Primary Care Partnership
BENDIGO LODDON

Greater Bendigo and Loddon Tobacco Reduction Plan

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Section 1: Introduction

In developing the Bendigo Loddon Primary Care Partnership Strategic Plan which incorporates the Integrated Health Promotion Plan 2009-2012, the partner organisations of the Primary Care Partnership identified the **reduction of tobacco related harm** as one of our four health promotion priorities. This priority now has a significant place in the work of our partnership, and five of those partner organisations who undertake health promotion activities have adopted reducing tobacco related harm as one of their key activities.

Whilst the overall national smoking prevalence of all Australians aged 14 years and over has reduced to 16.6%, high need and disadvantaged groups, who are hard to reach through mainstream advertising and programs, are significantly higher than this. Smoking rates of these groups are:

- Pregnant teenagers – 41%
- Unemployed people – 38%
- People unable to work – 34%
- People with a mental illness – 32%
- Male prisoners – 78%
- Female prisoners – 83%

(Commonwealth of Australia; "Taking Preventative Action, A Response to Australia: The Healthiest Country by 2020, the Report of the National Preventative Health Taskforce" 2010, pp65, 65)

Compared with 16.6% of all Australians aged 14 years and over, the smoking prevalence of Indigenous Australians is almost 50%. Aboriginal Regional Tobacco Coordinators and Tobacco Action Workers have initially been funded in 20 Regions around Australia by the Commonwealth Government, with two of these workers based in the Loddon Mallee Region. These workers will increase awareness of the harms from smoking and will facilitate smoking cessation and prevention programs within the Aboriginal community. The workers will also have access to funding and other resources to enable them to conduct community events and provide local community based marketing for the Aboriginal community.
(Commonwealth of Australia; "Taking Preventative Action, A Response to Australia: The Healthiest Country by 2020, the Report of the National Preventative Health Taskforce" 2010, p74)

The Health Promotion team at Bendigo Health has been working on tobacco reduction prior to 2009 and has met bimonthly with other health and education services including Bendigo Community Health Service, school nursing, City of Greater Bendigo, Bendigo and District Aboriginal Cooperative, Department of Human Services and Loddon Campaspe Multi-Cultural Service to work collaboratively. The Terms of Reference of the Group was to develop smoking reduction strategies, undertake joint projects, share information, promote consistent messages, and undertake community consultation regarding smoking reduction programs. In 2010 the PCP Secretariat was requested by PCP partners to facilitate a broader role for tobacco reduction in Greater Bendigo, given that it was now a shared health promotion priority, and Alan Taylor from ADT Mediation was contracted to work with our partner agencies, including the Community Tobacco Cessation Group, to develop a Greater Bendigo and Loddon Tobacco Reduction Plan.

The Consultant has held individual interviews with a range of partner agencies, including health agencies, local government, state government departments, and the division of general practice and facilitated a planning forum in conjunction with the PCP on 30 March 2011. Thirty-one partner agency staff and others attended the forum to develop this Plan and were assisted by two of the Tobacco Control staff of the Department of Health and Central Office and a staff member from Quit Victoria.

This Plan will provide guidance and direction to the Bendigo Loddon PCP for its tobacco reduction work and will enable partner agencies to work together to implement strategies that they developed and agreed upon. This Plan is owned by the partner agencies and will provide the opportunities for these partners to demonstrate their genuine belief in partnership and make a commitment to collaboration to benefit the communities of Greater Bendigo and Loddon by reducing tobacco related harm.

The Victorian Tobacco Control Strategy 2008-2013 states that "This strategy, challenges the Victorian Government, in partnership with key stakeholders, the community and individuals, to intensify our efforts to eliminate the harms of smoking. Significant gains can be made for achieving our targets by 2013 that focus on adults, smoking in pregnancy, and high-prevalence groups". (p6)

The Tobacco Reduction Plan has adopted the goals of the Statewide Plan and identifies strategies that the PCP members have developed and will endeavour to meet as part of their implementation of this Plan.

Members of the Tobacco Reduction Task Group will work in partnership in accordance with the philosophy of the Bendigo Loddon PCP and will endeavour to collaborate in their partnership work to enable the Plan to be implemented in a way that builds the capacity of all partners working to reduce tobacco consumption in the catchment.

Working in Partnership

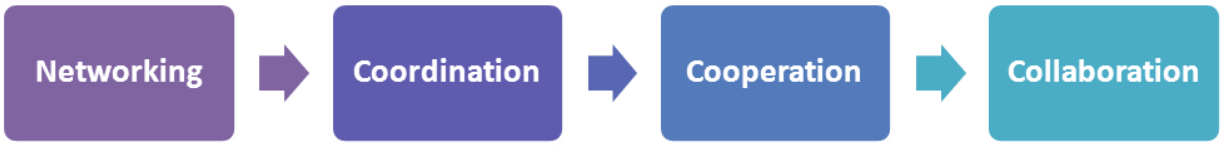
Exchanging information for mutual benefit is **"Networking".** Example: Organisations meet to share information about their goals, programs or projects.

Exchanging information and altering activities for mutual benefit and to achieve a common purpose is **"Coordination".** Example: Organisations share information about program activities and then agree to change their program content and timelines to better serve their common clients/community.

Exchanging information, altering activities and sharing resources for mutual benefit and to achieve a common purpose is **"Cooperation".** Example: Organisations share information about program activities, change their program timelines to better serve the community, and share activities or physical space for programs.

