Implementing the ABC Approach for Smoking Cessation

Framework and work programme

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1   Introduction

Outline

1   This document sets out a framework for implementing the ABC approach for Smoking Cessation. It outlines:

- the purpose and goals of the ABC approach

- the ABC approach – its objectives, rationale, and what it will mean for different people and organisations in the health system

- how the approach fits alongside other interventions aimed at reducing the number of people who smoke

- the expected impacts of the ABC approach on smoking and health outcomes

- the different elements and key points of leverage that will be used to implement and support the approach

- the work programme and high-level implementation plans, including workstreams and actions

- the approach to governance and management of the work programme.

Context

A shift in focus – 'more supported quit attempts, more often'

2   Smoking cessation is the focus of the ABC approach. Many people find it difficult to stop smoking tobacco, and in particular nicotine, is addictive. Evidence shows that the majority of smokers want to quit and need help to do so. Around 65 percent of smokers in New Zealand have made a quit attempt in the last five years[1] and 44 percent of smokers made at least one quit attempt in the previous 12 months. Most smokers who try to quit do so without the aid of evidence-based smoking cessation treatments (both behavioural and pharmacological), which is associated with a low success rate.

3   National and international evidence on best practice in smoking cessation shows that initiating more quit attempts that are supported by treatment, more often, is crucial to increasing the number of smokers who quit long-term.

4   While existing programmes are making an impact on quit rates, there is considerable scope for increasing the reach and intensity of smoking cessation services across the health sector and communities. Cessation has been identified by Government as a priority for New Zealand's tobacco control programme. This has resulted in a major increase in funding to enhance cessation announced in the 2007 and 2008 Budgets.

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[1]   NZ Tobacco Use Survey 2006/07.

What is the ABC approach?

5   The updated New Zealand Smoking Cessation Guidelines (Ministry of Health 2007) provide support for all health care workers who have contact with people who smoke. The guidelines are structured around a new approach – 'ABC'. 'ABC' is a memory aid for health care workers to understand the key steps to helping people who smoke. These steps are as follows:

    A.   **Ask** all people about their smoking status and document this.

    B.   Provide **Brief** advice to stop smoking to all people who smoke, regardless of their desire or motivation to quit.

    C.   Make an offer of, and refer to or provide, evidence based **Cessation** treatment.

The ABC approach does not replace specialist smoking cessation treatment. Smoking cessation specialists, such as Quitline staff, Aukati Kai Paipa kaimahi, and health care workers who have been trained as smoking cessation treatment providers, are a key component of the ABC approach.

The current approach to promoting cessation

6   Information and support on quitting smoking is promoted actively by the public health sector, particularly through extensive social marketing campaigns. Cessation services have been developed, notably the national Quitline, subsidised access to nicotine replacement therapy, and intensive face-to-face services for Māori (Aukati Kai Paipa) and Pacific people. The public health sector has made progress in delivering smoking cessation programmes, as shown by positive quitting trends over time.

7   Within the personal health sector, some hospitals and general practices offer smoking cessation services. However, smoking cessation advice and treatment have not been provided systematically by health care professionals across New Zealand as an essential part of everyday care for smokers. This can be seen, for example, in low NRT utilisation rates. Primary health care professionals have provided advice, support and prescriptions/referrals to smokers as required, but *overall* their involvement has not been as intensive as anticipated under the proposed approach.

Purpose and goals of the ABC approach

8   The purpose of the ABC approach is to make the health sector's approach to smoking cessation more systematic, by integrating the ABC approach into the everyday practice of all health care workers who have contact with smokers. In the medium-term, there is also scope for promoting cessation services through social service agencies and community networks, so that smokers are surrounded by a culture of support for quitting.

9   The goal of integrating cessation advice into personal health care is to generate 'more supported quit attempts, more often' by systematically providing smoking cessation advice and support reliably and repeatedly across the health sector (and beyond).

10   Success of the ABC approach will be measured by an increase in the quit rate, represented by the proportion of smokers per year who succeed in quitting smoking long term. An underlying goal of this new approach is not just to add another programme to the menu of interventions that health care workers currently deliver, but to change the way smoking is seen by clinicians. If successful, smoking will be treated as part of the vital clinical information that is recorded, monitored and acted on by health care workers, rather than a part of a patient's social history.

2   Smoking Outcomes and Trends

Overarching outcomes

11   Tobacco is the leading cause of preventable morbidity and mortality in New Zealand, accounting for an estimated 5000 deaths every year. It contributes significantly to cardiovascular disease, cancer and chronic obstructive pulmonary disease. It also impacts significantly on child health through its direct effects during pregnancy and indirect effects in childhood (eg, respiratory tract conditions).

12   The societal cost of smoking in New Zealand was recently estimated at $1.685 billion, or about 1.1 percent of GDP. Major components are lost production due to premature mortality, lost production due to smoking-related morbidity, and in excess of $1.5 billion in health care costs.[2] In addition, it is estimated that 81,650 quality-adjusted years of life are lost to smoking each year.[3]

13   Helping people to stop smoking is therefore a leading national health goal. The vision of the national five-year strategic plan on tobacco control 'Clearing the Smoke 2004–2009' is for New Zealand to be a country where smokefree lifestyles are the norm. The plan identifies the following four goals:

1   To significantly reduce levels of tobacco consumption and smoking prevalence.

2   To reduce inequalities in health outcomes.

3   To reduce the prevalence of smoking among Māori to at least the same level as among non-Māori.

4   To reduce New Zealanders' exposure to second-hand smoke.

14   Each goal has a number of associated targets including:

- reduce the adult smoking prevalence from 25 percent to at least 20 percent by 2009

- reduce smoking prevalence among people aged 15–19 from 26 percent to at least 20 percent by 2009

- reduce smoking prevalence of Māori adults from 49 percent to at least 40 percent by 2009.

15   These targets will be reset as part of an upcoming review and update of 'Clearing the Smoke'.

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[2]   Wright C. 2008. *Excess Costs to Health Care as a Result of Tobacco Use in New Zealand During 2006/2007*. Ministry of Health.

[3]   *Report on Tobacco Taxation in New Zealand*. Commissioned by the Smokefree Coalition and ASH New Zealand, 12 July 2007 (yet to be published).

The current situation

Smoking trends

16   The 2006 Census reported that 20.7 percent of the population aged 15+ years were regular smokers.[4] This equates to around 654,000 New Zealand adults. Smoking is more prevalent in particular population groups, including young people, those from more deprived socioeconomic quintiles and Māori (who also make up a significant proportion of the other groups).

17   The prevalence of smoking amongst the general population has been trending down, as seen in the decrease in prevalence of daily smoking from 23.7 percent in 1996 to 20.7 percent in 2006.[5]

18   The three key objectives of tobacco control activities remain:
   1   To reduce smoking initiation.
   2   To increase quitting.
   3   To reduce exposure to second-hand smoke.

19   New Zealand has made progress in reducing initiation rates over time. The 3 percent overall drop in the prevalence of daily smoking between 1996 and 2006 was due to an increase in the proportion of 'never-smokers' in the population. Annual ASH surveys show rapidly declining initiation rates.

20   Census data shows there has been greater success with reducing initiation than with getting existing smokers to quit. The first graph below shows that the proportion of ex-smokers in the population remained static over this period. However, in terms of absolute numbers of people, the quit rate has been increasing over time, albeit slower than the decrease in initiation rates.

21   On the third objective, legislative (smokefree public places, schools and workplaces) and social marketing initiatives (smokefree homes and cars) have substantially reduced exposure to second-hand smoke.

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[4]   Data on smoking prevalence in New Zealand varies depending on the survey approach used. There are currently four different datasets which enable prevalence to be estimated: the NZ Census (gathered every five years); the NZ Tobacco Use Survey (employed for the first time in 2006, and to be run every two years); the New Zealand Health Survey (last run in 2006/07, and run every two years); and the annual ACNielsen (NZ) Ltd omnibus survey (which gathered smoking prevalence data for every year from 1976 to 2007). Trends for smoking prevalence will be monitored primarily through the NZTUS and the NZ Health Survey in the future. The range of prevalence estimates for 2006 is from 20.7 percent (people aged 15+) as reported in the Census, to 23.6 percent in the ACNielsen survey (people aged 15+), with the NZTUS reporting 23.5 percent (for people aged 15–64 years).

[5]   Based on Census data.

