A PRIORITY-DRIVEN RESEARCH AGENDA FOR TOBACCO CONTROL IN AUSTRALIA
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final report
The Priority-driven Research Agenda for Tobacco Control is an initiative of the Australian National Preventive Health Agency (the Agency) — an Australian Government agency committed to supporting the development and implementation of evidence-based approaches to preventive health initiatives targeting obesity, harmful alcohol consumption and tobacco.

Australia’s approaches to tobacco control have formed an excellent track record in reducing smoking prevalence and tobacco-related disease throughout its population. However, smoking still remains one of Australia’s single most preventable causes of ill health and latest figures show that approximately 2.8 million Australians over the age of 18 continue to smoke daily. We also know that approximately 48 per cent of Aboriginal and Torres Strait Islander people smoke and some of our most disadvantaged groups have smoking rates up to five times higher than the population average.

Research that contributes directly to policy reform and sustained support for tobacco control policies in Australia is essential if we are to meet the Council of Australian Governments’ target of reducing Australia’s national smoking rate to 10 per cent of the population and halving the Indigenous smoking rate by 2018. Most important is the need to direct research efforts towards specific high-smoking prevalence population groups for whom tobacco control efforts to date have had limited success.

The development of this consensus-based research agenda was undertaken in response to a need identified by members of the Agency’s Expert Committee on Tobacco, for a focused and timely priority-driven research agenda that reflects Australia’s emerging tobacco research requirements over the coming decade. The report will also serve as an annex to the Agency’s 2013-2018 National Preventive Health Research Strategy which aims to foster Australia’s capacity to carry out applied research to enable evidence-informed activities by governments, health care systems, individuals, and by civil society and private organisations in the area of preventive health.

I would like to acknowledge the collaborative and consultative approach that was undertaken to develop this agenda and the valuable contribution of so many working in tobacco control — both internationally and within Australia. It is hoped that the research questions prioritised in this document will be used by the broader tobacco control community to inform many future evidence-based tobacco control initiatives.

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- Ella Curnow, Assistant Director, Tobacco Control who managed the project for the Agency.
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BACKGROUND

Tobacco smoking remains the single most preventable cause of ill health and death in Australia today\(^1\). Tobacco is a highly addictive and lethal product that kills around half of its long-term users\(^2\). Despite reductions in smoking prevalence, around 3.3 million Australians still smoke at least daily or weekly\(^3\) and the most recent estimate available suggests that around 15,000 people die each year of smoking related disease\(^4\).

Following the development of the Framework Convention on Tobacco Control (FCTC)\(^5\) by the World Health Organization (WHO), tobacco control is now a global health priority. Globally, tobacco kills nearly 6 million people each year. That toll is rising rapidly, especially in countries in our region\(^6\). The WHO estimates that approximately one person dies every six seconds due to tobacco, accounting for one in 10 adult deaths.

Australia has a long and successful record in tobacco control. Over the past four decades Australia has implemented comprehensive tobacco control strategies that have included mass media campaigns, pricing and tax strategies, cessation support, regulation of tobacco advertising, sponsorship and marketing, sale of tobacco to minors and smoke free public places.

Underpinning these approaches has been a commitment to a population focus and to evidence based practice informed by an extensive knowledge base and effective public health research and evaluation programs. The history of tobacco control in Australia—as elsewhere—features many examples where research was instrumental, and sometimes pivotal to policy reform or sustaining support for tobacco control policies\(^7\). The evidence generated by Australian preventive health research efforts is critical to informing tobacco control policies both here and internationally. For example, as Australia implements the world’s first tobacco plain packaging legislation there is a need to comprehensively evaluate the impact of this important policy and build a knowledge base that can be used by other countries.

Almost 25 years ago, the National Health and Medical Research Council (NHMRC) called for a greater emphasis on priority-driven research. The NHMRC defined priority-driven research as strategic development and evaluation research that contributes directly, in the short to medium term, to population health and the effectiveness, efficiency and equity of the health system\(^8\).

In response to this important issue, the Australian Cancer Society and the National Heart Foundation initiated a consensus process in 1999 to develop Australia’s first priority-driven research agenda for tobacco control. The resultant report included research ideas judged by tobacco control experts to be both practical and necessary in order to advance strategic tobacco control goals in Australia.

“Rather than continuing to be dominated by investigator-driven research, tobacco policy research in Australia could be tied to a set of priorities agreed to by those working in the fields of tobacco research, policy and control. This would concentrate the research effort, addressing more policy-relevant questions than is currently the case.”

_Tobacco Control in Australia: A Priority-Driven Research Agenda 1999._

Analysis of the 1999 document confirms that research has been undertaken to answer the vast majority of the questions identified in the report. The process was particularly successful at identifying the most useful research questions for informing future tobacco control policies in Australia.
The purpose of this report

This report builds on the successful consensus process undertaken in 1999, and identifies an updated priority-driven research agenda for tobacco control in Australia for the coming decade.

The priority-driven research agenda has been developed to:

- Inform future tobacco control policies and programs;
- Enhance the national research capacity to respond in a focused and timely fashion to emerging tobacco research needs; and
- Enhance the shared understanding between policy makers, advocates and researchers about research priorities in tobacco control and encourage links between these groups.

Policy context for tobacco control in Australia

The National Tobacco Strategy 2012-18 (NTS) articulates Australia’s national policy framework to reduce tobacco-related harm. The goal of the strategy is “to improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes”[9].

The Strategy also details objectives and targets for tobacco control until 2018 and sets out nine priority areas for action. These priority areas take account of the extensive evidence base for tobacco control and reflect best practice approaches to reducing tobacco-related harm. The nine priority areas are as follows:

1. Protect public health policy, including tobacco control policies, from tobacco industry interference;
2. Strengthen mass media campaigns to: motivate smokers to quit and recent quitters to remain quit; discourage uptake of smoking; and reshape social norms about smoking;
3. Continue to reduce the affordability of tobacco products;
4. Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander people;
5. Strengthen efforts to reduce smoking among people in populations with a high prevalence of smoking;
6. Eliminate remaining advertising, promotion and sponsorship of tobacco products;
7. Consider further regulation of the contents, product disclosure and supply of tobacco products and alternative nicotine delivery systems;
8. Reduce exceptions to smoke-free workplaces, public places and other settings; and
9. Provide greater access to a range of evidence-based cessation services and supports to help smokers to quit.

Several states and territories have also developed strategies to guide tobacco control policies in their jurisdictions.

Other policy frameworks are also relevant to tobacco control such as the National Healthcare Agreement[10] and the associated National Partnership Agreement on Preventive Health[11] which set the target of reducing the national adult daily smoking rate to 10 per cent of the population and halving the Indigenous smoking rate, by 2018.

The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes is also highly relevant because smoking is the leading risk factor for chronic disease in Aboriginal and Torres Strait Islander peoples, making efforts to reduce smoking in this population a priority.

Australia is a signatory to the World Health Organization’s Framework Convention on Tobacco Control (FCTC). The FCTC and its Guidelines commit nations to implement policies on tobacco price and tax increases, prohibiting or restricting tobacco advertising, promotion and sponsorship, introducing labelling with more prominent health warnings, reducing exposure to second-hand smoke, smoking cessation interventions and combating illicit trade. The Australian Government reports every two years to the Conference of the Parties on progress in implementing the FCTC[8].
Links between the National Tobacco Strategy and this project

The NTS provides a framework for national policy and tobacco control in Australia. At the time this project was undertaken the NTS had not been finalised or formally approved by governments. The FCTC was therefore used as the framework for the priority-driven research agenda with two additional themes focussing on smoking rates among high smoking prevalence groups: low socio-economic and disadvantaged groups, and Aboriginal and Torres Strait Islander peoples.

It should be noted that there is high degree of consistency between the NTS and the FCTC Articles and that the FCTC provided an internationally recognised framework for tobacco control that enhanced the ability of expert researchers from Australia and internationally to collaborate and identify priority research questions relevant to the Australian context.

Methodology

FCTC Articles relevant to future tobacco control in Australia were used to identify and organise research questions that will help inform future policies and programs in Australia, and evaluate existing ones. Two themes targeting smoking rates among high smoking prevalence groups: low socio-economic and disadvantaged groups, and Aboriginal and Torres Strait Islander peoples, were added.

The first stage of the process required the identification of Australian and international researchers and tobacco control experts with suitable expertise and research track records who would be prepared to generate research questions. Suitable experts were identified under each FCTC article according to their identified area(s) of research expertise. These experts were then invited to participate in the project by identifying up to 4 potential research questions with supporting rationales—under their respective FCTC article(s)—that they believed are the most important priorities for Australia, based on their experience and the information provided to them. Each international expert was provided with a briefing paper summarising Australia’s progress to date in meeting its obligations under the relevant FCTC Article, and addressing smoking among disadvantaged groups and Aboriginal and Torres Strait Islander peoples. To assist in the ranking process, experts were asked to ensure that research questions were very specific, rather than too general or broad brush. A total of 48 researchers/experts agreed to participate in the research agenda, of which 44 generated questions. A list of these researchers is provided in Appendix 1.

The generation of research questions was completed in September – October 2012. Once submitted, the questions were reviewed by a working group comprising Agency staff and some members of its Expert Committee on Tobacco (ECT). A number of questions were merged or deleted to reduce duplication and others were amended to ensure greater clarity or relevance to the Australian context. The shortlist of questions and their accompanying rationales were reviewed and gaps identified by the Agency's ECT. Some additional questions were generated in relation to these issues.

The second stage involved developing a comprehensive list of Australian tobacco control experts from the government and non-government sectors. These experts were assigned to the various FCTC articles and additional themes according to their identified area of expertise, and asked to rank the research questions. Of the 53 Australian tobacco control experts approached to participate, 44 participated in the final ranking exercise (Appendix 2). Each participant was asked to read the proposed research questions and supporting rationales provided by the research experts during the first stage, and rank the questions in terms of their relevance and importance to the development of Australian tobacco control policies for the next 5 to 10 years. They then ranked the questions on a scale of 1-5 (1 being the highest priority and 5 being the lowest priority). A full list of the research questions provided to experts for ranking is in Appendix 3.

The method used to rank questions in relation to disadvantaged groups and Aboriginal and Torres Strait Islander peoples was slightly different to that used for the FCTC Articles. While relevant experts were approached in the first stage to generate up to 4 research questions for these groups, there was an additional step in the process. Questions from the other FCTC Articles that related to disadvantaged groups and Aboriginal and Torres Strait Islander peoples were also included in the list of research questions for ranking. As this process resulted in a large number of research questions for ranking, experts were asked to rank the questions from 1-10 with 1 being the highest priority and 10 the lowest priority.
A score was assigned based on each ranking: a ranking of 1 received a score of 5, while a ranking of 2 received a score of 4 and so on down to a ranking of 5 which received a score of 1. In relation to disadvantaged groups and Aboriginal and Torres Strait Islander peoples where the ranking was 1-10, a ranking of 1 received a score of 10 points and so on down to a ranking of 10 which received a score of 1 point. The 5 questions that received the highest scores for each Article and the 10 questions for the disadvantaged groups and Aboriginal and Torres Strait Islander peoples were the questions judged by tobacco control experts as being the most important and relevant to informing future tobacco control policies.

The release of the draft report for consultation was the third and final stage of the project. This stage involved consultation with tobacco control representatives from Australian and state and territory governments and non-government organisations such as Cancer Councils, the National Heart Foundation, ASH Australia, the Australian Medical Association, peak Indigenous organisations and social and community service organisations relevant to tobacco control. The report was also distributed to members of the Intergovernmental Committee on Drugs - Standing Committee on Tobacco, as well as the Smoking and Disadvantage Network for comments and feedback.