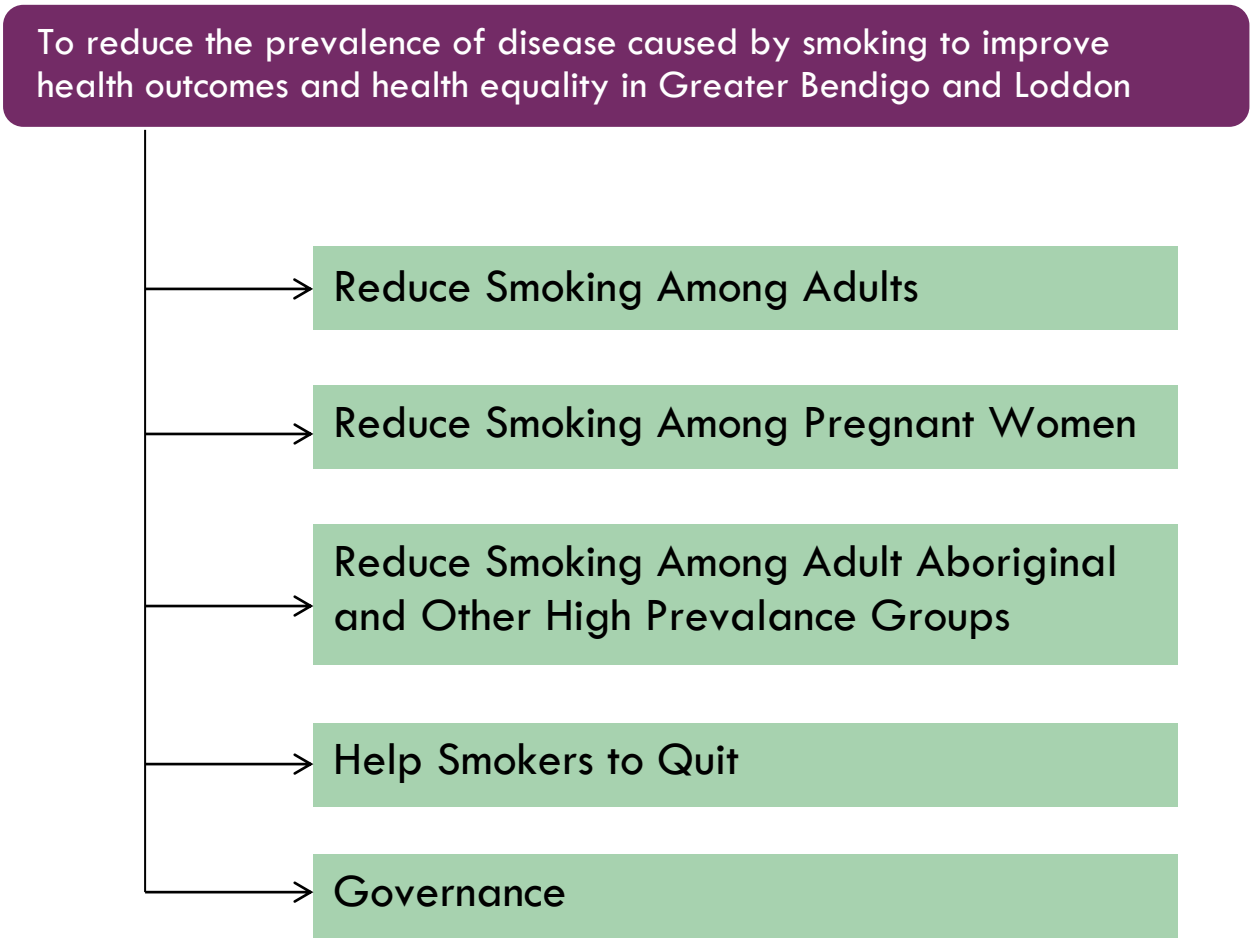
Exchanging information, altering activities, sharing resources and enhancing the capacity of others for mutual benefit and to achieve a common purpose is **"Collaboration".** Collaboration is the most advanced partnership and is a relationship in which each partner assists the other partners to become better at what they do.

Long term sustainability results from collaborative partnerships.



Reference: American Journal of Community Psychology, Vol. 29, No. 2 April 2001, pp. 277-285
Himmelman, Arthur T. "Communities Working Collaboratively for a Change." In *Resolving Conflict: Strategies for Local Government,* edited by Margaret Herrman. Washington, D.C.: International City/Country Management Association, 1994, 27-47

Section 2: Goal and Objectives



Section 3: Priority Action Areas

Reduce Smoking Among Adults

The Victorian Tobacco Control Strategy 2008-2013 has a target to reduce smoking among adults by 20%, from 17.3% to 13.8% in Victoria. In Greater Bendigo and Loddon we will accept this challenge and intensify our efforts by implementing the following strategies.

Strategy	Convenor	Partner Agencies	Performance Measures
1.1: To provide access to tobacco cessation programs and services to employees of health and community services agencies, by: • Including tobacco cessation in workplace health and wellbeing plans. • Providing group sessions to high risk workers, eg mental health workers, disability workers, aboriginal health workers, youth workers. • Enabling work release for employees to access clinicians for nicotine replacement therapy (NRT) and other quit therapies. • Facilitating the sharing of information about the implementation of smoke-free workplaces in the health and community services sector. • Promoting the use of Quit material to reinforce smoke-free messages in workplaces. • Building into position descriptions the requirement that staff must not smoke in view of clients. • Seek workplace grants for "one off" smoking reduction programs in member agency workplaces.	TRTG	PCP Members WorkSafe Vic	• Number of health and wellbeing plans of partner agencies which include tobacco cessation. • The number of sessions on Quit provided to high risk workers. • The number of PCP partner agencies which have policies and practices that allow for staff release to access clinicians for smoking cessation issues. • Evidence of information sharing between agencies. • Evidence of position descriptions containing smoke free requirements. **Evaluation by:** PCP Project Officer. **Note:** Common tools to be developed and used. Each organisation to evaluate individually using the common tools and provide feedback to PCP.
1.2: To conduct individual skill development and capacity building in response to those community members who wish to cease smoking.	TRTG	Quit Facilitators	Number of individual sessions held. **Evaluation by:** PCP Project Officer.