Figure 1: Cigarette smoking prevalence 1976–2006 (census data)
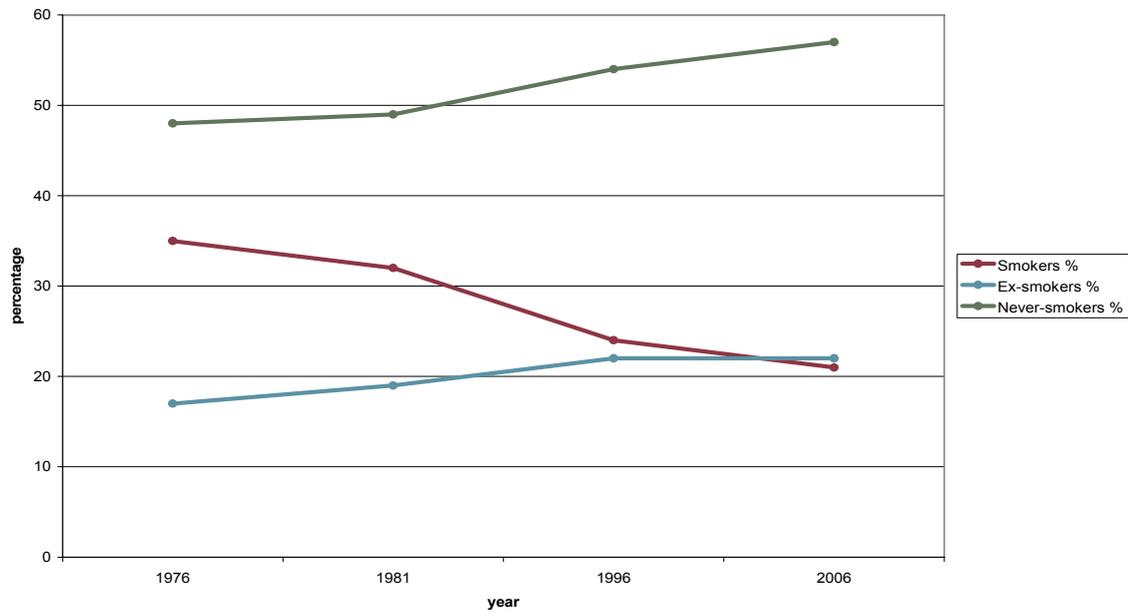
Figure 2: Number of quit attempts in the last 12 months (%) among smokers who have ever quit for more than a week
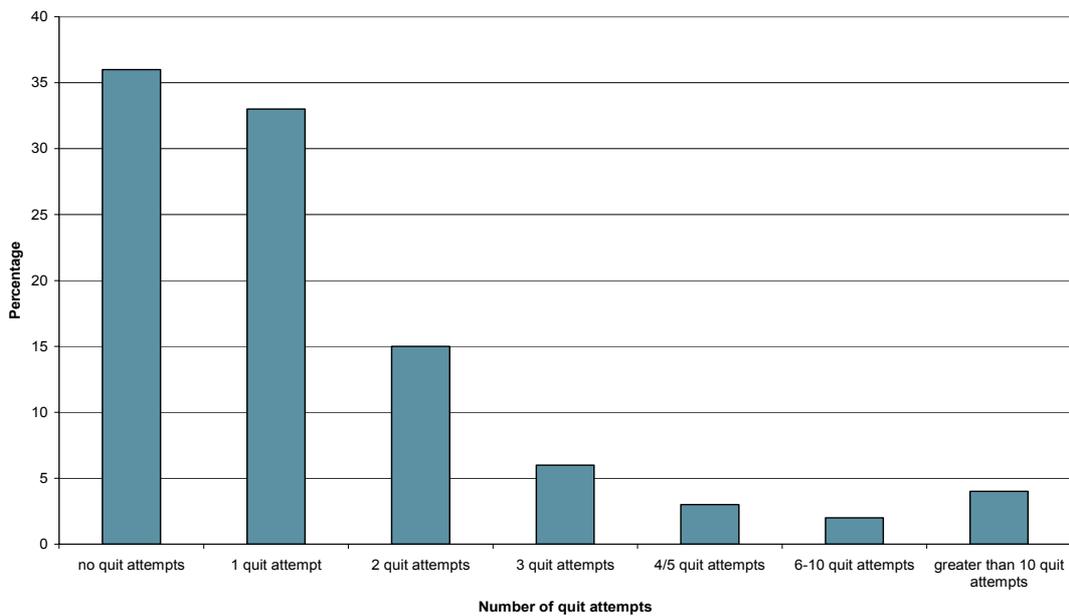
What data on quitting shows us

22   Data on quitting shows:[6]

- it takes the average smoker a number of attempts before quitting successfully long term

- less than 25 percent of serious quit attempts last a week and most quit attempts remain unaided

- of people who had quit or tried to quit smoking, 26 percent received some form of advice on how to quit during their last attempt. Smokers receive advice or help to quit predominantly from four types of providers; Quitline (47 percent), friend or family (39 percent), doctor or general practitioner (32 percent) and from a stop-smoking programme (29 percent)

- 27 percent of people used a quitting product of some sort during their last quit attempt. Nicotine patches are the preferred product over any other, being used by 68 percent of people who used quit products in their last quit attempt.

23   Barriers to smokers successfully quitting include:

- inadequate knowledge of the role and safety of NRT products

- a residual belief that will power is the key to quitting – there is still a strong perception amongst smokers that 'smokers who fail to quit do not really want to quit' (38 percent agree) and that 'people should be able to quit without the help of programmes or products (28 percent agree).

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[6]   Ministry of Health. 2007. *New Zealand Tobacco Use Survey 2006.* Wellington: Ministry of Health.

3   Description of the ABC Approach

Rationale and objectives

24   Decreasing smoking prevalence depends on two things: decreasing the rate at which people start smoking (the initiation rate), and increasing the rate at which people quit smoking (the quit rate). If the quit rate *exceeds* the initiation rate over time, the proportion of the population who smoke will reduce.
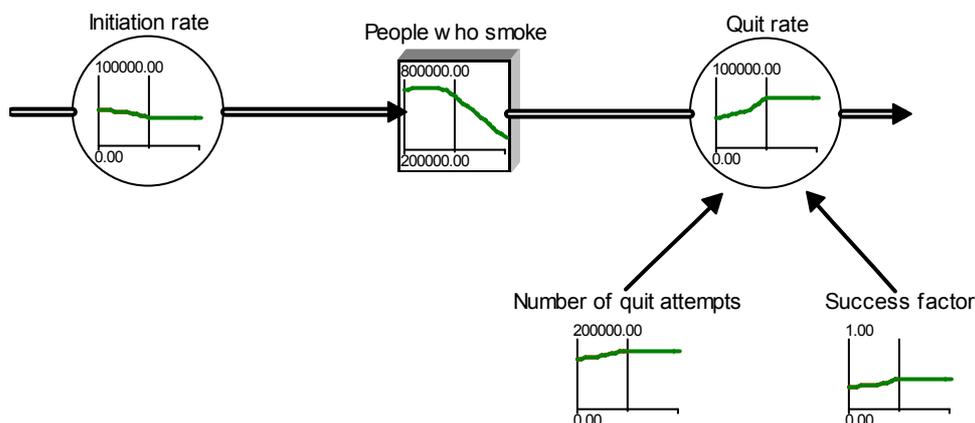
25   In crude terms, the quit rate equals the number of attempts in a certain period multiplied by the likelihood of success for each attempt. The two points of leverage to increase the quit rate are therefore to:

- increase the number of quit attempts in the first place, and
- improve the likelihood of success for each attempt.

26   Accordingly, the ABC approach has a goal of integrating cessation advice into personal health care to generate 'more supported quit attempts, more often' by systematically assessing smoking status and providing smoking cessation advice and support reliably and repeatedly across the health sector. This can be broken down into two objectives:

1   **Trigger more quit attempts**: when a person has been identified as smoking then they should always be advised to stop. Studies show that brief advice to stop smoking from a general practitioner improves six-month abstinence rates. Brief advice appears primarily to trigger the person to make a quit attempt rather than increasing the chances of success of quit attempts.

2   **Improve the likelihood of success of each attempt by using treatment**: quit attempts are less successful than they could be because many people who smoke do not think they need treatment, and do not understand how the treatments work or what the benefits are. To increase the chance of quit attempt success, people who smoke need guidance and treatment based on approaches that are shown clinically to promote the greatest chance of success. Pharmacotherapies, such as nicotine replacement therapy (NRT), bupropion, and varenicline at least double the likelihood of a successful quit attempt. Adding behavioural support to these further increases long-term quit rates.

27   The ABC approach will act on these objectives by embedding smoking cessation advice, information and support as an essential health care activity for health professionals (and potentially beyond the health care sector, in the longer term).

How the ABC approach expects to reduce the number of people who smoke

End goal

Reduce the number of people who smoke

Intermediate goal

Increase the quit rate
(number of successful quit attempts per year)

Immediate goals

Number of attempts
Increase number of quit attempts

Success factor
Increase the likely success of each quit attempt

Getting healthcare workers to systematically...

By…

'Triggers'
Trigger more attempts (through applying ABC)

'Treatment'
Advise on treatments and support approaches which have greatest likelihood of success

What is required?

1. Encouraging uptake of ABC by providers

Leadership and communication (context and expected benefits, roles and expectations)
Plans and contracts
Incentives and targets

2. Developing knowledge and clinical competencies to deliver ABC

Information and guidance
Competencies
Training

3. Systems to support ABC

Reporting systems
Contract monitoring
Advisory services
Patient Information Systems (covers non-primary care setting databases)
Referral pathways
NRT availability

4. Encouraging demand for ABC by smokers

Knowledge and awareness
Addressing barriers

What difference is ABC expected to make?

28   An important action within the ABC work programme is to develop a model to assist DHBs and local providers to estimate the impact of increasing quit rates on

their own performance measures, including prevalence of smoking, health care costs and quality-adjusted life years. Modelling work will also be done to show the expected impact of the ABC approach under different assumptions about key variables (such as number of quit attempts, and uptake of cessation treatments such as NRT).

29   As an indication of the potential impact of the ABC approach, the graph below shows the estimated effects on smoking prevalence if all people who smoke made one attempt per year to stop, starting at age 35.[7] The effect of only prompting a quit attempt on a yearly basis is shown by the dark blue bars – within 15 years half of all people who smoked would have stopped.

