CONSULTATION DRAFT

NATIONAL TOBACCO STRATEGY 2022–2030

A Strategy to improve the health of all Australians by reducing the prevalence of tobacco use and its associated health, social, environmental and economic costs, and the inequalities it causes

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PART ONE: INTRODUCTION

Tobacco smoking remains the leading cause of preventable death and disability in Australia and is estimated to have killed 1,280,000 Australians between 1960 and 2020.[1] In 2015 alone, tobacco use was estimated to kill almost 21,000 people.[2] Tobacco use causes more deaths than all other external risk factors put together and contributes to nine out of the ten diseases with the highest total disease burden in Australia.[3]

Up to two-thirds of deaths in tobacco smokers can be attributed to smoking, and long term smokers die an average of 10 years earlier than non-smokers.[4] Exposure to secondhand smoke is also a cause of preventable death and disability in adults and children.[5]

In addition to its health impacts, tobacco production, marketing and consumption also has serious environmental consequences. The global tobacco supply chain requires significant resource inputs that have detrimental effects on the environment, including the use of harmful chemicals on tobacco farms, deforestation, carbon and other waste emissions, residential and bush fires, and non-biodegradable litter.[6]

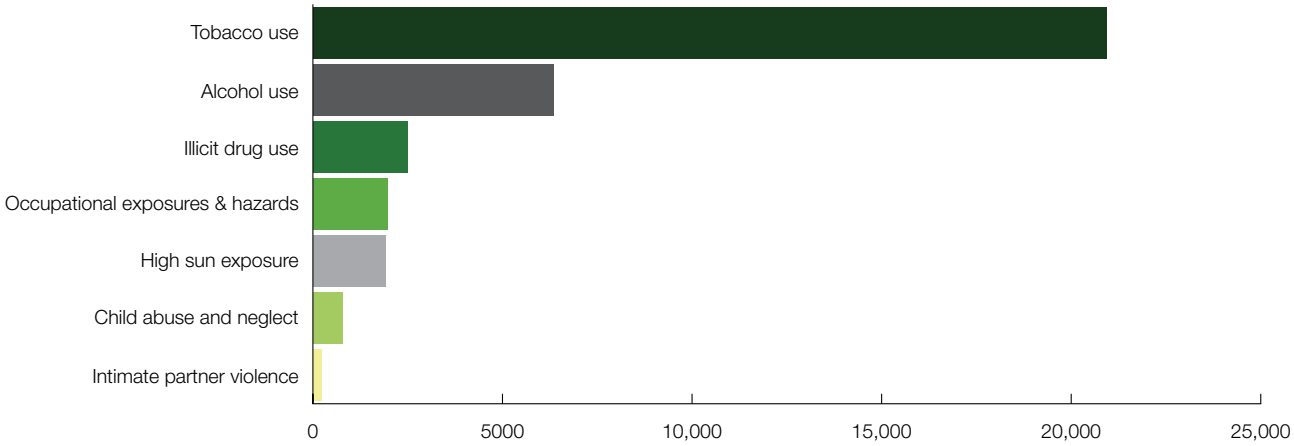
Ending the tobacco epidemic is a priority for all Australian governments and accords with a high level of continued public support for policy measures to reduce tobacco related harm.[7] Significantly reducing and eventually eliminating tobacco use in Australia would dramatically reduce illness, increase quality of life, and reduce health, social and economic inequalities for smokers, their families and the wider Australian community. It would prevent hundreds of thousands of premature deaths, reduce the burden of costly tobacco-attributable disease, increase workers' economic productivity and reduce the burden on carers.

All Australian governments have overseen the development of the National Tobacco Strategy 2022–2030 (the Strategy). The Strategy takes into account input from stakeholders including experts, non-government organisations (NGOs) and the public.

The Strategy sets out a new national policy framework for tobacco control in Australia and complements existing policies and legal frameworks at the state and territory, national and international levels. It provides an overview of the effects of tobacco use in Australia, and outlines shared goals, objectives, principles and targets for tobacco control across government and non-government agencies between 2022 and 2030. It also identifies 11 priority areas and associated actions to be implemented, together with mechanisms for monitoring and evaluation.

The approach in this Strategy is to build on the success of previous National Tobacco Strategies, and to strengthen population-wide approaches that have been successful in reducing the prevalence of tobacco use over the past four decades. It includes new demand and supply side measures and new measures to protect public health policies from tobacco industry interference. It also maintains a strong emphasis on reducing health and social inequalities by complementing population-wide strategies with more targeted approaches to reduce smoking[i] among populations with a high prevalence of tobacco use.

Figure 1: Number of deaths due to external risk factors, 2015



Source: Australian Burden of Disease Study 2015

Note: Each risk factor was assessed independently and it is not appriate to sum deaths between risk factors

i As tobacco smoking remains the predominant form of tobacco use in Australia by a wide margin, all prevalence estimates in this document refer to tobacco smoking unless stated otherwise.

1.1 Policy Context

Policy Frameworks

This Strategy draws on existing policy and legal frameworks and operates as a sub-strategy of the National Drug Strategy (NDS) 2017–2026. The national framework outlined in the NDS 2017–2026 to minimise and prevent harm relating to tobacco use is supported by the priorities and actions under this Strategy.[8] This Strategy also complements the Australian Government's National Preventive Health Strategy 2021–2030, released on 13 December 2021.

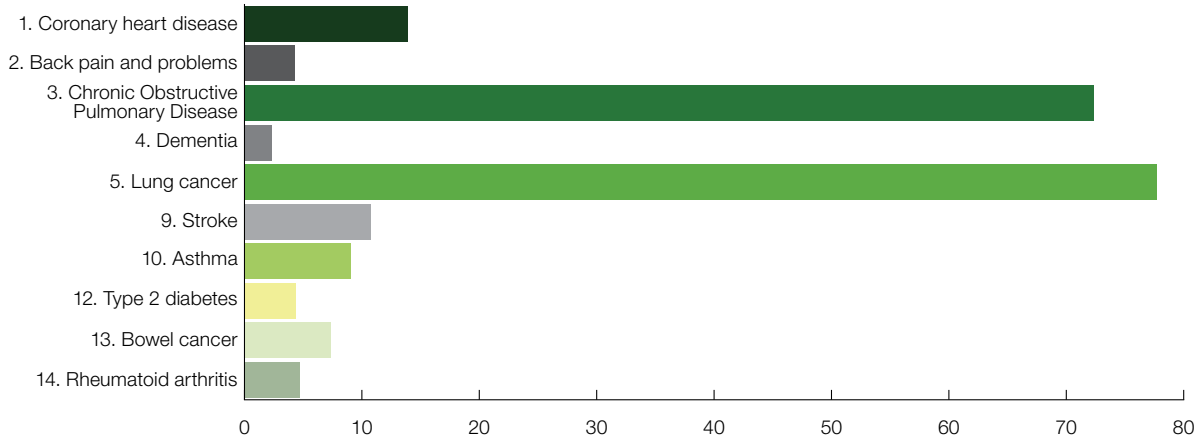
This Strategy builds on the achievements of and lessons learned from previous National Tobacco Strategies which have been in place since 1999. These strategies have outlined a comprehensive and evidence-based approach to tobacco control in Australia, with the most recent National Tobacco Strategy 2012–2018 emphasising nine priority areas.[9] Achievements under the 2012–2018 Strategy are summarised in Part 1.2 of this document. Priorities and actions from the 2012–2018 Strategy that remain relevant have been carried over to this Strategy to ensure continued focus, investment and action.

This Strategy recognises Australia's obligations as a Party to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC). The WHO FCTC aims to advance international cooperation to protect present and future generations from the preventable and devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.[10]

The WHO FCTC commits Parties to implement tobacco control measures, including policies on tobacco price and tax increases; prohibiting or restricting tobacco advertising, promotion and sponsorship; requiring labelling with more prominent health warnings; preventing and reducing tobacco consumption and nicotine addiction; protecting against exposure to second-hand smoke; funding tobacco cessation interventions, education and public awareness activities; and combating illicit trade.[11] The WHO FCTC also obliges Australia to take steps to protect its tobacco control policy making and implementation from interference from the tobacco industry and its interests. The Australian Government reports every two years to the Conference of the Parties on Australia's progress in implementing the WHO FCTC.[12]

This Strategy also recognises the relationship between tobacco control and Australia's commitment to the United Nations (UN) Sustainable Development Goals (SDGs). The SDGs were adopted by the UN General Assembly on 25 September 2015 and include 17 goals and 169 targets to be achieved by 2030, with the aim to *"end poverty, protect the planet, and ensure prosperity for all as part of a new sustainable development agenda"*.[13] Many of the SDGs have a direct or indirect relation to tobacco control, and further reducing tobacco use will play a major role in global efforts to achieve the SDG target to reduce premature deaths from noncommunicable diseases by one third by 2030.[14]

Figure 2: Contribution of tobacco to diseases* ranked in top 15 for highest total burden (DALYs) in Australia, 2015



Source: Australian Burden of Disease Study 2015
*Excludes mental health disorders

1.2 Progress and Achievements To Date

Progress and achievements under the National Tobacco Strategy 2012–2018

The National Tobacco Strategy 2012–2018 delivered many achievements. A number of measures were introduced by the Australian Government to reduce the affordability of tobacco products. Most notably, staged 12.5% increases in tobacco excise and excise-equivalent customs duty were implemented annually from December 2013 to September 2020. On 1 March 2014, the basis for the bi-annual indexation of tobacco products was also changed from the Consumer Price Index to a measure based on Average Weekly Ordinary Time Earnings to ensure that tobacco products do not become relatively more affordable over time.

From December 2012, all tobacco products in Australia were required to be sold, offered for sale or otherwise supplied in plain packaging and feature graphic health warnings, which were expanded and updated under the *Competition and Consumer (Tobacco) Information Standard 2011*. The implementation of tobacco plain packaging was a world first and eliminated a major form of tobacco advertising and promotion in Australia. State and territory governments also took additional steps to prohibit and/or further restrict the advertising, display, promotion and sale of tobacco products, particularly in point-of-sale settings.

Australian governments continued to invest in tobacco control mass media and other social marketing campaigns to motivate smokers to quit and recent quitters to continue smoking abstinence, discourage the uptake of smoking and reshape social norms about smoking. Major investments were also made to reduce tobacco use among Aboriginal and Torres Strait Islander people and other populations with a high prevalence of smoking.

Nicotine replacement therapies (NRT) for smoking cessation have become increasingly accessible for individuals attempting to quit smoking through the Pharmaceutical Benefits Scheme (PBS), with the additional listing of nicotine gums and lozenges in February 2019. Other pharmacotherapies for smoking cessation, such as varenicline and bupropion, are also available on the PBS. In March 2014, an additional course of varenicline was made available through the PBS to patients who have been unsuccessful in achieving smoking abstinence during or after an initial course of PBS-subsidised varenicline.

Smoke-free laws were strengthened in most states and territories to capture e-cigarettes and/or cover a wider range of public places and other settings such as outdoor dining areas, public transport settings, custodial settings and in cars when children are present.

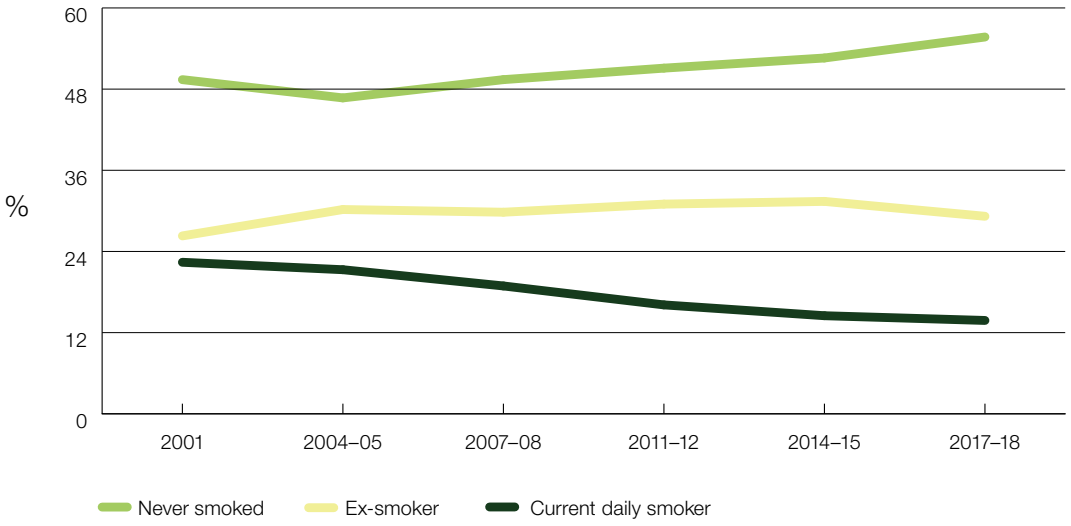
Other key achievements included significant investments by the Australian Government to prevent and minimise the trade in illicit tobacco and the publication of Australian Government guidance regarding the legal obligations placed on public officials under Article 5.3 of the WHO FCTC (see Part 3.1 for further detail).