A submission form was developed to assist stakeholders in responding to this report. A copy is provided in Appendix 4.
**METHODOLOGY**

**PROJECT WORKING GROUP**

- Key international and Australian researchers identified under each WHO FCTC article and additional theme according to their area(s) of research/expertise

**EXPERT COMMITTEE ON TOBACCO**

- Review of research questions, including any necessary merging of questions (due to duplication)
- List of researchers reviewed for gaps

**CONSULTATION**

- **STAGE 1**
  - International and Australian researchers briefed on current Australian tobacco control environment & invited to identify priority research questions for Australian tobacco control under their identified area of expertise (FCTC article/Aboriginal & Torres Strait Islander peoples/disadvantaged groups)

- **STAGE 2**
  - Australian tobacco policy experts and researchers asked to prioritise research questions under their respective FCTC article(s)

- **STAGE 3**
  - Draft report with prioritised research questions distributed throughout the Australian tobacco control community for comment

- Draft report including questions and detailed description of the methodology reviewed

- Final report reviewed
RESULTS

Overview

This report identifies those research questions judged through a collaborative, consultative process to be most important and relevant to inform tobacco control policies over the next decade in relation to each of the relevant FCTC Articles as well as disadvantaged groups and Aboriginal and Torres Strait Islander peoples. In doing so it is consistent with the comprehensive approach to tobacco control implemented in Australia over many years.

A broad range of important tobacco control policies and programs is covered including tobacco advertising, marketing and sponsorship, protection from exposure to environmental tobacco smoke, tobacco company interference in public health, price and tax policies, packaging and labelling, illicit trade, cessation services, and mass media campaigns. There is also a focus on emerging issues such as the regulation of tobacco products, the regulation of tobacco product disclosures and liability. Importantly, this process has placed a strong emphasis on identifying priority research needs in relation to Aboriginal and Torres Strait Islander peoples and other groups with high smoking rates. The need for a stronger evidence base in relation to these population groups is highlighted in the National Tobacco Strategy 2012-18.

This report focuses on identifying the most important and relevant research questions as judged by tobacco control experts who participated in this process for each of these important areas. For each of the relevant FCTC Articles, the top 5 research questions from the ranking process are presented. In relation to Aboriginal and Torres Strait Islander peoples and disadvantaged groups the top 10 research questions are presented.

It is hoped that linking future tobacco control research efforts to the set of priorities developed through this consensus process will concentrate future research efforts, and focus attention on the most policy-relevant questions.


**Article 5.3 — Tobacco company interference**

**FCTC OBLIGATION**

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.

The Guidelines for Article 5.3 recommend the following activities to limit tobacco industry interference in public health policies:

1. Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties’ tobacco control policies;
2. Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur;
3. Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry;
4. Avoid conflicts of interest for government officials and employees;
5. Require that information provided by the tobacco industry be transparent and accurate;
6. Denormalize 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”;
7. Do not give preferential treatment to the tobacco industry;
8. Treat State-owned tobacco industry in the same way as any other tobacco industry.

**RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES**

1. What are the extent, nature, and consequences of “third party” strategic engagement by Australian tobacco companies post 2012? Which Australian organisations are directly or indirectly associated with tobacco companies and thus supporting their activities? What is the nature and extent of their association?
2. What is the extent and nature of tobacco industry engagement with government agencies other than health (e.g. Department of Foreign Affairs and Trade, and The Treasury)? What is the nature and extent of the discussions, association and support between these agencies and the tobacco industry? How can these arrangements be made more transparent? What do government employees in other agencies outside the Department of Health and Ageing know about the FCTC and the provisions of Article 5.3?
3. How do tobacco industry “corporate social responsibility activities” (CSR) affect recipients’ views and activities related to tobacco control policy and their support for stronger regulation? Does this vary by type of CSR or type of recipient/beneficiary of CSR?
4. What is the extent of tobacco industry marketing, promotional and support activities remaining in Australia – including public relations and lobbying by tobacco companies and associated groups and legal activities? How much is the tobacco industry continuing to invest in these activities?
5. To what extent are tobacco companies able to exert influence through commercial or other associations? What is the nature and extent of this influence?
6. How much do the tobacco industry and industry-affiliated groups contribute to political parties annually, and are there differences between the parties in amounts received and organisations donating?

*Note: six questions are presented for this Article. The last two received the same score in the ranking process.*
Article 6 — Price and tax measures to reduce the demand for tobacco

FCTC OBLIGATION

Each Party should take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include:

(a) implementing tax policies and, where appropriate, price policies, on tobacco products so as to contribute to the health objectives aimed at reducing tobacco consumption; and

(b) prohibiting or restricting, as appropriate, sales to and/or importations by international travellers of tax- and duty-free tobacco products.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. How has the tobacco market changed in Australia since the 25 percent increase in tobacco excise and customs duty in April 2010, in relation to: overall volume of sales; market share smoking tobacco vs. cigarettes vs. cigars; number and nature of brands on the market; market share by pack size (sales revenue and volume); brand share (sales revenue and volume) both for individual brands and by market segment; and estimated prevalence of use of illicit tobacco products?

2. What influence has tax reform, and associated industry pricing strategies, had on smokers’ purchasing habits – in particular down trading (i.e. moving to a cheaper brand) versus premiumisation (smoking premium brands) and choice of pack size? What has been the effect on disadvantaged smokers in particular?

3. Would the effect of an increase in the taxation of tobacco products (i.e. the effect of the increase, not the effect of the tax itself) most likely be regressive, proportional, or progressive? Would the relative burden on the low-income population decline as a result?

4. How does the price elasticity of demand for cigarettes change as taxes and prices increase further and further?

5. What industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among smokers from low-socioeconomic groups and other disadvantaged populations? (* This question was also identified as a priority under Disadvantaged groups)
Article 8 — Protection from exposure to tobacco smoke

FCTC OBLIGATION

Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What combination of individual/household level interventions and population-based policies (mass media, smoke free policies in other settings, community based interventions etc) are most effective at reducing smoking in homes, particularly among disadvantaged populations?

2. What are the levels of tobacco smoke exposure in prisons for non-smoking prisoners and non-smoking prison officers- measured by e.g. PM2.5 (air in prison locations, individuals with monitors), cotinine in non-smokers? What are the barriers and facilitators to creating smoke-free prisons, including prisoners’ and staff’s experiences of and views on smoking in prison?

3. What is the impact of smoke free home policies on the health of children, in terms of change in health outcomes (such as hospital admissions for respiratory disease, lung function etc), especially among disadvantaged populations?

4. What are the exposure levels of children (by age) in the home in relation to disadvantage (socioeconomic status and ethnicity) - measured by e.g. PM2.5 (airborne smoke particles in the home) and/or children's salivary cotinine? Who are the main sources of this exposure?

5. What are the levels of tobacco smoke exposure in outdoor areas where smoking is permitted, as measured by e.g. PM2.5 (airborne smoke particles in general, workers with monitors), and/or cotinine in non-smoking workers and clients?

*Note: while some tobacco control experts ranking this Article felt it was an important priority for future research, other experts commented that they viewed this issue as a lower priority compared to other issues given the progress already made in Australia.
Article 9 — Regulation of the contents of tobacco

FCTC OBLIGATION

Each Party shall, where approved by competent national authorities, propose guidelines for testing and measuring the contents and emissions of tobacco products, and for the regulation of these contents and emissions.

Each Party shall, where approved by competent national authorities, adopt and implement effective legislative, executive and administrative or other measures for such testing and measuring, and for such regulation.

GUIDELINES FOR ARTICLES 9 & 10

In 2010, the Conference of Parties (COP) agreed on partial guidelines to assist parties in the implementation of Articles 9 and 10 of the FCTC. 7

The guidelines recommend that member countries take action to:

• require manufacturers and importers to disclose information on ingredients used at each stage of the manufacturing process and notify when changes are made;
• require manufacturers and importers to disclose information about design features;
• prohibit or restrict ingredients that may be used to increase palatability, have colouring properties, create the impression that they have a health benefit or are associated with energy and vitality (such as stimulant compounds);
• require manufacturers and importers to report on sales to assist with effective product regulation.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What health, behavioural and social impacts would a nation-wide policy of reducing nicotine content in cigarettes have on addicted tobacco users and on non-addicted tobacco users, both positive and negative? What would be the impact on youth and adult prevalence and consumption, as well as morbidity and mortality? What would be the impact of cigarettes with very low nicotine content and unchanged tar (reduction in filler nicotine, not tar delivery) on quitting success? How could the impact of a nationwide policy of reducing nicotine content be evaluated? What information should be collected prior to, during, and after, such a policy?

2. What would be the impact of banning additives and flavours (including menthol) in cigarettes on the uptake of smoking, transition to dependence, smoking behaviour and smoking cessation in children and adult smokers?

3. What is the impact of e-cigarettes on the perception of the product, tobacco use behaviours and potential for initiation and use of other tobacco products? Are there differences between adults and children and vulnerable groups with high smoking prevalence? Do cigarette smokers who try to quit using e-cigarettes switch completely or do they continue to smoke cigarettes? What is the extent of reduction in cigarette smoking? What has been the impact on smoking prevalence in countries where Electronic Nicotine Delivery Systems (e.g. e-cigarettes) are widely available (e.g. the USA)?

4. What impact would a ban on tobacco additives have on the brand variants in the market and brand selection/brand switching by smokers? What would be the impact on smokers as some products disappear, change recipe or alter cigarette engineering features as a result of a ban? What would be the impact of a ban on additives on the composition of cigarettes and smoke deliveries of tobacco products following such a ban? What would be the impact on puffing patterns in both the short term and long term as smokers adapt to the changes?

5. How do components and design features of new and emerging tobacco products like e-cigarettes affect the bioavailability of nicotine, other addictive substances, and harmful tobacco constituents? What are the tobacco use behaviours of individuals using new and emerging tobacco products, including the multiple tobacco use behaviours?
Article 9 — Regulation of the contents of tobacco (continued)

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

6. What additives enhance the palatability, attractiveness and addictiveness of tobacco products? What is their role and how do they act? Are particular brands of Australian cigarettes designed through the use of variable additive levels to appeal to specific groups of smokers? What influence do tobacco additives have on quitting behaviour?

7. What is the impact of tip ventilation (i.e. filter vents) on cigarette experimentation? Are inexperienced smokers more likely to start with a highly ventilated product or one with little ventilation? Note: Filter vents are perforations in the tipping paper of cigarettes. Filter vents dilute the smoke with fresh air when the smoker takes a puff thereby creating a lighter and milder taste and making the smoke easier to inhale.

8. What would be the potential implications (risks and benefits) of requiring higher pH levels in tobacco smoke to attempt to make inhalation less likely or less deep? What is the capacity for smokers to inhibit the tendency to inhale cigarette smoke into the lung?

*Note: there was a large degree of variance in the ranking of these research questions, perhaps reflecting less agreement on future priorities among tobacco control experts in relation to this issue. Two factors were identified as likely to have had a significant influence on these rankings. The first is that regulation of the contents of tobacco and disclosure arrangements are relatively new tobacco policy areas in Australia and policy and regulatory responses are still in a developmental stage. Unlike some other countries, Australia has relatively little regulation governing the contents of tobacco and a Voluntary Agreement is in place to guide the disclosure of ingredients. The second significant factor that may have influenced the rankings and the comments received is that at the time of consultation, the Australian government was undertaking work on the development of a Regulation Impact Statement for further implementation of Articles 9 (tobacco product regulation) and 10 (tobacco product disclosure) of the WHO FCTC. The consultation process highlighted the need for ongoing discussion to continue to refine the research priorities for Articles 9 and 10 as the preferred policy options for Australia become clearer. This will ensure “strategic fit” between the research priorities in this area and the policy initiatives under consideration by the Australian government. In light of these issues and comments received during the consultation, 8 questions are presented for this Article. The last three questions all received the same score in the ranking process.
Article 10 — Regulation of tobacco product disclosures

FCTC OBLIGATION
Each Party shall, in accordance with its national law, adopt and implement effective legislative, executive, administrative or other measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products. Each Party shall further adopt and implement effective measures for public disclosure of information about the toxic constituents of the tobacco products and the emissions that they may produce.