Figure 3:   Effects on smoking prevalence of strategies to help smokers if all smokers made one attempt per year to stop, starting at age 35
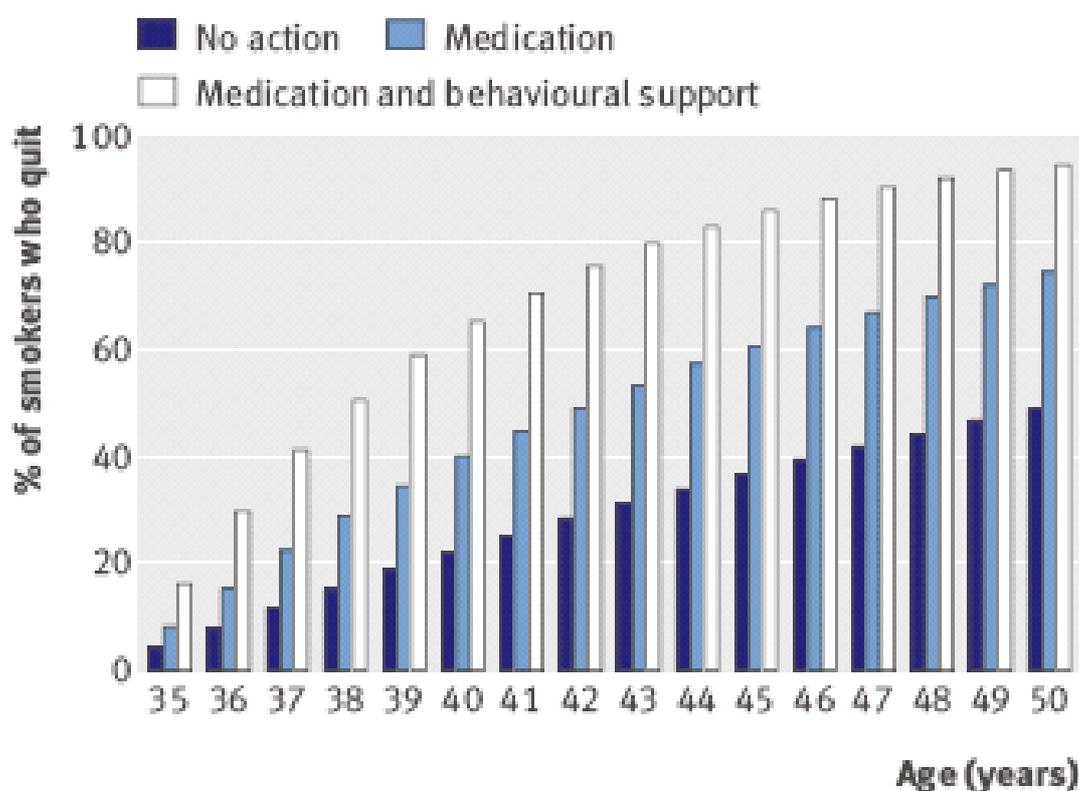
By adding pharmacotherapy and behavioural support to each of these quit attempts over 90 percent of all people would have stopped smoking within this 15-year period.

Who are the target groups?

30   ABC is intended to become routine practice for all health care workers in relation to all people who smoke. However, within the population of people who smoke there are particular target groups for whom increasing the quit rate is crucial. These include:

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7   Aveyard and West. 2007. Managing smoking cessation. *British Medical Journal* 335: 37–41. Used with permission.

A **Māori and Pacific people** – these population groups demonstrate significantly higher prevalence of smoking than other segments of the population, and disproportionate adverse health outcomes that can be attributed to smoking. In the New Zealand Health Survey 2006/07, Māori women were more than twice as likely to be current smokers than women in the total population. Māori and Pacific men were 1.5 times more likely to be current smokers than men in the total population.

B **Pregnant women** – the impact of smoking during pregnancy on infant and child health is substantial. Smoking cessation advice and support is arguably the most important component of maternity care for pregnant smokers.

31 A particular focus on these groups will mean ensuring that health care workers:

- have suitable targets and incentives to apply ABC in relation to these priority groups

- understand the impact and benefits of smoking cessation within these groups

- know the appropriate and relevant messages in delivering ABC to encourage cessation within these groups

- receive training on the delivery of ABC in a way that is tailored to particular cultural needs, to increase the chances of success.

32 Another important target population is **parents (15–45 years)** – helping parents to quit is crucial to further reducing smoking initiation by children and young people. The 2006 Year 10 survey showed that students with two parents who smoke were much more likely to be smokers (33 percent) than if only one (19 percent) or neither parent smokes (8 percent). The impact of ABC approach on parents whom are a reasonable subset using health care services, will be evaluated.

33 The ABC approach will also actively consider suitable approaches for ensuring that mental health clients, and youth are appropriately targeted.

Who will deliver ABC and in which settings?

Settings	General (including parents)	Pregnancy	Māori (including parents)	Pacific (including parents)
Health care services				
Primary and community health care settings	General practices • Clerical staff in practices • General practitioners • Practice nurses Healthline advisers Dentists and oral hygienists Public health nurses Occupational health nurses Pharmacists and pharmacy staff Physiotherapists Alcohol and drug workers Psychologists and psychiatrists Screening clinics Wellchild providers/Plunket Mental health community services Youth/Student Health Services	General setting and: • midwives • obstetricians • Family Planning • Wellchild/Tamariki Ora • Plunket nurses	General setting and health care workers who have contact with Māori clients/patients, and: • Māori hauora providers • Māori-led PHOs • Tamariki Ora nurses • Plunket Kaiawhina • community health workers • health promotion organisations	General setting and health care workers who have contact with Pacific clients/patients, and: • Pacific health providers • Pacific-led PHOs • Plunket Cultural Support • health promotion organisations • community health workers • at-home care services
Hospital settings	Clerical staff in hospitals and clinics All hospital-based doctors, nurses, pharmacists, dentists, OTs, PTs, psychologists, psychiatrists, social workers Allied health		Māori cultural support workers Kaumatua Māori social workers	Pacific cultural support units CMDHB Lotu Mo'ui Church Programme Pacific social workers
Specialist cessation services				
	Quitline advisers Locally developed cessation services	Regional specialist cessation services for pregnant women	Aukati Kai Paipa	Pacific smoking cessation service

Settings	General (including parents)	Pregnancy	Māori (including parents)	Pacific (including parents)
Non-health care settings				
	Workplaces WINZ Housing NZ Budget Advisory/Citizens Advice Educational settings		Community/lay workers who have contact with Māori clients	Community/lay workers who have contact with Pacific clients

NB: Please note the content of this table is not limited to those listed.

Outline of the ABC approach

Who   **What**

Support and leadership   **Delivery**

| Ministry of Health |
| DHBs |
| Provider organisations (eg, PHOs, midwife collectives, private hospitals) |
| NGOs |
| Educational institutions |
| Professional bodies |

Frontline clerical staff

Health care workers

Specialist cessation services

A Ask patients whether they smoke

Ask all people documented as current smokers at each presentation to a health service whether they are still smoking

B Give brief advice (based on an understanding of tobacco control)

C Refer people who smoke to a appropriate specialist cessation support service

Recommend pharmacotherapy and explain how to use it

Provide follow-up support

Document ABC using the appropriate systems

Encouraged by ...
- Knowledge and understanding of context
- Leadership and expectations
- Incentives and targets
- Feedback on progress

Supported by ...
- Information and guidelines
- Training
- Administrative systems

How does ABC fit alongside other interventions?

34   The ABC approach is designed to complement other interventions aimed at reducing smoking. Some of these interventions are focused on encouraging people not to start smoking (ie, lowering the initiation rate), including:

- social marketing initiatives (eg, smokefree homes and cars)
- legislation (eg, smokefree public places, schools and workplaces).

35   Some of the same interventions, and others, are targeted at encouraging and supporting people to quit smoking (ie, increasing the quit rate). These include:

- an active national Quitline service
- heavily subsidised nicotine replacement therapy
- culturally appropriate smoking cessation services for Māori and Pacific people
- mass media campaigns.

36   The diagram below shows how the ABC approach will fit alongside other
      interventions as part of an overall strategy to reduce smoking in New Zealand.
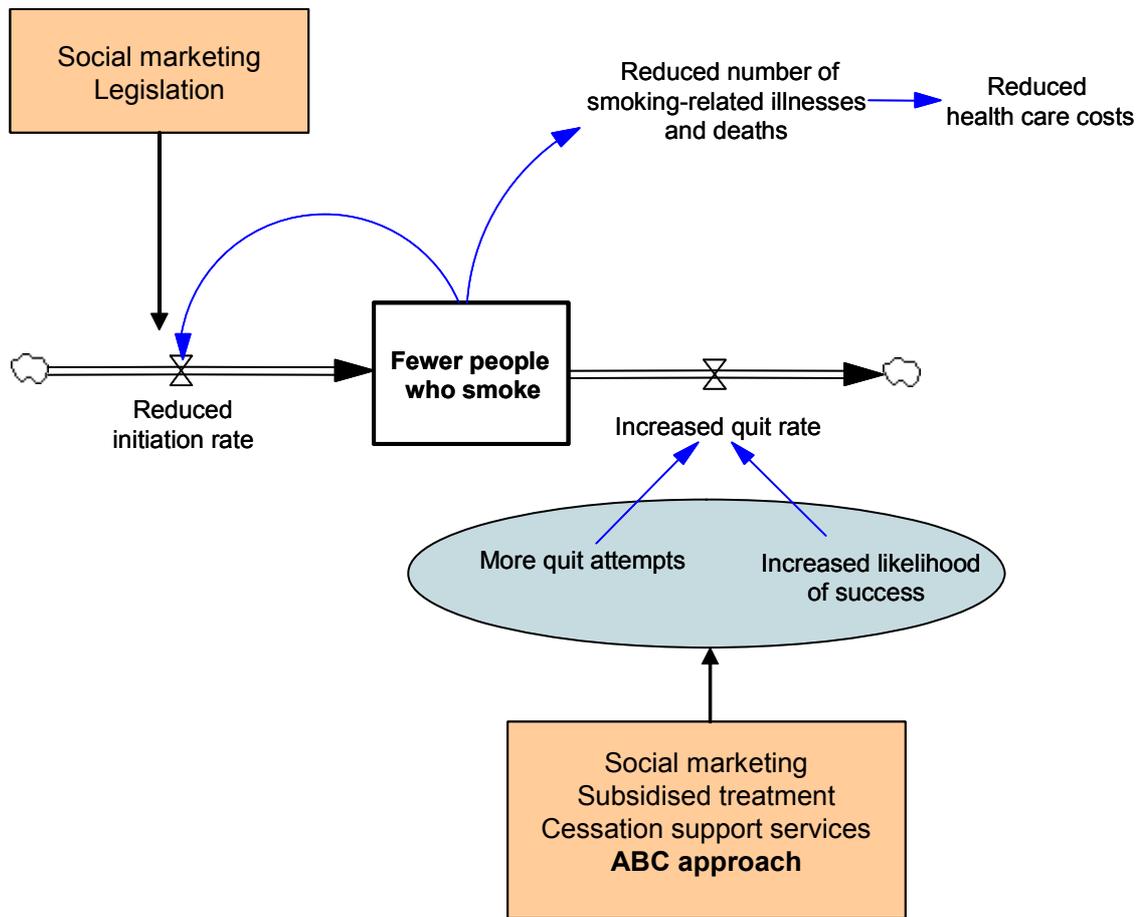
4   Approach to Implementing ABC

Key areas of focus

37   There are four areas of focus over the short to medium term that are needed to implement the ABC approach effectively:

1   Encouraging health care workers to deliver ABC

This means ensuring that health care workers and organisations embed ABC into their daily practice by:

- promoting knowledge among health care workers and organisations about:
  - the context and expected benefits of ABC
  - their role in implementing the approach
- creating expectations and a culture that support uptake of ABC, particularly through leading health care organisations and professional bodies
- putting in place appropriate incentives to meet targets which drive success
- utilising contractual requirements to ensure delivery of certain aspects of the ABC approach
- regularly feeding back information to health care workers about successes and progress.

