the main themes identified in reports from each phase of the engagement process, which were then reviewed by the ASAP team. The ASAP team drafted this report, with input from Hāpai te Hauora.

Further detail on methods for phase 2 engagement process

The second engagement phase was more detailed and complex than the other two. Views were sought from stakeholders on six potential areas of intervention to reduce smoking and availability of tobacco products. The six interventions were identified by the ASAP team, as priorities for feedback from stakeholders based on a review of evidence and feasibility (see aspire2025.org.nz/smokefree-actionplan).

We did not consult about interventions that were deemed a low priority and hence very unlikely to be included in the final action plan. Similarly, interventions to increase the availability of e-cigarettes and introduce standardised packaging were already planned for implementation, and hence were certain to be included in the final action plan.

We selected six interventions to include in the phase 2 consultation:

1. Significantly reduce retail availability of tobacco products
2. Increase tax and price of tobacco products
3. Strengthen packaging and product requirements for tobacco (e.g. pack inserts, dissuasive sticks, enhanced pictorial health warnings combined with integrated mass media campaigns etc.)
4. Increase the minimum purchase age for tobacco
5. Remove additives from tobacco products
6. Reduce nicotine content in tobacco products

The engagement aimed to identify which of the six potential areas of intervention were the highest priority for stakeholders, and which of the specific options within each area of intervention were considered to be the highest priority (most effective and feasible).

Recruitment and data collection for phase 2

Hāpai te Hauora followed up the initial email invitations with phone calls to explain the process and timeframes, and to introduce the project to participants who were not part of phase 1.

Information sheets for participants, including evidence and specific questions, were drafted by Otago University researchers in the ASAP team. Hāpai te Hauora then developed these into factsheets for participants, including images to illustrate the various intervention options. An information sheet and six factsheets (one for each intervention area above, see Appendix 2) were sent with email invitations to provide background information and evidence to participants before the discussion. Some stakeholder participants commented that this information was useful.

We asked stakeholders various questions, including their views on the six intervention areas, and to give a relative ranking on the six interventions in terms of effectiveness and feasibility. Stakeholders were asked to fill in a ranking sheet – to rank each of the six interventions, as well as all the specific options under each intervention topic. This happened at the end of each discussion.

Hāpai te Hauora also created a brief survey, based on the questions from the ASAP team. Staff distributed hard copies of the survey at the end of the group discussion meetings. Hāpai created the same survey online for any participants who were unable to complete their survey at the time of engagement. Some participants asked to complete the online survey later, to allow time to reflect on the discussion.

Data collation and analysis for phase 2

Hāpai te Hauora documented and collated the data from the engagement discussions, and a member of the ASAP team reviewed this data.

Analysis involved developing a list of potential tobacco control interventions, listed in priority order based on the prioritisation agreed by most participants in each engagement group. Descriptive statistics were used to summarise the survey feedback, using the Survey Monkey tool.

FINDINGS

Summary

Overall, the stakeholder engagement process identified broad support for the Smokefree Aotearoa 2025 goal statement and several key priorities for action. Tobacco control stakeholders strongly supported reducing retail availability as the most urgent, highest priority action. There was also strong agreement across groups that tax increases were a high-priority intervention. There was some debate and differing views over the relative merits of other intervention areas and particular policy options.

Key findings in phase 1

Overall, the majority of stakeholders said they agreed with the ASAP team's draft interpretation of the Smokefree Aotearoa 2025 goal, both the wording and intent. Views on the goal were generally positive; participants emphasised the importance of agreeing on a specific date for the endgame goal, and clarifying that all communities needed to reach the goal by 2025, particularly Māori and Pacific communities.

However, the meetings highlighted some specific concerns about the definition and interpretation of the goal. In addition, there was discussion on broader issues not specific to the 2025 goal definition.

Specific advice on the goal statement included the following recommendations:

- ensure the goal is inclusive of rangatahi (young people)
This was addressed by rewording the monitoring reference to include the ASH Year 10 survey, and removing references to adults
- add a second part to the goal to reduce availability of tobacco to less than 5% by December 2025
This was addressed by including significantly reducing retail availability as an objective in the action plan (Objective 2) – with a specific target of reducing the number of tobacco retail outlets to 5% or less (to around 300 retailers) of 2012 levels by December 2022
- simplify the wording of the goal and keep information in the text rather than using footnotes (as not everyone reads footnotes)
- include focus on preventing uptake as well as reducing smoking prevalence
- either include te reo Māori in the wording of the goal, or translate the full goal into te reo Māori.

Tupeka Kore and Smokefree goals

A universal theme across all groups was a preference for referring to the Tupeka Kore (tobacco-free) goal in the definition. Māori feedback, in particular, emphasised a Tupeka Kore goal, and Pacific participants recommended using the term 'elimination' in regards to eliminating harm.

This theme was discussed by the project team and advisory group, including key staff in Hāpai Te Hauora and other Māori and Pacific tobacco control experts. We made a decision to retain the focus on the Smokefree Aotearoa 2025 goal for this work, but wording was added to specify that this goal is a first step in a more comprehensive vision of ultimate elimination of tobacco-caused illness and death.

The ASAP agreed to focus on identifying the key outcomes and actions for the goal of a Smokefree Aotearoa by 2025, because this is the goal adopted by the Government. The Smokefree Aotearoa 2025 goal has the potential to dramatically reduce the adverse health, social and economic impacts of smoking – and could be an interim target towards a more comprehensive Tupeka Kore goal.

Key findings in phase 2

Overall, the broad priority interventions were rated in the following order of importance in terms of effectiveness and feasibility:

1. Significantly reduce retail availability of tobacco products
2. Increase tax and price of tobacco products
3. Strengthen packaging and product requirements for tobacco (e.g. pack inserts, dissuasive sticks, enhanced pictorial health warnings combined with integrated mass media campaigns etc.)
4. Increase the minimum purchase age for tobacco
5. Remove additives from tobacco products
6. Reduce nicotine content in tobacco products

Significantly reduce retail availability of tobacco products

Reduction of tobacco retail availability was the most-supported intervention across all stakeholder meetings. The groups strongly agreed that reducing retail availability and increasing tax/price were the two highest priorities.

All seven groups of stakeholders ranked retail reduction as either 1 or 2 (where 1 was the highest priority in terms of effectiveness and feasibility). Five of the seven groups rated this intervention area as their highest priority; the remaining two groups agreed it was their second-highest priority.