Changes in smoking prevalence

Australia has made significant progress in reducing smoking prevalence over many years. The prevalence of daily smoking among adults aged 18 years and over was 13.8% in 2017–18, a decline from 16.1% in 2011–12 and 23.8% in 1995.[15] The proportion of never smokers also increased from 50.9% in 2011–12 to 55.7% in 2017–18.[16]

Tobacco use among children and young adults fell to unprecedented levels during the period of the 2012–2018 Strategy. The average age at which young people aged 14–24 years smoked their first full cigarette increased significantly from 15.4 years in 2010 to 16.3 years in 2016.[17] Although preventing the uptake of smoking

Figure 3. Persons aged 18 years and over — Proportion by current smoker status, 2001 to 2017–18



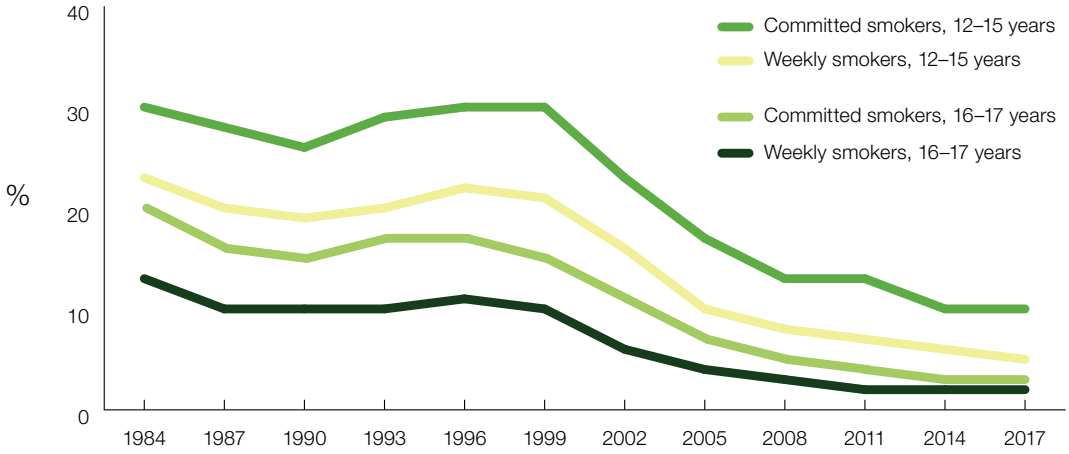
Source: Australian Bureau of Statistics. National Health Survey: first results, 2017–18. Cat. no. 4364.0.55.001. Canberra: ABS; 2018.

among all young people is preferable, delaying the age when young people first experiment with tobacco products can reduce the risk that they transition to regular or daily smoking and increase their chances of successfully quitting, if they do become regular users. Delaying the use of tobacco may also help reduce the duration and intensity of a person's smoking, factors which are strongly associated with tobacco attributable disease and premature death.[18]

The proportion of secondary school students who have never smoked increased from 77% in 2011 to 82% in 2017,[19] while the proportion of young adults aged 18–24 years who have never smoked also increased from 64% in 2007–08 to 75% in 2017–18.[20] Between 1984 and 2017, the proportion of teenagers smoking at least once in the previous week has declined from over 30% to 9% among 16–17 year-olds, and from 20% to just 3% among 12–15 year-olds. In 2017, 1% of teenagers aged 12–15 years had smoked more than 100 cigarettes in their lifetime.[21]

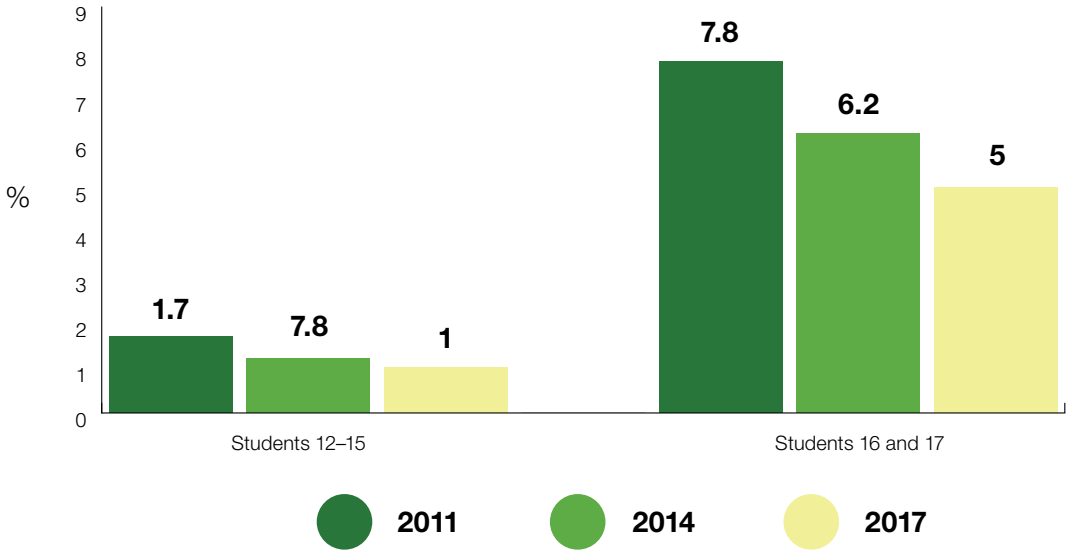
Substantial progress was also made in reducing exposure to secondhand smoke in homes with children aged 14 years or younger. In 2019, 2.1% of households with dependent children had an adult who smoked daily inside the home, compared with 19.7% in 2001.[22]

Figure 4. Prevalence of Australian secondary school students who report smoking in the last week, and percentage smoking at least three days in the last seven, Australia 1984 to 2017 — 12–15 year olds and 16–17 year olds



Sources: Guerin and White, 2018 and Centre for Behavioural Research in Cancer

Figure 5. Percentage of Australian teenagers, aged 12–15 and 16–17 years, who have ever smoked at least 100 cigarettes, 2011, 2014, 2017



Source: Guerin N and White V. Australian secondary students' use of tobacco, alcohol, over-the-counter drugs, and illicit substances. ASSAD 2017 Statistics & Trends. Melbourne: Cancer Council Victoria; 2018.

Populations with a high prevalence of tobacco use and populations at a higher risk of harm from tobacco use

Aboriginal and Torres Strait Islander populations

Findings published by the Australian Bureau of Statistics (ABS) showed that the proportion of Aboriginal and Torres Strait Islander people aged 15 years and over using tobacco has decreased from 41% in 2012–13 to 37% in 2018–19.[23]

The ABS reported on their analysis of trends in smoking prevalence, which accounted for the significant demographic changes in the Aboriginal and Torres Strait Islander population over time. The analysis compared the time period 1994 to 2004–05 'pre-investment in tobacco control' to 2008 to 2014–15 'post investment in Indigenous tobacco control', and found:

- declines in smoking rates in Aboriginal and Torres Strait Islander people aged 18 years and over (2.1 percentage point decline per year) in the investment period, compared to the 0.7 percentage point per year upward trend in smoking rates in the pre-investment period; and
- declines in smoking initiation in the investment period (1.9 percentage points per year), compared to no decline in the pre-investment period.[24]

The ABS concluded that specific funding for Aboriginal and Torres Strait Islander tobacco control since 2008 has contributed to the decline in smoking rates among Indigenous Australians.

Despite these declines, the prevalence of tobacco use among Aboriginal and Torres Strait Islander people remains very high in comparison to the general population and active measures need to be taken by all jurisdictions to reduce tobacco use in this population.

Other populations with a high prevalence of tobacco use or at a higher risk of harm from tobacco use

Progress in reducing smoking prevalence was also seen across all levels of remoteness in Australia. Between 2011–12 and 2017–18, daily smoking prevalence among adults aged 18 years and over declined from 14.7% to 12.7% among those living in major cities, from 18.5% to 15.4% among those living in inner regional Australia, and from 22.4% to 19% in outer regional and remote areas.[25]

Significant reductions in smoking prevalence were also observed in several other population groups during the period of the previous Strategy. In 2018, 9.6% of pregnant women who gave birth smoked at any time in their pregnancy, a decline from 14.6% in 2009.[26]

1.3 What Challenges Remain?

Despite Australia's success over many years in reducing the prevalence of tobacco use, significant challenges remain. In 2015–16, the costs of tobacco use borne by the Australian community were estimated to be $137 billion.[27] Tobacco use also remains the biggest contributor to Australia's preventable health burden, contributing 9.3% of the total burden of disease in Australia in 2015.[28]

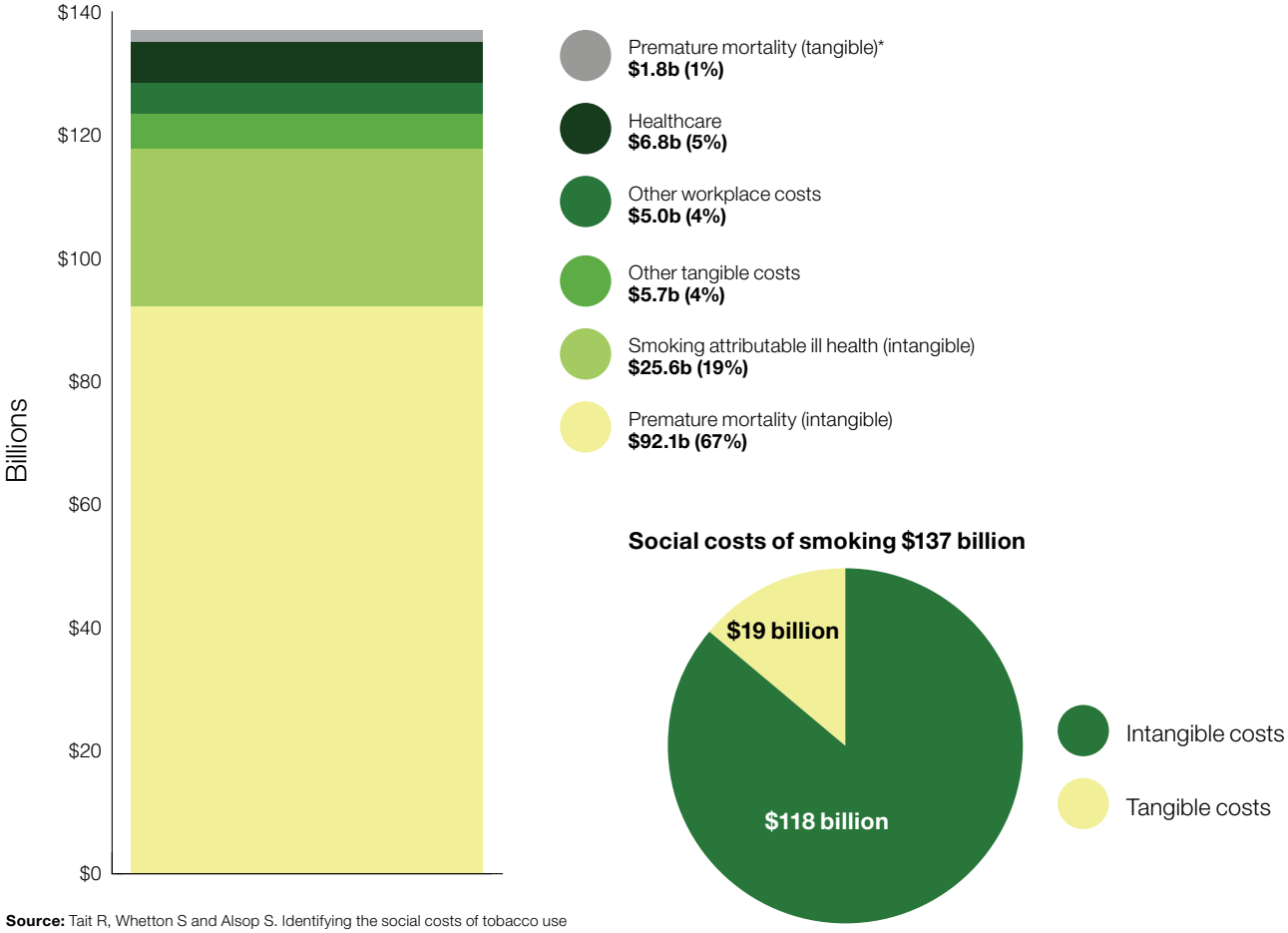
Tobacco use compounds health and social inequalities and is a major contributor to poorer health status in socioeconomically disadvantaged populations. In 2015, the tobacco attributable burden in Australia was more than 2.5 times higher in the lowest socioeconomic group compared to the highest socioeconomic group.[29]

The tobacco industry and its interests continue to resist and pose major challenges to Australia's efforts in tobacco control. As noted by the United States (U.S.) Surgeon General, the tobacco industry is the root cause of the tobacco epidemic and continues to aggressively market and promote lethal and addictive products, whilst recruiting children as new consumers of tobacco products.[30] Alongside efforts to maintain their core business in the marketing of tobacco products and determined opposition to evidence-based measures to reduce tobacco use, the tobacco industry has continued to invest in a range of novel and emerging products, including e-cigarettes.[31]

During the period of the 2012–2018 Strategy, rates of e-cigarette use among children and youth increased markedly in numerous markets globally, particularly in the U.S. Further growth in the marketing and use of novel products such as e-cigarettes has the potential to undermine population health and the significant achievements Australia has made in tobacco control to date. Reducing the use of tobacco products, e-cigarettes and other novel products will necessarily reduce the profits of the industries that market them. However, their resistance to the measures required cannot be allowed to undermine government efforts to protect population health and reduce tobacco attributable death and disease.

Encouragingly, the history of tobacco control in Australia and other countries shows that tobacco use can be substantially reduced over time through commitment to, and the implementation of, comprehensive and evidence-based measures. Avoiding complacency and re-emphasising that tobacco use remains the largest preventable cause of death must create a sense of urgency for further actions to be taken to reduce tobacco use in Australia.

Figure 6. Distribution of intangible and tangible costs of smoking in 2015/16



Source: Tait R, Whetton S and Alsop S. Identifying the social costs of tobacco use in Australia in 2015/16. Perth: National Drug Research Institute, Curtin University; October 2019.

PART TWO: THE FRAMEWORK

2.1 The Goal

The goal of this Strategy is *"to improve the health of all Australians by reducing the prevalence of tobacco use and its associated health, social, environmental and economic costs, and the inequalities it causes."*

This Strategy aims to achieve a national daily smoking prevalence of less than 10% by 2025 and 5% or less by 2030 in Australia, consistent with the commitments of the National Preventive Health Strategy and other countries which have announced plans and targets to eliminate tobacco.[32, 33]

Other national strategies, such as Australia's first National Strategic Action Plan for Lung Conditions (published in February 2019), are also supportive of the need for a new sense of urgency to overcome the challenges of substantially reducing the national smoking prevalence and working towards a tobacco free society.[34]

While these targets are ambitious, substantial progress will be made towards achieving them if the actions in this Strategy are fully implemented.

2.2 The Objectives

The objectives of the Strategy are to:

- Prevent uptake of tobacco use;
- Prevent and reduce nicotine addiction;
- Encourage and assist as many people who use tobacco to quit as soon as possible, and prevent relapse;
- Prevent and reduce tobacco use among Aboriginal and Torres Strait Islander people;
- Prevent and reduce tobacco use among groups at higher risk from tobacco use, and other populations with a high prevalence of tobacco use;
- Eliminate harmful exposure to tobacco smoke;
- Prevent and reduce harms associated with the marketing and use of novel and emerging products;
- Ensure that tobacco control in Australia is guided by focussed research, monitoring and evaluation;
- Protect tobacco control policy from all commercial and other vested interests; and
- Ensure all of the above contribute to the continued denormalisation of the tobacco industry and tobacco use.