Strategy	Convenor	Partner Agencies	Performance Measures
1.3: To provide local tobacco reduction services with information on current national and state tobacco campaigns.	DH/PCP	PCP Members	Information disseminated to local agencies about national and state tobacco campaigns. **Evaluation by:** PCP Project Officer.
1.4: To localise national and state tobacco reduction messages by using cinema, newspapers, billboards, and information packs.	TRTG	PCP Funding Bodies	Evidence of the use of local media for tobacco reduction messages. **Evaluation by:** PCP Project Officer.
1.5: To develop a "Smoke-Free in Greater Bendigo" brand for organisations in Greater Bendigo.	CoGB	TRTG PCP Project Officer	• The branding package including criteria, signage, policies and procedures is developed. • Development of a register of "smoke-free" organisations in Bendigo. **Evaluation by:** CoGB and PCP Project Officer.
1.6: To provide assistance to community organisations, including sporting clubs, to implement smoke-free policies within their organisations and to distribute example templates of smoke-free policies.	CoGB	Sports Focus PCP BH	An increase in local organisations adopting smoke-free policies. **Evaluation by:** PCP Project Officer.
1.7: Extend the use of place based settings for the provision of tobacco reduction information, including: • workplaces, • council facilities, • schools, • festivals, • public events, • field days, • markets, and • Swap meets.	TRTG	CoGB BH (HP)	The number of events where agency staff actively promote smoking cessation messages or distribute resources. **Evaluation by:** TRTG.
1.8: The City of Greater Bendigo to work with organisations and businesses to reduce the impact of cigarette litter in public areas, through education and provision of cigarette bins.	CoGB	TRTG	Evidence of a decrease in cigarette litter. **Evaluation by:** CoGB.

Reduce Smoking Among Pregnant Women

The Victorian Tobacco Control Strategy 2008-2013 has a target to reduce smoking among pregnant women by 50%, from 9.3% to 4.7%. In Greater Bendigo and Loddon we will accept this challenge and intensify our efforts by implementing the following strategies.

Strategy	Convenor	Partner Agencies	Performance Measures
2.1: Embed a Quit smoking message within existing support services for pregnant Aboriginal women, by: • Using the 5A's at ante-natal visits. • Extending the use of Ibera software by health workers to demonstrate the health impacts of smoking. • Increasing the referrals from GPs and other clinicians of pregnant Aboriginal women to smoking cessation programs.	BDAC	CVGPN MCHS	• Evidence of use of the 5A's by known ante-natal providers. • Evidence of improvement to referral and access to cessation programs. **Evaluation by:** BDAC and PCP Project Officer.
2.2: To implement strategies to encourage and support pregnant women generally to quit smoking, by: • Using the 5A strategy, when possible • Increasing the referrals from GPs and other clinicians of pregnant women to smoking cessation programs. • Using other support mechanisms, where possible.	TRTG	WHLM CVGPN	• Evidence of strong anti-smoking messages being embedded in health services accessed by pregnant women. • Evidence of improvement to referral and access to cessation programs **Evaluation by:** TRTG.

Reduce Smoking Among Adult Aboriginal and Other High Prevalence Groups

The Victorian Tobacco Control Strategy 2008-2013 has a target to reduce smoking among high prevalence groups by at least 20%, from 50% to 40% of Aboriginal adults and from 20% to 16% in socio-economically disadvantaged areas. In Greater Bendigo and Loddon we will accept this challenge and focus our efforts on Aboriginal people, the CALD community, young people and those with mental illness by implementing the following strategies.

Strategy	Convenor	Partner Agencies	Performance Measures
3.1: To implement a range of strategies that will discourage young people to take up smoking and to encourage young smokers to quit, by: • Providing professional development for youth workers to enable the promotion of smoke-free messages as part of daily practice, including the 5A's (Ask, Advise, Assess, Assist and Ask Again). • Supporting BDAC youth group to develop smoke-free messages through creative arts.	BDAC/PCP	CVGPN DH TRTG Members VACCHO Regional Aboriginal Tobacco Coordinator	• Professional development session about 5A's and smoke-free messages held. Number of youth workers participating. • Pre and post-surveys on attitudes to smoking in BDAC Youth Group Creative Arts Project. • Number of young people referred to Quit Facilitators. **Evaluation by:** BDAC and PCP Project Officer.
3.2: To deliver tobacco reduction programs to young people, by: • Delivering sessions for those who are part of an already defined group, eg schools, youth groups, church groups, sporting clubs. • Providing individual support to young smokers with psychological or physical issues, eg depression, substance abuse, asthma, eating disorders. • Promoting Quitline to young smokers with limited access to services, eg geographic isolation, lack of transportation, lack of time. • Promoting computer interactive smoking cessation resources to young smokers who are comfortable with and have access to computer technology.	TRTG	Mind Australia BCHS BH	• Number of sessions delivered to the defined groups. • Numbers of young smokers with other health issues receiving individual support to quit smoking. • Increased level of Quit promotion materials in rural areas for young smokers. • Improved access to cessation services and resources. **Evaluation by:** PCP Project Officer and TRTG.