These findings were consistent with the survey of stakeholders, which also showed a clear preference for reducing retail availability as the top priority.

The stated reasons for favouring this intervention included the lack of current action to reduce retail availability, and that it was a means to help address tobacco-related crime. For instance, the Northland group noted its region would likely support this option due to its relative isolation, strong community support, and the need to reduce burglaries of tobacco products.

Despite agreeing on the importance of reducing retail availability, stakeholder views were mixed on the specific options for how such reductions could be achieved. Options included the following measures (see Appendix 2 for a full list of all options discussed in the engagement process).

- Mandatory registration or licensing of tobacco retailers
- Mandatory licensing with regular increases in the annual licence fee and/or with phased reductions in the number of licences
- Implement a law requiring retailers to transition out of selling tobacco within a specified time period. After this, new tobacco retail licences would be issued to specialist non-profit outlets
- Prohibit the sale of tobacco within 1 km of secondary schools (applied to either new or all retailers including existing)
- Prohibit bars, pubs, taverns or nightclubs from selling tobacco (applied to either new or all retailers including existing retailers)
- Prohibit tobacco sales in some specified types of outlets, e.g. dairies and service stations as an immediate measure (applied to either new or all retailers including existing)
- Various endgame scenarios: pharmacy-only tobacco sale, allow only half of all liquor stores (off-licence) to sell tobacco, restrict tobacco sales to licensed non-profit outlets, and introduce a 'sinking lid' reduction in tobacco sales – to phase out tobacco products altogether by a specified end-date.

It is worth noting that views may change on these options as some of these ideas were novel and the advantages and disadvantages have not yet been clearly established or debated. The two most preferred options, across groups, were:

- a) a phased reduction in retail outlets, where the Government would require tobacco retailers to transition away from selling tobacco over a specified period of time
- b) a sinking lid reduction to phase out commercial tobacco sales altogether.

The next most supported retail policy option was prohibiting tobacco sales in dairies.

Overall, stakeholders showed less support for restricting tobacco sales near schools or to limiting the type of stores that could sell tobacco products to liquor stores or pharmacies. Suggested alternative ideas included restricting tobacco sale to supermarkets or specialist vape shops.

Increase tax and price

Stakeholders expressed consistent, strong support for increasing the price of tobacco products. They saw this option as backed by strong evidence. Pacific leaders said they felt Pacific communities would support and understand the need for tax increases, and that tax had been a deterrent for Pacific smokers. They said tax increases could help to reduce the sharing of cigarettes, as adults may be more reluctant to give away or share more expensive cigarettes with friends and younger smokers.

Another group commented that tax increases to date had not been high enough to reduce Māori smoking. Some stakeholders emphasised that tax increases must be accompanied by additional support for smokers on low incomes, such as enhanced stop-smoking services.

Another suggestion was to introduce a 'polluter' levy on the tobacco industry, where manufacturers and importers would be required to pay for the costs of secondhand smoke exposure and tobacco waste.

The survey of 32 stakeholders revealed that 20% annual increases were favoured over two other options (continuation of the current 10% annual increase, and a larger one-off increase of 30% followed by 20% increases annually).

Strengthen packaging and product requirements

Overall, this intervention area was ranked third in terms of likely effectiveness and feasibility. However, stakeholders held a range of views about specific interventions in this topic. Many expressed frustration at the length of time for the release of the Government's standardised packaging regulations. The idea of dissuasive sticks attracted considerable support. Some stakeholders said they didn't support the option of pack inserts with quit support information, as they felt smokers would ignore them and the inserts would add to the environmental waste from tobacco products. Some stakeholders were recent quitters themselves, and believed that inserts would irritate smokers and be ineffectual in prompting attempts to quit.

Increase the minimum purchase age for tobacco

Stakeholders ranked raising the minimum purchase age (either with an increase to the legal age to 21 or a tobacco-free generation policy) as the fourth most effective and feasible intervention. Some strongly disagreed with increasing the minimum purchase age to 21 years, and instead favoured the tobacco-free generation policy. Survey respondents expressed a strong preference for the tobacco-free generation policy over raising the minimum purchase age to 21 or 25.

The introduction of a tobacco-free generation policy in Aotearoa New Zealand attracted reasonable support, although views were diverse. One group commented that it supported the policy as long as it was well-implemented, with young people empowered as leaders and advocates for the approach. A concern raised about the tobacco-free generation option was the length of time the policy may take to have effect, with potential health impacts occurring into the future.

Many stakeholders expressed concern about age anomalies with the option of raising the minimum age (either to 21 or with a tobacco-free generation policy). They did not see increasing the legal age as a priority, and thought it may be difficult to argue for it given that 18 year olds can legally purchase alcohol and guns, and access adult unemployment benefits. Some said the proposals would need further discussion and engagement with young people to address concerns about age-based prohibition and inconsistency with other age-based laws, such as for alcohol or marriage.

Remove additives from tobacco products

In our engagement process, stakeholders ranked removing additives as among the least-preferred priorities (rated number five overall). However, respondents to the stakeholder survey ranked this option higher (rated number three overall). Concerns included anticipated opposition from the tobacco industry, the length of time the policy might take to be developed and a lack of strong evidence. In support of the policy measure, some said it would be less intrusive for smokers than the other options being considered. Two groups commented that banning additives should occur in tandem with reducing nicotine content. One group argued for replacing the additives and nicotine reduction options with smokefree environment policies, particularly expanding smokefree areas and banning smoking in vehicles.

When asked in the survey to rate three detailed options on additives, stakeholders favoured disallowing all additives over reducing additives annually over time or simply requiring tobacco companies to publicly report the elements of tobacco products.

Reduce nicotine content in tobacco products

In our engagement process, stakeholders ranked reducing nicotine content as among the least-preferred priorities (rated number six overall in both the meetings and survey).

Many said they were uncertain about the feasibility and effectiveness of this option, and were concerned about potential reaction from the tobacco industry. One group noted that very-low-nicotine-content (VLNC) cigarettes would still have the effect of normalising smoking and providing undesirable role modelling to children. Addiction to smoking behaviour, smell and taste was also identified as likely to continue with reduced nicotine cigarettes.

In contrast, two groups ranked this option as the second or third most effective and feasible. Reasons for this ranking included feasibility both politically and in terms of communities, and that it was seen as less 'punishing' on smokers than tax increases.