2.3 Priority Areas

This Strategy identifies 11 priority areas for future action. These priority areas have been informed by an extensive evidence-base and reflect best practice approaches to tobacco control.

Most of the priority areas identified in this Strategy build on those that were included in the 2012–2018 Strategy. This reflects that much of the scope and structure of the 2012–2018 Strategy remains relevant. However, this Strategy places a greater emphasis on reducing the supply, availability and accessibility of tobacco products, regulating the contents and product disclosures pertaining to tobacco products, and taking concerted action to minimise the risks associated with the marketing and use of novel and emerging products.

This Strategy also maintains a strong commitment to reducing the social and health inequalities associated with tobacco use. It strongly emphasises working in partnership with Aboriginal and Torres Strait Islander people and other populations with a high prevalence of tobacco use.

The 11 priority areas are:

1. Protect public health policy, including tobacco control policies, from tobacco industry interference;

2. Develop, implement and fund mass media campaigns and other communication tools to: motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use;

3. Continue to reduce the affordability of tobacco products;

4. Continue and expand efforts and partnerships to reduce tobacco use among Aboriginal and Torres Strait Islander people;

5. Strengthen efforts to prevent and reduce tobacco use among populations at a higher risk of harm from tobacco use and other populations with a high prevalence of tobacco use;

6. Eliminate remaining tobacco related advertising, promotion and sponsorship;

7. Further regulate the contents and product disclosures pertaining to tobacco products;

8. Strengthen regulation to reduce the supply, availability and accessibility of tobacco products;

9. Strengthen regulations for novel and emerging products;

10. Eliminate remaining exceptions to smoke-free workplaces, public places and other settings; and

11. Provide greater access to evidence-based cessation services to support people who use tobacco to quit.

2.4 Guiding Principles

Working in Partnership

Governments will work collaboratively to achieve national consistency in tobacco control approaches and the goals under the Strategy. However, reducing the prevalence of tobacco use cannot be achieved by governments alone and a strength of Australia's approach to tobacco control has been the strong and enduring partnerships developed between governments, NGOs, healthcare professionals, research groups and community groups.

Under this Strategy, governments and NGOs, healthcare professionals, research groups and community groups will:

- Strengthen long standing partnerships;
- Identify and form new partnerships in order to expand opportunities for tobacco control interventions within health and community settings; and
- Build the capacity of organisations and healthcare professionals to implement tobacco control programs.

A priority will be to strengthen existing partnerships between governments, NGOs and Aboriginal and Torres Strait Islander communities and community-controlled organisations. It will also be important to explore partnerships with mainstream services to ensure culturally safe smoking cessation support for Indigenous Australians. These partnerships will underpin the continued development and implementation of policies and programs to tackle tobacco use among Aboriginal and Torres Strait Islander people and contribute to efforts to close the gap in health outcomes.

New partnerships will be forged between health agencies, social service organisations, mental health care providers and corrections services to reduce smoking prevalence and exposure to secondhand smoke among populations at a higher risk of harm from tobacco use and other populations with a high prevalence of tobacco use.[35]

Australia will continue to engage in international partnerships to maximise the effectiveness of global tobacco control efforts and to learn and share best practice approaches to reducing tobacco related harm. Australian government agencies and NGOs will continue to engage with developing countries, particularly in the Asia-Pacific region, to provide assistance on tobacco control. Under this Strategy, Australia will also continue to actively engage in global tobacco control forums including the Conference of the Parties of the WHO FCTC.

The Evidence Base for Tobacco Control

Evidence about the harms caused by tobacco use is overwhelming. An extensive body of evidence has identified interventions effective in reducing tobacco use. Over the past 50 years, Australian researchers have been important contributors to strengthening this evidence base.

Tobacco control in Australia is underpinned by a commitment to evidence-based policy. Where the evidence does not yet exist on the most effective interventions, Australia will be guided by the best available information and conduct robust evaluation that contributes to the future evidence base. Ensuring that all involved in tobacco control can access the latest evidence and knowledge about tobacco control policies and issues is a priority. Partners will continue to support the free online publication *Tobacco in Australia: Facts and Issues*, a comprehensive review of the major issues in tobacco control, smoking and health in Australia.[36]

Protection from all commercial and other vested interests

Tobacco companies have employed sophisticated strategies to undermine the development and implementation of the WHO FCTC.[37] Studies have also illustrated tactics employed by the tobacco industry to attempt to counter Australian tobacco control policies.[38]

Article 5.3 of the WHO FCTC requires that *"in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law"*.[39] Strengthening Australia's implementation of Article 5.3 is a priority under this Strategy (see Priority Area 3.1 for further information).

This Strategy also recognises the need to protect Australia's tobacco control settings from all other commercial and vested interests. Consistent with this approach, relevant Commonwealth and state and territory Ministers have affirmed the importance of protecting public health policy from all commercial and other vested interests related to e-cigarettes, including the interests of the tobacco industry.[40]

Protecting Australia's tobacco control settings from all commercial and other vested interests also accords with Australia's obligations under Article 14 of the WHO FCTC (demand reduction measures concerning tobacco dependence and cessation).[41]

Compliance and enforcement of tobacco control legislation

Enforcement of tobacco control legislation in Australia has become increasingly important as a result of strategies devised by the tobacco industry, e-cigarette industry and their associated interests to exploit and evade these regulations. A stronger focus on enforcing regulations pertaining to tobacco products as well as novel and emerging products is necessary to protect the health of all Australians, and prevent the increasing uptake in the use of e-cigarettes and other novel and emerging products seen in other countries.

Effective monitoring of the tobacco supply chain at all stages will help identify the points at which illicit tobacco activity emerge and how the supply chain can be better secured to prevent infiltration. Evidence obtained through monitoring can also inform options to deter participation in illicit tobacco trade, such as severe penalties for those involved and other dissuasive law enforcement measures. Investment in research and evaluation in this area is necessary to help address gaps in enforcement and guide the development of a nationally consistent and evidence-based approach to tobacco control compliance and enforcement.

Further actions to strengthen compliance and enforcement of tobacco control legislation are included under the priority areas of this Strategy.

PART THREE: PRIORITY AREAS AND ACTIONS

Priority Area 1: Protect public health policy, including tobacco control policies, from tobacco industry interference

In November 2008, Parties to the WHO FCTC adopted Article 5.3 Guidelines for implementation. The Article 5.3 Guidelines were developed in recognition that *'the tobacco industry has operated for years with the express intention of subverting the role of governments and the WHO in implementing public health policies with respect to tobacco control'*. The Article 5.3 Guidelines recognise the fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests.[42]

The purpose of the Article 5.3 Guidelines is to ensure that efforts to protect tobacco control from commercial and other vested interests of the tobacco industry are comprehensive and effective. The Article 5.3 Guidelines also note that relevant measures should be implemented across all branches of government that may have an interest in, or the capacity to, affect public health policies with respect to tobacco control. Article 5.3 Guideline recommendations include:

- Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties' tobacco control policies;
- Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur;
- Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry;
- Avoid conflicts of interest for government officials and employees;
- Require that information provided by the tobacco industry be transparent and accurate;
- Denormalise and, to the extent possible, regulate activities described as "socially responsible" by the tobacco industry, including but not limited to activities described as "corporate social responsibility"; and
- Do not give preferential treatment to the tobacco industry.[43]

Parties to the WHO FCTC continue to report that the tobacco industry remains one of the biggest barriers to implementing the WHO FCTC.[44] Indeed, the WHO Expert Group reviewing the Impact of the FCTC concluded that *"the role and activities of the global tobacco industry remain by far the most important obstacle to action across all aspects of the FCTC"*. Evidence has also highlighted that selective and incomplete approaches to the implementation of Article 5.3 facilitate diverse opportunities for tobacco industry interference in tobacco control policies.[45]

Evidence from Australia and overseas also reinforces the need to ensure that efforts to protect tobacco control from commercial and other vested interests of the tobacco industry also extend to individuals and organisations whose interests may be aligned with the tobacco industry. This includes the tobacco industry's practice of using individuals, front groups and affiliated organisations to act, openly or covertly, on their behalf or to take action to further their interests.

The Australian Government has published *Guidance for Public Officials on Interacting with the Tobacco Industry* (the Guide).[46] The Guide outlines how all Australian Government agencies, officials and people acting on their behalf can deliver tobacco control policies in line with Australia's legal obligations under Article 5.3 of the WHO FCTC. The Guide will be reviewed during the life of this Strategy to ensure that the document remains current and comprehensive.

This priority area refers to a number of measures to further implement Australia's obligations under Article 5.3 of the WHO FCTC. However, this does not limit government organisations and NGOs from implementing additional measures beyond those explicitly recommended in the Article 5.3 Guidelines or the Guide.

Actions for Priority Area 1

1.1 Increase awareness among the public, government and non-government organisations about Article 5.3 and tobacco industry practices, including tobacco industry interference in tobacco control policies.
Responsibility: Australian Government, state and territory governments, NGOs.

1.2 Strengthen Australia's implementation of Article 5.3 and the Article 5.3 Guidelines through the development of further policy and regulatory approaches.
Responsibility: Australian Government, state and territory governments, NGOs.

1.3. Further develop and implement measures that limit interactions between governments and the tobacco industry to the extent strictly necessary to enable effective regulation of the tobacco industry and tobacco products, and ensure transparency of interactions that do occur.
Responsibility: Australian Government, state and territory governments.

1.4 Develop and implement measures to prohibit contributions from the tobacco industry and those working to further its interests to political parties, candidates or campaigns, or to require full disclosures of such contributions.
Responsibility: Australian government, state and territory governments.

1.5 Develop regulatory options to require the tobacco industry and those working to further its interests to periodically submit information on tobacco production, manufacture, market share, marketing expenditures, revenues and any other activity, including lobbying, philanthropy, and political contributions.
Responsibility: Australian Government, state and territory governments.

1.6 Review existing legislation and other arrangements and identify best practice policy approaches to prevent and avoid conflicts of interest and perceptions of preferential treatment, partnerships or non-binding agreements between Australian governments and the tobacco industry.
Responsibility: Australian Government, state and territory governments.

1.7 Explore the feasibility of regulating activities described as 'socially responsible' by the tobacco industry, and implement as appropriate.
Responsibility: Australian Government, state and territory governments.

1.8 Strengthen measures to monitor and evaluate Australia's implementation of Article 5.3 and the Article 5.3 Guidelines.
Responsibility: Australian Government, state and territory governments, NGOs.

1.9 Monitor international legal action undertaken against the tobacco industry and explore the feasibility of pursuing similar activities in Australia, including the release of corporate documents as part of settlement agreements.
Responsibility: Australian Government, state and territory governments.

Priority Area 2:
Develop, implement and fund mass media campaigns and other communication tools to: motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use

Reviews provide strong evidence that well-funded and sustained public education campaigns increase quitting and reduce smoking prevalence when implemented within the context of a comprehensive tobacco control program.[47,48] Campaigns, on average, are highly cost-effective.[49,50] Comprehensive tobacco control programs that include mass media campaigns can reduce smoking initiation,[51] increase quitting intentions and behaviours, and reduce smoking prevalence in adults.[52] Campaign reach, intensity and duration and the type of message are determinants of overall effectiveness.[53]

Article 12 of the WHO FCTC requires each Party to promote and strengthen public awareness of tobacco control issues, using all available communication tools.[54]

Mass media campaigns

Evidence confirms that mass media campaigns that are evidence-based in both their creative development and audience exposure are effective in reducing smoking prevalence across all socioeconomic groups. However, to maximise effectiveness, messages need to be broadcast broadly at a sufficient volume and at regular intervals to people who smoke.[55]

Evidence also suggests that mass media messages delivered via television remain an effective way to reach the Australian community, particularly among disadvantaged populations who continue to have much higher smoking rates than the general population.[56] The ongoing decline in the use of traditional media and increase in the use of digital media during the life of the previous Strategy reinforces the importance of moving quickly and continuing to monitor the appropriateness and effectiveness of recommended media weights and channels.

To ensure that future investments in this area are optimised, coordination and evaluation activities between government and NGOs will be strengthened under this Strategy.

Other forms of public education

Tobacco packaging and labelling measures are another effective way to: help motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use.

Since the initial development of the graphic health warnings in Australia in 2006, epidemiological research has linked many additional conditions and diseases to the use of tobacco. Many consumers are unaware of these health risks and lack understanding of the far-reaching ways in which smoking can affect their health.[57] Evidence is emerging that including information about toxic constituents on prominent health warnings increases awareness of these constituents and smoking-related conditions and may increase perceived risks of smoking.[58]

An evaluation of the graphic health warnings on tobacco packaging in 2018 showed that the warnings have increased consumer knowledge of the health effects relating to tobacco use and have encouraged the cessation of smoking.[59] The evaluation highlighted a need to reconsider the range of health warnings on tobacco products including images, warning statements and written information, and that health warnings and messages on tobacco packaging should be rotated frequently to ensure that the messages remain impactful.[60] The evaluation also recommended that if new or surprising information is used in graphic health warnings, complementary information through other communication channels can reinforce messaging and credibility.

The news media can convey information and messages about the harms of tobacco use and the practices of the tobacco industry to very large proportions of the population. Australian governments, tobacco control researchers, the non-government sector, and campaign workers will facilitate this wherever possible.[61]

Actions for Priority Area 2

2.1 Run mass media campaigns (including television, digital media, radio, and print formats) that are evidence-based in their creative development and that are at levels of reach and frequency demonstrated to reduce smoking prevalence.
Responsibility: Australian Government, state and territory governments, NGOs.

2.2 Continue complementary mass media campaigns targeted at high prevalence populations and populations at a high risk of harm from tobacco use.
Responsibility: Australian Government, state and territory governments, NGOs, Aboriginal and Torres Strait Islander health organisations such as the National Aboriginal Community Controlled Health Organisation and state/territory affiliates.

2.3 Continue to monitor the appropriateness and effectiveness of recommended media weights and mediums/channels, including exploring the role of emerging social and digital media in tobacco control campaigns.
Responsibility: Australian Government, state and territory governments, NGOs.

2.4 Continuously improve the effectiveness of mass media campaigns with rigorous developmental research and campaign evaluation to inform and refine future campaign development.
Responsibility: Australian Government, state and territory governments, NGOs.

2.5 Strengthen communication and collaborative action between the Australian Government, state and territory governments and NGOs to maximise the effectiveness of mass media campaigns and other tobacco control public education campaigns.
Responsibility: Australian Government, state and territory governments, NGOs.