Strategy	Convenor	Partner Agencies	Performance Measures
3.3: To implement a range of strategies that will encourage CALD smokers to quit, by: • Acquiring and distributing culturally appropriate Quit smoking material using both language and pictures to local organisations. • Identifying opportunities for the presentation of tobacco-reduction information to gatherings of CALD groups. • Referring CALD smokers to Quit Facilitators.	TRTG	CVGPN LCMS BCHS	• The provision of culturally appropriate information to CALD communities – when, where. • The number of occasions that engaged CALD communities about the health effects of tobacco consumption. • The number of referrals to Quit Facilitators. **Evaluation by:** LCMS/PCP
3.4: To investigate the evidence that may be available to assist adult Aboriginal people to reduce smoking and implement innovative and culturally acceptable approaches to quit smoking.	BDAC	TRTG Regional Aboriginal Tobacco Coordinator VACCHO	Discussion with VACCHO and an approach to Quit trialled in Bendigo with the Aboriginal community smokers. **Evaluation by: BDAC**
3.5: To implement a range of strategies that will encourage smokers with mental illness or alcohol and other drugs issues to quit, by: • Improving access to tobacco cessation programs. • Increasing referrals from GPs to tobacco cessation programs. • Encouraging mental health staff to provide smoking reduction messages to their clients. • Piloting an integrated life skills program for AOD clients with a focus on healthy lifestyle, including reducing tobacco intake.		Mind Australia CVGPN BCHS YSAS	• The number of tobacco cessation programs conducted for smokers with a mental illness. • Increase in the number of GP referrals to Quit Facilitators. • Participation by mental health workers in training to deliver smoking reduction messages. **Evaluation by:** PCP Project Officer.

Help Smokers to Quit

The Victorian Tobacco Control Strategy 2008-2013 tells us that "strong evidence exists that even brief advice and guidance from health professionals is a highly cost-effective way to prompt smokers to quit. This is not because any single patient-professional interaction will necessarily result in a quit attempt; rather a persistent message from a number of respected health professionals gradually increases the likelihood of quit attempts." (p.15) In Greater Bendigo and Loddon we will increase the capacity of our workforce to help smokers to quit by implementing the following strategies.

Strategy	Convenor	Partner Agencies	Performance Measures
4.1: To encourage member organisations of the TRTG to include the promotion of tobacco reduction to clients in position descriptions of health and community services staff regardless of the position held in the organisation.	TRTG	TRTG Members	Evidence that position descriptions of health and community services employees require the promotion of tobacco reduction to clients. **Evaluation by:** TRTG.
4.2: To provide professional development for health and community services workers to enable the promotion of smoke-free messages as part of their daily practice, by: • Training in the use of the 5A's. • Training in the use of referral pathways to smoking cessation programs. • The provision of appropriate resources.	PCP	Mental health staff BDAC (health workers) Maternal and Child Health Nurses Midwives HP Staff BH (HP)	• The number of training sessions provided. • The number of people attended the training. • The number of professions attended the training. **Evaluation by:** PCP Project Officer.
4.3: That the PCP provides funds to agencies to send additional staff to Quit Facilitator training.	PCP	TRTG	By agencies allocating staff to attend Quit Facilitator training. **Evaluation by:** TRTG.
4.4: To provide funds for Quit training for CALD community representatives.	PCP	LCMS	The number of Quit Facilitators from the CALD community trained. **Evaluation by:** LCMS.

Strategy	Convenor	Partner Agencies	Performance Measures
4.5: To hold discussions with LaTrobe University Bendigo with a view to including Quit training as part of undergraduate health courses.	TRTG Sub-committee	TRTG Members	Meeting with Latrobe University to discuss the inclusion of such training in all undergraduate health courses. **By:** Sub-Committee of TRTG.
4.6: To encourage GPs to implement the 5As, promote smoke-free messages and provide appropriate referrals to Quitline and local Quit Facilitators.	CVGPN	BCHS BDAC	• Number of GPs participating. • Number of referrals received by local Quit Facilitators. **Evaluation by:** CVGPN.
4.7 Map smoking cessation groups and programs across the City of Greater Bendigo including referral pathways, eg from GP to programs, from Quitline to local, across organisations, etc.	PCP Project Officer	TRTG Members Quit CVGPN	Referral pathways to programs documented. **Evaluation by:** PCP Project Officer.
4.8: To develop and promote a local database of accredited Quit Facilitators.	PCP Project Officer	TRTG	Current list developed, maintained and distributed. **Evaluation by:** PCP Project Officer.

Governance

The establishment of the Tobacco Reduction Task Group in Greater Bendigo and Loddon will bring leaders in Tobacco Reduction together to collaborate effectively on implementing this Plan. The Task Group will determine the way in which additional tobacco reduction funds are allocated and will oversee the delivery of this Plan. The Tobacco Reduction Task Group members will ensure that common assessment tools are used to robustly evaluate the strategies within the Plan and that all strategies are implemented. The Group will also ensure that the latest data on tobacco use and health effects is available to PCP partner organisations.