Of the three specific options discussed, the group meetings preferred a mandatory approach to limiting the sale of tobacco to VLNC products. In contrast, the survey responses favoured a phased approach, where the nicotine content in tobacco products would be reduced over time. The next preferred option in the survey was a mandated nicotine reduction strategy.

Key findings in phase 3

The final phase of the stakeholder engagement process sought to provide input and advice from tobacco control experts and practitioners on a draft action plan to achieve the Smokefree Aotearoa 2025 goal.

In general, the draft action plan was received positively by stakeholders as a sign of progress towards more action in the tobacco control area. The stakeholders recommended the detailed content be simplified and prioritised, with three or four priority areas rather than eight. A strong theme was questioning the extent to which the draft plan was politically feasible.

The eight priorities in the draft action plan were all seen as being part of the multi-faceted, integrated national tobacco control programme. Participants in the engagement noted that some interventions clearly stood out as the leading immediate priorities, others were more suited to a medium- to longer-term timeframe, and some could be implemented by further developing existing interventions. Reducing the retail availability of tobacco was seen by most stakeholders as the top-priority intervention, with immediate removal of cigarettes from dairies, in particular, as a recommended first action.

Raising the minimum purchase age for cigarettes (by increasing the age to 21 years) was the only intervention that many participants strongly disagreed with. Common reasons for opposing this option included:

- young people aged much younger than the legal age (e.g. as young as 13 years old) are able to easily purchase cigarettes currently
- dairies, in particular, were perceived as not complying with the current age restriction of 18 years
- the young adult population (aged 18-20 years) may oppose this intervention given its perceived discriminatory nature for that age-group.

In relation to the specific question on licensing (see page 6), several groups opposed the licensing of tobacco retailers. Overall, there was a preference for reducing retail availability by setting a specified end-date and requiring all existing retailers to transition out of tobacco sales by that date.

Views were mixed on the potential options for tobacco sales from a small number of specified outlets. Some participants opposed the option of selling tobacco in R18 bottle shops (off-licence alcohol outlets), and there was some strong opposition expressed to the idea of restricting tobacco sales to pharmacies.

On the second specific question (see page 6), in relation to youth access interventions, some stakeholders said they preferred the tobacco-free generation; however, others said they did not support either option. In general, views appeared mixed and no clear preference was expressed.

Key suggestions for changes to the interventions were to include and prioritise the interventions that were most likely to address ethnic and social inequalities in health. Stakeholders noted this will require innovative interventions that have greater impact on the specified priority populations – in particular, Māori population groups.

Several stakeholders expressed concern that e-cigarettes (and other nicotine delivery devices) were not sufficiently emphasised in the draft action plan. They wanted more focus on e-cigarettes because of their increasing availability and perceived popularity among smokers. On the other hand, some stakeholders strongly opposed e-cigarettes and didn't want them promoted as aids for smoking cessation. Stakeholders also stressed the importance of carefully monitoring new alternative nicotine delivery devices, such as 'heat not burn' cigarettes, to ensure their safety and effectiveness.

Some stakeholders called for improved or new wording around the commitment to te Tiriti o Waitangi and ethnic disparities in smoking between Māori and non-Māori. For example, one meeting recommended that the first priority objective be to "action te Tiriti o Waitangi in tobacco control and reduce inequalities." Commitment to te Tiriti o Waitangi was raised as an important consideration for this action plan since it will require new legislation, resources, and enhanced delivery and intensification of existing measures.

In addition, political feasibility was highlighted as crucial, given the new legislation and resources needed to put the plan into action. Several stakeholder groups said they wanted more emphasis in the action plan on the protection of children, tobacco denormalisation, and the vision for a Smokefree future. For example, one group wanted more emphasis on preventative services for young people, and more focus on supporting vulnerable populations who are likely to suffer as a result of increased prices of tobacco products. Some groups, such as the Wellington meeting, wanted higher priority given to expanding smokefree areas.

CONCLUSION

Each phase of the engagement process provided crucial information from across the broader tobacco control sector that informed the format and content of the final action plan. The participants were highly engaged with the process and supportive of the urgent need for an action plan setting how to achieve Smokefree Aotearoa 2025.

The need to focus on achieving Smokefree Aotearoa 2025 for all population groups, including Māori and Pacific peoples, was seen as extremely important, and there was broad agreement that the interventions in the action plan needed to reflect those priorities. There was general agreement that actions to reduce the availability of tobacco products and further reduce affordability are a high priority.

There was more diversity of opinion about the relative importance of other intervention areas, although there was often a lack of detailed knowledge and understanding about some of the proposed policy interventions, and this may have been reflected in how participants appraised and ranked the options.

APPENDIX 1:

Information for stakeholders in phase 1 engagement

Achieving a Smokefree Aotearoa Project (ASAP)

Proposed interpretation of the Smokefree 2025 goal – for consultation

Introduction

New Zealand's Smokefree 2025 goal has emerged from Māori advocacy for Kaupapa Tupeka Kore and the Māori Affairs Select Committee inquiry into the tobacco industry {Māori Affairs Select Committee, 2010 #550}. In 2011, the Government endorsed the Smokefree 2025 goal to cut smoking prevalence and tobacco availability to minimal levels by 2025 {NZ Government, 2011 #549}.

The tobacco control sector has also advocated for this goal. The goal appears to have broad support from the health sector and the wider public in New Zealand {Maubach, 2013 #465}.

The ASAP

The ASAP will review progress towards the Smokefree 2025 goal and set out an action plan for achieving the 2025 goal as adopted by the New Zealand Government. Based on a review of the evidence and engagement with the sector, the action plan will identify possible interventions to help achieve the goal for all ethnic groups, especially Māori and Pacific populations. The Quit Group has provided the core funding for the project. ASPIRE 2025 will work with Hāpai te Hauora to deliver this work.

Focus on Smokefree 2025 goal

The ASAP will focus on identifying the key outcomes and actions for the goal of a Smokefree Aotearoa by 2025, because this is the goal adopted and committed to by the Government. The smokefree goal has the potential to dramatically reduce the adverse health, social and economic impacts of smoking. The project team propose using the following definition of the 2025 goal for the development of the action plan. We are seeking views from the tobacco control sector on this definition.

Proposed definition of Smokefree 2025 (Auahi Kore) goal

The goal is to:

- a) reduce the prevalence (daily smoking) of smoked tobacco product use to less than 5%, and as close as possible to 0%, by December 2025 for the following adult populations:¹

- Māori adults
- Pacific adults
- All other NZ adults

and

- b) reduce the availability of tobacco to minimal levels by December 2025.