GUIDELINES FOR ARTICLES 9 & 10
In 2010, the Conference of Parties (COP) agreed on partial guidelines to assist parties in the implementation of Articles 9 and 10 of the FCTC. The guidelines recommend that member countries take action to:
1. require manufacturers and importers to disclose information on ingredients used at each stage of the manufacturing process;
2. require manufacturers and importers to disclose information about design features;
3. prohibit or restrict ingredients that may be used to increase palatability, have colouring properties, create the impression that they have a health benefit or are associated with energy and vitality (such as stimulant compounds);
4. require manufacturers and importers to report on sales to assist with effective product regulation.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES
1. How best might the information released under disclosure (now or in the future) be effectively used to inform the public? What are the risks, unintended consequences and benefits of potential approaches? How can we ensure that these efforts do not contribute to an increase in false beliefs among the population and vulnerable groups about reduced harmfulness of some tobacco products?
2. How can disclosure be an effective tool to guide/drive/boost other interventions (in particular product regulation)? How can policy makers use the information provided under disclosure arrangements to develop more effective regulatory models? What are the top priorities for using the information obtained via disclosure?
3. What is the impact of different formats for listing tobacco constituents on the public’s understanding of harmful and potentially harmful constituents? Does the format influence understanding among individuals from vulnerable groups with high smoking prevalence (e.g. Aboriginal and Torres Strait Islander people)?
4. Aside from studies of comprehension, how do different formats for communicating tobacco constituents ultimately influence downstream processes such as tobacco-related beliefs, intentions, product/brand selections and smoking behaviours?
5. What is the best approach to ensuring ingredients and engineering features of e-cigarettes are disclosed to governments and/or the general public? How should a disclosure regime check that the information disclosed by companies on e-cigarettes is accurate?
Article 11 — Packaging and labelling of tobacco products

FCTC OBLIGATION

Within a period of three years, adopt and implement effective measures to ensure that:

(a) tobacco product packaging and labelling do not promote a tobacco product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions.

(b) each unit packet and package of tobacco products also carry health warnings describing the harmful effects of tobacco use, and may include other appropriate messages.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What is the impact of plain packaging on the population overall, in youth and young adults, ethnic populations and in other vulnerable groups with high smoking prevalence in relation to brand loyalty and brand switching, the salience of health warnings, false beliefs about smoking harms, product appeal and social norms, the sensory experience of smoking (including perceptions of the taste of cigarettes), smoking uptake, consumption and cessation?

2. What tobacco marketing, pricing, brand variant and product variation strategies are used by tobacco companies to attempt to reduce the impact of plain packaging and larger pictorial health warnings? What marketing strategies are used by the tobacco companies to reduce the impact of plain packaging – for example creative naming of brands or brand variants, price discounting, use of social media and public relations activities?

3. How do smokers respond to plain packaging and new health warnings? Do they use strategies to minimize the impact of plain packaging and the new health warnings? What strategies do they use e.g. attempt to hide cigarette packs or use covers?

4. Which graphic health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a “set” of multiple warnings; What is the optimum rotation period; What are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; What is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and are there any differences between the whole population, youth and young adults and vulnerable population groups in relation to these issues?

5. What is the effect of plain packaging on new entrants in the tobacco market?

*Note: there was very strong agreement on the top two priorities for this Article with the other rankings very spread out. Note questions 4 and 5 received the same score in the ranking process.
Article 12 — Education, communication, training and public awareness

FCTC OBLIGATION

Each Party shall adopt and implement effective legislative, executive, administrative or other measures to promote:

(a) broad access to effective and comprehensive educational and public awareness programmes on the health risks including the addictive characteristics of tobacco consumption and exposure to tobacco smoke;

(b) public awareness about the health risks of tobacco consumption and exposure to tobacco smoke, and about the benefits of the cessation of tobacco use and tobacco-free lifestyles;

(c) public access, in accordance with national law, to a wide range of information on the tobacco industry as relevant to the objective of this Convention;

(d) effective and appropriate training or sensitization and awareness programmes on tobacco control addressed to persons such as health workers, community workers, social workers, media professionals, educators, decision-makers, administrators and other concerned persons;

(e) awareness and participation of public and private agencies and nongovernmental organizations not affiliated with the tobacco industry in developing and implementing inter-sectoral programmes and strategies for tobacco control; and

(f) public awareness of and access to information regarding the adverse health, economic, and environmental consequences of tobacco production and consumption

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. How can we optimise the reach and effect of mass reach health communications in an increasingly cluttered, complex and evolving media environment? What are the implications for future campaigning on smoking and health, and media planning in particular?

2. What is the optimal mix of ads focusing on why to quit (including graphic images and testimonials) versus how to quit in promoting sustained cessation among the whole population and smokers from low socio-economic groups? What mix is most effective and cost effective in generating quitting in the whole population? Which ads are not cost effective at a population level? (*This question was also identified as a priority under Disadvantaged groups.)

3. When is a little not enough? What intensity of broadcast media investment (i.e. minimum and maximum TARPs over what duration) is needed to reliably detect effects on smoking behaviour and how does this vary by type of message, and population subgroup?

4. How can digital media (such as online advertising, social media, SMS, interactive games, Smartphone applications and expert systems) best engage audiences with tobacco control messages, as well as complement or interact with broadcast media campaigns?

5. What are the immediate and long term impacts of reduced anti tobacco campaign spending (and the associated reduction in exposure to campaign messages) on the overall population and vulnerable groups?

*Note: questions 3 and 4 received the same score in the ranking process.
Article 13 — Tobacco advertising, promotion and sponsorship

**FCTC OBLIGATION**

Each Party shall, in accordance with its constitution or constitutional principles, undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship.

The Guidelines for Article 13 include the following:

- Bans on advertising should be comprehensive and should apply to cross-border advertising, promotion and sponsorship;
- Retail displays of cigarettes should be banned;
- Tobacco advertising has promotional effects, and parties should consider adopting plain packaging requirements;
- Internet sales should be banned;
- Brand stretching activities should be banned;
- Tobacco company donations under the guise of “corporate social responsibility” should be banned;
- The promotion of tobacco products through films and other entertainment media should be addressed.

**RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES**

1. In what ways does the tobacco industry continue to promote itself and its products (advertising/promotion/sponsorship) in Australia? What activities does it undertake, what is the total expenditure, and what legal/regulatory measures might be needed to obtain this information? What is the impact of these types of tobacco promotion on tobacco consumption? Are there any differences between states and territories who have taken action to restrict these remaining forms of promotion (e.g. price boards, digital media and social networking, internet sales, reward schemes)?

2. How do young people's perceptions of smoking, smokers and 'youth' tobacco brands develop as plain packaging is introduced? What is the relationship between these perceptions and smoking susceptibility? How do young people perceive the tobacco industry (e.g. measures of credibility, sympathy to key messages and arguments)?

3. In the absence of little branding on cigarette packaging, how important are other factors such as price and taste on brand selection?

4. Where have young adults seen or heard about tobacco brands? What brands are young people smoking and how are the identities of these brands being maintained in a ‘dark market’ like Australia?

5. What incentive schemes are provided to retailers to encourage them to sell tobacco products or to sell particular tobacco products? What legal/regulatory measures might be needed to obtain this information?

6. What is the nature and extent of young people’s exposure to cross-border tobacco marketing in Australia (as well as to tobacco portrayals and brand communication that may be independent of the tobacco industry), including on the internet and through social media? What is the impact on smoking attitudes and behaviours of such exposure?

*Note: Six questions are presented. The last two questions received the same score in the ranking process.*
Article 14 — Demand reduction measures concerning tobacco dependence and cessation

FCTC OBLIGATION

Each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence.

The Guidelines for Article 14 stress the importance of the following:

• tobacco dependence treatment measures must be implemented within a comprehensive integrated tobacco control framework;
• cessation strategies should be based on the best available evidence of effectiveness;
• cessation services should be accessible, affordable and inclusive;
• monitoring and evaluation are essential.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. Are smokers who use nicotine replacement therapy, bupropion, varenicline and other pharmacotherapies more likely to remain abstinent than those who quit without medications in the ‘real world’, when used outside of the clinical trial situation?

2. Have Australia’s smokers “hardened” i.e. are today’s smokers smoking more cigarettes on average than in the past; do a greater proportion of smokers smoke within 30 minutes of waking than in the past; has the ratio of daily to less than daily smokers changed?

3. What are the most effective approaches to encourage and support smokers from vulnerable high prevalence groups to quit? In particular, people with mental health problems, substance use problems, clients of social service organisations and prisoners? What are the costs and barriers to implementing these approaches and how can these be minimized? (*This question was also identified as a priority under Disadvantaged groups.)

4. Has smoking cessation really “stalled” in Australia, or does the apparent levelling off in the proportion of adults who are former smokers reflect the combined impact of (1) a growing cohort of never-smokers (who could never quit to become former smokers); and (2) deaths among smokers?

5. Does the experience of quitting match the anticipated experience of quitting i.e. do smokers who quit find the experience easier, harder or about as expected?

*Note: questions 4 and 5 received the same score in the ranking process.
Article 15 — Illicit Trade

FCTC OBLIGATION

Each Party shall adopt and implement effective legislative, executive, administrative or other measures to ensure that all unit packets and packages of tobacco products and any outside packaging of such products are marked to assist Parties in determining the origin of tobacco products, and in accordance with national law and relevant bilateral or multilateral agreements, assist Parties in determining the point of diversion and monitor, document and control the movement of tobacco products and their legal status.

The Parties shall, as appropriate and in accordance with national law, promote co-operation between national agencies, as well as relevant regional and international intergovernmental organizations as it relates to investigations, prosecutions and proceedings, with a view to eliminating illicit trade in tobacco products.

Each Party shall endeavour to adopt and implement further measures including licensing, where appropriate, to control or regulate the production and distribution of tobacco products in order to prevent illicit trade.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What are the best methods and models for estimating the magnitude, forms and causes of illicit trade activities related to tobacco products?

2. Are smokers from disadvantaged areas and/or backgrounds more likely to use illicit tobacco and to what extent is illicit trade undermining the progressive effects of tax and other tobacco control policy in Australia?

3. What, if any, laws, policies and/or programmes would need to be introduced/changed in order for Australia to implement the FCTC protocol on illicit trade?

*Note some experts only provided limited rankings for this Article (e.g. identifying only 2 or 3 priorities). For this reason only 3 research questions are presented. There was general agreement regarding the top priority for this Article (question 1) and lesser agreement regarding the other research questions.
Article 18 — Protection of the environment and the health of persons

FCTC OBLIGATION

In carrying out their obligations under this Convention, the Parties agree to have due regard to the protection of the environment and the health of persons in relation to the environment in respect of tobacco cultivation and manufacture within their respective territories.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What are the best methods and models for developing a comprehensive approach for butt waste mitigation in Australia?

2. Could a case be made to remove the cellulose acetate filter from commercial cigarettes in order to reduce the quantity of tobacco product waste in the environment?

3. What level of support might stakeholders (smokers, non-smokers, industry, government) show for policies on cigarette filters (i.e. regulating or removing filters), assuming the predicted impacts are significant?

4. What are the environmental and human health consequences of butt waste deposition?

5. What might be the impact of a ‘deposit’ or ‘abatement fee’ for cigarette butts levied on manufacturers to defray costs of cleanup and environmental impact? How can the environmental impact of plastic wrapping and packages be minimised?

*Note: there were differing views on the importance of this Article. There was general agreement regarding the top two priorities for this Article and less agreement regarding other research questions.
Article 19 — Liability

FCTC OBLIGATION

1. For the purpose of tobacco control, the Parties shall consider taking legislative action or promoting their existing laws, where necessary, to deal with criminal and civil liability, including compensation where appropriate.

2. Parties shall cooperate with each other in exchanging information including information on the health effects of the consumption of tobacco products and exposure to tobacco smoke; and information on legislation and regulations in force as well as pertinent jurisprudence.

3. The Parties shall, as appropriate and mutually agreed, within the limits of national legislation, policies, legal practices and applicable existing treaty arrangements, afford one another assistance in legal proceedings relating to civil and criminal liability consistent with this Convention.

4. The Convention shall in no way affect or limit any rights of access of the Parties to each other’s courts where such rights exist.

5. The Conference of the Parties may consider, if possible, at an early stage, taking account of the work being done in relevant international fora, issues related to liability including appropriate international approaches to these issues and appropriate means to support, upon request, the Parties in their legislative and other activities in accordance with this Article.

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What resources and infrastructure would be most effective to support and/or co-ordinate Australian and international efforts in tobacco litigation by governments and individuals? How could such an infrastructure be provided and funded?