Strategy	Convenor	Partner Agencies	Performance Measures
5.1: To develop and implement the Terms of Reference for the Tobacco Reduction Task Group to oversee the implementation and evaluation of this Plan.	Chairperson TRTG	BH BCHS LCMS HH BDAC PCP CoGB Mind Australia WHLM CVGPN Sports Focus DH	Terms of Reference developed and agreed for Tobacco Reduction Task Group.
5.2: To improve collaboration between agencies to enhance the delivery of smoking reduction programs.	PCP Project Officer	BH BCHS LCMS HH BDAC CoGB PCP Mind Australia CVGPN Sports Focus DH	VicHealth Partnership Tool will be applied in the Tobacco Reduction Task Group annually and results analysed by the PCP Project Officer.
5.3: To conduct an annual forum to: • Showcase best practice in Tobacco Reduction Programs. • Review the Tobacco Reduction Plan actions annually.	TRTG	Interested organisations	Annual forum held and participants surveyed and results reported. **Evaluation by:** PCP Project Officer.

Strategy	Convenor	Partner Agencies	Performance Measures
5.4: To ensure that the Community Profiles include the most current smoking data.	TRTG	CoGB BLPCP	Review the profiles annually to ensure current smoking data is contained within them. **Evaluation by:** PCP Project Officer.

Section 4: Supporting Documentation

Acronyms

5As	Ask, Advise, Assess, Assist, Ask Again
AOD	Alcohol and Other Drugs
BCHS	Bendigo Community Health Service
BDAC	Bendigo and District Aboriginal Cooperative
BH	Bendigo Health
BLPCP	Bendigo Loddon Primary Care Partnership
CALD	Culturally and Linguistically Diverse
CoGB	City of Greater Bendigo
CVGPN	Central Victoria General Practice Network
GP	General Practices or General Practitioners (Doctors)
HH	Heathcote Health
HP	Health Promotion
HR	Human Resources
IHP	Integrated Health Promotion
LCMS	Loddon Campaspe Multicultural Services
MCHN	Maternal and Child Health Nurses
MCHS	Maternal and Child Health Service
NDCHS	Northern District Community Health Service
NRT	Nicotine Replacement Therapies
PCP	Primary Care Partnership
TRTG	Tobacco Reduction Task Group
VACCHO	Victorian Aboriginal Community Controlled Health Organisations
WHLM	Women's Health Loddon Mallee
YSAS	Youth Substance Abuse Service

Preparation of Report

This Report was prepared by Alan Taylor, ADT Mediation, after extensive consultation with PCP partner organisations, the Department of Health, Department of Human Services, Department of Education and Early Childhood Development, Quit Victoria, and other community agencies in partnership with Bendigo Loddon PCP staff.

The design and layout of this report is by Leanne Oberin, Bendigo Loddon PCP.

Further Information

For further information on the strategies identified in this Report, contact the Executive Officer of the Bendigo Loddon PCP, Jeanette Grant. Details may be obtained through www.blpcp.com.au.

Background Information

(Provided by Department of Health, Loddon Mallee Regional Office)

1.1 The WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (FCTC) is the first treaty negotiated under the auspices of the WHO and was adopted in May 2003 and entered into force in 2005 (WHO, 2009). It was developed in response to what was recognised as a global tobacco epidemic with the objective of protecting present and future generations from the devastating effects of smoking tobacco (Scollo and Winstanley, 2008, chap.18, p.3). Obligations under the treaty are basically to reduce the demand for tobacco products and reduce the supply of tobacco products. The FCTC has a number of guidelines that signatories must agree to such as implementing and maintaining tobacco control strategies.

Australia was one of the first forty signatories (there are around 168 signatories currently). Australia's ratification of the FCTC changed the constitutional context of tobacco control in Australia slightly. Previously tobacco control legislation included both Commonwealth and State enactments. Constitutional limits meant that areas such as protection against second-hand smoke and some advertising were the domains of the states and territories (Scollo and Winstanley, 2008, chap.18, p.23). Ratification of the FCTC means that the Commonwealth has the power to legislate in some areas that previously it could not. However, there may remain practical reasons for States and Territories to continue to deal with certain matters.

1.2 National Tobacco Strategy 2004-2009

National policies aimed at preventing and reducing the harmful effects of substance abuse are developed by the National Drug Strategy (NDS). The NDS covers tobacco, alcohol and illicit drugs. The principle of harm minimisation forms the basis of the National Drug Strategy (NDS). The NDS framework is responsible for developing national substance specific strategies that provide a basis by Australian and State/Territory governments (Australian Government, 2009)

The objectives of the National Tobacco Strategy (NTS), 2004-2009 were; "to prevent uptake of smoking; to encourage and assist as many smokers as possible to quit as soon as possible; to eliminate harmful exposure to tobacco smoke among non-smokers; and where feasible, to reduce harm associated with continuing use of and dependence on tobacco and nicotine" (Ministerial Council on Drug Strategy, 2005, p.iii). Eight major areas for action were identified with a number of tools that could be implemented within each area (Appendix 1 **Error! Reference source not found.**).

It is expected a draft of the *National Tobacco Strategy 2010-2015* will be available for comment in the first half of 2010. The consultation paper notes that the Preventative Health Taskforce has made a number of recommendations in relation to tobacco and that the " next phase of the National Drug Strategy will need to take account of the National Preventative Health Strategy and be implemented in co-operation with the Preventative Health Agency to be established in 2010" (Australian Government, 2009a, p.7)

1.3 National Preventative Health Taskforce Australia: *The Healthiest Country by 2020*

The National Preventative Health Taskforce (NPHT) was created in April 2008. Its first task was the preparation of a strategy focusing on the obesity, tobacco and excessive consumption of alcohol. Its report, *Australia: The Healthiest Country by 2020. National Preventative Health Strategy – the roadmap for action,* was released 30 June 2009.