It is important to clarify that the Smokefree 2025 goal does not mean a commitment to the banning of smoking altogether by 2025, as the public have expressed confusion about its interpretation.

Priority groups

Māori and Pacific peoples are the main priority groups for this project. In addition, the ASAP has identified several other population groups of interest for our review and strategy development (e.g. children and youth, low-income populations, pregnant women and people with mental health conditions).

Home-grown tobacco

Commercial tobacco is the main target of the Smokefree 2025 goal. It is recognised that some personal 'home-growing' of tobacco is likely to occur even after the goal is achieved, although this may well diminish over time as tobacco use is further denormalised. We envisage that growing tobacco for personal use only would continue to be permitted after Smokefree 2025 is achieved; however, the sale of home-grown tobacco would continue to be prohibited.

¹ The definition of adult is aged 15 years and over, consistent with the New Zealand Health Survey.

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EXTRA INFORMATION:

More comprehensive goals

More comprehensive goals

This section notes some early thoughts on two other goals – Tupeka Kore and Nicotine-free goals. However, the ASAP's focus is on the Smokefree 2025 goal as the primary goal. The other two goals are mentioned here as context. Rather than presenting an agreed view, this section is preliminary and intended to add to the debate on the exact nature and priority of the three goals.

The Smokefree 2025 goal could be an interim target on the road towards a more comprehensive goal such as Tupeka Kore (tobacco-free) and/or Nicotine-free. These goals may be important to work towards over time (see possible definitions below).

The three goals are not mutually exclusive – it is possible that in achieving Smokefree 2025, one or both of the other goals are also achieved.

The Tupeka Kore (Tobacco-free) goal

The Tupeka Kore goal is a kaupapa Māori response to the tobacco epidemic and its damaging effects on Māori. In contrast to the term smokefree, which may be misinterpreted as only removing smoke from environments, the term 'tupeka kore' has been promoted by Māori politicians, advocates, and tobacco control workers since before the Government first committed to Smokefree 2025. It represents the concept of a tobacco-free Aotearoa, particularly a tobacco-free indigenous population {Gifford, 2009 #355}.

The Tupeka Kore intention and kaupapa is to eliminate tobacco from Māori communities and whānau.

A tobacco-free goal has also been promoted by national advocacy organisations, such as the Smokefree Coalition. The Smokefree Coalition's 2009 strategy document, *Tobacco Free New Zealand 2020 Tupeka Kore Aotearoa 2020 Achieving the Vision*, set a vision of future generations of New Zealand children being free from exposure to tobacco and enjoying smokefree lives. The strategy identified the following goals for eliminating children's exposure to tobacco by 2020:

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

Nicotine-free goal

Since this goal has not been widely discussed or agreed in the tobacco control or health sectors, this topic is only briefly discussed here.

We understand that diverse and conflicting views about nicotine have been expressed among tobacco control experts. Some in the sector argue that such a goal is unnecessary because nicotine on its own has relatively little impact on health, when separated out from other components of smoking.

In contrast, others advocate for a nicotine-free goal because nicotine is highly addictive, does some harm to health and has the potential for social and cultural harm (eg, the financial burden on those who are addicted). Some Māori tobacco control advocates, in particular, argue that nicotine is associated with significant cultural harm, and reflects ongoing impacts of colonisation. Views among the sector on the main sources of harm will depend on people's historical/cultural context and perspective. As part of the ASAP process, it is essential to enable people to discuss their views and preferences.

If adopted, a nicotine-free goal could potentially mean: a) minimal nicotine use, b) minimal nicotine addiction (regular use), or c) no availability of any nicotine or nicotine delivery products in New Zealand.

APPENDIX 2:

Information for stakeholders in phase 2 engagement



1. Introduction

Thank you for taking part in this stakeholder engagement process, which is one of several rounds of engagement with stakeholders and Māori and Pacific leaders as part of the Achieving a Smokefree Aotearoa Project (ASAP). This paper summarises information on potential intervention options to achieve the goal of a Smokefree Aotearoa by 2025. It also introduces you to our project and a proposed definition of the Smokefree 2025 goal. Please read this paper before attending the engagement hui.

Achieving a Smokefree Aotearoa Project (ASAP)

The ASAP is reviewing progress and evidence towards the Smokefree 2025 goal and will set out an action plan for achieving the 2025 goal. The action plan will recommend key interventions to help achieve the goal for all ethnic groups, especially Māori and Pacific populations. It will be informed by a review of the evidence and engagement with the tobacco control sector and Māori and Pacific leaders. The action plan is due to be released with a major launch in May/June 2016. The Quit Group has provided the core funding for the project. ASPIRE 2025 is working with Hāpai te Hauora to deliver this work.

Hāpai te Hauora is leading three rounds of stakeholder engagement for the ASAP:

- 1. Initial engagement to help shape the definition of the Smokefree 2025 goal (completed January-February)**
- 2. This engagement process to help prioritise potential policy options (March-April)**
- 3. A final engagement round to provide input and advice on a draft action plan to achieve a Smokefree Aotearoa by 2025 (April-May).**

Focus on Smokefree 2025 goal

The Smokefree 2025 goal emerged from Māori advocacy for Kaupapa Tupeka Kore and the Māori Affairs Select Committee inquiry into the tobacco industry (Māori Affairs Select Committee, 2010). In 2011, the Government endorsed the Smokefree 2025 goal to reduce smoking prevalence and tobacco availability to minimal levels by 2025 (NZ Government, 2011). The tobacco control sector has also advocated for this goal. The goal appears to have broad support from the health sector and the wider public in Aotearoa (Maubach et al., 2013). The project team propose using the following definition of the 2025 goal for the development of the action plan. This definition has incorporated feedback from initial consultation carried out by Hāpai Te Hauora about the wording of the goal among key stakeholders with strong Māori and Pacific representation.