2. Is it feasible to create an effective, and constitutionally valid, tobacco specific liability regime in Australia at State and/or Federal level that:

   • Recognises the right of governments and private health insurers to sue tobacco manufacturers to recover tobacco related health care costs and sets out rules for the calculation of such losses.

   • Modifies the cost rules (especially the loser pays rule) to prevent the tobacco industry from using the threat of adverse cost orders to deter litigation or force claimants to drop their claims.

   • Makes it easier for individual victims of smoking related disease to bring their claims to court, and obtain compensation.

3. Would it be legally feasible to bring ‘cost recovery’ litigation against the tobacco industry in Australia? If so, who would be the appropriate applicant/s and how could it be funded? Would cost recovery litigation require the enactment of any legislation, regulations or rules, and, if so, of what kind and by whom? What criteria might be applied to determine whether cost recovery litigation would be a worthwhile undertaking in Australia? What are the possible benefits and risks of undertaking cost recovery litigation in Australia, and what is a realistic timeframe for its conduct?

4. Is the use of certain descriptors and brand variants by the Australian tobacco industry e.g. ‘smooth’ and ‘gold’ misleading and deceptive or likely to mislead or deceive within the meaning of section 18 of the Australian Consumer Law?

*Note: there was less agreement on this issue compared to some others. In particular, the relative priority that should be given to this approach compared with other tobacco control strategies within the Australian context.
Aboriginal and Torres Strait Islander peoples

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What message strategies are persuasive among Aboriginal and Torres Strait Islander populations? For example, what is the impact of more general mass media campaigns on Indigenous audiences as well as Aboriginal and Torres Strait Islander-specific campaigns, such as the recent “Break the Chain” campaign? What is the impact in terms of quit intentions, quit attempts and successful cessation? (*Also nominated as a priority research question under Article 12 — Education, communication, training and public awareness)

2. Why is it that some Aboriginal people never take up smoking or are able to quit successfully despite often living in circumstances where the vast majority of their family and peers smoke? What is it about these individuals and their environment that support being a non-smoker or never-smoker? Are there attributes of the individuals’ coping mechanisms that could be learned by others? How might their experiences inform new approaches to communicating with Aboriginal people about smoking?

3. What is the impact of smoke free laws and rules (public places, health services, Aboriginal organisations, cars, events) on exposure to second hand smoke, smokers’ quit intentions, quit attempts, tobacco consumption and successful cessation among Aboriginal and Torres Strait Islander people? What has been the impact on children?

4. What works in targeting smoking and chewing of tobacco by Aboriginal and Torres Strait Islander youth?

5. What is the reach and effectiveness (short and long term) of social media strategies (i.e. smart phone apps, Twitter and Facebook) to communicate health messages to Aboriginal and Torres Strait Islander people? Are there any unintended barriers or consequences (for example high download costs for people living in rural and remote areas), and if so, how can these be overcome?

6. What are the most effective approaches to reduce tobacco use and exposure to second hand smoke among Aboriginal and Torres Strait Islander people in the justice system? What is the most effective way to support these individuals to remain quit once they leave prison?

7. What are the most effective ways that Aboriginal leaders and tribal authorities can be supported by health organisations to progress towards smoke free remote communities (e.g. workable bans on tobacco sales; feasible bans on tobacco products in certain remote towns and rural areas)?

8. What is the impact of raising the price of cigarettes and tobacco (through tax increases) on Aboriginal and Torres Strait Islander smoking prevalence, consumption, cessation and initiation?

9. What are the exposure levels of Aboriginal and Torres Strait Islander children (by age) in the home - measured by e.g. PM2.5 (airborne smoke particles in the home) and children’s salivary cotinine? Who are the main sources of this exposure? (*A similar question was nominated as a priority under Article 8 — Protection from exposure to tobacco smoke)

10. Which health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a “set” of multiple warnings; What is the optimum rotation period; What are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; What is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and Are there any differences between the whole population and Aboriginal and Torres Strait Islander people in relation to these issues? (*A similar question is nominated as a priority under Article 11 — Packaging and labelling).

*Note: The questions with an asterisk next to them also appear in other Articles in this report. One tobacco control expert noted that the research questions nominated are primarily from a public health/tobacco control perspective and that the importance of broader cross cultural issues should also be acknowledged.
Disadvantaged groups

RESEARCH QUESTIONS JUDGED TO BE MOST IMPORTANT AND RELEVANT TO FUTURE TOBACCO CONTROL POLICIES

1. What is the most effective approach to changing the behaviour of health professionals and other staff and the culture of social service organisations and other settings such as mental health facilities and prisons to ensure they can appropriately address smoking among socially disadvantaged groups?

2. What is the impact of financial incentive programs on smoking behaviour, including quit attempts and cessation, among the most disadvantaged population groups? To what extent would the provision of financial incentives through the social security system be an effective means of encouraging quit attempts among very disadvantaged smokers?

3. What is the optimal way to develop a national smoking prevalence monitoring or surveillance system among groups with multiple forms of disadvantage?

4. What industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among smokers from low socio-economic groups and other disadvantaged populations? (*This question was also identified as a priority under Article 6 — Price and tax measures)

5. What is the impact of a rise in tobacco excise on the smoking behaviour and financial stress of population groups experiencing multiple disadvantage e.g. clients of social and community service organisations? How have recent tax increases differentially affected cigarette smoking among disadvantaged groups? What percentage of their income are low-income Australians spending on cigarettes? What is the likely impact of future tax increases on smoking behaviour and financial stress among highly disadvantaged groups?

6. What are the most effective approaches to encourage and support smokers from vulnerable high prevalence groups to quit? In particular, people with mental health problems, substance use problems, clients of social service organisations and prisoners? What are the costs and barriers to implementing these approaches and how can these issues be minimized? (*This question was also nominated as a priority under Article 14 — Demand reduction measures concerning tobacco dependence and cessation.)

7. What are the social network factors that most impact on smoking uptake and quitting smoking among disadvantaged groups? How can social networks among these disadvantaged groups be employed to de-normalise smoking, discourage uptake and encourage quitting?

8. What is the optimal mix of ads focusing on why to quit (including graphic images and testimonials) versus how to quit in promoting sustained cessation among the whole population and smokers from disadvantaged groups? What mix is most effective and cost effective in generating quitting in the whole population? Which ads are not cost effective at a population level? (*This question was also identified as a priority under Article 12 — Education, communication, training and awareness)

9. What are the reasons underlying Quitline underutilisation among disadvantaged groups? How can these barriers be addressed?

10. What is the effect on ‘quit attempts’ and ‘amounts smoked’ when staff from community service organisations ask their clients the following questions:

   - How many cigarettes do you smoke each day?
   - Have you tried to quit in the last three months?
   - Are you interested in getting some help quitting? and
   - providing them with a brochure about quitting (and in a sub-sample of the group organising a call from Quitline)?

*Note: The questions with an asterisk next to them also appear in other Articles in this report.
Additional research questions identified during this process

During stage 2, in addition to ranking the lists of research questions, Australian tobacco control experts were also invited to respond to the following two questions:

Do you have any additional comments that you wish to make about this process?

Do you wish to nominate research questions within the Article that you think are important that were not on the list?

The additional research questions provided below were not ranked but are presented for completeness. These questions could be considered in future priority setting exercises.

ARTICLE 5.3 — TOBACCO INDUSTRY INTERFERENCE

• What tactics have been/are used by the tobacco industry to influence or obstruct public health policy in Australia? What specific strategies can policy makers use or develop to combat those tactics?

ARTICLE 8 — PROTECTION FROM EXPOSURE TO TOBACCO SMOKE

• What measures can be implemented for ensuring smoke-drift complaints and smoke-free areas in multi-unit housing are adequately addressed?
• How many and (in particular) how much are people bothered by smoking in areas such as outdoor dining spaces, the family areas of beaches, near play structures in parks etc.?
• What strategies are most effective when developing and implementing smoke-free policies in custodial settings?

ARTICLE 9 — REGULATION OF TOBACCO

• Can we effectively get rid of cigarettes rapidly using some combination of reducing nicotine in cigarettes and other sources of nicotine? What regulatory framework do we need to move forward to ensure any residual nicotine and tobacco problem is managed as effectively as possible?
• What are the actual impacts of policy changes to regulate tobacco after they are implemented?
• What data is necessary to establish a baseline data set relevant to the regulation of tobacco i.e. what is the level from which we should reduce?
• Do filters reduce the harmfulness of cigarettes and do they falsely reassure smokers?

ARTICLE 11 — PACKAGING AND LABELLING

• Would major changes to the style and design of the health warnings be a more effective way of refreshing health warnings rather than changing the content?

ARTICLE 12 — EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS

• What is the likely impact of media fragmentation and changes in the way that audiences are consuming media on anti-tobacco mass media campaigns? What would be the likely impacts and risks and benefits of diversifying from “traditional paid advertising” to placing greater emphasis on embedded marketing or working in content e.g. brand placement?
• Have the local community campaigns to support Aboriginal and Torres Strait Islander people and their families changed community behaviour?
ARTICLE 14 — DEMAND REDUCTION MEASURES CONCERNING TOBACCO DEPENDENCE AND CESSATION

- What proportions of smokers have a history of repeated failures in quit attempts and what characterizes them?
- Is there evidence that pharmaceutical advertising messages have a role in failed quit attempts? (Is there any evidence that plain packaging reduces the probability of relapse among recent quitters and does it differ by age? For recent quitters who have relapsed, what factors are associated with purchasing their first pack after a quit attempt? What is their exposure to marketing and price promotions and what are the predictors of relapse?)

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- What are the key lessons from successful community engagement with Aboriginal and Torres Strait Islander people and how can the relevant approaches best be applied to tobacco control?
- What is the relationship/association between alcohol and social smoking?
- Do Aboriginal and Torres Strait Islander people quit the same way as a non Aboriginal person?
- Have the local community campaigns to support Aboriginal and Torres Strait Islander people and their families changed community behaviour?

DISADVANTAGED GROUPS

- What will the cost be to governments for healthcare of prison populations due to smoking caused illnesses, what are the flow on effects for the community post-release (transfer of costs, etc), what interest is there in quitting amongst the prison populations, how might prisoners respond to different scenarios (e.g. increased costs of cigarettes, gradual toughening up of restrictions on smoking, improvements in support for quitting), what impact would changes in investment and range of recreational/occupational activities for prisoners have on their smoking behaviours?
- How effective are current strategies to reduce second-hand smoke in different settings such as prisons. How can these strategies be improved?
- Is there a difference in quit rates for disadvantaged groups between intensive support to quit versus taking NRT without support to quit?

LICENSEING AND AVAILABILITY OF TOBACCO PRODUCTS

- What are the potential benefits, feasibility and best practice regulatory approaches of placing controls on the number and type of tobacco outlets in the community?
- What is the relationship between tobacco retail density (number of tobacco outlets) and smoking behaviour (uptake, quit attempts, relapse)?
- What is the relationship between tobacco retail structure (types of tobacco outlets) and smoking behaviour (uptake, quit attempts, relapse)?
- What is the attitude of young people towards legislation that increases the legal age for purchasing tobacco (e.g. increasing it to 21 or 25 years of age)? Are there any differences between current smokers vs. non-smokers?

OTHER ISSUES

- What is the potential contribution of genomics to tobacco control?
- What are the effects of different tobacco policies on women?
- Does stigmatisation of smokers affect their access to preventive health care?
- What are the benefits and disadvantages of harm minimisation approaches to tobacco control?
CONSULTATION

Consultation took place between December 2012 and March 2013, during which time the draft report was widely distributed to tobacco control stakeholders across Australia. Feedback was received by respondents on the process undertaken to develop the research agenda, as well as the research questions’ comprehensiveness in scope and their importance and relevance to tobacco control in Australia over the coming decade.

While the majority of respondents agreed with the overall methodology used to develop the research agenda, the following comments were received for consideration:

• The process may have been improved with an additional step involving greater discussion or workshopping of the research questions between experts prior to the ranking of questions.

• When ranking the research questions, more explicit criteria for judging relevance and importance may have assisted the process.

• A different methodology for identifying, refining and ranking research questions may have resulted in better defined questions and a different ranking of questions.

• Some of the larger research questions may be refined with further discussion.

• The NTS may have provided a more relevant and comprehensive framework than the FCTC.