As it is not considered possible to implement all actions immediately, the report recommends a phased approach between 2010 and 2020 in three priority areas: obesity, alcohol and tobacco. Three phases were suggested with urgent priority areas set in place during the first

four years, Phase 1 (2010-2013). The second phase (2014-2017) was to build on these actions (learning from new research and evidence) and the third phase (2018-2020) "ensures long-term sustained action" (National Preventative Health Taskforce, 2009, p.13). The Tobacco Implementation plan (**Error! Reference source not found.**) is contained in Appendix 1.

Table 1 National Preventative Health Strategy targets

Targets	2011	2013	2020
Reduce prevalence of daily smoking among adults	15.4% or lower	14.1% or lower	10% or lower

Meeting these targets will require a continuation in the decline of smoking rates. It will also require significant declines in smoking rates amongst the disadvantaged and less educated smokers as smoking reduction in these groups lag behind the rest of the community (National Preventative Health Taskforce, 2009). Smoking rates amongst Aboriginal people will also have to reduce significantly. If the target of halving the rates amongst Aboriginal people is realised this will leave a rate of around 25%. This will need to be reduced through the setting of 'realistic phased targets' (National Preventative Health Taskforce, 2009, p.173).

To achieve the targets set, the report identifies eleven Key Action Areas within taxation policy, public education, legislation and health system interventions (Table 2).

Table 2 Key Actions required to achieve the tobacco targets.

Key action area 1	Make tobacco products significantly more expensive.
Key action area 2	Increase the frequency, reach and intensity of social-marketing campaigns.
Key action area 3	End all remaining forms of advertising and promotion including price.
Key action area 4	Eliminate exposure to second hand smoke in public places.
Key action area 5	Regulate manufacture and further regulate packaging and supply of tobacco products.
Key action area 6	Ensure all smokers in contact with health services are encouraged and supported to quit, with particular efforts to reach pregnant women and those with chronic health problems.
Key action area 7	Work in partnership with Indigenous groups to boost efforts to reduce smoking among Indigenous Australians
Key action area 8	Boost efforts to discourage smoking among people in other highly disadvantaged groups.
Key action area 9	Assist parents and educators to discourage tobacco use and protect young people from second-hand smoke.
Key action area 10	Ensure that the public, media, politicians and other opinion leaders remain aware of the need for sustained and vigorous action to discourage tobacco use.
Key action area 11	Ensure implementation and measure progress against and towards targets.

1.4 National Partnership Agreement on Preventive Health

All Australian states and territories have singed the National Partnership Agreement on Preventive Health (NPAPH) which commenced 1 July 2009 and continues to 30 June 2015.

1.5 Tobacco Policies – Victoria

2.5.1 Victorian Tobacco Control Strategy (VTCS) 2008-2013

The aim of the strategy is to 'improve the health of the Victorian population by reducing the social costs and inequalities caused by smoking' (Department of Human Services, 2008a, p.6).

The focus is on adults, pregnant women and high-prevalence groups. The targets are listed below (Table 3).

Table 3 Victorian Targets 2008-2013. (Department of Human Services, 2008a, p.6).

Target	Prevalence by 2013
Reduce prevalence of daily smoking among adults	13.8%
	Adult Smoking prevalence 2007 was 17.3%
Reduce prevalence among pregnant women by 50%	4.7%
	Smoking prevalence 9.3% at time of report
Reduce prevalence among Aboriginal people by at least 20%	40%
	Smoking prevalence 50% at time of report
Reduce prevalence among socio-economically disadvantaged groups by at least 20%	16%
	Smoking prevalence 20% at time of report

The VTCS lists six key action areas:

1. Banning tobacco point of sale displays in retail outlets (by January 2011)
2. Reviewing penalties and tougher enforcement of the Tobacco Act.
3. Supporting families.
    a. banning smoking in cars if a person under 18 is present (introduced 1 January 2010)
    b. promoting smoking cessation in pregnancy
    c. banning tobacco sales from temporary outlets (introduced 1 January 2010)
    d. providing the Minister of Health with the power to ban packaging and products that appeal to children
4. Helping smokers quit
5. Promoting anti-smoking social marketing.
6. Setting targets for pregnancy, Aboriginal and other high-prevalence groups.

Information about the latest reforms can be found on the Victorian Government Health Information website at http://www.health.vic.gov.au/tobaccoreforms/.

Enforcement

Local government environmental health officers play a large role in educating proprietors and ensuring compliance with the Victorian Tobacco Act 1987. A service agreement between the Municipal Association of Victoria and the Victorian Government Department of Health provides funds for local councils to carry out inspections and regular visits of premises in their areas.

The ban on smoking in cars if a person under 18 is present, which came into effect on the 1 January 2010, will be enforced by the Victoria Police as part of their everyday monitoring of road users.

Social marketing and smoking cessation services

Quit Victoria is responsible for all anti-smoking social marketing in Victoria. The Victorian Government will continue to invest in social marketing with a priority of supporting families, Aboriginal, socio-economically disadvantaged and pregnant Victorians. The Victorian Government will also support the enhancement of the Quitline service, which provides advice and assistance to smokers seeking to quit.

Research to improve tobacco policy

Further research into activities to reduce harm from tobacco will be funded through VicHealth. The Victorian Government also supports by the Cancer Council to undertake research into development of tobacco policy and programs (Department of Human Services, 2008a).

Evaluation

The VTCS also indicates that there will be a robust program to review and evaluate the success in achieving targets. A VTCS Taskforce will be convened to track progress towards the targets for smoking prevalence among adults, antenatal, Aboriginal and other high prevalence groups. The VCTS acknowledges that whilst there is data for smoking prevalence at the whole population level this is not the case for population subgroups such as pregnant women, Aboriginal or disadvantaged subgroups. Intermediate indicators, such as active smoke-free policies will also be used as an evaluation measure.