2   Equipping health care workers to deliver ABC

This means ensuring that people delivering the ABC approach have the technical knowledge and skills they need to apply it effectively, including knowledge about:

- common barriers for people trying to quit
- the ABC approach and its expected benefits
- their role in delivering ABC
- approaches to Asking and providing Brief advice (including how to apply successfully for different target groups and populations)
- different cessation treatments and support, which are proven to be effective.

3   Supporting the health system to deliver ABC

This means ensuring that the necessary systems and structures are in place across settings for effective ongoing support of the ABC approach, including:

- referral pathways
- responsive specialist services
- data collection, monitoring and improvement
- communication approach
- systems to support targets and incentives
- practice management systems/patient information systems

- contract monitoring.

4 Encouraging consumers to demand ABC

This means encouraging smokers who wish to quit to seek advice on treatments and support, by:

- increasing their awareness of the role of the health care workers and specialist cessation services

- the range of treatments and support available

- change the perceptions of people who smoke about the role of, and need for treatment and support as part of a successful quit attempt.

38   The key areas of focus for implementing the approach will be applied across four settings within and beyond the health sector: primary and community health care services; hospital-based settings; specialist cessation services; and non-health care settings, although implementation in these settings is a later priority.

39   The overall approach to implementing the delivery of ABC is to strike the right balance between ensuring a consistent national approach and enabling and supporting locally-driven structures and solutions to implement ABC in a manner that it meets the needs of local populations and health care systems.

Levers

40   The Ministry of Health and DHBs have a range of levers available to them to encourage uptake and practice of ABC by health care workers. These are described below.

Contractual arrangements

41   The Ministry and DHBs have funding contracts with a range of providers that specify services to be delivered. These contracts provide an opportunity to incorporate the ABC approach into the delivery of services. Examples of contractual levers include:
- the letter of expectation from the Ministry of Health to the DHBs
- the requirement for DHBs to develop tobacco control plans
- the Service Coverage Schedule, which specifies services that should be available to all New Zealanders.

Ability to outline expected impacts, set targets and create incentives

42   Experience with other programmes such as breast screening shows that providing something to aim for, clear measures of success, and financial incentives to achieve outcome targets all promote acceptance of a broad new approach. Ministry and DHBs have the ability to set targets and create incentives in the primary health care setting through the Performance Programme for PHOs.

43   Financially driven targets and incentives are less easily created in the hospital-based health care setting, where hospitals tend to respond more to contractual/

funding levers such as activity-based funding. Hospitals are also likely to respond to a clear articulation of the expected impacts of ABC on the burden of care in the future, such as impacts on surgical risk, level and type of admissions, and cost of smoking-related care.

Provision of guidelines, information and training

44   The Ministry and DHBs are able to develop national and local guidelines to explain the ABC approach and how it should be delivered by health care workers. This information and guidelines will be supported by specific, targeted training.

45   The Ministry and DHBs provide training, directly and through contracted providers, to a range of health care professionals and organisations. This is an important means of ensuring that these people have the knowledge and skills to apply ABC effectively in practice.

Leadership and influence within the health sector

46   Setting up expectations and communication about the ABC approach is a necessary part of creating an environment where ABC is accepted as a part of daily practice of health care workers. The Ministry, DHBs, and professional bodies are all well placed to exercise these leadership functions and communicate the importance of the ABC approach amongst other demands on the time of health professionals. Social marketing also plays a role in changing the ideas of health professionals as well as the general public.

Success factors and barriers

47   Success of this project will see more smokers making more quit attempts that are supported with effective treatments (eg, NRT) more often. In the long term this will be demonstrated by a drop in smoking prevalence.[8] 'Real life' data from Southern California has demonstrated that interventions, similar to ABC (eg, the 5As), delivered in primary care can make a significant difference to the number of people stopping smoking.[9]

48   Lessons from the PHO pilot in Auckland and from the implementation of other, similar health programmes in New Zealand (including the immunisation and breast screening programmes) suggest there are particular factors that will hinder or support successful implementation. These are discussed below.

Possible barriers

49   The main barriers identified to uptake of such approaches by health care workers are:

A.   lack of funding and incentives to take on new approaches

B.   high compliance costs

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[8]   Aveyard and West. 2007. Managing smoking cessation. *British Medical Journal* 335: 37–41.
[9]   Quinn VP, Hollis JF, Smith KS, et al. 2008. Effectiveness of the 5As tobacco cessation treatments in nine HMOs. *J Gen Intern Med*, 13 December [Epub ahead of print].

C.   lack of knowledge about the smoking cessation by general practice staff (including beliefs that smoking cessation treatments are ineffective)

D.   lack of time

E.   repetitive strain from new programmes

F.   lack of support from professional groups

G.   lack of support from organisational management

H.   professional ambivalence.

Success factors

50   Key success indicators are:

a)   95 percent GPs identified as routinely implementing ABC

b)   100 percent of all undergraduate courses related to health care have implemented ABC training into their curricula[10]

c)   100 percent of PHOs are able to report on smoking indicators

d)   95 percent of PHOs are achieving the set targets (targets will include, but are not limited to, increase in referrals to smoking cessation treatment providers, increase in use of smoking cessation medications)

e)   an improvement in the accuracy of smoking data collected in hospital admissions so that this data reflects the true smoking prevalence

f)   an increase in the number of people quitting smoking.

Notes regarding success indicators

(1)   All targets will be subjected to a priority populations lens to ensure that inequalities are being addressed.

(2)   In regard to PHO targets, the percentage to be achieved will be that of an enrolled population.

51   Key processes that are likely to demonstrate successful implementation of ABC include:

A.   ensuring that health care workers understand the context, importance and expected impact of ABC, because it is explained in tangible terms – lives saved, illness prevented, time and costs saved

B.   providing leadership commitment, support and signalling of importance – including from organisational management and leading professional groups, eg:

- involving the professional bodies in promoting and advising on the programme
- establishing clinician champions within DHBs and clinical practices

C.   providing something to aim for and a reason to do it – the right incentives and targets for population coverage and participation

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[10] The rationale for this indicator is that it will have an important impact on culture change within health care. ABC will become the standard of care.

D.   providing the necessary resources and tools, including:
   - making time available
   - adequate funding, including for implementation and ongoing evaluation

E.   keeping compliance costs and bureaucracy to a minimum

F.   investing in knowledge and training for staff (making sure that training is appropriate in terms of time and content)

G.   creating a feedback loop to health professionals – communication of success/progress against key indicators

H.   connecting the system – this involves implementing the necessary elements of the ABC approach in an integrated way, so that:
   - the 'system' is oriented around the needs of smokers and what works for them
   - smokers receive clear and consistent messages across the health system and beyond
   - the process related to ABC (eg, referrals) is seamless.

Workstreams

52   The work required to implement the ABC approach is divided into six integrated workstreams, described below:

1   Primary and community-based health care

   - Ensure that the ABC approach is embedded into the practice of health care workers and organisations operating in primary and community-based health care settings. The ABC approach in primary care will include a focus on the appropriate target populations.

2   Hospital-based health care

   - Ensure that the ABC approach is embedded into the practice of health care workers and organisations operating in hospital-based health care settings, including a focus on target groups and populations.

3   Specialist cessation services

   - Ensure that specialist cessation services are available, accessible, responsive, well linked to other health care services, and that collectively they meet the needs of people who smoke.

4   System support and training

   - Ensure that leadership and crosscutting system support is provided to health care workers and provider organisations to promote uptake and effective delivery of the ABC approach.
   - Ensure that people delivering the ABC approach have the knowledge they need to apply it effectively.
   - Ensure that the overall approach to training for ABC delivery is integrated, coherent, effective and provides value for money.

5   Increasing consumer demand

- Encourage smokers who wish to quit to seek advice on treatments and support.

6   Monitoring and improvement

- Ensure that the impact of the ABC approach is monitored and evaluated over time.

- Ensure that learning about the effectiveness of the ABC approach is fed into future strategy and policy development.

53   As the diagram below shows, there are three workstreams based on particular health care settings: primary and community; hospital; and specialist cessation services. The other three are either crosscutting (systems support and training, and monitoring and improvement), or separate from health care settings (increasing consumer demand).