• A five-year review of the research questions may assess progress and determine relevance and importance.

When asked to consider the research questions’ comprehensiveness in scope, respondents identified a number of gaps. Licensing of tobacco retailers and approaches to restricting the availability and supply of tobacco were identified as having not been adequately addressed. Some questions relevant to these issues are now included in the list of additional research questions.

The issue of smoking and mental health among disadvantaged groups was also raised as an area in need of stronger focus. However, several research questions identified under Articles 6, 14 and Disadvantaged Groups relate to this issue. The omission of FCTC Articles 20 (Research, surveillance and exchange of information) and 22 (Cooperation in the scientific, technical, and legal fields and provision of related expertise) was also raised. While this report focuses on identifying those research questions most relevant to Australian tobacco control, it is acknowledged that there is a need to ensure relevant research findings are widely distributed to our international partners.

There were also diverse views about the importance of Articles 8 (Protection from exposure to environmental tobacco smoke) and 18 (Protection of the environment and the health of persons). Some respondents argued that the questions identified under Article 8 were of lesser importance than others. However one respondent differed in opinion, suggesting that the involuntary exposure of disadvantaged groups (especially children) through smoke drift in multi-unit dwellings (particularly in public housing) is not receiving sufficient attention in Australia. Article 18 was considered by some respondents as relating more to the environmental agenda rather than health. One respondent also noted that all five questions pertaining to this Article dealt with cigarette butts and that plastic wrapping and packaging are also of concern. Question 5 was modified accordingly.

The significance of some of the additional research questions identified in this report was also highlighted. For example, one respondent suggested that the additional research questions under Article 9 (Regulation of the contents of tobacco) may help inform future policies in this area.

A range of views was received in relation to Article 9 and 10 (Regulation of tobacco disclosure). Both Articles were viewed as critically important to tobacco control efforts; however, respondents acknowledged that these are relatively new tobacco policy areas in Australia, and that policy and regulatory responses are still in the developmental stage. Unlike other countries, Australia has relatively little regulation of the contents of tobacco. A Voluntary Agreement is in place to guide the disclosure of ingredients. At the time of consultation, the Australian Government was developing a Regulation Impact Statement for further implementation of Articles 9 and 10. Respondents identified a need for ongoing discussion to continue refining the research priorities for these two Articles as policy options for Australia become clearer.

Finally, there was strong support for a research focus on disadvantaged groups and Aboriginal and Torres Strait Islander peoples. The need to strengthen the capacity of Indigenous Australians to undertake health research was highlighted as well as the importance of ensuring that the priority-driven research agenda is widely disseminated and “fed back” to Aboriginal community groups and organisations.
CONCLUSION

In 2008, all Australian governments made a commitment to reducing the adult daily smoking rate to 10 per cent or less, and halving the rate of smoking among Aboriginal and Torres Strait Islander peoples by 2018. In order to achieve these targets tobacco control must remain a priority for governments and non-government organisations alike. The National Tobacco Strategy 2012-18 sets out the policies and programs needed to achieve these targets including a focus on the continued implementation of proven tobacco control programs such as mass media campaigns, regulation and pricing policies. It also includes new tobacco control policies such as the world’s first implementation of plain packaging and development of policies in relation to the regulation of tobacco products and tobacco product disclosure. The NTS also places a priority on strategies to reduce smoking among disadvantaged groups in our community who have high smoking rates. Central to these approaches is the generation of new evidence to address knowledge gaps and robust evaluation of tobacco control programs. This report identifies those research questions judged by Australian tobacco control experts who participated in the process to be most important and relevant to inform tobacco control policies over the next decade.

Research should not only generate more knowledge but also help to translate knowledge into action through innovative approaches. It is hoped that this report will serve as a useful guide to those implementing and funding research in relation to preventive health and tobacco control in Australia; enhance the national research capacity to respond in a focused and timely fashion to emerging tobacco research needs over the coming decade; and further develop the shared understanding between policy makers, advocates and researchers about research priorities in tobacco control.
LIST OF AUSTRALIAN AND INTERNATIONAL TOBACCO CONTROL EXPERTS WHO GENERATED RESEARCH QUESTIONS

Article Experts

ARTICLE 5.3 — TOBACCO INDUSTRY INTERFERENCE
Professor Mike Daube, Curtin University, Australia.
Professor Simon Chapman, University of Sydney, Australia.
Professor Ruth Malone, University of California, San Francisco, USA.

ARTICLE 6 — PRICE AND TAX MEASURES TO REDUCE THE DEMAND FOR TOBACCO
Ms Michelle Scollo, Quit Victoria and Cancer Council Victoria, Australia.
Professor Frank Chaloupka, University of Illinois, Chicago, USA.
Professor Ken Warner, University of Michigan, Michigan USA.
Dr Evan Blecher, American Cancer Society, Atlanta Georgia USA.

ARTICLE 8 — PROTECTION FROM EXPOSURE TO TOBACCO SMOKE
Dr Mark Travers, Roswell Park Cancer Institute, Buffalo, New York.
Professor Sally Haw, University of Stirling, Scotland UK.
Professor Richard Edwards, University of Otago, New Zealand.
Professor Amanda Amos, University of Edinburgh, Scotland UK.

ARTICLE 9 — REGULATION OF THE CONTENTS OF TOBACCO
Dr David Ashley, Office of Science, Center for Tobacco Products, US Food and Drug Administration, USA.
Professor Ron Borland, Nigel Gray Distinguished Fellow in Cancer Prevention, Cancer Council Victoria Australia.
Professor Dorothy Hatsukami, University of Minnesota, Minnesota USA.
Professor Thomas Eissenberg, Commonwealth University, Richmond, Virginia USA.
Mr Denis Choiniere, Health Canada, Canada.
Ms Ana Claudia Andrade, National Health Surveillance Agency, Brazil.
Mr Andre Luiz Oliveira da Silva, Office of Tobacco Product Control, National Agency of Health Surveillance, Brazil.

ARTICLE 10 — REGULATION OF TOBACCO PRODUCT DISCLOSURES
Mr Matthew Allen, Allen & Clarke, Policy & Regulatory Specialists, New Zealand.
Dr Lois Biener, Center for Survey Research, University of Massachusetts, Boston USA.
Ms Ana Claudia Andrade, National Health Surveillance Agency, Brazil.
Mr Andre Luiz Oliveira da Silva, Office of Tobacco Product Control, National Agency of Health Surveillance, Brazil.
Dr Ellen Peters, Ohio State University (Chair Risk Communication Advisory Committee, FDA) USA.
Mr Denis Choiniere, Health Canada, Canada.

ARTICLE 11 — PACKAGING AND LABELLING OF TOBACCO PRODUCTS
A/Professor David Hammond, School Of Public Health and Health Systems, University of Waterloo Ontario, Canada.
Dr Crawford Moodie, University of Stirling, Scotland UK.
Professor Melanie Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria, Australia.
Dr Caroline Miller, South Australian Health & Medical Research Institute, South Australia.
Professor Andrew Mitchell, Melbourne Law School, University of Melbourne.
ARTICLE 12 — EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS
Professor Melanie Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria, Australia.
Dr Jeff Niederdeppe, College of Agriculture and Life Sciences, Department of Communication, Cornell University, New York, USA.
Ms Karen Gutierrez, Social Marketing Consultant.
Ms Trish Cotter, Victorian Comprehensive Cancer Centre, Victoria, Australia.
Ms Denise Sullivan, Chronic Disease Prevention, WA Department of Health, Australia.

ARTICLE 13 — TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP
Professor Gerard Hastings, University of Stirling, Scotland UK.
A/Professor Tim Dewhirst, University of Guelph, Ontario, Canada.
Professor Janet Hoek, Otago University, New Zealand.
Dr Becky Freeman, University of Sydney, Australia.
Mr Jonathan Liberman, McCabe Centre for Law and Cancer, Australia.

ARTICLE 14 — DEMAND REDUCTION MEASURES CONCERNING TOBACCO DEPENDENCE AND CESSATION
Professor John Pierce, University of California, San Diego, California USA.
Professor Gary Giovino, Department of Community Health and Health Behaviour, School of Public Health, University at Buffalo, New York USA.
Dr Lois Biener, Center for Survey Research, University of Massachusetts, Boston USA.
Professor Ron Borland, Nigel Gray Distinguished Fellow in Cancer Prevention, Cancer Council Victoria, Australia.
A/Professor Christine Paul, University of Newcastle, Australia.
Professor Simon Chapman, University of Sydney, Australia.

ARTICLE 15 — ILLICIT TRADE IN TOBACCO PRODUCTS
Ms Michelle Scollo, Quit Victoria and Cancer Council Victoria, Australia.
Mr Jonathan Liberman, McCabe Centre for Law and Cancer, Australia.

ARTICLE 16 — SALES TO AND BY MINORS
Not required, since all states have appropriate legislation.

ARTICLE 17 — PROVISION OF SUPPORT FOR ECONOMICALLY VIABLE ALTERNATE ACTIVITIES
Not required, since no tobacco grown in Australia.

ARTICLE 18 — PROTECTION OF THE ENVIRONMENT AND THE HEALTH OF PERSONS.
Professor Thomas Novotny, San Diego State University, California USA.
Dr Richard O’Connor, Roswell Park Cancer Institute, Buffalo, New York USA.

ARTICLE 19 — LIABILITY
Dr Andrew Higgins, Oxford Law Faculty, Oxford University, UK.
Mr Jonathan Liberman, McCabe Centre for Law and Cancer, Australia.
DISADVANTAGED GROUPS

Ms Anita Tang/Mr Scott Walsberger, Cancer Council NSW, Australia.
Dr Billie Bonevski, School of Medicine and Public Health, University of Newcastle, Australia.
A/Professor Nick Wilson, Otago University, New Zealand.
Ms Michelle Scollo, Quit Victoria and Cancer Council Victoria, Australia.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Dr Tom Calma, National Coordinator, Tackling Indigenous Smoking, Department of Health and Ageing, Canberra, Australia.
A/Professor David Thomas, Menzies Research Institute, Alice Springs Northern Territory, Australia.
Ms Denise Sullivan Chronic Disease Prevention, WA Department of Health, Australia.
LIST OF TOBACCO CONTROL EXPERTS WHO RANKED THE RESEARCH QUESTIONS

Professor Mike Daube, Director, Public Health Advocacy Institute of WA.
Professor Simon Chapman, University of Sydney.
Professor Ron Borland, Nigel Gray Distinguished Fellow in Cancer Prevention, Cancer Council Victoria.
Ms Anne Jones, Chief Executive, Action on Smoking and Health.
Mr Maurice Swanson, Chief Executive Officer, National Heart Foundation (WA Division).
Dr Caroline Miller, Executive Officer, SA Health & Medical Research Institute.
Ms Michelle Scollo, Senior Consultant Tobacco Control Unit, Cancer Council Victoria.
Ms Denise Sullivan, Director, Chronic Disease Prevention, Department of Health WA.
Professor Melanie Wakefield, Director, Centre for Behavioural Research in Cancer, Cancer Council Victoria.
Dr Becky Freeman, Research Fellow, University of Sydney.
Mr Scott Walsberger, Manager, Tobacco Control Program, Cancer Council New South Wales.
Ms Kylie Lindorff, Policy Manager, Quit Victoria, Cancer Council Victoria.
Professor David Hill, Honorary Professorial Fellow, School of Population Health, University of Melbourne.
Dr Billie Bonevski, Senior Research Academic, Centre for Health Research and Psycho-oncology, University of Newcastle.
Mr Todd Harper, Chief Executive Officer, Cancer Council Victoria.
Dr Vicki White, Deputy Director, Centre for Behavioural Research in Cancer, Cancer Council Victoria.
Mr Jonathan Liberman, Director, McCabe Centre for Law and Cancer.
Ms Trish Cotter, Public Health and Social Marketing Consultant, Victorian Comprehensive Cancer Centre.
Dr Ross MacKenzie, Lecturer, Health Studies, Macquarie University.
Dr Coral Gartner, NHMRC Postdoctoral Research Fellow, University of Queensland.
Dr David Thomas, Tobacco Control Research Program, Menzies School of Health Research.
Ms Fiona Sharkie, Executive Director, Quit Victoria, Cancer Council Victoria.
Dr Sarah Durkin, Senior Research Fellow (Tobacco), Centre for Behavioural Research in Cancer, Cancer Council Victoria.
Ms Kathryn Barnsley, Menzies Research Institute, Tasmania.
Associate Professor Christine Paul, Senior Research Academic Priority Research Centre for Health Behaviour.
Professor Wayne Hall, UQ Centre for Clinical Research, University of Queensland.
Mr Bill King, Senior Research Officer, Vic Health Centre for Tobacco Control.
Dr Lyn Roberts, Chief Executive Officer, National Heart Foundation.
Dr Clair Scrine, Senior Research Officer, Kulunga Research Network.
Professor Mark Davison, Faculty of Law, Monash University.
Mr Mark West, Director, Tobacco and Alcohol Branch, Preventive Health Directorate.
Dr Roscoe Taylor, Director, Public Health, Department of Health and Human Services.
Ms Anita Dessai, Manager, Cancer Prevention, Cancer Institute NSW.
Ms Della Rowley, Tobacco Control Unit, Drug & Alcohol Services, SA Health Department.
Dr Bruce Bolam, Executive Manager, Knowledge & Environments for Health, Vic Health.
Professor Andrew Mitchell, Melbourne Law School, University of Melbourne.
Ms Sharon Appleyard, Assistant Secretary, Tobacco Control Taskforce, Commonwealth Department of Health and Ageing.
Professor Nigel Gray, Cancer Council Victoria.
Ms Louise Galloway, Manager Screening and Cancer Prevention, Department of Health Victoria.
Professor Ian Olver, CEO, Cancer Council Australia.
Dr Rohan Greenland, National Director Government Relations National Heart Foundation.
Mr Warwick Kneebone, Coordinator, Tobacco Enforcement & Education, Department of Health NT.
Mr Paul Grogan, Director, Advocacy, Cancer Council Australia.