2.5.2 Closing the Gap in Aboriginal Health Outcomes - Smoking

The Victorian Government is committed to improving the quality and length of life of Aboriginal Victorians. The *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation plan. Jurisdiction Victoria* (2009) is a key component to this commitment. Tackling smoking is one of the 5 priority areas for reform.

In conjunction with the Commonwealth government and as stated in the VTCS 2008-2013, the aim is to reduce smoking among Aboriginal people by at least 20% (from 50% to 40%) by 2013. Two further aims included in the *Closing the Gap Implementation Plan* are to reduce the burden of smoking related chronic diseases within the Aboriginal community and by 2023 halve the gap in the number of Aboriginal women smoking during pregnancy. Data from a national study conducted between 2001 and 2003 found fifty-two per cent of Aboriginal mothers reported smoking during pregnancy compared to sixteen per cent of mothers in the general population (Laws, Grayson & Sullivan, 2006).

Priority Areas include establishing an Aboriginal Smoking Control Subcommittee of the *Victorian Tobacco Control Strategy* Taskforce and implementing actions identified in the Victorian Advisory Council on Koori Health (VACKH) *Victorian Aboriginal Health Plan* (2009, p19). The VACKH plan identifies a number of actions aimed at developing and implementing comprehensive smoking prevention and cessation programs (including assisting pregnant women to quit). Actions that may be undertaken include:

- Developing and delivering community based interventions for smoking cessation and prevention
- Increasing awareness to smoking cessation interventions for individuals through primary health care services eg brief interventions and support services. (Ability to deliver on this will be impacted by current access of primary care services by Aboriginal people also contained in this report)
- Developing and delivering health information messages and social marketing which can be adapted to local communities
- Developing and delivering smoking cessation training for health staff treating Aboriginal people in Victoria
- Establishing totally smoke-free workplace policies in ACCHOs

- Improving evidence-base for smoking prevention/cessation programs for Aboriginal people in Victoria through research and evaluation.

Factors influencing smoking

It is now known that nicotine addiction is an important component of smoking cigarettes; however other social, economic, personal and political factors play an important role in smoking uptake and cessation (Jarvis, 2004). The teenage years are a critical time in smoking uptake. It is the time when adolescents begin to experiment with smoking for various psychosocial reasons (Jarvis, 2004) and it is also the time when most people become addicted (Scollo & Winstanley, 2008). According to Scollo and Winstanley (2008) only a few cigarettes can addict young people to smoking. They refer to the Theory of Triadic Influence to explain why young people use tobacco. According to this theory three broad factors influence a young person's decision to begin smoking. They are the individual's:

- *Biology and personality*, which includes physiological and psychological factors, which influence an individual's sense of self efficacy, social competence, and self determination;
- *Social context,* which relates to the influence of family and friends in the development of a perception of what is normative behaviour, and;
- *Broader environment,* which takes in cultural contexts, the information environment, and legislative and policy issues that affect pricing and availability of tobacco.

(Scollo and Winstanley 2008, chap.5, p.6)

Rates of smoking are also higher in disadvantaged groups, the cause of which is complex and possibly not well understood (Scollo and Winstanley 2008, chap.9;p.47). Low socio-economic status is thought to influence smoking behaviour for three reasons; little relevance of concerns about the health risks of smoking, weak social norms for quitting and high daily stress (Manfredi, Cho, Crittenden & Dolecek, 2007, p.748).

1.6 Population Groups at Risk

Whilst considerable success has been achieved in reducing smoking rates in Australia, there are population groups that continue to smoke at higher rates than the general population (Table 4). These include Aboriginal and Torres Strait Islanders, the unemployed, people with low education levels or low socio-economic status. According to the National Preventative Health Taskforce report (2009a) the decline in smoking rates among adults living in the most disadvantaged areas of Australia appears to have levelled off. It also reports that children from disadvantaged areas, who live in households where at least one parent is a smoker, are almost four times more likely to be exposed to second-hand smoke indoors than children in more advantaged areas.

Table 4 Percentage of daily smoking by socio-economic status in Australians 18 years, 2004-05.*

Highest level of qualification	Associate Diploma or above	Other qualification
	12.2	24.4
Labour force status	**Employed**	**Unemployed**
	22.6	41.9
Household income	**Highest Income**	**Lowest income**
	16.3	21.5
Index of disadvantage	**Most advantaged**	**Most disadvantaged**
	13.5	29.9

* Source: Scollo & Winstanley, 2008, chap.9, p16)

Pregnant women constitute another high risk group due to the harm caused by tobacco to the unborn child as well as the mother. Almost 20% of pregnant women report smoking during

pregnancy, with higher rates amongst teenage (42%) and Aboriginal mothers (National Preventative Health Taskforce, 2009a).

Other vulnerable and disadvantaged groups include:

- Lone parents, particularly women
- Prisoner
- People with mental illness
- People who abuse drugs and alcohol

(Scollo & Winstanley, 2008, chap.9)

1.4.1 Aboriginal health and smoking rates

There are significant inequalities in the health status of Aboriginal Australians compared to the general population. Recent evidence shows that the life expectancy gap between Aboriginal Australians and non-Aboriginal gap is 17 years. Deaths from cardiovascular disease are three times more common in Aboriginal people, cancer related deaths in the 35-64 age groups are about twice as high in the Aboriginal population and nationally, babies born to Aboriginal women are twice as likely to be of low birthweight (<2500g) (Australian Indigenous Health*InfoNet,* 2009). Aboriginal Australians carry a significantly greater disease burden than non-Aboriginal Australians (Figure 1).