Primary & community

Specialist cessation

Hospital

System support and training

Increasing demand

Monitoring and improvement
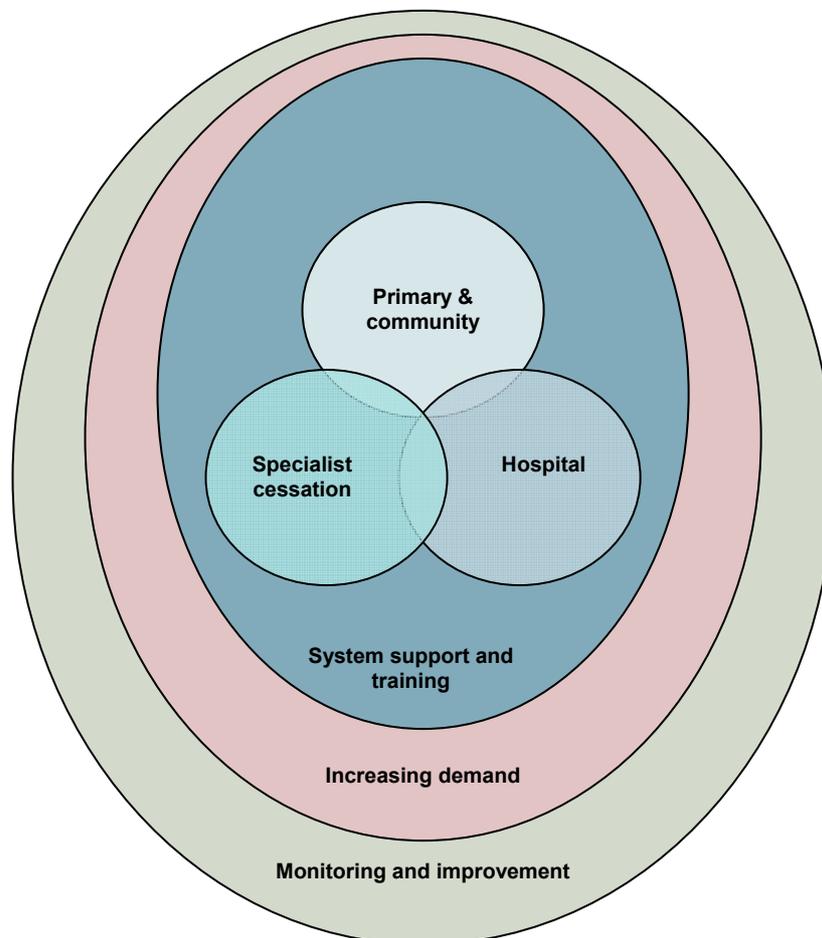
Focus within each health care setting

54 People employed within the health workforce are also, of course, part of families, whanau and the wider communities. As such they are a key audience for role modelling or 'walking the talk' of the ABC approach. DHBs and other organisations are responsible for the health and welfare of employees and have a role in assisting those currently smoking to stop.

Primary care

55 The primary health care sector is potentially large. To ensure that implementation work is focused first on the areas of primary health care that are likely to have the greatest impact on smoking cessation, the groups within primary health care that will be targeted initially are:

- PHO-based services – in practice this means focusing on general practice, as the evidence suggests that this is an area where impacts will be greatest
- Māori and Pacific health care services and workers
- midwives and lead maternity carers.

Secondary/tertiary care

56 Implementing ABC within secondary health care will be run in parallel with the primary setting, with an initial focus on clinicians operating in hospitals, including maternity services.

57 To ensure success it is critical all staff (including non-clinical staff) within DHBs are involved in prompting and supporting quit attempts.

Other settings outside of health

58 The focus of implementing ABC is within the health sector. Transferring this model into non-health care settings will be addressed once the approach is embedded in relevant health care settings. This may take at least 3–5 years to achieve.

Perspectives on target groups

59 In addition to the six 'vertical' workstreams, the work programme builds in perspectives on three target groups – pregnant women, Māori, and Pacific people.

60 Individuals will be assigned responsibility for working across the different workstreams, applying the lens of these three target groups. The role of these people is to:

- take an integrated 'target group' perspective on implementation of the ABC approach
- provide input and advice on the specific actions within each workstream that are needed to take account of the needs and approach to each target group

- where appropriate, maintain the interface with stakeholders and specialist services that deal specifically with these target groups to inform the broader workstreams and provide information back to stakeholders.

61   The figure below illustrates how these crosscutting responsibilities for considering specific target groups will intersect with the six workstreams. The example shown is in relation to smoking in pregnancy, but a similar approach will be taken to Māori and Pacific perspectives. Note that accountability for developing and implementing relevant actions relating to target groups will rest with the workstream leaders.

62   Parents are also an implied priority group as their smoking behaviour is the primary risk factor to their children's likelihood of smoking. Parents and parents-to-be enter the health system through all services and as such this group will be responded to within all health care settings.

63   Beyond the three specific target groups of Māori, Pacific Island and pregnancy, each workstream will also actively consider suitable approaches for ensuring that mental health clients and youth are appropriately targeted through the different workstreams.

Workstreams					
	Primary/community and hospital based	**Specialist services**	**Systems support and training**	**Increasing consumer demand**	**Monitoring and improvement**
Target area: smoking in pregnancy	Work with specific pregnancy health care workers on ABC implementation Advise on pregnancy-related dimensions of implementing ABC in general primary/ community and hospital settings	Work with specific pregnancy specialist cessation services Advise on pregnancy-related dimensions of smoking cessation treatment Procurement plan for specialist cessation services	Input into competencies, information, guidelines and training programmes from pregnancy perspective	Awareness of impact of smoking in pregnancy Stocktake of current and recent local and national public health initiatives and recommendations for future programmes	Review of data and information available about the prevalence of smoking in pregnancy Action plan for future monitoring and surveillance of smoking in pregnancy

Roles and structures to support implementation and delivery

Ministry of Health
- Provide leadership and set out expectations
- Lead development and refinement of ABC strategy
- Lead development of national training approach
- Incorporate ABC into contracts with DHBs
- Outline expected impacts of ABC
- Create incentives and targets

Director-General and SLT

Public Health Operations

Programme sponsor and manager
Ensure system is integrated and coherent

DHBNZ

DHBs
- Provide leadership, set out expectations, and outline rationale and expected impacts
- Contribute to strategy and provide feedback
- Deliver training on ABC
- Provide information and support to healthcare workers delivering ABC
- Create incentives and targets
- Advise on protocols

Board/General management
- Sets expectations
- Provides leadership and mandate
- Approves resources

Relevant PHO staff
- Provides advice to clinicians
- Ensures integration of systems for secondary care
- Key contact point for Ministry
- Provide feedback to workstream leaders

Clinical champions
Clinical leadership and experience

Primary Care Programme Managers

Public Health, Planning and Funding and other staff with Tobacco Control in their portfolio

Practice Management Vendors

PHOs - Provider organisations

General Manager/Clinical Director
- Organisational leadership and mandate

PHO Smokefree Co-ordinators
- Set up systems and protocols
- Provide feedback to improve strategy and delivery

Practice managers
- Integration/administration of systems
- Organisational leadership

Clinical champions, especially GP leadership
- Clinical leadership and experience

Non-PHO provider organisations

Secondary and allied health care workers

Primary health care workers

Professional bodies
- Provide leadership and set out expectations
- Incorporate smoking cessation into professional development

Educational institutions
- Incorporate smoking cessation into curricula for health care professionals

High level implementation plan (2008/09)

	Primary/community settings	Hospital-based settings	Specialist cessation services	Systems support and training	Increasing consumer demand	Monitoring and improvement
End December 2008	Consult primary care stakeholders on their needs Establish clear targets and incentives	ABC approach and rationale clearly communicated within DHBs	Monitor impact of implementing ABC on specialist services	Establish clinical leadership across settings (including professional bodies)		
End March 2009	Clinical leadership established for primary care Input to training design for primary care CPI report/IT systems incorporate ABC targets	Protocols in place Clinical leadership in place	Determine needs of smokers, and the range of services needed to meet smokers' needs Stocktake of specialist services Review of specialist service approach in other countries	Incorporate cessation objectives into SCS and letters of expectation and tobacco control plans	Social marketing campaign developed	Indicators and monitoring framework developed (November–February) Baseline data compiled and communicated Simulation model scoped and developed
	← Training delivered →					Data gathering systems developed/modified as required
End June 2009	PMS modified Training programmes commenced Protocols/Smokefree policies developed, including NRT distribution	Quality improvement levers linked to ABC Pharmacotherapy guidelines developed DHB smoking cessation policies in place (January–June)	Guidance for service funders on meeting needs of priority groups Referral pathways in place	Increased access to NRT – prescription and standing orders		Reporting and feedback (ongoing)
End December 2009	PHO organisational plans for ABC, including resources			ABC/NRT part of tertiary curriculum		Evaluation projects identified (ongoing)

5 Project Structure, Governance and Management

Roles and responsibilities

Programme sponsor

64   The sponsor chairs the Steering Group and provides overall leadership for the implementation of the ABC approach. A further role of the sponsor is to ensure that the Programme Manager and Workstream Leaders have sufficient funding and resources to successfully complete their projects.

65   The programme sponsor is Dr Ashley Bloomfield, National Director Tobacco Control and Chief Advisor Public Health (Ministry of Health).

Steering Group

66   The Steering Group will provide direction and advice to the Programme Manager and Working Group.

67   Activities of the Steering Group include approving the work programme, commenting on project plans for individual workstreams, allocating resources, monitoring progress, approving any variations, assisting with stakeholder management, and managing high level risks. The Steering Group will meet at appropriate intervals during the initial development and implementation period, and quarterly after this period. Steering Group meetings will be convened by the Programme Manager, and chaired by the Programme Sponsor.

68   The Steering Group will include representatives from the key stakeholder groups: the Ministry, District Health Boards, clinicians, and tobacco control organisations. The chair is the National Director, Tobacco Policy and Implementation Team, Ministry of Health.

Programme Manager

69   The Programme Manager for the ABC work programme is responsible for co-ordinating, monitoring and reporting the progress of the overall work programme to the Steering Group, including highlighting any risks or issues. The Programme Manager will attend Steering Group meetings, and plays a key role in ensuring that the programme as a whole 'thinks systemically' so that it is integrated across settings, and reflects the desired emphasis on particular target groups and populations.

70   The Programme Manager is the National Programme Manager, Tobacco Policy and Implementation Team, Ministry of Health.

Working Group

71   The Working Group will ensure consistency between the projects, identify and manage any inter-dependencies and provide a forum to raise and resolve common issues. The Group will also ensure that the right focus and emphasis of effort is applied across all workstreams.

72   The Working Group will comprise the Workstream Leaders of each workstream. The Working Group will meet regularly as convened by the Programme Manager and prior to the Steering Group meetings.

Workstream Leaders

73   The Workstream Leaders are responsible for overseeing their workstreams, further developing the project plans for approval by the Steering Group and for the achievement of deliverables on time and within budget. People will be appointed as Workstream Leaders. These people may come from any of the key stakeholder groups.