2.6 Continue to share campaign materials, evaluations and other evidence of effectiveness of public education campaigns with the global tobacco control community.
Responsibility: Australian Government, state and territory governments, research organisations, NGOs.

2.7 Update the range of graphic health warnings on tobacco products to cover additional health effects now established to be caused by smoking, with evidence-based content and presentation; continue to monitor the need for further updates.
Responsibility: Australian Government.

2.8 Complement the development of new graphic health warnings on tobacco products with other evidence-based messages to: motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use.
Responsibility: Australian Government, state and territory governments.

Priority Area 3:
Continue to reduce the affordability of tobacco products

Reducing the affordability of tobacco products through tobacco tax increases is the single-most effective measure that Governments can adopt to reduce smoking.[62] Real price increases used in tandem with mass-media advertising campaigns have had an even stronger, synergistic benefit. Article 6 of the WHO FCTC recognises that price and tax measures are an effective and important means of reducing tobacco consumption, particularly among young people and lower income populations.[63]

Some stakeholders, including the tobacco industry and its allies, have claimed that tobacco taxes are regressive. However, as affirmed by a 2019 report from the World Bank, when all relevant costs and benefits are taken into account, the effects of raising taxes on tobacco are progressive and welfare-increasing.[64]

The tobacco industry continues to use calculated strategies to undermine the public health effects of tobacco excise increases. These include the sale of large packs of manufactured cigarettes and small pouches of roll-your-own tobacco,[65] as well as the sale of odd pack and pouch sizes to create confusing price signals. Other strategies include absorbing tax increases in the cheapest segments of the market, introducing new cheaper products, the sale of discounted tobacco through favourable deals with high-volume retailers, and gradually introducing price increases to cushion the effect of excise increases.[66] Governments need to counter these strategies and strengthen monitoring and surveillance in this area. Related issues regarding tobacco advertising, promotion and sponsorship are discussed in Priority Area 6.

Illicit trade in tobacco products also undermines efforts to reduce the affordability of tobacco products. Notably, evidence from Australia and overseas has demonstrated that substantial increases in tobacco excise can be achieved without substantial increases in the illicit tobacco trade. Findings from the Australian Taxation Office's (ATO) tobacco tax gap analysis[ii] show that the net size of the illicit tobacco market relative to the licit market in Australia has remained low, declining from 5.5% in 2015–16 to 5% in 2017–18 in net terms.[67] Measures to address the illicit tobacco trade are discussed in more detail under Priority Area 8.

Actions for Priority Area 3

3.1 Continue to monitor the need for, and benefit of, changes in tobacco excise and excise-equivalent customs duty.
Responsibility: Australian Government.

3.2 Amend the Commonwealth *Tobacco Plain Packaging Act 2011* to standardise pack sizes of manufactured cigarettes and roll-your own-tobacco products.
Responsibility: Australian Government.

3.3 Review tobacco industry strategies and other practices that may be undermining the public health benefits of tobacco excise increases and implement strategies to prevent and minimise these practices.
Responsibility: Australian Government, state and territory governments, NGOs.

3.4 Analyse the effects of tobacco excise increases, including on young people and in low income populations.
Responsibility: Australian Government, state and territory governments, NGOs.

3.5 Complement tobacco excise increases with additional efforts to motivate and support quit attempts among low income populations.
Responsibility: Australian Government, state and territory governments, NGOs.

3.6 Complement tobacco excise increases with additional efforts to prevent and minimise the illicit tobacco trade.
Responsibility: Australian Government, state and territory governments.

3.7 Explore the potential impacts, feasibility and best practice regulatory approaches to further reduce affordability of tobacco products, such as introducing a minimum floor price on tobacco products and once-only price changes after each excise increase.
Responsibility: Australian Government.

ii Data relating to tobacco tax gap estimates will be updated pending the release of the ATO's tobacco tax gap analysis for 2018–19.

Priority Area 4:
Continue and expand efforts and partnerships to reduce tobacco use among Aboriginal and Torres Strait Islander people

Tobacco use is the most significant modifiable risk factor contributing to the gap in health status between Indigenous and non-Indigenous Australians and is responsible for 12% of the total preventable health burden for Aboriginal and Torres Strait Islander people.[68]

In Indigenous adults aged 18 years and over, the daily smoking rate has steadily decreased from 50% in 2004–05 to 40% in 2018–19. However, the proportion remains higher for people living in remote areas (49%) than in non-remote areas (35%), and the proportion of Indigenous smokers in remote areas has not changed significantly since 2004–05.[69]

Challenges to effective smoking cessation outcomes in remote areas are multi-faceted, in many cases location-specific, and include underlying social determinants such as high unemployment rates, poverty, overcrowding and access to/uptake of services and treatments to support smoking cessation; the normalisation of smoking behaviours, including in children, particularly in locations where smoking rates are high; the impacts of economic interdependence and the sharing of tobacco products in locations with very small populations; and the reduced likelihood of tobacco regulations being enforced, including the comparative lack of smoke-free areas, media campaigns, services and cessation support when compared to non-remote areas.

Indeed, strong social norms in many Aboriginal and Torres Strait Islander communities reinforce high smoking prevalence among Aboriginal people. However, many Aboriginal and Torres Strait Islander people want to quit smoking. In 2018–19, 51.4% of Indigenous smokers aged 15 years and over had tried to quit smoking in the previous 12 months.[70]

In December 2007, all Australian governments agreed to close the gap in life expectancy between Aboriginal and Torres Strait Islander people and the general population within a generation,[71] and reducing smoking prevalence is integral to this goal. The WHO FCTC recognises the high levels of smoking and other forms of tobacco consumption by Indigenous peoples, as well as the need to take measures to promote the participation of Indigenous individuals and communities in the development, implementation and evaluation of tobacco control programs.[72]

In the context of Australia's approach to tobacco control, continuation of targeted investments to support culturally safe and locally relevant approaches will continue to be important for further reduced smoking prevalence among Aboriginal and Torres Strait Islander people. Several priority groups within the Aboriginal and Torres Strait Islander population will also require a particular focus:

- **Remote areas:** The prevalence of daily Aboriginal and Torres Strait Islander tobacco use in remote areas has not decreased as it has in non-remote areas and additional approaches should be explored.[73]
- **Pregnant women:** While the proportion of Aboriginal and Torres Strait Islander women who smoke during pregnancy is falling (from 52% in 2009 to 44% in 2018), it is still over three and a half times the smoking rate for non-Indigenous mothers.[74]
- **Young people:** While there have been large reductions in tobacco use rates among young Indigenous Australians, they are significantly higher than those of their non-Indigenous peers. To reduce uptake among Aboriginal and Torres Strait Islander young people, it will continue to be important to address broader social normative beliefs about tobacco use (e.g. through primary health care brief interventions and further increase the establishment of smoke-free homes and public places).[75]
- **Prisoners:** The prevalence of tobacco use among people entering prison is much higher than in the general community, and especially so for Indigenous Australians, three quarters (73%) of whom report smoking daily.[76] While prisons in most states and territories are now smoke-free, most prisoners recommence smoking on release.[77] Culturally appropriate support to quit tobacco use should be provided within prisons, with referral to local Aboriginal Community Controlled Health Services on release for assistance with remaining smoke-free.

Other priorities in this Strategy will additionally benefit the Aboriginal and Torres Strait Islander population as they affect the whole population. Measures under these priorities will also need to support Aboriginal and Torres Strait Islander people who live in areas outside the reach of Tackling Indigenous Smoking funded programs.

Actions for Priority Area 4

4.1 Continue existing Commonwealth investment in multi-faceted and culturally safe approaches to reduce tobacco use among Aboriginal and Torres Strait Islander people, and expand state and territory investments to complement and reinforce these approaches.
Responsibility: Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream services.

4.2 Monitor and evaluate the effects of these initiatives to improve future programs to reduce tobacco use among Aboriginal and Torres Strait Islander people.
Responsibility: Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream services.

4.3 Continue to build tobacco control capability and capacity for Aboriginal and Torres Strait Islander communities within Aboriginal community-controlled organisations and mainstream services.
Responsibility: Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream services.

4.4 Support Aboriginal and Torres Strait Islander organisations in their efforts to promote the benefits of being smoke-free, as reflected in their organisational policies and community programs.
Responsibility: Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream services.

4.5 Strengthen partnerships and collaboration between Aboriginal and Torres Strait Islander organisations, governments and NGOs.
Responsibility: Australian Government, state and territory governments, Aboriginal and Torres Strait Islander organisations, mainstream services, NGOs.

4.6 Continue to provide training to Aboriginal and Torres Strait Islander health workers and other relevant workers on effective tobacco control interventions.
Responsibility: Australian Government, state and territory governments, other training providers. Aboriginal community-controlled organisations, mainstream services.

4.7 Deliver best practice and culturally safe screening and tobacco use cessation as part of all routine health service delivery, and social and community service provision to Aboriginal and Torres Strait Islander clients.
Responsibility: Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream health services, government and non-government social service providers.

4.8 Ensure Aboriginal and Torres Strait Islander people have appropriate access to subsidised nicotine replacement therapy and other cessation supports, identify any barriers to access and uptake of tobacco use cessation services, and develop strategies to overcome these barriers.
Responsibility: Australian Government, state and territory governments, Aboriginal and Torres Strait Islander organisations, mainstream services, NGOs.

4.9 Encourage and support people from Aboriginal and Torres Strait Islander priority groups (i.e. pregnant women, young people, remote populations and prisoners) and their families to quit and provide messages about the harm associated with second-hand smoke exposure.
Responsibility: Australian Government, state and territory governments, Aboriginal and Torres Strait Islander organisations, mainstream services, NGOs.

4.10 Enhance mass media campaigns for Aboriginal and Torres Strait Islander people by complementing them, where appropriate, with Aboriginal and Torres Strait Islander people–specific campaign elements and local community-specific campaigns.
Responsibility: Australian Government, state and territory governments, Aboriginal community-controlled organisations, NGOs.

Priority Area 5:
Strengthen efforts to prevent and reduce tobacco use among populations at a higher risk of harm from tobacco use and populations with a high prevalence of tobacco use

There are a number of population groups for whom tobacco control should be considered a particular priority, including populations that are at a higher risk of harm from tobacco use and populations with a higher prevalence of tobacco use compared to the general population.

Note that while some populations are specifically referenced in this priority area, this does not limit governments or other organisations from targeting other populations at a higher risk of harm from tobacco use or with higher rates of tobacco use.

Populations with higher prevalence of tobacco use than the general population

Interacting psychological, social, economic and cultural factors mean that certain populations are more likely to use tobacco and face more barriers to quitting.[78] Populations in Australia with higher rates of tobacco use than the general population include:

- Aboriginal and Torres Strait Islander populations (see Priority Area 4);
- People living with mental illness;
- People with lower levels of education;
- People from socioeconomically disadvantaged areas;
- People residing in regional and remote areas of Australia;
- People identifying as lesbian, gay, bisexual, transgender and intersex (LGBTI);
- People experiencing drug and/or alcohol dependence;
- People currently in or recently released from prison;
- People who are unemployed;
- People experiencing homelessness;
- People living in lone parent households with dependent children; and
- People who have emigrated from countries with high rates of tobacco use.[79]

Tobacco use is strongly associated with social disadvantage and contributes significantly to health and financial inequalities in Australia. In 2015, people living in the most disadvantaged socioeconomic areas experienced 2.6 times the rate of tobacco attributable death and disease compared to those living in the highest socioeconomic areas.[80] As levels of social disadvantage accumulate, smoking prevalence increases. For example, in 2019, Australians living in the most disadvantaged socioeconomic areas were 3.7 times more likely than those in the most advantaged socioeconomic areas to smoke daily.[81]

Other populations at a higher risk of harm from tobacco use

There are also a number of populations that are more vulnerable to the health harms of tobacco use that may or may not have higher rates of tobacco use than the general population, such as pregnant women, children and youth, and those living with a chronic health condition.

Tobacco use and exposure among pregnant women and their babies is one of the most prevalent preventable causes of infant death and illness and adverse pregnancy outcomes.[82]

Children and young people who are exposed to nicotine can become addicted at lower or more intermittent levels of consumption compared to adults.[83] Evidence also shows that exposure to nicotine during adolescence may result in damaging and long lasting impacts on brain development.[84]

The harms of tobacco use are also likely to be more significant for people living with one or more chronic health conditions, those admitted into hospital settings and/or those who are taking medications. For example, evidence has shown increased levels of all cause mortality for people who continue to use tobacco products after a diagnosis of cancer, decreased effectiveness of chemotherapy and radiotherapy, and reduced effectiveness of certain medications.[85]

Actions for Priority Area 5

5.1 Complement population level measures with targeted policies, programs and investments to prevent and reduce tobacco use among populations with a high prevalence of tobacco use and populations at a higher risk of harm from tobacco use.
Responsibility: Australian Government, state and territory governments, NGOs, social service organisations (both government and non-government).

5.2 Continue to build the evidence base to identify cost-effective approaches to preventing and reducing tobacco use among populations with a high prevalence of tobacco use and for those at a higher risk of harm from tobacco use.
Responsibility: Australian Government, state and territory governments, research organisations, NGOs.

5.3 Increase awareness among populations with a high prevalence of tobacco use and for those at higher risk of harm from tobacco use of the availability of evidence-based support to quit smoking.
Responsibility: Australian Government, state and territory governments, NGOs, social service organisations.

5.4 Implement evidence-based tobacco prevention and cessation programs as part of routine care across all health, social care and custodial settings.
Responsibility: Australian Government, state and territory governments, research organisations, NGOs.

5.5 Embed evidence-based smoking cessation programs across all primary, acute, mental health, drug and alcohol and other health care settings and where applicable, explore the feasibility of mandating these programs as a condition of government funding.
Responsibility: NGOs, Australian Government, state and territory governments.

5.6 Enhance evidence-based tobacco cessation support for prisoners, recently released prisoners, prison staff and their families.
Responsibility: state and territory governments, Australian Government.

5.7 Strengthen collaboration and referral between health services, social services, custodial organisations and tobacco cessation services, such as Quitline services, and identify new partnerships to reduce tobacco use among populations with a high prevalence of tobacco use and for those at higher risk of harm from tobacco use.
Responsibility: Australian Government, state and territory governments, Quitline services, health services, social service organisations.

5.8 Enhance Quitline services for populations with a high prevalence of tobacco use and populations at higher risk of harm from tobacco use.
Responsibility: state and territory governments, Australian Government.