Increase the price of tobacco products through tax increases and other strategies

Increasing the tax on tobacco products is a well-established, evidence-based tobacco control measure. Research evidence from multiple countries shows that it is the most effective and cost-effective single policy action in tobacco control. Tax increases were recommended by the Māori Affairs Select Committee (MASC) in their 2010 inquiry. Aotearoa has a history of regular annual tax increases, including current increases of 10% annually. Since 2010, the tax on tobacco has been increased each year, on average by about 10%. Evidence from Aotearoa and overseas also suggests that increasing tobacco tax can help to reduce socioeconomic and ethnic disparities in smoking (e.g. to help close the gap between Māori/Pacific and general smoking rates). This is because people in low socioeconomic groups are more likely to quit smoking in response to price increases, as they are less able to accommodate the price rise. However, some low-SES smokers will continue to smoke and will be disadvantaged financially as a result. Without other interventions to help increase quitting, such as targeted cessation support, such increases will impact more on smokers on low incomes who continue to smoke. An additional concern for Māori is the Treaty implications of a government tax regime that disproportionately affects Māori.

Potential alternative options to choose from

Potential options

1.1 Continue with the current policy of annual tobacco tax increases of 10%, but extend until 2025 Could implement with differential increases in the tax on roll-your-own (RYO) tobacco – because RYO tobacco is a cheaper option for most smokers and is disproportionately used by Māori and young smokers.

1.2 Larger annual tobacco tax increases e.g. 20% for three years to 2020 (alongside further differential increases in the tax on roll-your-own tobacco). Review the impact to inform future policy.

Key advantages

Established measure so highly feasible.
Politically acceptable.

More likely to achieve 2025 goal. Incremental extension of an established measure so relatively feasible.
Higher tax increases are recommended by international expert bodies (e.g. IARC).

Key disadvantages

NZ modelling evidence suggests that larger increases will be needed to reach the 2025 goal. Effect can be eroded by low cost brands and RYO.

More potential for hardship among those who don't quit (if other interventions don't mitigate this)



Reduce retail availability of tobacco products

Tobacco can be sold anywhere in Aotearoa at present, with no restrictions (apart from the minimum purchase age of 18 years). There is no requirement for a licence to sell tobacco or to store tobacco securely, as exists for ammunition, pharmaceuticals or agricultural chemicals. The reduction of tobacco availability was recommended by the MASC in 2010. Considerable evidence suggests that wide availability of and access to tobacco outlets is associated with smoking initiation and relapse after quit attempts. Research indicates that living in an area with higher numbers of tobacco outlets increases the odds of smoking, and greater density of tobacco retailers around schools tends to be associated with higher experimental smoking, ever-smoking, and future smoking susceptibility (but not with higher regular smoking status). Strategies to reduce tobacco retail availability and accessibility are a newly emerging area of tobacco control. Limited evidence is available because retail reduction policies have only been implemented recently in a few jurisdictions. Several papers have attempted to use modelling to assess the relative effectiveness of various approaches, but as yet, no 'real world' evaluations of policies have been reported.

This project is examining three broad potential retail control policies:

- Registration / licensing of tobacco retailers
- Interventions to reduce numbers or density of tobacco retail outlets
- Interventions to restrict the type of retail outlets that sell tobacco products (e.g. restricting access to certain outlet types) Various options are presented under each heading below.

Potential options: (more than one could be implemented)

Potential options

Registration and licensing schemes

2.1 Introduce mandatory registration: Require all tobacco retailers to register on a national database of retail outlets that sell tobacco

2.2 Introduce mandatory licensing: Require all tobacco retailers to apply and pay for an annual licence. With no required regular increases in the licence fee (see alternative option below)

Key advantages

More politically acceptable than a licensing scheme.

Creates incentive for retailers to stop selling tobacco. Tobacco control stakeholders prefer licensing over registration. Can be used as a way to reduce the number of outlets. Requirements can be built into licence, and could make purchase age enforcement easier.

Key disadvantages

Highly unlikely to be effective in reducing smoking and less effective at facilitating other supply-side interventions. Although registration would be mandatory, some may not register.

Cost to government (but could cover all or most of the costs with the licence fees). Anticipated opposition from some retailers (particularly if scheme favours some retailers over others).



Increase the legal minimum purchase age for tobacco products

Increase the minimum age: The current minimum age to legally purchase tobacco in Aotearoa is 18 years of age. Options under consideration in this project include to raise the minimum purchase age to 21 years, or to raise the legal purchase age in a more incremental way (e.g. by one year annually up to 21). These policy options would require legislative change, but would be relatively straightforward to implement.

There is moderate evidence for the effectiveness of minimum age laws in reducing youth smoking prevalence, as long as the laws are comprehensive, well-enforced and disrupt the sale of tobacco to young people. Retailer education and community mobilisation strategies may also enhance impact.

In the United States there has been a recent increase in laws to a minimum tobacco purchase age of 21 years (to over 125 jurisdictions in 2016). The states of Hawaii, California and Texas now have minimum age laws of 21 years. Newly emerging evidence from the past 3 years suggests positive effects of increasing the minimum purchase age, including reduced adolescent smoking prevalence and reduced tobacco purchasing by adolescents.

Introduce the tobacco-free generation: The Tobacco-free generation idea proposes that cigarettes are phased out over time by prohibiting retailers from selling tobacco to new generations – those born after a certain date (e.g. 1 January 2000). Existing smokers would not be affected by this policy. This would mean that tobacco products could only be legally sold to New Zealanders born last century. Over time this policy would effectively phase out the sale of tobacco. A key advantage of this policy option is that it sends a clear message that tobacco is unsafe at any age – and avoids the ‘coming of age’ implication of minimum purchase laws.

This idea has been proposed by researchers in Singapore, and a tobacco-free generation bill was introduced to Tasmania’s parliament in November 2014, but has not yet been enacted.





Expand requirements on packaging and type of products

Aotearoa introduced pictorial health warnings on tobacco product packs in 2008. These are required to cover 30% of the front, and 90% of the back, of the pack.

The current government has committed to introducing standardised packaging (i.e. plain packaging) in 2018 together with an increase in the size of the health warnings (particularly on the front of the pack) and enhanced prominence of the Quitline information highly likely, although the exact details for these interventions have not yet been released.

A range of potential interventions could be implemented to further enhance the degree to which the product design and packaging deters smoking uptake, and promotes and maintains the quitting of smoking.