*Two experts on this list utilised an alternative system of ranking the research priorities. The ranking results of these experts were therefore unable to be used for this project.
COMPLETE LIST OF QUESTIONS SUBMITTED FOR THE RANKING PROCESS

Article 5.3 — Tobacco Industry Interference

Q What are the extent, nature, and consequences of “third party” strategic engagement by Australian tobacco companies post 2012?

Q What incentive schemes operate in Australia today between tobacco manufacturers and retailers?

Q What is the extent of tobacco industry marketing, promotional and support activities remaining in Australia – including public relations and lobbying by tobacco companies and groups with which they are associated and legal activities and costs? How much is the tobacco industry continuing to invest in these activities?

Q Which Australian organisations are directly or indirectly associated with tobacco companies and thus supporting their activities? What is the nature and extent of their association?

Q To what extent are tobacco companies able to exert influence through commercial or other associations? What is the nature and extent of this influence?

Q What is the extent and nature of tobacco industry engagement with government agencies other than health (e.g. Department of Foreign Affairs and Trade, Department of Commerce, and The Treasury)? What is the nature and extent of the discussions, association and support between these agencies and the tobacco industry? How can these arrangements be made more transparent? What do government employees in other agencies outside the Department of Health and Ageing know about the FCTC and Article 5.3’s provisions?

Q How much do the tobacco industry and industry-affiliated groups contribute to political parties annually, and are there differences between the parties in amounts received and organizations donating?

Q How does industry “corporate social responsibility activities” (CSR) affect recipients’ views and activities related to tobacco control policy and their support for stronger regulation? Does this vary by type of CSR or type of recipient/beneficiary of CSR?

Article 6 — Price and tax measures to reduce the demand for tobacco

Q How have industry pricing strategies changed and/or will they change in response to the increasingly high taxes and stronger tobacco control environment in Australia?

Q How does the price elasticity of demand for cigarettes change as taxes and prices are raised further and further?

Q What strategies are most effective in mitigating illicit trade in tobacco products?

Q How has over shifting of excise tax increases influenced cigarette price trends? Note: Over shifting is when the consumer price rises by more than the tax increase.

Q What influence has tax reform had on smokers purchasing habits – in particular down trading (i.e. moving to a cheaper brand) versus premiumisation (smoking premium brands)?

Q What are the best measures to use in establishing a baseline for illicit trade in cigarettes and assessing change over time?

Q How have recent tax increases differentially affected cigarette smoking among disadvantaged groups? What percentage of their income are low-income Australians spending on cigarettes? What is the likely impact of future tax increases on smoking behaviour and financial stress among highly disadvantaged groups?

Q Is a cigarette tax increase (not the total tax) regressive, proportional, or progressive? That is, do enough more low-income smokers quit or reduce their daily consumption than do high-income smokers that the relative burden on the low-income population declines?

Q What are the cross-elasticities of demand for roll-your-own cigarettes and other non-manufactured cigarette products (cigars, etc.) and how are these reflected in changes in consumption of these other products when the cigarette tax is increased? Does RYO consumption increase, for example?

Q How are youth smoking rates associated with cigarette price increases? Does smoking prevalence in the 18-24 year-old age group strongly reflect price when this group was 4-5 years younger?
Q How has the tobacco market changed in Australia since the 25% increase in tobacco excise and customs duty in April 2010, in terms of overall volume of sales, market share smoking tobacco vs. cigarettes vs. cigars; number and nature of brands on the market; market share by pack size (sales revenue and volume); brand share (sales revenue and volume) both for individual brands and by market segment; and estimated prevalence of use of illicit tobacco products?

Q What industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among low-SES smokers?

**Article 8 — Protection from exposure to tobacco smoke**

Q What are the exposure levels of children (by age) in the home in relation to disadvantage (socioeconomic status and ethnicity) - measured by e.g. PM2.5 (airborne smoke particles in the home) children’s salivary cotinine? Who are the main sources of this exposure?

Q What are the levels of tobacco smoke exposure in outdoor areas where smoking is permitted, as measured by e.g. PM2.5 (airborne smoke particles in general, workers with monitors), and/or cotinine in non-smoking workers and clients?

Q What are the levels of tobacco smoke exposure in prisons, non-smoking prisoners and non-smoking prison officers - measured by e.g. PM2.5 (air in prison locations, individuals with monitors), cotinine in non-smokers? What are the barriers and facilitators to creating smoke-free prisons, including prisoners’ and prison staff’s experiences of and views on smoking in prison?

Q What has the impact of smoke free cars legislation been in Australian States e.g. on smoking prevalence and SHS exposure among children and adults, particularly from more disadvantaged populations?

Q What combination of individual/household level interventions and population-based policies (mass media, other smoke free policies in other settings, community based interventions etc.) are most effective at reducing smoking in homes, particularly among disadvantaged populations?

Q What is the broader impact of smoke free policies (e.g. parks, beaches, streets etc.) on social norms about smoking among smokers, non-smokers and children, particularly in disadvantaged populations?

Q What is the impact of smoke free home policies on health of children, in terms of change in health outcomes (such as hospital admissions for respiratory disease, lung function etc.), especially in disadvantaged populations?

Q What is the most successful approach to ensure all common areas in strata title developments (such as apartment complexes) are smoke free? What are the barriers and how can they be overcome? What personal, social and environmental factors and policy development approaches lead to positive progress on this issue?

**Article 9 — Regulation of the contents of tobacco**

Q What health, behavioural and social impacts would a nation-wide policy of reducing nicotine content in cigarettes have on addicted tobacco users and on non-addicted tobacco users, both positive and negative? What would be the impact on youth and adult prevalence and consumption, as well as morbidity and mortality? What would be the impact of cigarettes with very low nicotine content and unchanged tar (reduction in filler nicotine, not tar delivery) on quitting success?

Q How could the impact of a nationwide policy of reducing nicotine content be evaluated? What information should be collected prior to, during, and after, such a policy?

Q What is the impact of tip ventilation (i.e. filter vents) on cigarette experimentation? Are inexperienced smokers more likely to start with a highly ventilated product or one with little ventilation? **Note:** Filter vents are perforations in the tipping paper of cigarettes. Filter vents dilute the smoke with fresh air when the smoker takes a puff thereby by creating a lighter and milder taste and making the smoke easier to inhale.

Q What would be the potential implications (risks and benefits) of requiring higher pH levels in tobacco smoke to attempt make inhalation less likely or less deep? What is the capacity for smokers to inhibit the tendency to inhale cigarette smoke into the lung?
Q What is the impact of e-cigarettes on the perception of the product, tobacco use behaviours and potential for initiation and use of other tobacco products? Are there differences between adults and children and vulnerable groups with high smoking prevalence? Do cigarette smokers who try to quit using e-cigarettes switch completely or do they continue to smoke cigarettes? What is the extent of reduction in cigarette smoking?

Q What would be the impact of banning flavoured cigarettes and the potential banning of menthol cigarettes on the uptake of smoking, transition to dependence, and smoking cessation in adult smokers? What influence does the availability of flavoured cigarettes have on smoking behaviour in children and teenagers?

Q What influence do cigarette product design features in Australian brands have on smoking behaviour? What is the relationship between smoking topography (i.e. volume inhaled, puff number, puff duration, etc.) among Australians and cigarette product design features (for example additives, paper porosity, filter type, cigarette length and diameter, filter vents)?

Q What impact would a ban on tobacco additives have on the brand variants in the market and brand selection/brand switching by smokers? What would be the impact on smokers as some products disappear, change recipe or alter cigarette engineering features as a result of a ban? What would be the impact of a ban on additives on the composition of cigarettes and smoke deliveries of tobacco products following such a ban? What would be the impact on puffing patterns in both the short term and long term as smokers adapt to the changes?

Q What approach to tobacco addictiveness reduction would provide the most benefit to public health? What might such an approach involve e.g. steps/processes/ main points to be investigated?

Q Considering the existence of addictiveness models for some drugs, is it necessary to develop a model specific for tobacco control regulation?

Q What additives enhance the palatability, attractiveness and addictiveness of tobacco products? What is their role and how do they act? Are particular brands of Australian cigarettes designed through the use of variable additive levels to appeal to specific groups of smokers? What influence do tobacco additives have on quitting behaviour?

Q Are there alkaloids other than nicotine for which a maximum content should be established? What are their current levels in Australian cigarettes? Are there substances, other than alkaloids, that play a role in developing or sustaining tobacco addiction? How could governmental authorities monitor these substances and, if necessary regulate them?

Q To minimize, or eliminate, tobacco addictiveness, what criteria should be used to establish the maximum nicotine content that would be permissible in the various types of tobacco products marketed in Australia? For example, set the level according to the lowest nicotine level technologically feasible or set the level just below the level where tobacco dependence cannot develop? What other criteria could be used?

Q How can we ensure that tobacco product emissions used for determining toxicant yields are produced in a way that ensures they reflect actual human tobacco use behaviour?

Q How do components and design features of new and emerging tobacco products like e-cigarettes affect the bioavailability of nicotine, other addictive substances, and harmful tobacco constituents? What are the tobacco use behaviours of individuals using new and emerging tobacco products, including the multiple tobacco use behaviours?

Q What level of reduction in harmful and potentially harmful constituents results in decreased disease risk?

Q What is known about the evidence of short-term and long term intakes of toxicants comparing smokers of filtered and unfiltered cigarettes (using cellulose acetate filters)? What is known about smoker perceptions of the impact of filters on cigarette harmfulness?
Article 10 — Regulation of tobacco product disclosures

Q How best might the information released under disclosure (now or in the future) be effectively used to inform the public? What are the risks, unintended consequences and benefits of potential approaches?

Q How can disclosure be an effective tool to guide / drive / boost other interventions (in particular product regulation)? How can policy makers use the information provided under disclosure arrangements to develop more effective regulatory models? What are the top priorities for using the information obtained via disclosure?

Q What is the impact of different formats for listing tobacco constituents on the public’s understanding of harmful and potentially harmful constituents? This research priority requires first understanding what Australia’s goals for communication are (what do you want the public to understand)? Does the format influence understanding among individuals from vulnerable subpopulations (e.g. Aboriginal and Torres Strait Islander people; less numerate or less health literate populations)?

Q Aside from studies of comprehension, how do different formats for communicating tobacco constituents ultimately influence downstream processes such as tobacco-related beliefs, intentions, product/brand selections and smoking behaviours?