5.9 Consider feasibility of introducing a Census question on tobacco and e-cigarette use and complement this with additional related questions in other government funded surveys to strengthen monitoring of tobacco prevalence in smaller geographic areas and population subgroups.
Responsibility: Australian Government, state and territory governments.

Priority Area 6:
Eliminate remaining tobacco-related advertising, promotion and sponsorship

Tobacco advertising, promotion and sponsorship contribute to an increase in uptake and progression of smoking (particularly among young people), reduce smoking cessation attempts and encourage former tobacco users to relapse. Article 13 of the WHO FCTC recognises that comprehensive bans on tobacco advertising, promotion and sponsorship are needed to decrease tobacco use.[86] However, the tobacco industry continues to market its products through innovative promotional tactics and it is critical that remaining forms of tobacco related advertising, promotion and sponsorship and attempts by the tobacco industry to circumvent the current controls in place are eliminated.

There has been a marked increase in the use of tobacco brand variant names and descriptors. Variant names can enhance the appeal of tobacco products, create misperceptions about relative harmfulness and ease of quitting and contribute to consumer misperceptions regarding product risk.[87] Other ongoing forms of product promotion include the use of filter innovations, cigarette design features and odd pack sizes.

Evidence from Australia and overseas highlights that commercial suppliers of tobacco products also provide numerous avenues for tobacco advertising and promotion. At present, few regulatory requirements govern payments or other contributions to tobacco retailers or wholesalers, or the provision of financial support to venue operators. In some jurisdictions, tobacco products also continue to be included in retailer shopper loyalty or reward programs. These programs reward customers for smoking, as higher rewards go to those who continue to purchase tobacco products.[88, 89] Vending machines, price boards and other signage in retail settings are also opportunistic forms of tobacco advertising for tobacco retailers.

Self-promotion of tobacco companies is a marketing strategy, as is publicity of tobacco industry business practices that may be described as socially responsible. With the exception of some restrictions under state and territory legislation, controls governing these activities in Australia are currently limited. Similarly, regulatory controls prohibiting or restricting sponsorship agreements involving the tobacco industry in Australia are also limited.

New forms of digital media emerging during the period of the last Strategy have been increasingly used to directly and indirectly promote tobacco products by the tobacco industry and individuals and organisations whose interests align with the tobacco industry. This strategic approach evades legislation and controls that apply to traditional forms of marketing. A new focus will be required to monitor, identify and eliminate these forms of promotion.

The portrayal of smoking in digital content, including films, television and computer games, is managed under the classifiable element of themes through the National Classification Code, the Guidelines for the Classification of Films and the Guidelines for the Classification of Computer Games.[90] The Australian Government has commenced a review of Australian classification regulations, which seeks to update the criteria used to classify films, episodic series and computer games, and redesign current classification laws to reflect the current and future digital environment.

The Australian Government Department of Health has also commenced a review of its tobacco legislation which covers the *Tobacco Advertising Prohibition Act 1992*, the Tobacco Advertising Prohibition Regulation 1993, the *Tobacco Plain Packaging Act 2011*, and the Tobacco Plain Packaging Regulations 2011. The Review will ensure that the Department of Health's tobacco control legislative framework continues to support the objectives of this Strategy.

Actions for Priority Area 6

6.1 Complete the Australian Government Department of Health's review of its tobacco control legislation and amend, where appropriate, to eliminate remaining forms of tobacco advertising and promotion.
Responsibility: Australian Government.

6.2 Prohibit other forms of tobacco promotion including: price specials and other displays of tobacco products at point of sale; public relations and lobbying activities; and payments, incentives and rebates by tobacco manufacturers, importers or wholesalers to tobacco retailers and proprietors of hospitality venues.
Responsibility: Australian Government, state and territory governments.

6.3 Continue to monitor and enforce legislation relating to the plain packaging of tobacco products, health warnings on tobacco packaging and the advertising of tobacco products.
Responsibility: Australian Government.

6.4 Require tobacco companies, importers and wholesalers of tobacco products in Australia to report details and expenditure on any form of tobacco promotion and marketing activity, including contributions to third parties.
Responsibility: Australian Government, state and territory governments.

6.5 Consider the adequacy of the current classification guidelines for television, films and computer games in relation to the portrayal of smoking.
Responsibility: Australian Government, state and territory governments, Australian Communications and Media Authority and broadcasters.

6.6 Monitor, identify and act to prohibit the promotion of tobacco products through current and emerging media platforms and consider pursuing international approaches to such forms of promotion.
Responsibility: Australian Government, state and territory governments.

Priority Area 7:
Further regulate the contents and product disclosures pertaining to tobacco products

The manufacturing of tobacco products is subject to very few controls considering the harm caused by its use. Article 9 of the WHO FCTC provided for the Conference of the Parties, in consultation with competent international bodies, to propose guidelines for testing, measuring and regulation of the contents and emissions of tobacco products. This Article also provides for each Party to adopt and implement measures for such testing, measuring and regulation.[91]

Article 10 of the WHO FCTC requires Parties to adopt and implement effective legislative or other measures to require manufacturers and importers of tobacco products to disclose to government authorities information about the contents and emissions of tobacco products, and to require public disclosure of information about toxic constituents and emissions.[92]

Further regulation of the contents and product disclosures of tobacco products is an important area of tobacco control that warrants additional investigation, analysis and implementation of appropriate policies.[93]

All states and territories have prohibited the sale of fruit and confectionery flavoured cigarettes. Flavours appear to play a particularly important role in influencing smoking.[94, 95] Additives such as menthol, sugar, honey, liquorice and cocoa are often used to enhance the "taste" of tobacco smoke to make the product more palatable and desirable to people who use tobacco, especially those experimenting with tobacco.[96] Such cigarettes can be perceived as having a more positive appeal, better taste and less risk.[97] There is also evidence that tobacco manufacturers have used additives to mask the smell and visibility of side stream smoke.[98]

Variations in filter design and appearance are also common and further regulation in this area should be considered. For example, filter ventilation (cigarettes with ventilation perforations in the tipping paper) dilutes the smoke inhaled by the smoker, thereby appearing to the user to reduce its harshness and strength of taste. However, such ventilation does not reduce (and may even increase) health risks and misleads consumers about the harmfulness of products.[99, 100, 101, 102]

The appearance and design of tobacco products can also contribute to perceptions of taste, harm and appeal. Regulating product appearance and design features, such as innovative filters, may be an effective strategy to correct misperceptions and reduce tobacco use.[103]

Actions for Priority Area 7

7.1 Explore regulatory options to enhance controls on tobacco product ingredients, emissions and product disclosures in line with agreed Guidelines for the implementation of Articles 9 and 10 of the WHO FCTC, and implement where appropriate.
Responsibility: Australian Government.

7.2 Continue to participate in international cooperation relating to tobacco product regulation and disclosures, including the development of international guidelines for the implementation of Articles 9 and 10 of the WHO FCTC.
Responsibility: Australian Government.

7.3 Explore and implement where appropriate regulatory options to standardise the design and appearance of cigarette filters.
Responsibility: Australian Government.

7.4 Require tobacco manufacturers to disclose all additives used in each individual tobacco product, including roll-your-own tobacco products, and the purpose for their inclusion.
Responsibility: Australian Government.

7.5 Explore options to prohibit the use of all additives in tobacco products, including flavourings and menthol.
Responsibility: Australian Government, state and territory governments.

Priority Area 8: Strengthen regulation to reduce the supply, availability and accessibility of tobacco products

The widespread availability of tobacco is incongruent with the immense health and social burden associated with its use and is at odds with progress that has been made in other areas of tobacco control in Australia. Reducing retail availability of tobacco is an aspect of a comprehensive approach to tobacco control that requires further strengthening. Reducing the overall supply, availability and accessibility of tobacco products will significantly influence smoking prevalence and Australia's goal to achieve a tobacco free society.

The retail availability of tobacco products can be associated with an increased prevalence of tobacco use and likelihood of relapse among people attempting to quit smoking.[104, 105] Tobacco retailer density is also higher in socio-disadvantaged areas and reducing retail availability may be an effective approach to reduce tobacco use in socioeconomically disadvantaged populations.[106] Licensing schemes for tobacco retailers may provide additional benefit through restricting the circumstances in which a licence can be obtained and increasing costs of licences, which may deter retailers from selling tobacco products.[107]

Other strategies that have been implemented internationally to further reduce supply, availability and accessibility of tobacco products include prohibiting the sale of tobacco products to people under 21 years.[108] More broadly, the widespread availability of tobacco perpetuates the normalisation of tobacco products and potentially undermines the effectiveness of other tobacco control measures.

Implementing and enforcing strong measures to control illicit tobacco trade can enhance the effectiveness of high tobacco taxes and other tobacco control policies. Additionally, strong surveillance, enforcement and fines, across all supply chains are warranted. Other successful strategies undertaken internationally include implementing tracking and tracing systems; controlling the entire supply chain by licensing all parties involved in tobacco product manufacturing and distribution; and international cooperation in investigation and prosecution of participants in illicit trade.[109]

Significant investment has been taken to prevent and minimise the illicit tobacco trade. As part of the 2018–19 Federal Budget, the Australian Government announced a comprehensive suite of measures to combat illicit tobacco, including the establishment of the Illicit Tobacco Taskforce on 1 July 2018 and additional funding to detect and destroy domestically grown illicit tobacco crops. A permit regime was also introduced for the importation of most tobacco products, with importers being required to pay all duty and tax liabilities for tobacco products at the border from 1 July 2019.

In September 2019, the Australian Government enacted legislation to support regulation of tobacco products at the border by allowing for the immediate destruction of tobacco seized by the Australian Border Force (ABF). These amendments will allow the ABF to target its border operation more efficiently and place a greater focus on detecting and disrupting black economy activity.

Actions for Priority Area 8

8.1 Continue to monitor and enforce all tobacco control legislation applicable at the retail level, including legislation prohibiting the sale of tobacco to minors.
Responsibility: state and territory governments.

8.2 Consider regulatory approaches to reduce or prohibit the sale of tobacco products in premises where alcohol consumption occurs, including through vending machines.
Responsibility: state and territory governments.

8.3 Consider banning or further restricting the sale of tobacco products online.
Responsibility: Australian Government, state and territory governments.

8.4 Prohibit alternative and emerging avenues for the sale of tobacco products, such as cigarette delivery services through smartphone applications.
Responsibility: Australian Government, state and territory governments.

8.5 Explore mechanisms to have a consistent licensing scheme in place for tobacco retailers and wholesalers in Australia, such as establishing a national framework for licensing schemes.
Responsibility: Australian Government, state and territory governments.

8.6 Explore options to further regulate where tobacco products are retailed, including regulatory approaches to control or restrict the number, type and location of tobacco outlets.
Responsibility: Australian Government, state and territory governments, NGOs.

8.7 Consider requiring tobacco wholesalers to report on the characteristics and prices of all tobacco products purchased and sold.
Responsibility: Australian Government.

8.8 Continue to engage in international cooperation relating to tobacco taxation and addressing illicit trade in tobacco products, including through the WHO FCTC.
Responsibility: Australian Government.

8.9 Continue to monitor the supply and use of illicit tobacco in Australia and continue enforcement efforts to prevent the illegal importation, supply and cultivation of tobacco, and enhance technology and staff capability to identify and respond to illicit trade in tobacco.
Responsibility: Australian Government, NGOs.

8.10 Monitor international developments regarding reducing nicotine content in tobacco products and explore the feasibility of pursuing similar measures in Australia.
Responsibility: Australian Government, state and territory governments.

8.11 Consider the feasibility of raising the minimum age of purchase of tobacco products and monitor international developments on this matter.
Responsibility: Australian Government, state and territory governments.

Priority Area 9: Strengthen regulations for novel and emerging products

The tobacco industry has a long history of marketing a diverse range of products to support its commercial interests and divert public resources away from evidence-based approaches to reduce tobacco use.[110] A wide range of novel and emerging products and alternative nicotine delivery systems continue to be marketed globally by the tobacco industry. Broadly, these products include, but may not be limited to, e-cigarettes (including electronic nicotine delivery systems and electronic non-nicotine delivery systems), heated tobacco products, shisha, nicotine pouches, lozenges and gums.[111] Tobacco products that do not involve heating also continue to be marketed globally including various types of snuff (including snus), chewing tobacco and dissolvable tobacco.

Between 2012 and 2018, most state and territory governments amended their tobacco control laws to further restrict the advertising and sale of e-cigarettes in a similar manner as conventional tobacco products[iii] and prohibited the use of e-cigarettes in legislated smoke-free areas. However, to date, Australia's tobacco control efforts have largely focussed on preventing and reducing the use of conventional tobacco products. Accordingly, there is a need to ensure that sufficient controls are in place to protect the Australian community from the range of tobacco, nicotine and other drug delivery systems that may be marketed by the tobacco industry, e-cigarette industry and their associated interests.

E-cigarettes

In 2019, e-cigarettes were the most common alternative nicotine delivery system marketed globally. E-cigarettes are operated by using a battery to heat nicotine and/or other chemicals to generate an aerosol for inhalation. Initially, many e-cigarettes resembled conventional tobacco products but a broader range of devices have now become available on the global market, including those that are sleek, discreet and similar in appearance to a USB flash drive. Many newer products are also customisable and some are capable of delivering nicotine to users as efficiently as, and in some cases more efficiently than, cigarettes.

Although most e-cigarettes marketed globally are likely to contain nicotine, there is also a need to prevent and reduce the risks posed by e-cigarette products that do not contain nicotine, including the use of flavourings. As part of this, e-cigarettes containing tetrahydrocannabinol (THC – the principal psychoactive constituent of cannabis) and nicotine liquids that have been labelled as nicotine free should also be considered.

To date, Australian governments have taken a precautionary approach to the marketing and use of e-cigarettes in view of the risks these products pose to tobacco control and population health. Broadly, this approach is underpinned by the current state of evidence regarding: the direct harms e-cigarettes pose to human health, their impacts on smoking initiation and cessation, uptake among youth and dual use with conventional tobacco products.[112, 113, 114]

Relevant Commonwealth and state and territory Ministers have agreed to national guiding principles for e-cigarettes. The principles affirm the need to maintain and, where appropriate, strengthen and make consistent across jurisdictions the current controls that apply to the marketing and use of e-cigarettes in Australia. The principles also acknowledge that any change to the regulation of e-cigarettes in Australia will have protecting children and young people as its primary focus and goal.[115]

Other forms of novel and emerging products

The global market for heated tobacco products has continued to grow and poses a major threat to Australia's progress in tobacco control. Like e-cigarettes, heated tobacco products use a battery powered heating system to heat tobacco to produce an aerosol, similarly mimicking the behaviour of smoking conventional cigarettes. However, unlike e-cigarettes, heated tobacco products contain nicotine in the form of tobacco and may include specifically designed cigarettes for heating.[116]

iii Conventional tobacco products include manufactured cigarettes, roll-your-own cigarettes, pipes and cigars.