The main interventions considered in this project are:

- Further strengthening of the pictorial health warnings through (i) increasing the size and prominence of the warnings, (ii) implementing a more diverse range of themes, images and messages, (iii) ensuring best practice in message/image rotation to ensure continuing impact; • Improving the display of the Quitline information and smoking support information;
- Ban the introduction of new evocative brand descriptors (may be used to enhance brand differentiation and reduce impact of standardised packaging);
- Mandating pack inserts that provide further information to deter smoking uptake or promote and support quitting;
- Mandating the display of information about the constituents or emissions from cigarettes/tobacco
- Introducing 'dissuasive sticks' – mandating the colours and/or design of the cigarette stick, for factory-made cigarettes, in order to deter smoking uptake, or promote and support quitting. This includes printing dissuasive messaging directly onto the cigarette, for example:



There is strong evidence that: a) increasing the size of pictorial health warnings enhances their effectiveness, and b) graphic depictions of health effects, and warning that elicits negative emotions, have the greatest effect. Evidence also supports increasing the number and frequency of rotation of pictorial health warnings to reduce 'wear-out'. Moderate evidence exists to support combining pictorial health warnings with positive messages (e.g. about efficacy of quitting, quitting support) and increasing the prominence of the Quitline number. There is preliminary evidence for the effectiveness of pack inserts, that integrated mass media campaigns can enhance the impact of pictorial health warnings, and that on-stick warnings and dissuasive stick colours can promote quitting and dissuade initiation. There is only weak evidence available to suggest that displaying information on constituents on packaging results in increased quitting, cessation or reduced initiation. Aotearoa has a much higher rate of roll-your-own (RYO) tobacco smoking than other comparable countries. Despite a misperception that RYO tobacco is more natural and less harmful, the evidence shows that RYO tobacco is more harmful than factory-made tobacco. RYO tobacco is a cheaper option for most smokers and is disproportionately used by Māori and young smokers. Mass media campaigns and pack warnings could be used to communicate the harm to current and potential RYO smokers; differential increases in taxes on RYO tobacco (as implemented in 2010) could be repeated. However, a more radical approach would be to ban RYO tobacco altogether.



Reduce the nicotine content of tobacco products

The composition of tobacco products can be regulated as a strategy to reduce the addictiveness of tobacco products. This could potentially help current smokers to cut down or quit, and prevent new or experimenting smokers from becoming addicted. The reduction of nicotine in products in Aotearoa was recommended by the MASC.

Nicotine is believed to be the primary addictive component of tobacco products. Although it is present in tobacco, it is possible to remove the majority of the nicotine content, similar to the way that coffee can be decaffeinated. It is thought that removal of most of the nicotine is sufficient to make cigarettes minimally addictive.

Such reduced-nicotine cigarettes are already available in the United States and are called Very Low Nicotine Cigarettes (VLNC). The nicotine content of VLNC is generally less than 0.4 mg per gram of tobacco.

Greatly reduced nicotine content could potentially be mandated for all cigarettes sold in Aotearoa, or the use of reduced nicotine cigarettes could be encouraged in an incremental way with incentives to switch to VLNC.

Policy options include:

- Encourage the introduction of VLNC cigarettes that have ≤ 0.4 mg of nicotine content per gram of tobacco in NZ - with a two-tiered tax system favouring VLNC.
- Pilot or trial the use of VLNC as a smoking cessation aid in a small number of communities and report the results, with mandated VLNCs introduced if successful.
- Phase down the maximum permitted level of nicotine in cigarettes over time to a non-addictive level
- Limit the sale of all combusted tobacco products (or just cigarettes) to brands with a very low nicotine content – less than 0.4 mg per gram of tobacco in Aotearoa (i.e. a mandated nicotine reduction policy). It is important to note that VLNC differs from 'light' or low-tar cigarettes (these are called low-yield cigarettes). Low-yield cigarettes and VLNC are equally hazardous to health as non-light cigarettes, but unlike VLNC, low-yield cigarettes are also as addictive as non-light cigarettes.

This topic is a newly-emerging area of tobacco control, but there is now a moderate and growing body of evidence of its likely effectiveness in reducing dependence and increase quitting without causing a compensatory increase in the number of cigarettes smoked. No country has yet implemented a mandated nicotine reduction policy (where non-VLNCs or traditional cigarettes are not available).

Reduce or ban additives in tobacco products

There are over 350 known additives in cigarettes sold in Aotearoa. These include preservatives, flavours and other chemicals to change the properties of tobacco or enhance the experience of smoking. Some additives, such as ammonia, increase the addictiveness of tobacco products.

This is a newly emerging area in tobacco control, so only limited evidence is available on the actual or potential effects of removing additives. Beyond Canada, the EU and Brazil, there is almost no successful international regulatory experience to draw upon to inform product regulation, although governments are increasingly considering potential regulatory measures.

Nonetheless, there is sound logic and rationale for this policy option. If flavourings are removed, then tobacco products will be more distasteful and less palatable, if constituents like ammonia are removed, then tobacco products will be less addictive, and if preservatives are removed there will be a lower shelf life, which is likely to push up the price.

A range of potential policy options to regulate the additives and/or other constituents in tobacco products are set out below.

Potential options: (more than one could be implemented)

Potential options

6.1 Require tobacco companies to publicly report the elements of their tobacco and smoke, so consumers and the Ministry of Health know exactly what cigarettes and loose tobacco contain (i.e. implement the Māori Affairs Select Committee recommendation 8). The measure should be standardised across the industry.

6.2 Use the provisions in the Smoke-free Environments Act for regulating additives in tobacco to reduce the additives in tobacco on an annual basis (Māori Affairs Select Committee recommendation 9)

6.3 Comprehensive restrictions to ban all additives that plausibly have the effect of: (1) increasing addictiveness; (2) increasing toxicity; (3) increasing attractiveness (particularly to young people); and (4) increasing palatability of tobacco products.

Key advantages

The Government has committed to considering this option. Recommended by MASC, with strong public support. The Government’s response to the MASC was that it ‘would consider developing a more stringent, specific and effective information disclosure regime’. Relatively easy to implement.

The legislation allows for regulations on additives to be introduced. Recommended by the MASC. The Government committed to considering this option in its MASC response. A phased / incremental approach is likely to be politically acceptable. There are precedents from other products, e.g. lowering sugar and salt content of food products.

Recommended by the MASC Strong public support Some overseas precedents and local precedents such as psychoactive substances. (As with the Psychoactive Substances legislation in NZ, the onus of proof would be on the industry to show that additives were safe, non-addictive, and did not increase attractiveness or palatability.)

Key disadvantages

Cost of monitoring and using information. May be difficult for consumers to understand what the information means (but information graphics could be used to summarise and present the data). Impact of just providing information unlikely to be significant.

Evidence base for impact is less clear than for VLNCs. Gradual reduction less likely to have significant impact, and impact is likely to be delayed.