Q What is the purpose of individual tobacco ingredients? What system and processes should be put in place and followed to see if there is a secondary purpose or hidden primary purpose to tobacco ingredients (e.g. a ‘processing aid’ that in reality is a flavouring agent). How should a disclosure regime check that the information disclosed by tobacco companies is accurate?

Q What is the best way to communicate with the public about cigarette ingredients and emissions, while ensuring that these efforts do not contribute to an increase in false beliefs among the population and vulnerable groups about reduced harmfulness of some tobacco products? For example, what is the best way to communicate with the public about regulatory or policy approaches that seek to influence the attractiveness, addictiveness and toxicity of cigarettes, while at the same time not discounting the risks of smoking tobacco itself?

Q What is the best approach to ensure ingredients and engineering features of e-cigarettes are disclosed to governments and/or the general public? How should a disclosure regime check that the information disclosed by companies on e-cigarettes is accurate?

Q To what extent, and/or under what circumstances, does branding information (such as the use of descriptive brand variant names) influence the comprehension and use of different formats for listing potentially harmful tobacco product constituents?

Article 11 — Packaging and labelling

Q What is the impact of plain packaging on the population overall, in youth and young adults, ethnic populations and in other vulnerable high prevalence population subgroups in relation to brand loyalty and brand switching, the salience of health warnings, false beliefs about smoking harms, product appeal and social norms, the sensory experience of smoking (incl. perceptions of the taste of cigarettes), smoking uptake, consumption and cessation?

Q What tobacco marketing, pricing, brand variant and product variation strategies are used by tobacco companies to attempt to reduce the impact of plain packaging and larger pictorial health warnings? What marketing strategies are used by the tobacco companies to reduce the impact of plain packaging – for example creative naming of brands or brand variants, price discounting, use of social media and public relations activities?

Q Under the policy of plain packaging, what is the impact on Australian smokers and young people of potentially misleading descriptive brand variant names, different pack sizes and stick lengths, as well as potentially more unattractive stick colours?

Q What are the impacts, if any, of plain packaging for other tobacco products?
Q What other innovative packaging measures, beyond plain packaging, can be used to communicate risk/cessation messages to consumers, e.g. pack inserts, the use of on-pack Quick Response (QR) barcodes directing the user to available help, on-cigarette health warnings.

Q How do smokers respond to plain packaging and large graphic health warnings? Do they use strategies to minimize the impact of plain packaging and the large graphic health warnings e.g. attempt to hide cigarette packs or use covers?

Q Which graphic health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a “set” of multiple warnings; What is the optimum rotation period; What are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; What is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and Are there any differences between the whole population, youth and young adults and vulnerable population groups in relation to these issues?

Q Does the impact of plain packaging vary by brand (i.e. major brands versus generics)?

Q How effective are various pack modifications in reducing the beneficial impact of plain packaging? Relative to responses to a particular brand in a plain package with no inserts or changes to cigarette papers or descriptive text (i.e. the control stimulus), how do a variety of modifications effect perceptions of harmfulness, expectations regarding product strength and palatability, and appeal of brand?

Q What is the effect of plain packaging on new entrants in the tobacco market?

Q How long might plain packaging take to have an impact on smoking rates, particularly of young people, and how could this be discerned from the effects of multiple other tobacco control strategies.

Article 12 — Education, communication, training and public awareness

Q How can digital media (such as online advertising, social media, SMS, interactive games, smartphone applications and expert systems) best engage audiences with tobacco control messages, as well as complement or interact with broadcast media campaigns?

Q What is the impact of news media coverage of tobacco issues (volume of coverage, framing of coverage) on population tobacco-related beliefs and behaviours?

Q Are mass media campaigns important in terms of relapse prevention? If so, what types of messages are most effective at preventing relapse among quitters (recent or otherwise)? Can advertising reduce the time from first quit attempt to final quit attempt? What are the predictors of reduced relapse in the population?

Q What types of messages are most effective at promoting support for (subsequent) tobacco control policies?

Q What message strategies are persuasive among indigenous populations? For example, what is the impact of more general mass media campaigns on Indigenous audiences as well as Indigenous-specific campaigns, such as the recent “Break the Chain” campaign?

Q Which attitudes and beliefs are the best predictors of support for tobacco control policy advancement? What are the community attitudes and perceptions toward (a) the denormalisation of smoking in Australia and (b) denormalisation of the tobacco industry?

Q What is the optimal mix of ads focusing on why to quit (including graphic images and testimonials) versus how to quit in promoting sustained cessation among the whole population and low-SES smokers? What mix is most effective and cost effective in generating quitting in the whole population? Which ads are not cost effective at a population level?

Q When is a little not enough? What intensity of broadcast media investment (i.e. minimum and maximum TARPs over what duration) is needed to reliably detect effects on smoking behaviour and how does this vary by type of message, and population subgroup?

Q What are the immediate and long term impacts of reduced anti-tobacco campaign spending, on the overall population and vulnerable high prevalence population subgroups?

Q Do the effects of different types of ads decay at different rates?

Q What are the effects of broadcast mass media campaigns when run with and without implementation of key tobacco control policies such as price increases, package health warnings, product regulation, and tobacco marketing bans?
What are the health risks of new and emerging alternatives to combustible tobacco and how do we communicate these to smokers, the public and regulators, and in an environment where the evidence and regulatory controls are contested by pro and anti-tobacco interests?

How can we optimise the reach and effect of mass reach health communications in an increasingly cluttered, complex and evolving media environment? What are the implications for future campaigning on smoking and health, and media planning in particular?

Australia is one of the few countries in the world contemplating an end to smoking. What does an end to smoking mean for the lay public and broader public health community? What might the transition to a largely non-smoking Australian population look like? How do we build understanding, support and create a greater sense of urgency and shared responsibility about what might be possible?

**Article 13 — Tobacco advertising, promotion and sponsorship**

In what ways does the tobacco industry continue to promote itself and its products (advertising/promotion/sponsorship) in Australia? What activities does it undertake, what is the total expenditure, and what legal/regulatory measures might be needed to obtain this information?

What incentive schemes are provided to retailers to encourage them to sell tobacco products or to sell particular tobacco products? What legal/regulatory measures might be needed to obtain this information?

In the absence of little branding on cigarette packaging, how important is price on brand selection?

What impact does trade-based advertising and promotions have on consumer tobacco brand choices?

Where have young adults seen or heard about tobacco brands? What brands are young people smoking and how are the identities of these brands being maintained in a ‘dark market’ like Australia?

What impact is the marketing of alternative nicotine delivery systems (ANDs) (including e-cigarettes) having on the consumption of conventional tobacco products? How does the marketing of ANDs (including e-cigarettes) interact with the marketing of conventional tobacco products?

What is the nature and extent of young people’s exposure to cross-border tobacco marketing in Australia (as well as to tobacco portrayals and brand communication that may be independent of the tobacco industry), including on the internet and through social media? What is the impact on smoking attitudes and behaviours of such exposure?

How do young people’s perceptions of smoking, smokers and ‘youth’ tobacco brands develop as plain packaging is introduced? What is the relationship between these perceptions and smoking susceptibility? How do young people perceive the tobacco industry (e.g. measures of credibility, sympathy to key messages and arguments)?

What types of tobacco promotion persist in Australia (e.g. price boards, promotion through digital media and social networking, internet sales, reward schemes) and what is the impact on consumption? Are there any differences between states and territories who have taken action to restrict these remaining forms of promotion?

**Article 14 — Demand reduction measures concerning tobacco dependence and cessation**

Has smoking cessation really “stalled” in Australia, or does the apparent levelling off in the proportion of adults who are former smokers reflect the combined impact of (1) a growing cohort of never-smokers (who could never quit to become former smokers; and (2) deaths among smokers?

Have Australia’s smokers “hardened” i.e. are today’s smokers smoking more cigarettes than on average in the past; do a greater proportion of smokers smoke within 30 minutes of waking than in the past; has the ratio of daily to less than daily smokers changed?

Does the experience of quitting match the anticipated experience of quitting i.e. do smokers who quit find the experience easier, harder or about as expected?

Are smokers who use nicotine replacement therapy, bupropion, varenicline and other pharmacotherapies more likely to remain abstinent than those who quit without medications in the ‘real world’, when used outside of the clinical trial situation?
Are smokers properly informed about the effects of and proper use of medications? Would correcting misperceptions facilitate quitting? Do smokers equate stop-smoking medications with other medications, which often solve the problem simply by taking the pill?

What progress is being made in quit proportions* over time in Australia? Does this differ by state and territory? To what extent do tobacco control policies explain any differences?

What are the most effective approaches to encourage and support vulnerable high prevalence sub-populations to quit? In particular, people with mental health problems, substance use problems, clients of social service organisations and prisoners? What are the costs and barriers to implementing these approaches and how can they be minimized?

What is the potential of various alternative forms of nicotine (in particular e-cigarettes) to act as long term substitutes for the much more harmful cigarette smoking, rather than being used as short term cessation aids among people who have had a long history of unsuccessful quitting?

What are the most appropriate methods for rapidly assessing the potential of evidence-based smoking cessation interventions for priority high-prevalence sub-populations?

What are the critical factors that influence relapse and do they vary by length of time quit? Are there any differences in outcomes between spontaneous quitting attempts and planned quitting attempts?

Are there any additional benefits associated with cessation approaches that tailor cessation assistance to the needs of the individual, rather than taking a one-size-fits-all approach?

What is the relationship between financial stress and depression and smoking cessation? Do these factors influence successful quitting behaviours and what interventions are likely to be effective?

**Article 15 — Illicit trade in tobacco products**

What are the best methods and models for estimating the magnitude, forms and causes of illicit trade activities related to tobacco products?

Is it possible to articulate an ‘optimal level’ of illicit trade in Australia?

What, if any, laws, policies and/or programmes would need to be introduced / changed in order for Australia to implement the draft FCTC protocol on illicit trade?

How best (if at all) can we determine the extent of use in Australia of branded cigarettes which carry health warnings and otherwise appear to be genuine, but on which neither excise nor customs duty has been paid?

What is the source of cigarettes used in illicit trade (i.e. cigarettes where duty has not been paid rather than counterfeit cigarettes)? Where were they manufactured and by which tobacco companies? Are there links to organized crime?

Are smokers from disadvantaged areas and/or backgrounds more likely to use illicit tobacco and to what extent is illicit trade undermining the progressive effects of tax and other tobacco control policy in Australia?

What does the British experience and experience from other consumer fields tell us about feasible and potentially effective deterrents against retailers selling illicit tobacco products?

**Article 18 — Protection of the environment and the health of persons**

What are the best methods and models for developing a comprehensive approach for butt waste mitigation in Australia?

What are the environmental and human health consequences of butt waste deposition?

Could a case be made to remove the cellulose acetate filter from commercial cigarettes in order to reduce the quantity of tobacco product waste in the environment?

What would be the potential public health and environmental impact of a biodegradability standard for cigarette filters?

What might be the impact of a ‘deposit’ or ‘abatement fee’ for cigarette butts levied on manufacturers to defray costs of cleanup and environmental impact?
Q What level of support might stakeholders (smokers, non-smokers, industry, government) show for such filter policies, assuming the predicted impacts are significant?
Q What has been the impact of the reduced cigarette ignition propensity standard on smoking materials fire incidence?

Article 19 — Liability
Q Would it be legally feasible to bring ‘cost recovery’ litigation against the tobacco industry in Australia? If so, who would be the appropriate applicant/s? Would cost recovery litigation require the enactment of any legislation, regulations or rules, and, if so, of what kind and by whom? What criteria might be applied to determine whether cost recovery litigation would be a worthwhile undertaking in Australia?
Q In what ways could cost recovery litigation be conducted in Australia – how could it be funded and who might be best placed to undertake it? What are the possible benefits and risks of undertaking cost recovery litigation in Australia, and what is a realistic timeframe for its conduct?
Q Is the use of certain descriptors and brand variants by the Australian tobacco industry e.g. ‘smooth’ and ‘gold’ misleading and deceptive or likely to mislead or deceive within the meaning of section 18 of the Australian Consumer Law?
Q Is it feasible to create an effective, and constitutionally valid, tobacco specific liability regime in Australia at State and/or Federal level that:
   • Recognises the right of governments and private health insurers to sue tobacco manufacturers to recover tobacco related health care costs and sets out rules for the calculation of such losses.
   • Modifies the cost rules (especially the loser pays rule) to prevent the tobacco industry from using the threat of adverse cost orders to deter litigation or force claimants to drop their claims.
   • Makes it easier for individual victims of smoking related disease to bring their claims to court, and obtain compensation.
Q What resources and infrastructure would be most effective to support and/or co-ordinate Australian and international efforts in tobacco litigation by governments and individuals? How could such an infrastructure be provided and funded?