At the eighth session of the Conference of the Parties to the WHO FCTC, Australia and other Parties to the WHO FCTC were invited to prioritise a comprehensive range of measures to prevent and reduce the risks posed by heated tobacco products and other forms of novel and emerging tobacco products. Among other measures, this included restricting or prohibiting the manufacture, importation, distribution, presentation, sale and use of novel and emerging tobacco products.[117] Australia's policy settings for novel and emerging tobacco products will continue to be guided by the WHO FCTC and the relevant decisions of the WHO FCTC Conference of the Parties.

Shisha and other forms of novel products including snuff, chewing tobacco and dissolvable tobacco also have the potential to disrupt Australia's long standing progress in reducing tobacco use. Accordingly, this Strategy supports the strengthening of existing controls to prohibit or further restrict the marketing and use of these products.

Several tobacco companies are also marketing tobacco free nicotine products which may be sold in a variety of flavours and with differing levels of nicotine content.[118] There is a need to closely monitor the marketing and use of these products and their impact on population health, and identify the most appropriate policy response in Australia.

Actions for Priority Area 9

9.1 Develop and implement additional measures to further restrict the marketing, availability and use of all e-cigarette components in Australia, regardless of their nicotine content.
Responsibility: Australian Government, state and territory governments.

9.2 Raise awareness about the marketing and use of e-cigarettes and their immediate and long-term impacts on individual and population health.
Responsibility: Australian Government, state and territory governments, NGOs

9.3 Develop and implement a comprehensive regulatory framework for all novel and emerging products that pose risks to tobacco control and population health.
Responsibility: Australian Government, state and territory governments.

9.4 Prohibit the use of all novel and emerging products such as shisha and e-cigarettes in areas where smoking is prohibited.
Responsibility: state and territory governments, Australian Government.

9.5 Prohibit the advertising, promotion and sponsorship of all forms of new and emerging tobacco products, shisha, e-cigarettes and other alternative nicotine delivery systems.
Responsibility: Australian Government, state and territory governments.

9.6 Strengthen research, monitoring and surveillance activities pertaining to the marketing and use of novel and emerging products
Responsibility: Australian Government, state and territory governments.

Priority Area 10:
Eliminate exceptions to smoke-free workplaces, public places and other settings

Exposure to secondhand smoke causes serious adverse health effects in both adults and children. Under Article 8 of the WHO FCTC, Parties recognise that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability. Article 8 requires Parties to adopt and implement effective measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.[119]

Smoke-free policies are designed not only to protect nonsmokers and provide incentives to quit among those that use tobacco, but also with the aim of preventing uptake and denormalising smoking.[120]

Evaluation studies of the implementation of smoke-free legislation overwhelmingly report that the legislation is popular, compliance is high, and the laws are effective in improving air quality and reducing exposure to second-hand smoke.[121] Legislative bans on tobacco use lead to improved health outcomes in the community more generally through reduction in exposure to secondhand smoke, with the clearest evidence for reduced heart attacks and other cardiovascular disease[122, 123] and reductions in childhood hospital admissions for asthma and lower respiratory tract infections.[124] Smoke-free policies do not have a negative economic impact on the restaurant and bar industry.[125]

Smoke-free legislation can also influence exposure to second-hand smoke in domestic environments. In addition to protecting children and non-smokers from exposure to second-hand smoke, smoke-free policies at home can increase the chances of smoking cessation among adults and decrease the likelihood of smoking initiation by children in the home.[126] Smoke-free apartment building policies are likely to reduce exposure to secondhand smoke, may improve cessation outcomes among current smokers, and are likely to yield considerable cost-savings for landlords and society. Such policies appear to be supported by most residents.[127]

As public awareness of the risks of secondhand smoke has increased and the introduction of smoke-free public spaces has become the norm, the number of smoke-free homes has increased. However, among populations with a high prevalence of smoking, exposure to secondhand smoke remains high, particularly for children from low socioeconomic groups and Aboriginal and Torres Strait Islander children. In 2014–15, 73% of Indigenous children up to age 14 in remote areas and 53% in non-remote areas were living in households with daily smokers. The proportion of Indigenous children living in households where smoking occurs indoors ranged from 11% in major cities to 20% in very remote areas.[128]

Non-smokers can be exposed to high levels of secondhand smoke in outdoor settings when close to or downwind of people smoking.[129] As restrictions on smoking in enclosed public places have become more common, people who smoke are increasingly required to smoke outdoors. Problems arise when people who smoke cluster around entrances and exits and near air conditioning intake vents to smoke. People who enter and exit the building are exposed to secondhand smoke and smoke may drift into indoor smoke-free areas.

Third-hand smoke can also develop when residue from tobacco smoke accumulates on surfaces and in dust, and subsequently reacts with other chemicals in the environment to form additional pollutants. Whilst second-hand smoke exposure involves the inhalation of smoke from a burning tobacco product, third-hand smoke exposure can mean coming into contact with other compounds that have formed from the tobacco smoke residue through inhalation, ingestion and dermal absorption.[130] There is a need to further analyse the health impacts of third-hand smoke exposure and increase awareness among the public about its potential harms.

Actions for Priority Area 10

10.1 Continue to monitor and enforce existing smoke-free legislation.
Responsibility: state and territory governments.

10.2 Strengthen partnerships between the health sector and local governments to enhance the promotion, monitoring and enforcement of smoke-free laws and policies.
Responsibility: state and territory governments, local governments, NGOs.

10.3 Ensure all publicly funded health and social services work towards introducing and enforcing comprehensive smoke-free policies.
Responsibility: state and territory governments, Australian Government, community and social sectors, drug treatment agencies.

10.4 Monitor the issue of smoking and smoke-drift at residential premises and consider policy and regulatory approaches to encourage smoke-free homes, including for public housing and multi-unit housing.
Responsibility: state and territory governments, NGOs.

10.5 Introduce further smoke-free policies in public places, healthcare facilities and outdoor areas where people are in close proximity.
Responsibility: Australian Government, state and territory governments, local government.

10.6 Ensure the provision of smoking cessation support services in smoke-free workplaces to encourage and assist employees and employers who smoke to quit.
Responsibility: Australian Government, state and territory governments, NGOs.

10.7 Improve education about the dangers of second-hand smoke and consider appropriate public messaging options for third-hand smoke exposure.
Responsibility: state and territory governments.

Priority Area 11:
Provide greater access to evidence-based cessation services to support people who use tobacco to quit

Smoking cessation results in immediate and long-term health benefits, regardless of age and duration of tobacco use. It reduces the risk of premature death and adverse health events such as cardiovascular diseases, chronic obstructive pulmonary disease, cancer and reproductive health outcomes.[131] Quality of life is improved not just for the person quitting, but also those around them by preventing harms from exposure to second-hand smoke and reducing the likelihood of tobacco use uptake.

Although quitting can be a difficult process and may take several attempts before complete cessation, most smokers want to quit and more than half make a serious attempt to quit every year.[132] In 2019, 61% of smokers attempted to undertake activities to quit or cut back in the previous 12 months, with 21% successfully giving up on smoking for at least a month.[133] While quitting cold turkey remains the most commonly used method to quit, evidence indicates that the success rate of quitting is much higher when evidence-based behavioural support and smoking cessation pharmacotherapy are concurrently used.[134, 135]

Quitting smoking can prevent disease progression and recurrence and promote recovery for almost every health condition, illness and medical procedure.[136] Every encounter in a healthcare setting involving a patient who uses tobacco and a healthcare professional is an opportunity to encourage and promote quitting and should be set as a standard of care.

Interventions in a clinical and health system setting can be improved by: embedding comprehensive policies and protocols for tobacco use screening and support for cessation as part of clinical workflow, incorporating reminders in health record systems, providing training for health professionals and the development of clinical treatment guidelines. The Royal Australian College of General Practitioners have updated the *Supporting smoking cessation: A guide for health professionals* guidelines to provide health professionals with guidance on how to encourage and support smoking cessation and individualise smoking cessation therapies for their patients.[137]

Other system wide strategies that have been implemented internationally include establishing minimum standards for the identification and referral of smokers as criteria for health service accreditation and routine reporting and monitoring of adherence to these standards.[138] In practice, this would mean that every patient in Australia within a hospital, primary care setting, mental health or alcohol and drug treatment service would: be asked about their tobacco use; be offered advice on the benefits of quitting and how to best approach quitting; be provided with pharmacotherapy to manage nicotine withdrawal during their stay, and to assist their quit attempt post-discharge; and be referred to a Quitline or accredited face-to-face clinic for evidence-based behavioural support.

Broadening interventions beyond health professionals will reduce burden for time-constrained health professionals and extend support to all populations, including groups that have a high prevalence of smoking or are severely affected by tobacco use. With appropriate training and guidance, staff in other organisations who are already working with these populations can provide brief interventions and support quit attempts.

Additional efforts can be made to improve access to NRT and other smoking cessation medications, such as through the PBS, to encourage individuals attempting to quit tobacco use to use subsidised and evidence-based cessation therapies. NRTs increase the rate of quitting by 50–70% regardless of setting and combination NRT, consisting of a slow-release patch and fast-acting oral form, can almost double quit rates.[139]

To effectively influence smoking behaviour, promote smoking cessation and increase the accessibility of evidence-based cessation services, measures will also need to be implemented at a population level. Population-based strategies (e.g. tobacco excises, mass media campaigns, smoke-free policies) are broader than those at the clinical or health system and have an impact on the overall community. They aim to influence tobacco cessation by providing an environment that supports or simplifies efforts for smokers to quit, or lowers barriers that smokers may encounter.[140] Combining clinical and health system-based strategies with population-based strategies can have a synergistic effect on improving cessation outcomes.

Evidence indicates that Quitline services are an effective population targeted approach to provide information and advice to people who are interested in or are quitting, and by health systems as an additional aid to clinical interventions as part of follow-up support for patients attempting to quit.[141] There is a need to review and monitor the use of Quitline services across Australia to improve their accessibility and effectiveness, particularly in populations with a high prevalence of tobacco use.

Actions for Priority Area 11

11.1 Conduct an evaluation of smoking cessation services available in Australia, including Quitline services, and monitor innovative approaches to deliver smoking cessation services.
Responsibility: state and territory governments, Australian Government, NGOs.

11.2 Commission a national situation analysis of treatment of tobacco dependence as outlined in the WHO FCTC Article 14 implementation guidelines.
Responsibility: Australian Government,

11.3 Conduct a national workshop to determine best practice approaches to smoking cessation within the healthcare system.
Responsibility: Australian Government, state and territory governments, NGOs.

11.4 Improve and extend Quitline services, and ensuring that there is sufficient capacity to run these services during mass media campaigns.
Responsibility: state and territory governments, Australian Government, NGOs.

11.5 Improve referral pathways to the Quitline from other programs across the health system, primary care services and from relevant services and NGOs which focus on populations with a high prevalence of tobacco use and those most severely affected by tobacco use (as outlined in Priority Area 5).
Responsibility: state and territory governments, Australian Government, NGOs.

11.6 Implement IT and accreditation systems to ensure that health professionals routinely ask all patients in health care facilities about their smoking status and provide smokers with appropriate advice and support to quit.
Responsibility: state and territory government, Australian Government, health professional organisations.

11.7 Provide policy guidelines and accredited training in smoking cessation (particularly brief interventions) to health professionals; health, community and welfare workers; and social service organisations, and ensure these are regularly updated to reflect best practice.
Responsibility: state and territory governments, NGOs, smoking cessation services, health services, Aboriginal community-controlled organisations, Australian Government.

11.8 Improve public awareness of services demonstrated to assist with smoking cessation.
Responsibility: state and territory governments, Australian Government, NGOs.

11.9 Monitor and continue to update the evidence base for smoking cessation therapies and tobacco dependence treatment.
Responsibility: state and territory governments, Australian Government, NGOs, smoking cessation services, health services, Aboriginal community-controlled organisations, social service organisations.

11.10 Review restrictions and accessibility of current smoking cessation pharmacotherapies available on the PBS in the context of latest evidence, best clinical practice and cost-effectiveness and enhance the provision of these medications.
Responsibility: Australian Government.

11.11 Implement measures to ensure best practice cessation support and tobacco dependence treatment is offered to every tobacco user in every interaction within the health, mental health and alcohol and drug dependence treatment systems, with reporting of brief intervention strategies and cessation service outcomes routinely.
Responsibility: Australian Government, service providers.

11.12 Develop and disseminate comprehensive national clinical guidelines and supportive policy strategies to embed the treatment of tobacco dependence into health services, primary care, and community and social service organisations.
Responsibility: Australian Government, state and territory governments, NGOs.

PART FOUR: GOVERNANCE

Policy options and objectives related to tobacco control are a shared responsibility between the Commonwealth and state and territory governments, with NGOs also playing a crucial role. Engagement with a wide range of stakeholders has helped to further inform the priorities and objectives as outlined in this Strategy.

The Strategy is a sub-strategy to the NDS 2017–2026 and its development has been supported by the Commonwealth and states and territories. All jurisdictions will continue to identify, coordinate and provide advice on tobacco issues in the context of Australia's national alcohol, tobacco and other drug policy frameworks, including the Strategy.

Maintenance of a governance structure over the life of the Strategy will ensure a consistent whole-of-government approach to the implementation of the Strategy and tobacco control in Australia.

PART FIVE: MONITORING AND EVALUATING PROGRESS

Monitoring the implementation of this Strategy will require a coordinated national effort. Progress will be monitored towards the targets in this Strategy to reduce Australia's daily smoking prevalence to below 10% by 2025 and 5% or less by 2030.

A mid-point review of progress will be undertaken in 2025 to assess whether Australia is on track to achieve the targets against the actions in each priority area. An end-point review will also be conducted to assess achievements from the Strategy and determine areas of improvement to inform the development and implementation of the next iteration of the Strategy.

Activity reports relating to tobacco control measures will be included in annual reports developed under the NDS 2017–2026.