# ABC programme management structure

Governance

- Oversight and development
- Approving work programme and workstream plans
- Approving resources
- Monitoring programme progress
- Stakeholder management and communications

Programme sponsor
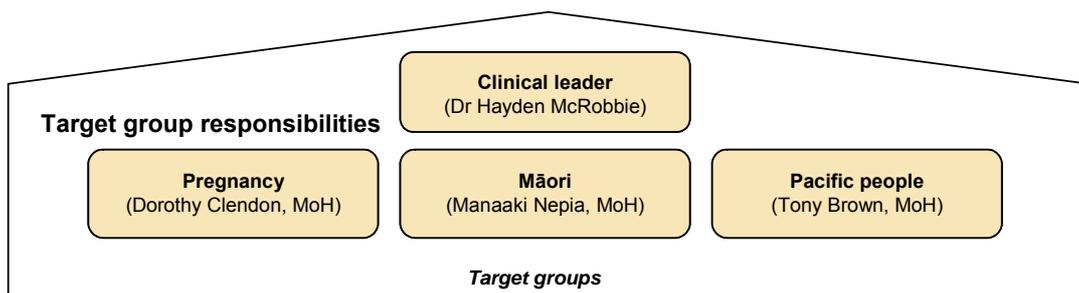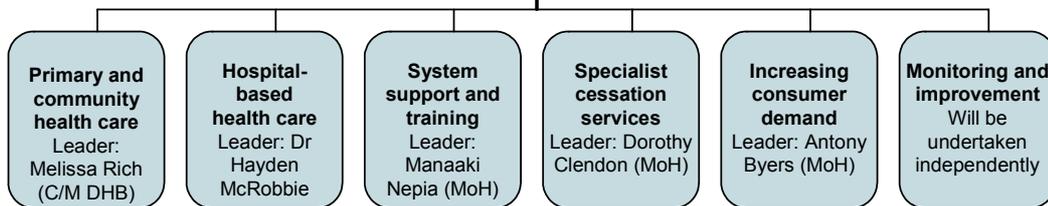Dr Ashley Bloomfield
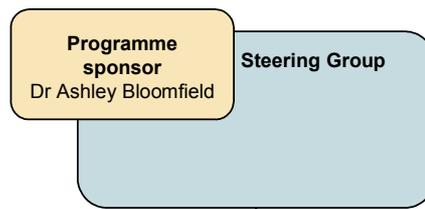
Steering Group

Management

- Day to day oversight of work programme
- Monitoring and reporting progress to steering group
- Discussing common issues
- Managing interdependencies between workstreams
- Developing communications plan

Programme manager
(Karen Evison, MoH)

Working Group
(Workstream leaders)

Communications plan
(Anthony Byers, MoH)
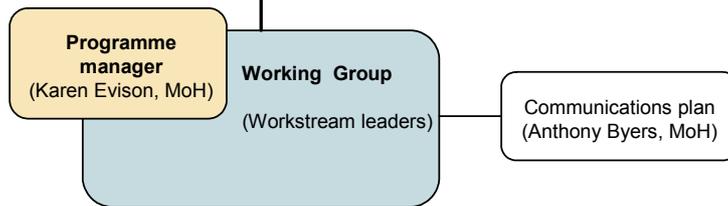
Delivery

- Developing project plans
- Managing individual workstream and implementing actions
- Reporting to working group

Workstreams

| **Primary and community health care** Leader: Melissa Rich (C/M DHB) | **Hospital-based health care** Leader: Dr Hayden McRobbie | **System support and training** Leader: Manaaki Nepia (MoH) | **Specialist cessation services** Leader: Dorothy Clendon (MoH) | **Increasing consumer demand** Leader: Antony Byers (MoH) | **Monitoring and improvement** Will be undertaken independently |

Clinical leader
(Dr Hayden McRobbie)

Target group responsibilities

| **Pregnancy** (Dorothy Clendon, MoH) | **Māori** (Manaaki Nepia, MoH) | **Pacific people** (Tony Brown, MoH) |

Target groups

Monitoring and reporting

74   The monitoring and reporting mechanisms will include:

A.   The Workstream Leaders will each provide a draft project plan (including project scope) for approval by the Steering Group. The project plan will include objectives, scope, deliverables, milestone dates, and resources.

B.   Workstream Leaders will provide a monthly progress report to the Programme Manager noting progress against milestones, and highlighting any risks to achievement of project deliverables or other issues.

C.   The Programme Manager will provide a consolidated monthly report to the Steering Group outlining briefly the progress of each project.

D.   The Programme Manager will integrate reporting on the review into internal Ministry of Health reporting systems, as required.

Stakeholders and communications

75   The programme manager will be responsible for ensuring that a communications and stakeholder management plan and approach is developed and used by the workstreams to:

- ensure that the overall approach to communicating with stakeholders and the public about the ABC approach is focused and integrated

- ensure coherent and integrated communication of key messages across all settings.

Programme-level risks

Risk/issue	Description of risk	Mitigation
Insufficient resources – workstream leaders	Workstream leaders are not available to manage the projects.	Project Sponsor/Programme Manager to identify and assign workstream and project leaders. Workstream leaders and their managers to ensure that competing commitments are managed effectively.
Insufficient resources – other staff	People are not available to provide the necessary support to the projects.	Workstream leaders to identify the time and resource requirements as soon as possible as part of project scoping and planning. Steering Group and Programme Manager to ensure that staff are available to support projects.
Insufficient funding	Projects require additional resources or specialist support that cannot be funded within existing budgets.	Workstream leaders to highlight funding requirements in project plans.
Misalignment of actions	Actions are not integrated across the different settings or elements required to implement ABC, creating duplication of effort, inconsistencies or anomalies in the system.	Working Group and Programme Manager to communicate effectively across workstreams and ensure that all Workstream Leaders have a clear view of the whole programme. Programme Manager responsible for developing a communications and stakeholder plan.
Bottlenecks in the system	Due to incorrect phasing of action to implement ABC, bottlenecks are created, leading to frustration and resistance from either consumers or providers, eg, increasing consumer demand for ABC before health care workers are trained; increasing referrals from GPs before cessation services have capacity.	Working Group to ensure that it regularly identifies and discusses dependencies across the whole programme of work.
Resistance from health care workers and provider organisations	Health care workers and provider organisations do not respond to the ABC approach and uptake is low.	Addressed through concentrating implementation on the success factors outlined in the framework.
Unintended consequences	The programme creates unforeseen side effects or unintended consequences.	Regular monitoring and evaluation of impact of the ABC approach and its component actions.

6   Summary of Workstream Activities

This section contains summaries of the objectives, context and focus of each of the six workstreams. For more detail on actions, timeframes and responsibilities, refer to the individual project plans held by the Programme Manager and Workstream Leaders.

Primary and community health care workstream

Objectives

The ABC approach will be embedded into the practice of health care workers and organisations operating in primary and community-based health care settings.

The ABC approach in primary care will include a focus on the appropriate target populations.

Context

Primary care is well placed to promote evidence-based smoking cessation interventions, as approximately 80 percent of adults visit their GP each year. Yet research highlights that patients who smoke are not routinely identified in general practice. To assist primary care to develop systems that would support health professionals in addressing smoking with their patients, a PHO Smokefree Systems Pilot was initiated in the Auckland region and ran for 17 months. Overall positive, yet limited progress was made in the project with the six participating PHOs. The main challenges to the pilot were: insufficient time available for PHO and practice staff; limited priority and management buy-in of Smokefree work and a lack of clear national targets and incentives.

The ABC primary care workstream seeks to address these systemic challenges to facilitate the delivery of the ABCs in general practice and associated community settings. Primary care is increasingly being required to manage chronic illness and cardio-vascular disease risk – addressing smoking routinely aligns with this shift in care. The primary care workstream will accommodate other health care initiatives in the sector, while keeping a focus on priority groups, such as Māori, Pacific communities and pregnancy.

Focus

This workstream will develop and implement the relevant aspects necessary to support the uptake and delivery of the ABC approach in the primary and community health care settings. The key areas of focus are:

- **Support and resourcing:** Support and resources will be available to DHBs and primary care organisations to implement the ABC strategy, through consultation and planning processes.

- **Leadership – clinical and community:** Strong clinical and community leadership for primary care to promote ABC delivery by health professionals.

- **Reporting and feedback:** Reporting and feedback processes will facilitate primary care professionals to deliver ABC support to the communities they work in. The impact of the ABC approach will be communicated back to health professionals to further inform their work.

- **Pharmacotherapy:** Pharmacotherapy options will be understood by primary care professionals and will be easily accessible for the primary care professional and the patient.

- **Training:** Appropriate training programmes that facilitate ABC intervention will be available for primary care professionals *(led through systems support and training).*

- **Services**: Cessation services and health promotion activities are available and effectively utilised by primary care *(led through specialist cessation services).*

Hospital-based health care workstream

Objectives

The purpose of this workstream is to ensure that the ABC approach is embedded into the practice of health care workers and organisations operating in hospital-based health care settings, including a focus on target groups and populations.

Context

Smoking is directly responsible for many illnesses that require hospital admissions, medical procedures and surgical operations. Being admitted to, or visiting, hospital brings smokers into direct contact with health care professionals who can advise on smoking cessation. In addition, the consequences of smoking are directly relevant, the smokefree environment provides few smoking cues and for some there will be less desire to smoke when feeling ill. The hospital health care setting therefore represents an important opportunity to assist people to stop smoking.

Focus

This workstream will develop and implement relevant requirements needed to support uptake and delivery of ABC in hospital-based health care settings. The key areas of focus for this workstream are:

- **Leadership:** Fostering clinical leadership of smoking cessation in hospital-based settings, by developing clinical leadership and promoting the ABC approach.

- **Policy and protocols that support the ABC approach:** Assisting hospital-based settings to develop suitable plans, policies, guidelines and protocols to support the delivery of the ABC approach.

- **Reporting and feedback:** Reporting and feedback processes to facilitate health care workers to implement the ABC approach. The impact of the ABC approach can also be communicated back to health professionals.