Aboriginal and Torres Strait Islander Peoples
Q What is the impact of national mainstream, national Indigenous-specific and local Indigenous specific social marketing campaigns on Indigenous smokers’ quit intentions, quit attempts and successful cessation?
Q What is the impact of smoke free laws and rules (public places, health services, Aboriginal organisations, cars, events) on Indigenous exposure to second-hand smoke and Indigenous smokers’ quit intentions, quit attempts, tobacco consumption and successful cessation?
Q What is the impact of raising the price of cigarettes and tobacco (through tax increases) on Indigenous smoking prevalence, consumption, cessation and initiation?
Q Why is it that some Aboriginal people never take up smoking or are able to quit successfully despite often living in circumstances where the vast majority of their family and peers smoke? What is it about these individuals and their environment that support being a non-smoker or never-smoker? Are there attributes of the individuals’ coping mechanisms that could be learned by others? How might their experiences inform new approaches to communicating with Aboriginal people about smoking?
Q What are the most effective ways that Aboriginal leaders and tribal authorities can be supported by health organisations to progress towards smoke free remote communities (e.g. workable bans on tobacco sales; feasible bans on having any tobacco products in certain remote towns and rural areas)?
Q What is the incidence and what are the health implications of tobacco chewing in Australia, particularly among Aboriginal and Torres Strait Islander populations? What additives, such as bark ash, are used and what are the health and addiction implications of both tobacco chewing and the additives?
Q Are the interventions to address smoking addiction applicable for chewers of commercial tobacco and / traditional tobaccos?
What is the reach and effectiveness (short and long term) of social media strategies (i.e. smart phone apps, Twitter and Facebook) to communicate health messages to Aboriginal and Torres Strait Islander people? Are there any unintended barriers or consequences (for example high download costs for people living in rural and remote areas), and if so, how can these be overcome?

What works in targeting smoking and chewing of tobacco by Aboriginal and Torres Strait Islander youth?

What are the most effective approaches to reduce tobacco use and exposure to second hand smoke among Aboriginal and Torres Strait Islander people in the justice system? What is the most effective way to support these individuals to remain quit once they leave prison?

What message strategies are persuasive among Indigenous populations? For example, what is the impact of more general mass media campaigns on Indigenous audiences as well as Indigenous-specific campaigns, such as the recent “Break the Chain” campaign?

Are Aboriginal and Torres Strait Islander smokers more likely to use illicit tobacco and to what extent is illicit trade undermining the progressive effects of tax and other tobacco control policies?

Which graphic health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a “set” of multiple warnings; What is the optimum rotation period; What are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; What is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and Are there any differences between the whole population and Aboriginal and Torres Strait Islander people in relation to these issues?

What is the impact of plain packaging on Aboriginal and Torres Strait Islander smokers in relation to brand loyalty and brand switching, the salience of health warnings, false beliefs about smoking harms, product appeal and social norms, the sensory experience of smoking (including perceptions of the taste of cigarettes), smoking uptake, consumption and cessation?

What are the exposure levels of Aboriginal and Torres Strait Islander children (by age) in the home - measured by e.g. PM2.5 (airborne smoke particles in the home) and children’s salivary cotinine? Who are the main sources of this exposure?

What tobacco industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among Aboriginal and Torres Strait Islander smokers?

In the Australian setting, what are the specific health benefits of raising tobacco tax for Aboriginal and Torres Strait Islander smokers (in terms of lower uptake of smoking and increased quitting), relative to any increased economic hardship (for those who neither quit nor reduce their tobacco consumption)?

Are there any unintended consequences of anti-tobacco mass media campaigns on Aboriginal and Torres Strait Islander people (especially smokers)?

What has the impact of smoke free cars legislation been in Australian States e.g. on smoking prevalence and second hand smoke exposure among Aboriginal and Torres Strait Islander children and adults compared to the general population?

Disadvantaged groups

In the Australian setting, what are the specific health benefits of raising tobacco tax for disadvantaged populations (in terms of lower uptake of smoking and increased quitting), relative to any increased economic hardship (for those who neither quit nor reduce their tobacco consumption)?

What is the scope for making smoke free area laws more effective, especially in deprived communities?

What are the levels of tobacco smoke exposure in prisons? What are the barriers and facilitators to creating smoke-free prisons, including prisoners’ and prison staff’s experiences of and views on smoking in prison?

What is the relative cost effectiveness of local advertising (billboards, bus shelters etc.) versus direct marketing (electronic vs. paper-based mail vs. personal detailing) to doctors to increase referral to Quitline and prescription of NRT specifically to people living in very low SES (lowest decile of index of social disadvantage) neighbourhoods?
Q Could financial incentives delivered via community bank savings accounts be a cost-effective strategy for increasing school retention and reducing smoking uptake in highly disadvantaged communities in non-metropolitan areas?

Q What is the effect on ‘quit attempts’ and ‘amounts smoked’ of welfare workers (simply) asking about smoking status (‘how many cigarettes do you smoke each day?’) whether the person has tried to quit in the last three months, & interest in getting help quitting (‘are you interested in getting a bit of help with quitting?’) and providing a brochure (and in a sub-sample organising a call from Quitline)?

Q What proportion of prisoners quit and to what extent do remaining smokers cut down following the introduction of smoke-free prisons in the NT (perhaps using a WA or Qld control group)?

Q What proportion of people living with psychotic illness have been prescribed NRT patches since PBS listing in January 2011 (could question be inserted in triennial Australian national survey)? Does use of NRT patches increase the odds of quitting among those with mental illness in a real-life setting? Does the provision of NRT gum increase the odds of quitting among those with a mental illness who call the Quitline or participate in quit groups, both among those also using patches and those not?

Q What is the impact of a rise in tobacco excise on the smoking behaviour and financial stress of population groups experiencing multiple disadvantage e.g. clients of social and community service organisations?

Q How can we best obtain reliable smoking prevalence data over time for the groups experiencing multiple disadvantage?

Q What is the impact of financial incentive programs on smoking behaviour, including quit attempts and cessation, among the most disadvantaged population groups? To what extent would the provision of financial incentives through the social security system be an effective means of encouraging quit attempts among very disadvantaged smokers?

Q What are the social network factors that most impact on smoking uptake and quitting smoking among disadvantaged populations? How can social networks among disadvantaged groups be employed to de-normalise smoking, discourage uptake and encourage quitting?

Q What is the optimal way to develop a national smoking prevalence monitoring or surveillance system among groups with multiple forms of disadvantage i.e. highly socially disadvantaged.

Q What are the reasons underlying Quitline underutilisation amongst socially disadvantaged groups?

Q Are there any unintended consequences of anti-tobacco mass media campaigns on some disadvantaged groups (e.g. people with psychosis and people with other substance abuse problems, those with low health literacy)?

Q What is the most effective approach to changing the behaviour of health professionals and social service organisations to ensure they can appropriately address smoking amongst socially disadvantaged groups?

Q How have recent tax increases differentially affected cigarette smoking among disadvantaged groups? What percentage of their income are low-income Australians spending on cigarettes? What is the likely impact of future tax increases on smoking behaviour and financial stress among highly disadvantaged groups?

Q Is a cigarette tax increase (not the total tax) regressive, proportional, or progressive? That is, do enough more low-income smokers quit or reduce their daily consumption than do high-income smokers that the relative burden on the low-income population declines?

Q What industry pricing strategies undermine the effectiveness of tax policies in reducing smoking among low-SES smokers?

Q What are the exposure levels of children (by age) in the home in relation to disadvantage (socioeconomic status and ethnicity) - measured by e.g. PM2.5 (airborne smoke particles in the home), children’s salivary cotinine? Who are the main sources of this exposure?
Q What are the levels of tobacco smoke exposure in prisons, non-smoking prisoners and non-smoking prison officers- measured by e.g. PM2.5 (air in prison locations, individuals with monitors), cotinine in non-smokers? What are the barriers and facilitators to creating smoke-free prisons, including prisoners’ and prison staff’s experiences of and views on smoking in prison?

Q What has the impact of smoke free cars legislation been in Australian States e.g. on smoking prevalence and second hand smoke exposure among children and adults, particularly from more disadvantaged populations?

Q What combination of individual/household level interventions and population-based policies (mass media, other smoke free policies in other settings, community based interventions etc.) are most effective at reducing smoking in homes, particularly among disadvantaged populations?

Q What is the impact of smoke free home policies on health of children, in terms of change in health outcomes (such as hospital admissions for respiratory disease, lung function etc.), especially in disadvantaged populations?

Q What is the impact of plain packaging on the population overall, in youth and young adults, ethnic populations and in other vulnerable high prevalence population subgroups in relation to brand loyalty and brand switching, the salience of health warnings, false beliefs about smoking harms, product appeal and social norms, the sensory experience of smoking (incl. perceptions of the taste of cigarettes), smoking uptake, consumption and cessation?

Q Which graphic health warning messages work best and why? What are the most effective types of message content, including the combination of messages across a “set” of multiple warnings; What is the optimum rotation period; What are the best ways of integrating cessation information with health warnings and ways in which packages can be used to promote effective forms of smoking cessation; What is the impact of new and larger graphic health warnings within the context of plain packaging of tobacco; and Are there any differences between the whole population, youth and young adults and vulnerable population groups in relation to these issues?

Q What is the optimal mix of ads focusing on why to quit (including graphic images and testimonials) versus how to quit in promoting sustained cessation among the whole population and low-SES smokers? What mix is most effective and cost effective in generating quitting in the whole population? Which ads are not cost effective at a population level?

Q When is a little not enough? What intensity of broadcast media investment (i.e. minimum and maximum TARPs over what duration) is needed to reliably detect effects on smoking behaviour and how does this vary by type of message, and population subgroup?

Q What are the immediate and long term impacts of reduced anti-tobacco campaign spending, on the overall population and vulnerable population subgroups?

Q What are the most effective approaches to encourage and support vulnerable high prevalence sub-populations to quit? In particular, people with mental health problems, substance use problems, clients of social service organisations and prisoners? What are the costs and barriers to implementing these approaches and how can they be minimized?

Q What are the most appropriate methods for rapidly assessing the potential of evidence-based smoking cessation interventions for priority high-prevalence sub-populations?

Q Are smokers from disadvantaged areas and/or backgrounds more likely to use illicit tobacco and to what extent is illicit trade undermining the progressive effects of tax and other tobacco control policy in Australia?
SUBMISSION FORM

Name:
Organisation:
Mailing Address:
Phone:
Email:

1. Do you think the research questions identified in this report are important and relevant for tobacco control in Australia over the coming decade?
   
   Yes  No  Somewhat  (please circle one)

   Why? / Why not?
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2. Do you think the research questions identified in this report are comprehensive in scope?

   Yes  No  Somewhat  (please circle one)

   Why? / Why not?
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3. Would you like to comment on the research questions relating to any specific issue?

☐ Article 5.3 Tobacco industry interference
☐ Article 6 Price and tax measures
☐ Article 8 Protection from exposure to tobacco smoke
☐ Article 9 Regulation of tobacco
☐ Article 10 Regulation of tobacco product disclosures
☐ Article 11 Packaging and labelling
☐ Article 12 Education, communication, training and public awareness
☐ Article 13 Tobacco advertising, promotion and sponsorship
☐ Article 14 Demand reduction measures concerning tobacco dependence and cessation
☐ Article 15 Illicit trade in tobacco products
☐ Article 18 Protection of the environment and the health of persons
☐ Article 19 Liability
☐ Aboriginal and Torres Strait Islander peoples
☐ Disadvantaged groups

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4. Would you like to comment on the process and how it could be improved?

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REFERENCES