REFERENCES

1 Peto R, Lopez AD, Pan H, Boreham J and Thun M. Mortality from smoking in developed countries 1950–2020. Oxford: Nuffield Department of Population Health; 2015. Available from: **http://gas.ctsu.ox.ac.uk/tobacco/contents.htm**.

2 Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease Study series no. 19. Cat. no. BOD 22. Canberra: AIHW; 2019. Available from: **https://www.aihw.gov.au/reports/burden-of-disease/burden-disease-study-illness-death-2015/contents/table-of-contents**.

3 Ibid.

4 Banks E et al. Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence. BMC Medicine 2015; 13, 38.

5 US Department of Health and Human Services. The health consequences of involuntary exposure to tobacco smoke. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006. Available from: **https://www.ncbi.nlm.nih.gov/books/NBK44324/**.

6 World Health Organization. Tobacco and its environmental impact: an overview. Geneva: WHO; 2017. Available from **https://apps.who.int/iris/bitstream/handle/10665/255574/9789241512497-eng.pdf;%20jsessionid=BD2557674D779E620%20DFA9569F9EA6827?sequence=1**.

7 Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2019. Drug statistics series no. 32. Cat. no. PHE 214. Canberra: AIHW; 2020. Available from: **https://www.aihw.gov.au/getmedia/3564474e-f7ad-461c-b918-7f8de03d1294/aihw-phe-270-NDSHS-2019.pdf.aspx?inline=true**.

8 Australian Government Department of Health. National Drug Strategy 2017–2026. Canberra; 2017. Available from: **https://health.gov.au/resources/publications/national-drug-strategy-2017-2026**.

9 Australian Government Department of Health. National Tobacco Strategy 2012–2018. Canberra; 2012. Available from: **https://health.gov.au/resources/publications/national-tobacco-strategy-2012-2018**.

10 World Health Organization Framework Convention on Tobacco Control. Opened for Signature 16 June 2003, 2302 UNTS 166 (entered into force 27 February 2005).

11 Ibid.

12 World Health Organization Framework Convention on Tobacco Control. Reporting on the implementation of the Convention. Available from: **https://untobaccocontrol.org/impldb/**.

13 United Nations. Sustainable Development Goals. 2015. Available from: **https://www.un.org/sustainabledevelopment/sustainable-development-goals-retired-link/**.

14 World Health Organization Regional Office for South-East Asia. Tobacco control for sustainable development. New Dehli: WHO; 2017. Available from: **https://apps.who.int/iris/handle/10665/255509**.

15 Australian Bureau of Statistics. National Health Survey: first results, 2017–18. Cat. no. 4364.0.55.001. Canberra: ABS; 2018. Available from: **http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.001Main+Features12017-18?OpenDocument**.

16 Ibid.

17 Ibid.

18 Bach L. Campaign for tobacco free kids: the path to tobacco addiction starts at very young ages. Fact sheet. Washington DC: Tobacco Free Kids; 2020. Available from: **https://www.tobaccofreekids.org/assets/factsheets/0127.pdf**.

19 Guerin N and White V. Australian secondary students' use of tobacco, alcohol, over-the-counter drugs, and illicit substances. ASSAD 2017 Statistics & Trends. Melbourne: Cancer Council Victoria; 2018. Available from: **https://www.health.gov.au/resources/publications/secondary-school-students-use-of-tobacco-alcohol-and-other-drugs-in-2017**.

20 Australian Bureau of Statistics. National Health Survey: first results, 2017–18. Cat. no. 4364.0.55.001. Canberra: ABS; 2018. Available from: **http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.001Main+Features12017-18?OpenDocument**.

21 Guerin N and White V. Australian secondary students' use of tobacco, alcohol, over-the-counter drugs, and illicit substances. ASSAD 2017 Statistics & Trends. Melbourne: Cancer Council Victoria; 2018. Available from: **https://www.health.gov.au/resources/publications/secondary-school-students-use-of-tobacco-alcohol-and-other-drugs-in-2017**.

22 Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: detailed findings. Drug statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW; 2017. Available from: **https://www.aihw.gov.au/getmedia/3bbdb961-ed19-4067-94c1-69de4263b537/21028-13nov2017.pdf.aspx**.

23 Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey, 2018–19. Cat. no. 4715.0. Canberra: ABS; 2019. Available from: **https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4715.02018-19?OpenDocument**.

24 Australian Bureau of Statistics. Aboriginal and Torres Strait Islander peoples: smoking trends, Australia, 1994 to 2014–15. Media release. Cat. no. 4737.0. Canberra: ABS; 2017. Available from: **https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by Subject/4737.0~1994 to 2014-15~Media Release~Aboriginal and Torres Strait Islander smoking down (Media Release)~10000**.

25 Australian Bureau of Statistics. National Health Survey: first results, 2017–18. Cat. no. 4364.0.55.001. Canberra: ABS; 2018. Available from: **http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0.55.001Main+Features12017-18?OpenDocument**.

26 Australian Institute of Health and Welfare. Australia's mothers and babies 2018 – in brief. Perinatal statistics series no. 36. Cat. no. PER 108. Canberra: AIHW; 2020. Available from: **https://www.aihw.gov.au/getmedia/aa54e74a-bda7-4497-93ce-e0010cb66231/aihw-per-108.pdf.aspx?inline=true**.

27 Tait R, Whetton S and Alsop S. Identifying the social costs of tobacco use in Australia in 2015/16. Perth: National Drug Research Institute, Curtin University; October 2019. Available from: **http://ndri.curtin.edu.au/NDRI/media/documents/publications/T273.pdf**.

28 Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease Study series no. 19. Cat. no. BOD 22. Canberra: AIHW; 2019. Available from: **https://www.aihw.gov.au/reports/burden-of-disease/burden-of-tobacco-use-in-australia/contents/summary**.

29 Ibid.

30 US Department of Health and Human Services. The health consequences of smoking — 50 years of progress. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014. Available from: **https://www.hhs.gov/surgeongeneral/reports-and-publications/tobacco/index.html**.

31 Mathers A, Hawkins B and Lee K. Transnational tobacco companies and new nicotine delivery systems. Am J Public Health 2019; 109(2), 227–35.

32 Reynolds A. An ethical framework for tobacco control policy. PhD thesis. University of Surrey, 2015.

33 Reynolds A. A tobacco free generation — Singapore or Tasmania to lead the world? Presentation. Tasmania: UTAS Medical School, Menzies Research Institute; 21 July 2014.

34 Australian Government Department of Health. National strategic action plan for lung conditions. Canberra; 2019. Available from: **https://lungfoundation.com.au/wp-content/uploads/2019/02/Information-paper-National-Strategic-Action-Plan-for-Lung-Conditions-Feb2019.pdf**.

35 US National Cancer Institute. A socioecological approach to addressing tobacco related health disparities. National Cancer Institute tobacco control monograph 22. NIH publication no. 17-CA-8035A. Bethesda: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute; 2017.

36 Scollo MM and Winstanley MH. Tobacco in Australia: facts and issues. Melbourne: Cancer Council Victoria; 2019. Available from: **https://www.tobaccoinaustralia.org.au/**.

37 Weishaar H et al. Global health governance and the commercial sector: a documentary analysis of tobacco company strategies to influence the WHO framework convention on tobacco control. PLoS Medicine 2012; 9(6), e1001249. doi:10.1371/journal.pmed.1001249.

38 Bryan-Jones K and Chapman S. Political dynamics promoting the incremental regulation of secondhand smoke: a case study of New South Wales, Australia. BMC Public Health 2006; 6, 192.

39 World Health Organization Framework Convention on Tobacco Control. Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control (Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry). FCTC/COP3(7). Geneva: WHO; November 2008. Available from: **https://www.who.int/fctc/guidelines/article_5_3.pdf**.

40 Australian Government Department of Health. Policy and regulatory approach to electronic cigarettes (e-cigarettes) in Australia. Canberra; 2019. Available from: **https://www.health.gov.au/resources/publications/policy-and-regulatory-approach-to-electronic-cigarettes-e-cigarettes-in-australia**.

41 World Health Organization Framework Convention on Tobacco Control. Guidelines for implementation of Article 14 of the WHO Framework Convention on Tobacco Control (Demand reduction measures concerning tobacco dependence and cessation). FCTC/COP4(8). Geneva: WHO; November 2010. Available from: **https://www.who.int/fctc/Guidelines.pdf**.

42 World Health Organization Framework Convention on Tobacco Control. Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control (Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry). FCTC/COP3(7). Geneva: WHO; November 2008. Available from: **https://www.who.int/fctc/guidelines/article_5_3.pdf**.

43 Ibid.

44 World Health Organization Framework Convention on Tobacco Control. Australia. Available from: **https://untobaccocontrol.org/impldb/australia/**.

45 Fooks GJ, Smith J, Lee K and Holden C. Controlling corporate influence in health policy making? An assessment of the implementation of article 5.3 of the World Health Organization Framework Convention on Tobacco Control. Global Health 2017; 13, 12. Available from: **https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-017-0234-8**.

46 Australian Government Department of Health. Guidance for public officials on interacting with the tobacco industry. Canberra; 2019. Available from: **https://www.health.gov.au/resources/publications/guidance-for-public-officials-on-interacting-with-the-tobacco-industry**.

47 Wakefield MA et al. Time series analysis of the impact of tobacco control policies on smoking prevalence among Australian adults, 2001–2011. Bull World Health Organ 2014; 92(6), 413–22.

48 Centers for Disease Control and Prevention. Best practices for comprehensive tobacco control programs. Atlanta: US Department of Health and Human Services; 2014. Available from: **http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm?s_cid=cs_3281**.

49 Xu X et al. A cost-effectiveness analysis of the first federally funded antismoking campaign. Am J Prev Med 2015; 48(3), 318–25.

50 Atusingwize E, Lewis S and Langley T. Economic evaluations of tobacco control mass media campaigns: a systematic review. Tob Control 2015; 24(4), 320–7.

51 US Department of Health and Human Services. Preventing tobacco use among youth and young adults: a report of the Surgeon General. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2012. Available from: **https://www.hhs.gov/surgeongeneral/reports-and-publications/tobacco/index.html**.

52 Durkin S, Brennan E and Wakefield M. Mass media campaigns to promote smoking cessation among adults: an integrative review. Tob Control 2012; 21(2), 127–38.

53 Australian National Preventative Health Agency. Tobacco control and mass media campaigns: evidence brief. Canberra; 2013. Available from: **https://breakingthebrand.org/wp-content/uploads/2016/02/eR13_SD_Promoting-a-healthyAustralia-Tobacco-control-briefs.pdf**.

54 World Health Organization. Framework Convention on Tobacco Control. Opened for signature 16 June 2003, 2302 UNTS 166 (entered into force 27 February 2005).

55 Kuipers MAG, Beard E, West R and Brown J. Associations between tobacco control mass media campaign expenditure and smoking prevalence and quitting in England: a time series analysis. Tob Control 2018; 27(4), 455–62.

56 Durkin S, Brennan E and Wakefield M. Mass media campaigns to promote smoking cessation among adults: an integrative review. Tob Control 2012; 21, 127–38.

57 US Department of Health and Human Services. The health consequences of smoking — 50 years of progress. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014. Available from: **https://www.hhs.gov/surgeongeneral/reports-and-publications/tobacco/index.html**.

58 Cho YJ et al. Does adding information on toxic constituents to cigarette pack warnings increase smokers' perceptions about the health risks of smoking? A longitudinal study in Australia, Canada, Mexico, and the United States. Health Educ Behav 2018; 45(1), 32–42.

59 Essence Communications. Evaluation of the effectiveness of graphic health warnings on tobacco product packaging: an evaluation report prepared for the Department of Health. East Malvern; 2018. Available from: **https://www.health.gov.au/resources/publications/evaluation-of-effectiveness-of-graphic-health-warnings-on-tobacco-product-packaging**.

60 Ibid.

61 For example, see Lyons A. Smoking triples risk of death from heart disease and stroke: study. NewsGP, 4 July 2019. Available from: **https://www1.racgp.org.au/newsgp/clinical/smoking-triples-risk-of-death-from-heart-disease-a**; Australian Competition and Consumer Commission. Low yield cigarettes 'not a healthier option': $9 million campaign. Canberra: Australian Competition and Consumer Commission; 2006. Available from: **http://www.accc.gov.au/content/index.phtml/itemId/719575**; Aubusson K. 'Nowhere to hide': world-first study exposes untold risk of smoking. Sydney Morning Herald; 4 July 2019. Available from: **https://www.smh.com.au/healthcare/nowhere-to-hide-world-first-study-exposes-untold-risk-of-smoking-20190703-p523tg.html**.

62 World Health Organization. Report on the global tobacco epidemic: raising taxes on tobacco. Geneva: WHO; 2015. Available from: **http://apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf**.

63 World Health Organization. Framework Convention on Tobacco Control. Opened for signature 16 June 2003, 2302 UNTS 166 (entered into force 27 February 2005).

64 Fuchs A, Marquez PV, Dutta S and Icaza FG. Is tobacco taxation regressive? Evidence on public health, domestic resource mobilization, and equity improvements. Washington DC: World Bank Group; 2019. Available from: **http://documents.worldbank.org/curated/en/893811554737147697/Is-Tobacco-Taxation-Regressive-Evidence-on-Public-Health-Domestic-Resource-Mobilization-and-Equity-Improvements**.

65 Bayly M, Scollo MM and Wakefield MA. Who uses rollies? Trends in product offerings, price and use of roll-your-own tobacco in Australia. Tob Control 2018; 28(3), 317–24.

66 Hiscock R, Branston JR, McNeill A, Hitchman SC, Partos TR and Gilmore AB. Tobacco industry strategies undermine government tax policy: evidence from commercial data. Tob Control 2018; 27, 488–97.

67 Australian Taxation Office. Trends and latest findings. Canberra; 2019. Available from: **https://www.ato.gov.au/About-ATO/Research-and-statistics/In-detail/Tax-gap/Tobacco-tax-gap/?anchor=Trendsandlatestfindings1 - Trendsandlatestfindings1**.

68 Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6. Cat. no. BOD 7. Canberra: AIHW; 2016. Available from: **https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/older-people**.

69 Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey, 2018–19. Cat. no. 4715.0. Canberra: ABS; 2019. Available from: **https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4715.02018-19?OpenDocument**.

70 Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey, 2018–19. Cat. no. 4715.0. Canberra: ABS; 2019. Available from: **https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4715.02018-19?OpenDocument**.