- **Pharmacotherapy**: Assisting hospital-based settings to develop suitable plans, policies, guidelines and protocols to facilitate the supply of pharmacotherapy to patients, staff and visitors.

- **Training**: Implement training that enables health care workers to deliver the ABC approach in hospital based settings.

Specialist cessation services

Objective

This workstream aims to ensure that specialist cessation services (the 'C' of ABC) are available, accessible, responsive, well linked to other health care services, and that collectively they meet the needs of people who smoke.

Context

The Ministry of Health, through the Public Health Group, funds all national and the majority of local specialist cessation services in New Zealand, including (but not limited to) the Quitline, Aukati Kai Paipa services, some specialist pregnancy and Pacific specific services. At a local level, some DHBs and PHOs fund and/or provide cessation services, the extent to which varies widely.

The majority of training for smoking cessation specialist workers is funded by the Ministry and provided by the National Heart Foundation or Te Hotu Manawa Māori (for AKP). There is no formally recognised qualification in smoking cessation at present.

Access and referral to specialist services

Smoking cessation services differ from most other health services in that the responsibility for initiating treatment usually falls to the smoker themselves. Self referral may be triggered in a number of ways, for example, in response to advertising or to advice from family, friends or health professionals. Access to specialist services requires a smoker to know about the services available and to be proactive in seeking help.

The Quitline number is widely advertised and often used as a first port of call for information about cessation.

In most settings referral pathways do not exist to enable a health care worker to directly refer a smoker to a cessation service (and for the service then to proactively contact the smoker to initiate cessation services). In some areas local referral pathways have been established (for example, between the hospital and the local AKP provider) but this is in no way routine.

Focus

This workstream aims to, first and foremost, determine the needs of smokers of specialist cessation services. The specialist cessation services required to meet those needs across New Zealand will then be determined.

Guidance for funders will be developed, including:

- the type, quality and quantity of services needed to meet the needs of smokers
- the referral pathways between health services and specialist cessation services that are required.

The workstream also aims to ensure that information about cessation services is readily available to both smokers and health care workers.

The workstream will consider the role of DHBs in funding and providing specialist cessation services.

System support and training

Objectives

The objective of this workstream is to ensure that training and crosscutting systems support is provided to health care workers and provider organisations to promote uptake and effective delivery of the ABC approach.

Context

An underlying goal of the ABC approach is not to add further programmes and demands to the menu of interventions that health care workers currently deliver, but to change the way smoking is seen by clinicians. If successful, smoking will be treated as part of the vital clinical information that is recorded, monitored and acted on by health care workers, rather than a part of a patient's social history. This means ensuring that the necessary systems and structures are in place across settings for effective ongoing support of the ABC approach.

To ensure the integration of the ABC approach systematically into everyday practice of health care workers, strong links will need to be applied across all six workstreams, with a specific emphasis applied across four settings within and beyond the health sector; primary and community health care services; hospital-based settings; specialist cessation services; and (ultimately) non-health care settings.

Focus

The key areas of focus for this workstream are:

- **Leadership:** promoting the ABC programme and its importance through all forms of leadership (including clinical, professional bodies, planning/funding and provider arm services).

- **Policy and protocols that support the ABC approach:** influencing DHBs to provide leadership and to incorporate smoking cessation objective and targets into relevant systems, eg, in DHB contracting processes, ministerial letters, service coverage schedule.

- **Training:** develop and implement training for ABC delivery across primary and community health care services; hospital-based settings; specialists cessation services, in conjunction with the other workstreams that focus on those settings.

- **Referral pathways:** ensure strong links into the development of the referral process in primary, community, hospital and specialist cessation health care services.
- **Pharmacotherapy:** support the availability of NRT by prescription and establish standing orders to allow greater access and supply of smoking cessation medicines.

The systems support aspects of this work will not include systems that are specific to particular health care settings (eg, primary care). Where this is the case, systems support actions will be led out of the relevant setting-based workstream.

Increasing consumer demand

Objectives

This workstream is responsible for promoting awareness and ultimately increasing demand for services and products that support quit attempts. The objectives of this workstream are to ensure that:
- priority audiences receive good information about tobacco harm
- audiences know what services and products are available to help quit
- demand for support services and products increases.

Context

The Ministry supports DHBs with effective social marketing, using accurate and compelling information to encourage smokers to make their homes smokefree. By reducing exposure to tobacco, an intended spinoff will be an increase in the 'never smokers' in the annual Year 10 survey.

There are two Ministry-funded organisations that are responsible for the significant majority of tobacco control social marketing. Much of the budget is used on mass-media advertising. The Health Sponsorship Council (HSC) focuses on smokefree environments such as homes, cars, and in the past, workplaces. The Quit Group focuses on encouraging individual smokers to try and quit and offers support services.

There are some priority groups who are over-represented in tobacco statistics, and these are priority audiences for our information. They include Māori women, Māori men, Pacific women, Pacific men, pregnant women, and teenagers.

Focus

This workstream will focus on developing and assessing the impact of a social marketing campaign/s to encourage quit attempts and the wider health sector support of those attempts.

Monitoring and improvement

Purpose

This workstream will guide and integrate monitoring and improvement across the work programme for the approach. It will ensure that this information and learning is received by the people that need it, in a timely way, and in a form that is useful for improving decision-making and approach at national and local levels.

Context

Monitoring and improvement activity enables stakeholders and decision-makers to be informed about:

- what is changing – from whether programmes and actions are being designed and implemented effectively, to whether key impact variables (eg, uptake of new practices by health professionals) are changing over time and at what rate change is occurring

- which components of the approach are working well and which need to be improved or adjusted.

Monitoring also provides a basis from which to identify key evaluation questions over time, which involves delving deeper into reasons underpinning the behaviour shown by certain indicators.

Focus

This workstream will develop and run the approach to monitoring progress (in relation to both implementation and impact), and guide learning about how to improve the effectiveness of the ABC approach. Four areas of activity will be undertaken:

- Develop a monitoring framework: including identifying key indicators, a stocktake and development of data and data gathering systems, and developing an approach to reporting and analysis of performance over time, including feedback to stakeholders on progress.

- Develop a simulation model that enables national and local stakeholders to estimate the expected impact of adjusting key variables (eg, quit attempts, treatment uptake) on important downstream performance measures (eg, prevalence of smoking-related illnesses, health care costs, surgical outcomes, mortality).

- Carry out monitoring and reporting.

- Identify evaluation questions, and design and implement evaluation projects as required.

7   Priority Populations

Nga Manukura mo te Iwi Māori
Māori Leadership in Tobacco Control

Context

Tobacco and smoking continue to be a major preventable cause of many chronic diseases, an important contributor to health inequalities. Māori population continues to demonstrate significantly higher prevalence of smoking than other segments of the population. In the New Zealand health survey 2006/07, Māori women were more than twice as likely to be current smokers as women in the total population, and Māori men were 1.5 times more likely to be smokers than men in the total population. For this reason, the Ministry continues to prioritise Māori in order to reduce the harm caused by tobacco.

Approach

Te Pae Mahutonga[11] is a model of six guiding principles, and an overarching framework that will guide the development of the ABC approach and its implementation for Māori. Although Te Pae Mahutonga is a health promotion model, it is an integrated approach to health gain and the principles within the model have great significance in terms of Māori health.

Nga Manukura (leadership): should reflect a combination of skills and a range of influences. Leadership within the ABC process will need to reflect:

- clinical leadership
- community leadership
- tribal leadership
- health/education leadership
- communication
- alliances between leaders and groups.

Nga Manukura is one of two overarching principles that will be an intrinsic part of the six work streams. Leadership is a critical factor in the successful implementation of ABC, whether this is encouraging health care workers to deliver ABC, or equipping health care workers to deliver ABC. Whatever the case maybe, leadership of Māori throughout this process is required to ensure effective delivery of ABC for Māori.

Te Mana Whakahaere (autonomy): recognises that good health cannot be prescribed and that communities, whether based on hapū, marae, iwi, whānau or place of residence must ultimately be able to demonstrate a level of autonomy and self determination in promoting their own health. The promotion of health therefore requires the promotion of autonomy:

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[11]   Durie Mason. 1999. Te Pae Mahutonga; a model for Māori health promotion. *Health Promotion Forum of NZ Newsletter* 49, 2–5 December.

- control
- recognition of aspirations
- relevant processes
- sensible measures
- self-governance.

Te Mana Whakahaere is the second overarching principle that will be an intrinsic part of the six work streams, and ensure effective delivery of ABC for Māori. In the context of ABC, this means ensuring that the necessary systems and structures are in place across settings for effective ongoing support of the ABC approach for Māori.

Mauri Ora (access to Te Ao Māori): good health depend on many factors, but among indigenous peoples world over, cultural identity is considered to be a critical factor. Identity means little if it depends only on a sense of belonging without actually sharing the group cultural, social and economic resources, therefore a secure identity requires:
- access to language and knowledge
- access to culture and cultural institutions
- access to Māori economic resources such as land, forests, fisheries
- access to social resources such as whānau, hapū, iwi networks
- access to societal domains where being Māori is facilitated not hindered.

The Ministry, DHBs, PHOs, NGOs, professional health bodies and health care workers will need to demonstrate a commitment to identifying pathways that focus on improving access to effective services for Māori, in alignment with 'He Korowai Oranga' to reduce health inequalities for Māori particularly within mainstream services.

Waiora (environmental protection): is linked to the external world and recognises the importance of ones environment on the health and wellbeing between people and places. There needs to be balance between development and environmental protection and recognition of the fact that the human condition is intimately connected to the wider domains of Rangi (Sky Father) and Papa (Earth Mother). Harmonising people with their environment requires:
- air can be breathed without fear of inhaling irritants or toxins
- opportunities are created for people to experience the natural environment
- water is free from pollutants
- earth is abundant in vegetation.

The ABC approach is designed to complement other interventions aimed at reducing smoking, through social marketing initiatives (eg, smokefree homes and cars) or legislation (eg, smokefree public places, schools and workplaces). These interventions along with the ABC approach can be beneficial to Māori if supported with the right resources, and culturally appropriate (eg, Aukati Kai Paipa service, marae-based services – hauora-based services).