Evidence base for impact is less clear than for VLNCs.

APPENDIX 3:

Information for stakeholders in phase 3 engagement

Achieving a Smokefree Aotearoa Project (ASAP)

Consulting on draft action plan – Information sheet

Thank you for taking part in this stakeholder engagement process – your views will help to inform an action plan to achieve a Smokefree Aotearoa by 2025.

Achieving a Smokefree Aotearoa Project (ASAP)

The ASAP is reviewing progress and evidence towards the Smokefree 2025 goal and will set out an action plan for achieving the 2025 goal. The action plan will recommend key interventions to help achieve the goal for all ethnic groups, especially Māori and Pacific populations. It will be informed by a review of the evidence and engagement with the tobacco control sector and Māori and Pacific leaders. The action plan is due to be released with a major launch in late June 2017. The Quit Group has provided the core funding for the project. ASPIRE 2025 is working with Hāpai te Hauora to deliver this work.

Input from stakeholders

Hāpai te Hauora is leading three rounds of stakeholder engagement for the ASAP:

1. Initial engagement to help shape the definition of the Smokefree 2025 goal (completed February)
2. An engagement process to help prioritise potential policy options (completed early May)
3. A final engagement round – involving wānanga and teleconferences with organisations to provide input and advice on a draft action plan to achieve a Smokefree Aotearoa by 2025 (late May).

The aim of this engagement process is to seek: a) your general views on the draft action plan as a whole (see below), and b) more detailed input to help improve the detail of the action plan. We want to develop an action plan that has broad support from the tobacco control sector, and Māori and Pacific leaders. In light of the previous rounds of engagement, this process is more about fine-tuning the detail of the action plan, rather than revisiting the fundamentals at this stage.

Process of drafting this action plan

Selection of interventions for this action plan has been guided by several pieces of work:

- A review of evidence and current progress towards the 2025 goal, including appraisal of each intervention's likely effectiveness, impact on equity/reducing disparities, feasibility and acceptability.
- Input from an expert advisory group comprised of tobacco control experts.
- Feedback from the first two rounds of stakeholder engagement.

The action plan's focus is on national policy rather than local action. Local action and coordination is vital for achieving the smokefree 2025 goal. National-level policy actions can support local initiatives, and local efforts are needed to support and help to implement this national plan.

We acknowledge the 2010 report of the Māori Affairs Select Committee (MASC), which was important, ground-breaking work that has not yet been implemented. The proposed interventions in this draft action plan are consistent with many of the MASC recommendations.

Questions for stakeholders

1. What are your views on the draft action plan as a whole?
2. What would help to improve the detailed content in Table 1?
3. Do you agree with the eight priority areas? Why/why not?
4. Are there any priority areas that you think should not be included?
5. In each of the priority areas, are there any immediate or medium/longer term interventions that you strongly disagree with? Which ones?
6. In each of the priority areas, would you suggest any changes to the interventions? What changes do you think are needed?
7. Do you have any other comments?

We also have two specific questions:

1. Which of the following two retail reduction policies do you think is most feasible and effective?

a) Retail reduction with licensing:

Introduce a new licensing scheme for all tobacco retailers. Gradually reduce the number of licences granted. From 2022, restrict tobacco sales to 300-400 retail outlets. The type of outlets would be determined after appraisal of the options in 3.2.

b) Retail reduction without licensing:

Require all current tobacco retailers to transition out of selling tobacco by December 2021. From 2022, restrict tobacco sales to 300-400 retail outlets. The type of outlets would be determined after appraisal of the options in 3.2. No national licensing scheme would be required – there would need to be some type of permit or contracting system for the 300-400 retail outlets.

Options include:

- not-for-profit outlets (new or existing retailers, NGOs or govt bodies that would sell tobacco on a non-profit basis)
- pharmacies
- half of liquor stores (R18)
- supermarkets
- vape shops
- specialist tobacco shops

2. Which of the following two medium-longer term policies do you think is most feasible and effective in reducing youth access to tobacco?

a) **Raise the minimum age** for sale and supply of tobacco products to 25 years

b) **Tobacco-free generation** Cigarettes would be phased out over time by prohibiting retailers from selling tobacco to new generations – those born after a certain date (e.g. 1 January 2000). This would mean that tobacco products could only be legally sold to New Zealanders born last century. Over time this policy would effectively phase out the sale of tobacco.

DRAFT ACTION PLAN

Achieving a Smokefree Aotearoa Project (ASAP)

Draft action plan – for stakeholders, late May 2017

The intended audience for this action plan includes the tobacco control sector, iwi, Ministers and MPs, government agencies, local government, NGOs and the public. The final version will include a summary of the reviewed evidence that informed these priority actions.

Goal

Reduce the prevalence of smoked tobacco use to less than 5% (daily smoking), and as close as possible to 0%, by December 2025. The goal applies to the general New Zealand population (aged 15 years and over); and specifically Māori and Pacific populations. The goal is a first step in a more comprehensive vision of ultimate elimination of tobacco-related disparities, illness and deaths. [To add in the final action plan: translation of the goal in te reo Māori].

Objectives

1. Increase the price of tobacco products
2. Reduce youth access to tobacco products
3. Reduce the supply of tobacco products
4. Make tobacco products less addictive and less appealing
5. Enhance and intensify mass media campaigns
6. Regulate to enable appropriate access to e-cigarettes and other potential cessation and harm reduction products
7. Enhance and target smoking cessation advice and support
8. Expand smokefree environments

Priority groups

Māori and Pacific peoples are the main priority groups for action to achieve the Smokefree 2025 goal. Several other population groups are also important: children and youth, low-income populations, pregnant women and people with mental health conditions.

Implementation

Interventions to achieve the eight objectives must be implemented as part of a multi-faceted, integrated national tobacco control programme. Some interventions should be implemented immediately, others in the medium to longer term. Some can be implemented through further development, enhanced delivery and intensification of existing measures; others will require new legislation and resources. We recommend a new major overarching Smokefree 2025 Act is developed and progressed from 2018 onwards to implement the measures requiring new legislation. The focus of the stakeholder consultation is the following table set on next page.