71 Council of Australian Governments. Council of Australian Governments Meeting: Communiqué. 20 December 2007. Available from: **https://www.coag.gov.au/meeting-outcomes/coag-meeting-communique-20-december-2007**.

72 World Health Organization Framework Convention on Tobacco Control. Opened for Signature 16 June 2003, 2302 UNTS 166 (entered into force 27 February 2005).

73 Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey, 2018–19. Cat. No. 4715.0. Canberra: ABS; 2019. Available from: **https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4715.0Main Features152018-19?opendocument&tabname=Summary&prodno=4715.0&issue=2018-19&num=&view=**.

74 Australian Institute of Health and Welfare. Australia's mothers and babies 2018 – in brief. Perinatal statistics series no. 36. Cat. no. PER 108. Canberra: AIHW; 2020. Available from: **https://www.aihw.gov.au/getmedia/aa54e74a-bda7-4497-93ce-e0010cb66231/aihw-per-108.pdf.aspx?inline=true**.

75 Johnston V et al. Starting to smoke: a qualitative study of the experiences of Australian indigenous youth. BMC Public Health 2012; 12(1), 963.

76 Australian Institute of Health and Welfare. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra: AIHW; 2015. Available from: **https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/contents/table-of-contents**.

77 Robertson J, Stevenson L, Usher K, Devine S and Clough A. A review of trends in Indigenous Australian tobacco research (From 2004 to 2013), its associated outputs and evidence of research translation. Nicotine Tob Res 2013; 17(8), 1039–48.

78 Cancer Council Victoria. Smoking & disadvantage evidence brief. Canberra: Australian National Preventive Health Agency; 2013. Available from: **https://www1.health.gov.au/internet/publications/publishing.nsf/Content/smoking-disadvantage-evidence-brief**.

79 Scollo MM and Winstanley MH. Tobacco in Australia: facts and issues. Melbourne: Cancer Council Victoria, 2018. Available from: **http://www.tobaccoinaustralia.org.au/**.

80 Australian Institute of Health and Welfare. Burden of tobacco use in Australia: Australian Burden of Disease Study 2015. Australian Burden of Disease series no. 21. Cat. no. BOD 20. Canberra: AIHW; 2019. Available from: **https://www.aihw.gov.au/reports/burden-of-disease/burden-of-tobacco-use-in-australia/contents/summary**.

81 Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2019. Drug statistics series no. 32. Cat. no. PHE 214. Canberra: AIHW; 2020. Available from: **https://www.aihw.gov.au/getmedia/3564474e-f7ad-461c-b918-7f8de03d1294/aihw-phe-270-NDSHS-2019.pdf.aspx?inline=true**.

82 Dietz P, England L, Shapiro-Mendoza C, Tong V, Farr S and Callaghan W. Infant morbidity and mortality attributable to prenatal smoking in the US. Am J Prev Med 2010; 39(1), 45–52.

83 Doubeni C, Reed G and Difranza J. Early course of nicotine dependence in adolescent smokers. Pediatrics 2010; 125(6), 1127–33.

84 US Department of Health and Human Services. The health consequences of smoking — 50 years of progress. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014. Available from: **https://www.hhs.gov/surgeongeneral/reports-and-publications/tobacco/index.html**. See also US Department of Health and Human Services. Prevention tobacco use among youth and young adults. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2012. Available from: **http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/index.html**.

85 US Department of Health and Human Services. The health consequences of smoking — 50 years of progress. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2014. Available from: **https://www.hhs.gov/surgeongeneral/reports-and-publications/tobacco/index.html**.

86 World Health Organization. Guidelines for implementation of Article 13 of the WHO Framework Convention on Tobacco Control (Tobacco advertising, promotion and sponsorship). FCTC/COP3(12). November 2008. Geneva: WHO; 2008. Available from: **https://www.who.int/fctc/guidelines/adopted/article_13/en/**.

87 Hoek J, Gendall P, Eckert C, Kemper J and Louviere J. Effects of brand variants on smokers' choice behaviours and risk perceptions. Tob Control 2016; 25(2), 160–5.

88 Tasmanian Government Department of Health and Human Services. Building on Our Strengths. Public Health Act 1997. Hobart; 2010.

89 Western Australian Government Department of Health. Review of the Tobacco Products Control Act 2006. Discussion Paper 2011. Perth; 2011.

90 Australian Government Department of Communications and the Arts. Community standards and media content. Research with the general public — final report. Canberra; 2017. Available from: **https://www.classification.gov.au/about-us/research-and-publications/community-standards-and-media-content**.

91 World Health Organization. Tobacco Free Initiative. Articles 9 and 10 WHO Framework Convention on Tobacco Control — regulation of the contents and disclosures of tobacco products. Geneva: WHO; 2020. Available from: **https://www.who.int/tobacco/industry/product_regulation/articles_9_10_fctc/en/**.

92 Ibid.

93 Chapman S. 'Keep a low profile': pesticide residue, additives and freon use in Australian tobacco manufacturing. Tob Control 2003; 12 (Suppl 3), iii45–iii53.

94 Huang LL et al. Impact of non-menthol flavours in tobacco products on perceptions and use among youth, young adults and adults: a systematic review. Tob Control 2017; 26(6), 709–19.

95 Feirman SP, Lock D, Cohen JE, Holtgrave DR and Li T. Flavored tobacco products in the United States: a systematic review assessing use and attitudes. Nicotine Tob Res 2016; 18(5), 739–49.

96 US Department of Health and Human Services. Preventing tobacco use among youth and young adults. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2012. Available from: **https://www.hhs.gov/surgeongeneral/reports-and-publications/tobacco/index.html**.

97 Thrasher J et al. Cigarette brands with flavour capsules in the filter: trends in use and brand perceptions among smokers in the USA, Mexico and Australia, 2012–2014. Tob Control 2016; 25(3), 275–83.

98 Connolly G et al. How cigarette additives are used to mask environmental tobacco smoke. Tob Control 2000; 9(3), 283–91.

99 Samet JM and Aladadyan L. Should the FDA ban cigarette filter ventilation? J Natl Cancer I 2017; 109(12).

100 Stein JS, Koffarnus MN, O'Connor RJ, Hatsukami DK and Bickel WK. Effects of filter ventilation on behavioral economic demand for cigarettes: a preliminary investigation. Nicotine Tob Res 2018; 20(10), 1278–82.

101 Song MA et al. Cigarette filter ventilation and its relationship to increasing rates of lung adenocarcinoma. J Natl Cancer I 2017; 109(12).

102 Cancer Council Australia. Position statement — reducing the palatability of tobacco products: banning the use of filter design features and flavourings. National Cancer Control Policy. Canberra: Cancer Council Australia; 2018. Available from: **https://wiki.cancer.org.au/policy/Position_statement__Reducing_palatability**.

103 Drovandi A, Teague PA, Glass B and Malau-Aduli B. A systematic review of smoker and non-smoker perceptions of visually unappealing cigarette sticks. Tob Induc Dis 2018; 16(2).

104 Marsh L et al. Association between density and proximity of tobacco retail outlets with smoking: A systematic review of youth studies. Health & Place 2020.

105 Chaiton MO, Mecredy G and Cohen J. Tobacco retail availability and risk of relapse among smokers who make a quit attempt: a population-based cohort study. Tob Control 2018; 27(2), 163–9.

106 Melody SM, Martin-Gall, V, Harding, B and Veitch MGK. The retail availability of tobacco in Tasmania: evidence for a socio-economic and geographical gradient. Medical Journal of Australia 2018; 208(5), 205–8.

107 Greenhalgh EM, Scollo MM and Winstanley MH. Chapter 11: Retail promotion and access. In: Tobacco in Australia: facts and issues. Melbourne: Cancer Council Victoria; 2020. Available from: **https://www.tobaccoinaustralia.org.au/chapter-11-advertising/11-9-retail-promotion-and-access**.

108 Greenhalgh EM, Scollo MM and Winstanley MH. Chapter 5: Reducing tobacco access and supply. In: Tobacco in Australia: facts and issues. Melbourne: Cancer Council Victoria; 2020. Available from: **https://www.tobaccoinaustralia.org.au/chapter-5-uptake/5-21-reducing-tobacco-access-and-supply**.

109 US National Cancer Institute and World Health Organization. The economics of tobacco and tobacco control. National Cancer Institute tobacco control monograph 21. NIH publication no. 16-CA-8029A. Bethesda: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute; and Geneva: WHO; 2016. Available from **http://www.thecre.com/ccsf/wp-content/uploads/2017/01/m21_complete.pdf**.

110 Elias J, Dutra LM, St Helen G and Ling PM. Revolution or redux? Assessing IQOS through a precursor product. Tob Control 2018; 27, s102–s110.

111 Robichaud M, Seidenberg A and Byron M. Tobacco companies introduce 'tobacco-free' nicotine pouches. Tob Control 2019; 0, 1–2.

112 Byrne S et al. E-cigarettes, smoking and health. A literature review update. Canberra: CSIRO; 2018.

113 Gotts JE, Jordt SE, McConnell R and Tarran R. What are the respiratory effects of e-cigarettes? BMJ 2019; 366.

114 Kennedy CD, van Schalkwyk MCI, McKee M and Pisinger C. The cardiovascular effects of electronic cigarettes: a systematic review of experimental studies. Prev Med 2019; 127, 105770.

115 Australian Government Department of Health. Policy and regulatory approach to electronic cigarettes (e-cigarettes) in Australia. Canberra; 2019. Available from: **https://www.health.gov.au/resources/publications/policy-and-regulatory-approach-to-electronic-cigarettes-e-cigarettes-in-australia**.

116 World Health Organization. Heated tobacco products (HTPs) information sheet. WHO/NMH/PND/17.6. May 2018. Available from: **https://www.who.int/tobacco/publications/prod_regulation/heated-tobacco-products/en/**.

117 World Health Organization Framework Convention on Tobacco Control. Novel and emerging tobacco products. FCTC/COP8(22). 6 October 2018. Available from: **https://www.who.int/fctc/cop/sessions/cop8/FCTC__COP8(22).pdf?ua=1**.

118 Robichaud M, Seidenberg A and Byron M. Tobacco companies introduce 'tobacco-free' nicotine pouches. Tob Control 2019; 0, 1–2.

119 World Health Organization Framework Convention on Tobacco Control. Guidelines for implementation of Article 8 (Protection from exposure to tobacco smoke). FCTC/COP2(7). Geneva: WHO; July 2007. Available from: **https://www.who.int/fctc/guidelines/adopted/article_8/en/**.

120 US Department of Health and Human Services. Preventing tobacco use among youth and young adults. A report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2012. Available from: **https://www.hhs.gov/surgeongeneral/reports-and-publications/tobacco/index.html**.

121 Pierce JP and León ME. The effectiveness of smoke-free policies — An IARC review of actions to reduce exposure to carcinogens in secondhand smoke. Lancet Oncol 2008; 9, 614.

122 Frazer K et al. Legislative smoking bans for reducing harms from secondhand smoke exposure, smoking prevalence and tobacco consumption. Cochrane Database Syst Rev 2016; 2, CD005992.

123 Jones MR., Barnoya J, Stranges S, Losonczy L and Navas-Acien A. Cardiovascular events following smoke-free legislations: an updated systematic review and meta-analysis. Curr Environ Health Rep 2014; 1(3), 239–49.

124 Faber T et al. Effect of tobacco control policies on perinatal and child health: a systematic review and meta-analysis. Lancet Public Health 2017; 2(9), e420–e437.

125 Cornelsen L, McGowan Y, Currie-Murphy LM and Normand C. Systematic review and metaanalysis of the economic impact of smoking bans in restaurants and bars. Addiction 2014; 109(5), 720–7.

126 International Agency for Research on Cancer and World Health Organization. Evaluating the effectiveness of smoke-free policies. IARC handbooks of cancer prevention: tobacco control. Volume 13. Lyon: IARC; 2009. Available from: **https://www.iarc.fr/wp-content/uploads/2018/07/handbook13.pdf**.

127 Snyder K, Vick JH and King BA. Smoke-free multiunit housing: a review of the scientific literature. Tob Control 2016; 25(1), 9–20.

128 Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey, 2014–15. Cat. no. 4714.0. Canberra: ABS; 2016. Available from: **https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4715.0Main Features152018-19?opendocument&tabname=Summary&prodno=4715.0&issue=2018-19&num=&view=**.

129 Western Australian Government Department of Health. Appendix 7: Smoking in specific outdoor public places, prisons and in private cars. A review, October 2008. In: Parliament of Western Australia, Legislative Assembly, Education and Health Standing Committee. Inquiry into the Tobacco Products Control Amendment Bill 2008. Report No. 1, 38th Parliament. Perth: Parliament of Western Australia; 2009.

130 Matt GE et al. Third-hand tobacco smoke: emerging evidence and arguments for a multidisciplinary research agenda. Environ Health Perspect 2011; 119(9), 1218–26.

131 US Department of Health and Human Services. Smoking cessation. A report of the Surgeon General. Rockville: Public Health Service, Office of the Surgeon General; Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2020. Available from: **https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf**.

132 Ibid.

133 Australian Institute of Health and Welfare. National Drug Strategy Household Survey (NDSHS) 2016: key findings. Cat. no. WEB 180. Canberra: AIHW; 2017. Available from: **https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-key-findings/contents/summary**.

134 Stead LF, Bergson G and Lancaster T. Physician advice for smoking cessation. Cochrane Database Syst Rev 2008; 2, CD000165.

135 Fiore MC et al. Treating tobacco use and dependence: clinical practice guideline. Rockville: US Department of Health and Human Services; 2000.

136 US Department of Health and Human Services. Smoking cessation. A report of the Surgeon General. Rockville: Public Health Service, Office of the Surgeon General; Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2020. Available from: **https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf**.

137 Royal Australian College of General Practitioners. Supporting smoking cessation: a guide for health professionals. 2nd ed. East Melbourne: RACGP; 2019. Available from: **https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/supporting-smoking-cessation**.

138 US Department of Health and Human Services. Smoking cessation. A report of the Surgeon General. Rockville: Public Health Service, Office of the Surgeon General; Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2020. Available from: **https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf**.

139 Stead LF, Perera R, Bullen C, Mant D and Lancaster T. Nicotine replacement therapy for smoking cessation. Cochrane Database Syst Rev 2008; 1, CD000146.

140 US Department of Health and Human Services. Smoking cessation. A report of the Surgeon General. Rockville: Public Health Service, Office of the Surgeon General; Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2020. Available from: **https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf**.

141 Ibid.

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