Toiora (healthy lifestyles): depends on personal behaviour, however it would be an oversimplification to suggest that everyone had the same degree of choice regarding the avoidance of risk. Risks are highest where poverty is greatest. A shift from harmful lifestyles to healthy lifestyles requires actions at several levels and the key areas for consideration include:

- harm minimisation
- targeted interventions
- risk management
- cultural relevance
- positive development.

The ABC approach recognises that tobacco continues to have disproportionate adverse health outcomes for Māori, and a targeted approach for Māori is needed. Training and education around the delivery of ABC needs to be tailored to particular cultural needs to increase the chances of success, and for Māori this is about cultural relevance and positive development.

Te Oranga (participation in society): wellbeing is not only about a secure cultural identity, or an intact environment, or even about the avoidance of risks. It is also about the goods and services which people can count on, and the voice they have in deciding the way in which those goods and services are made available. While access is one issue, decision making and a sense of ownership is another.

Evidence indicates that Māori participation in the wider society falls considerably short of the standards of a fair society, therefore enhancing the levels of wellbeing for Māori will require an increase of Māori participation in:

- economy
- education
- employment
- knowledge in society
- in decision making.

Like Nga Manukura (leadership), participation in the implementation of ABC by all relevant stakeholders is critical to the success of this approach. Māori participation throughout this process needs to be reflected in all avenues, whether this is in the steering group process through to engagement with the current Aukati Kai Paipa providers.

Te Pae Mahutonga as an overarching framework for ABC reminds us that health is more than simply the provision of health services; it is also about healthy cultures, healthy environments, healthy lifestyles and healthy participation in the wider society.

Pacific leadership in tobacco control

Context

Tobacco smoking is a leading cause of preventable deaths for Pacific people. Tobacco control is a major issue for Pacific peoples in New Zealand because of their higher overall smoking rates (compared with the European population). The difference is mainly due to the higher smoking rates of Pacific men (36 percent compared with 24 percent in European men).[12]

Smoking is also an important – and reversible – contributor to ethnic and socioeconomic inequalities. Reducing health inequalities remains a key focus for the Ministry and District Health Boards, and addressing smoking is an essential part of this.

Pacific people have been identified by the Ministry as one of the priority target groups for the delivery of the ABC programme. The current Pacific population of 6.9 percent is expected to grow to around 373,000 people, or 8.3 percent of the population, by 2021, and to around 599,000 people, or 12.1 percent of the New Zealand population, by 2051.[13]

The National Primary Medical Care (NatMedCa) Survey 2001/02 was undertaken to describe primary health care in New Zealand, including the characteristics of providers and their practices, the patients they see, the problems presented and the management offered. The study covered private general practices, community-governed organisations, accident and medical clinics, and emergency departments.

The NatMedCa report on Pacific patterns in primary health care provides a description of the weekday, daytime experience of visits to primary health care doctors by patients of Pacific origin. The report notes that the GPs surveyed were less likely to say that they had high rapport with their Pacific patients (54.8 percent compared with 68.7 percent for patients drawn from the entire sample).[14]

The survey also found that fewer tests and investigations were conducted for the Pacific clients (17.8 percent for Pacific compared with 24.9 percent for the whole sample). Pacific patients had a lower rate of referral to specialists than the total surveyed (10.2 percent versus 15.8 percent), although the distribution of referrals differed little between the Pacific group and the total. About half of all referrals were to medical/surgical specialists, about one-third were non-medical, and the remainder were either emergency or unspecified.

The study also found that overall referral rates were higher for patients attending community governed practices. Indeed, in the case of medical/surgical specialists, these rates were strikingly high. On average the length of visits for Pacific patients was also shorter at 11.9 minutes, against an overall sample average of 14.9. Pacific

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[12] Minister of Health and Associate Minister of Health 2002.

[13] Statistics New Zealand. 2002. Pacific Progress: A report of the economic status of Pacific peoples in New Zealand. Wellington: Statistics New Zealand..

[14] Ministry of Health. 2008. *Improving Quality of Care for Pacific Peoples*. Wellington: Ministry of Health, 2008. p. 28. .

patients were less likely to receive a script or a non-drug treatment, and were less likely to be referred, but they had a higher rate of follow-up.

Careful consideration should be given when applying ABC to Pacific peoples as there are many complex issues that should be taken into account when dealing with diverse Pacific communities. This should be integrated and applied across all of the ABC work streams and have a strong focus on the hospital setting, primary care setting, community health worker setting, and the specialist services setting.

Scope/approach

For ABC to be successful in the different health care settings, the health care providers will need to be more culturally aware. Pacific cultural competencies are crucial to better health outcomes for Pacific peoples.[15] The provision of culturally competent health care is one of the strategies advocated for reducing or eliminating racial and ethnic health disparities.[16]

The patient-provider relationship is really important for reducing barriers to care for Pacific people in the delivery of ABC. This has proven successful in areas with high Pacific populations and a relatively resourced Pacific workforce like Counties Manukau DHB and Auckland DHB in the hospital setting, and in the Pacific primary care setting with Pacific health care and community workers. Research carried out by the HRC NZ, 2004, looking at Pacific models of mental health found the following:

Building trust and rapport with Pacific consumers, especially for the first time, often requires utilising the 'roundabout' Pacific rapport building approach. This 'roundabout' rapport building approach is a technique used by Pacific service workers to ascertain whether there might be any potential barriers to working with the Pacific consumer and/or family. It is a technique best learnt through actual practice rather than through the classroom.

The 'roundabout' approach noted here is perceived by many service providers to be one of the uniquely Pacific styles of their practices of care. It is, as described by one participant, a necessary part of the process of establishing trust and rapport between a service worker (in whatever role and whether Pacific or not) and the consumer and/or family. This approach involves, upon first meeting, engaging in a general exploratory type discussion about anything of common interest. This discussion can continue for some time before getting to the purpose of the meeting.[17]

[15] Tiatia J. 2008. Pacific Cultural Competencies: A Literature Review. Wellington: Ministry of Health.

[16] Ngo-Metzger Q, et al. 2006. Cultural Competency and Quality of Care: Obtaining the patient's perspective.

[17] Health Research Council NZ. *Pacific Models of Mental Health in New Zealand Project.* Clinical Research and Resource Centre Centre, Waitemata DHB, Auckland, 2004. p25.

According to a Pacific mental health professional, the intervention from the GP or practice nurse might include using a 'motivational interview' for Pacific people and having a 'self statement' during the course of this interview. By using a more positive approach the doctor may ask the patient something like – do you want to be a great rugby player or do you want to be a good mother? Once that rapport or connection is made, then using this statement to go on and inform the patients about the importance of stopping smoking.

Being able to communicate effectively with Pacific consumers and/or build good rapport with them requires, according to service workers, competency in certain key service areas. Language competency was top of the list. This pertained not just to competency in an ethnic language, but also in the languages of certain age or status or professional groups. Communication via appropriate language skills was therefore critical to gaining good rapport and building trust between consumers and/or their families. Each of these skills and attitudes are essential to helping consumers recover.

The health needs of Pacific peoples appear to be met through services that are provided parallel to mainstream services. The concept of 'by Pacific for Pacific' is integral to this.[18]

The challenge for ABC will be getting both the hospitals without Pacific speaking cultural support units/smoke free workers, and the mainstream PHOs with non-Pacific GPs and nurses, to be responsive to Pacific peoples needs when attempting to reduce tobacco consumption. Concentrating on workforce and training strategies will be crucial for ABC in these areas.

Pacific models of health care have been developed which recognise Pacific worldviews and beliefs about health. One example is the Fonofale model created by Fuimaono Karl Pulotu-Endemann, for use in the New Zealand context. According to Pulotu-Endemann, the Fonofale model incorporates the values and beliefs that many Samoans, Cook Islanders, Tongans, Niueans, Tokelauans and Fijians had conveyed to him during workshops relating to HIV/AIDS, sexuality and mental health in the early 1970s through to 1995. In particular, these Pacific groups all stated that the most important things for them were family, culture and spirituality. The concept of the Samoan fale (house) was a way to incorporate what they considered important components of Pacific people's health. The metaphor of the fale with the foundation or the floor, posts and roof, encapsulated in a circle, promotes the philosophy of holism and continuity.[19]

Pacific cultural competencies are crucial to better health outcomes for Pacific peoples, and in the context of ABC, remind us that health is more than simply the provision of health services, it recognises, healthy cultures, health environments, healthy lifestyles and healthy participation in the wider society.

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[18] Pacific Health in New Zealand: Our Stories. Wellington: Ministry of Health, 2003.

[19] Fuimaono Karl Pulotu-Endemann. Ministry of Health. 2008. *Improving Quality of Care for Pacific Peoples*. Wellington: Ministry of Health, 2008. p. 25.

Pregnancy

Context

While overall smoking rates continue to decrease, smoking during pregnancy remain a source of considerable and serious negative health outcomes for women and babies in New Zealand. For this reason, the Ministry has identified pregnant women as a priority group for reducing the harm caused by tobacco.

Approach

The Tackling Smoking in Pregnancy project aims to reduce the rates of smoking in women of childbearing age and during pregnancy, thereby improving the quality of care and outcomes for pregnant women and their babies.

This will be achieved in three ways:

1. Developing a coordinated whole of health sector approach to routinely and systematically address smoking during pregnancy in line with the New Zealand Smoking Cessation Guidelines.

   - Increasing routine use of ABC by health care and community workers working with women of childbearing age, pregnant women and their families.

   - Improving linkages at a local level between health care and community workers, and the range of smoking cessation services.

2. Ensuring that evidence based specialist cessation services is accessible for all women in New Zealand who require intensive support.

3. Creating an environment that increases wider public understanding of the significant harms of smoking during pregnancy and the importance of quitting.

At the same time the Ministry intends to implement a viable and ongoing monitoring and surveillance programme of smoking in pregnancy to support this project, and for ongoing use.