Draft action plan

Recommended interventions (not in priority order)

Objectives	Immediate actions	Medium-longer term actions
1. Increase the price of tobacco products	<p>1.1 Increase the tobacco excise tax by 20% annually for three years from 2019 to 2021. Allocate the additional revenue raised from the tobacco excise tax to the national tobacco control programme and particularly to supporting smokers to quit.</p> <p>1.2 In combination with the above, Introduce an additional 15% increase on RYO in the first year, over and above the base increase of 20%. This aims to stop RYO cigarettes being a cheaper alternative to factory-manufactured cigarettes, which can undermine the impact of tax increases in promoting cessation.</p> <p>1.3 Maximise the impact of the tax increases through appropriate timing, integrated mass media campaigns and concurrent enhanced cessation support and marketing (e.g. Quitline) etc.</p> <p>1.4 Mitigate the potential adverse effects of the tax increases with interventions to help support quitting among the most disadvantaged smokers, such as targeted cessation support for people on low incomes, Māori, Pacific smokers who may continue to smoke after the tax increases.</p> <p>1.5 Commit to signing the World Health Organization-led global protocol on illicit tobacco trade.</p>	<p>1.6 Monitor and review the impact of tax increases and responses of the tobacco industry to assess the need for further action to reach the 2025 goal.</p> <p>1.7 Consider introducing minimum price or price cap regulation, if this is considered necessary to address tobacco industry strategies to mitigate the impact of the tax increases.</p>

Objectives

Immediate actions

Medium-longer term actions

2. Reduce youth access to tobacco products

2.1 Raise the minimum age for sale of tobacco products to 21 years of age by December 2019.

2.2 Raise the minimum age of supply of tobacco products to 21 years of age - in a public place (consistent with current legislation).

2.3 Ban tobacco retail outlets located within 1 km of schools by December 2020 (including existing outlets).

2.4 Implement one of the following two options:

Either:

- a) Raise the minimum age for sale and supply of tobacco products to 25 years OR
- b) Introduce the tobacco-free generation policy. This would phase tobacco out over time by prohibiting retailers from selling tobacco to new generations - those born after a certain date (e.g. 1 January 2000).

3. Reduce the supply of tobacco products

Decrease the number of tobacco retail outlets to 5% or less (to around 300-400 retailers) of 2012 levels by December 2022, starting with the following outlet reduction measures and option appraisal beginning in 2018:

3.1 Prohibit all alcohol on-licensed premises (bars, pubs, taverns and nightclubs) from selling tobacco by December 2018.

3.2 Review the feasibility and advantages and disadvantages of various options for the type of store that will be allowed to sell tobacco products after 2022.

Options include:

- not-for-profit stores (new or existing retailers, NGOs or govt bodies that would sell tobacco on a non-profit basis)
- pharmacies
- half of liquor stores (R18)
- supermarkets
- vape shops
- specialist tobacco shops

3.3 Complete the substantial reduction in the number of tobacco retail outlets to 5% or less by 2022 by:

Either: (to be agreed after stakeholder engagement)

a) Retail reduction with licensing:

Introduce a new licensing scheme for all tobacco retailers. Gradually reduce the number of licences granted.

From 2022, restrict tobacco sales to 300-400 retail outlets. The type of outlets would be determined after appraisal of the options in 3.2.

OR:

b) Retail reduction without licensing:

Require all current tobacco retailers to transition out of selling tobacco by December 2021.

From 2022, restrict tobacco sales to 300-400 retail outlets. The type of outlets would be determined after appraisal of the options in 3.2.

No national licensing scheme would be required - there would need to be some type of permit or contracting system for the 300-400 retail outlets.

3.4 Reduce the number of tobacco retail outlets to 0% by 2025 with a sinking lid reduction of the remaining licences or permits/contracts.

Objectives

Immediate actions

Medium-longer term actions

4. Make tobacco products less addictive and less appealing

4.1 Ban the additives in tobacco products (e.g. flavours, sugar, menthol, preservatives, chemicals that enhance addictiveness) by regulating under current provisions of the Smoke-free Environments Act by December 2019 (or medium to longer term?) or amending Act where necessary.

4.2 Expand the requirements on packaging and type of tobacco products to reduce the appeal of tobacco packaging. This should include enlarged pictorial health warnings (at least 75% on the front, and 90% on the back, of the tobacco product pack) with integrated ongoing mass media campaigns.

Note: This will only be required if the anticipated standardised packaging regulation doesn't include these aspects.

4.3 Explore the feasibility and impact of a mandated introduction of very-low-nicotine cigarettes by carrying out a pilot for a nicotine reduction policy in selected communities (completed by December 2020).

4.3 If pilot of nicotine reduction is successful, introduce a national policy mandating very-low-nicotine cigarettes by December 2021.

4.4 Introduce new pack inserts to provide advice and support for quitting

4.5 Explore the potential for mandated dissuasive sticks (e.g. mandating colours and/or design of factory-made cigarettes, dissuasive messaging printed onto cigarette sticks).

5. Enhance and intensify mass media campaigns

5.1 Implement best-practice, integrated mass media campaigns (ideally using funds from tobacco tax increases) to: a) increase public awareness of the harm and addictiveness of tobacco products, and b) increase successful long-term quitting by current smokers c) increase awareness of the Smokefree 2025 goal and the national tobacco control strategy and measures being taken to achieve the Smokefree 2025 goal. Ensure mass media campaigns are appropriately targeted to or have adequate reach and impact with priority groups, including Māori and Pacific smokers.

Objectives	Immediate actions	Medium-longer term actions
6. Regulate access to e-cigarettes and other alternative nicotine delivery products	6.1 Regulate to enable appropriate access to alternative nicotine delivery products for adult smokers and recent quitters, from selected outlets by July 2018 (restricted to pharmacies and specialist vape shops). This includes electronic cigarettes and heat-not-burn devices.	6.2 Evaluate impact of e-cigarettes and other alternative nicotine delivery products on smoking cessation and uptake, and modify policy as appropriate.
7. Enhance and target smoking cessation advice and support	7.1 Ensure access to appropriate smoking cessation advice and support (or referral for support) for all smokers who want to quit, targeted to Māori and Pacific smokers and provided in a range of settings (e.g. primary health care, pharmacies, other health sector settings, workplaces, WINZ offices, community-based services, Quitline etc.).	
8. Expand smokefree environments	8.1 Extend smokefree environment legislation to cover vehicles carrying children and adolescents aged under 18 years.	8.2 Extend smokefree environment legislation to cover all outdoor hospitality areas, building entrances and outdoor recreation areas (e.g. parks, playgrounds) and all sporting and recreational facilities with outdoor stands [including racecourses]).