Results from the *National Aboriginal and Torres Strait Islander survey 2004-05* (ABS, 2006) found that 50% of Aboriginal adults smoked daily; more than double those in the rest of the community. This has serious implications for health policies aimed at closing the health gap between Aboriginal and non-Aboriginal Australians.

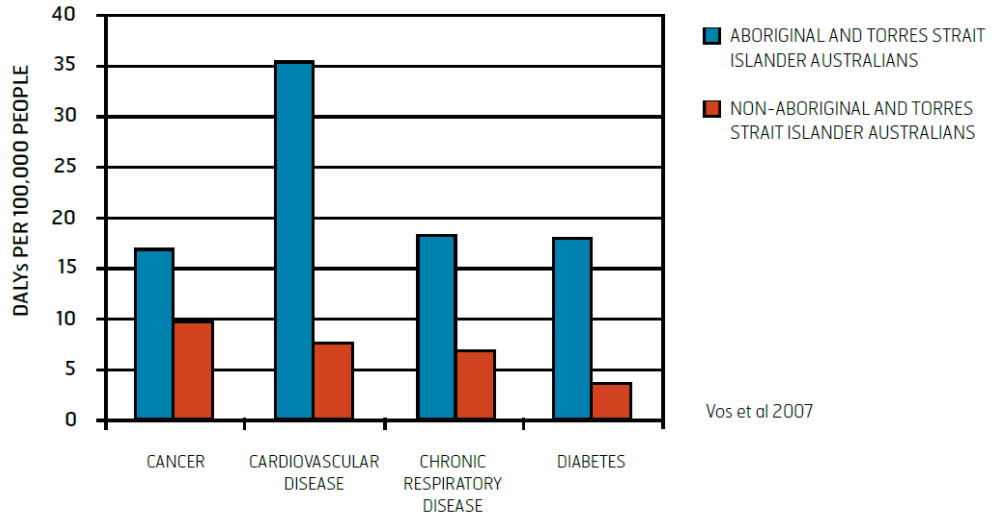


Figure 1 Disability adjusted life years (DALYs) for selected causes: Comparison of Aboriginal and Torres Strait Islander with non-aboriginal and Torres Strait Islander Australians, 2003 (Source Victorian Advisory Council on Koori Health, 2009, p.24)

Smoking and the burden of disease in the Aboriginal population

Tobacco smoking is the main risk factor that contributes to the health gap between Aboriginal and non-Aboriginal populations (Vos, Barker, Begg, Stanley & Lopez., 2009). Around 12% of the total burden of disease and one fifth of Aboriginal and Torres Strait Islander deaths are related to tobacco smoking (Vos et al., 2007 as cited in Victorian Advisory Council on Koori Health, 2009). Thirty seven percent of the burden of disease can be attributed to eleven key risk factors of which smoking is the highest (Vos et al., 2009).

The most recent estimates indicate that 51% of Aboriginal people in Victoria smoke (Victorian Advisory Council on Koori Health, 2009). Thirty-eight per cent of Aboriginal mothers indicated they had smoked in the month prior to birth (Department of Human Services, 2008a). In the LMR the percentage of Aboriginal babies born who are of low birthweight is three times that of the non-Aboriginal population (Department of Human Services, 2009d).

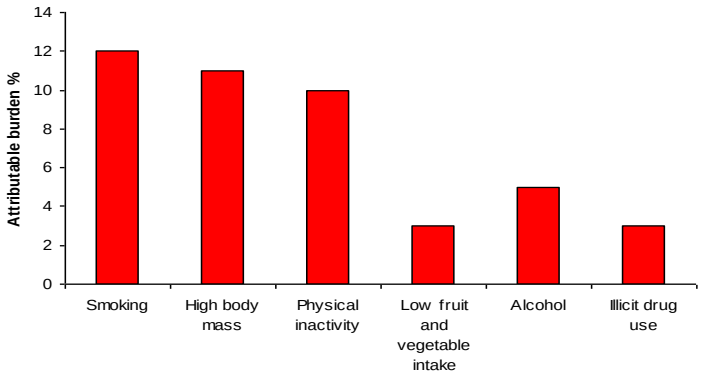


Figure 2 Total burden of disease attributable to selected risk factors in Aboriginal and Torres Strait Islander Australians, 2003 **(Source Vos et al., 2009)**

The National Preventative Health Taskforce reports that "Closing the Gap will not be possible while Indigenous people smoke at a higher rate than other Australians" (National Preventative Health Taskforce, 2009, p.173).

Department of Health – Regional Role

1. Advocate the importance of including the *reducing tobacco-related harm* health promotion priority in health promotion interventions and strategic plans.
2. Promote strategies that embed the tobacco priority into a range of prevention programs including physical activity, nutrition, mental health and wellbeing.
3. Adopt a multi-sectorial approach to tobacco and develop partnerships across health, community services and local government. For example, consider the role of GP's, maternal and child health, homelessness, mental health and drug and alcohol services.
4. Build capacity in the health, local government and community sector to plan, implement and evaluate tobacco interventions.
5. Conduct a service mapping exercise in the Region to determine level of tobacco interventions across health, community services and local government.
6. Collate and promote the evidence for tobacco interventions that work, particularly for high risk and disadvantaged population groups.
7. Implement National Preventive Health Strategy, Victorian Tobacco Control Strategy and Closing the Gap tobacco strategies in the Region where appropriate.