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The Smokefree message: emphasising the positive

New Zealand has enacted some of the most exciting, far-reaching smoking legislation in the world. From October to December 1990 I was awarded a Winston Churchill Memorial Trust Fellowship to study their smoking education, having taught for seven years in primary schools in the London Borough of Ealing.

I now work on the HEA's *My Body* project, which has a particular emphasis on smoking education. The report of this visit is not an in-depth study of one aspect; it is a broad view of smoking and health education that reflects all the areas I feel are important in my work with those in health promotion work, teachers and primary-school children.

Toxic

An important reason for New Zealand's anti-smoking stance is that tobacco is listed as a toxic substance. In 1989 the Toxic Substances Board produced a very thorough and readable report called *Health or Tobacco — An End to Tobacco Advertising and Promotion.* It was based on information from both the health lobby and the tobacco companies (although the latter seemed to be unhappy with their representation). Balancing all the information, the Board came up with this statement:

The Toxic Substances Board recommends that Tobacco Advertising and Sponsorship in all their forms be totally eliminated throughout New Zealand from December 1990.

Aims

These were the aims of the government:

Goals

To reduce the onset of smoking in non-smokers, especially adolescents, and to reduce the number of smokers and the consumption of tobacco.

Targets

1. To reduce tobacco consumption from 2068 grams per person 15 years and over per year (1989) to 1500 grams or less by the year 1995 and to 1000 grams or less by the year 2000.

2. To reduce the prevalence of current smokers from 27% (1989) to 23% or less by the year 1995 and to 15% or less by the year 2000.

3. To reduce the prevalence of current smokers aged 15 to 24 years from 33% (1988) to 27% or less by the year 1995 and to 15% or less by the year 2000.

Tobacco lobby

The tobacco industry was very concerned at the developments that were taking place. Much money and effort were put in to counterbalance the health lobby.

The Tobacco Institute, which was funded by Rothmans, paid for a report to stand against that of the Toxic Substances Board: *A review of materials against smoking.* No one was credited for writing this report.

The Institute also formed 'New Zealanders' Right to Decide'. This did an enormous amount of lobbying on behalf of the tobacco industry, but concentrated particularly on the sponsorship issue. It set up petitions at sporting events, selling the idea that if tobacco sponsorship was not available, events would collapse. Sporting personalities were encouraged to sign against any changes in large advertisements in the newspapers.

One of their arguments was that the government was acting against tobacco now, and that it would only be a question of time before alcohol was hit.

One aspect which I found particularly interesting was that these very same arguments appeared when the EEC were considering acting against tobacco advertising and sponsorship.

In the end, the force for legislation won through and the Smokefree Environments Act 1990 became law on 28 August 1990.

Astute

One vital point to note was the very astute decision by the government to put advertising and sponsorship alongside its plan to introduce smokefree workplaces. All the adverse publicity concentrated on the former, whereas the actual changes to everyday life are more far-reaching through the latter.

The Act consists of three parts:

1. *Smokefree Indoor Environments.* The aim of this is to protect people from passive smoking.

2. *Tobacco Products Control.* By 16 December 1990 all tobacco advertisements were banned, with some minor exceptions.

3. *Health Sponsorship Council.* This was set up to provide sponsorship for up to three years to organisations previously sponsored by tobacco companies. It was also to become an important force in health promotion.

Not so rosy?

Unfortunately I have to relate that not all is as rosy as it seems.

The day I arrived in New Zealand, 27 October 1990, was Polling Day. The Labour government was replaced by a National government. One of their election promises was to repeal the Act. At the time of writing no new Act has actually been passed — but it does seem that New Zealand may lose itself the position of being the country that has moved closest to producing a Smokefree Generation.

The Act, still in place at the time of writing, is excellent. It is far-reaching without being too dictatorial. The three-part nature of it is inspired: the critics could only really concentrate on one aspect — the sponsorship. Whereas, if all parts had been introduced separately it would have invited reaction to them all.

There was just one negative aspect that came through very clearly to me. It was just how little impact the actual legislation had on general smokefree promotion, and more specifically in schools' smoking education. It seems such a wasted opportunity.

To get such wonderful legislation in place in Britain certainly needs a government with a real interest in reducing the numbers of smokers and those now dying from smoking-related diseases. With the government producing its Green Paper on *The Health of the Nation*, and the pressure that is being exerted through the EC, perhaps the time is close.

Uninspiring

There can be something intrinsically negative in posters and materials that aim to encourage young people to stop smoking or not to start. Uninspiring phrases like 'Anti-smoking' and 'Say No to Smoking' can abound. The ethos in smoking education is that success is more likely with positive encouragement and informed decision-making, rather than an order not to smoke or the scare-tactics approach.

New Zealand has gone a long way towards redressing this imbalance. In all aspects the positive position of remaining or becoming Smokefree is stressed. The phrase 'Smokefree New Zealand' is everywhere. Posters produced by the Department of Health in recent years have developed from the negative *Smoking Sucks* and *Winners Don't Smoke* to *FEEL GOOD — remain Smokefree*. The artwork reflects the messages. One poster is a beautiful photograph of New Zealand with just the words 'Smokefree New Zealand' underneath.

Smokefree UK?

In New Zealand there were never any cigarettes on posters. If there were full-length glamorous cigarettes it was felt it would encourage smoking; if there were horrible stub ends it would reinforce the negative.

I personally feel it would be wonderful to have some beautiful pictures of British scenery with the words 'Smokefree UK' on them. How pertinent that would be at the moment, with everyone's — particularly young people's — concern for environmental issues.

A positive health syllabus

New Zealand has had a Health Syllabus since 1940. However, the present one was introduced in 1985. There are many positive aspects of this syllabus:

- *It was introduced after 12 years of consultation with pupils, teachers, parents and the community.*
- *It is a core subject, so it has to be taught in every school in the country.*
- *The content is child-centred and based on a holistic view of health.*
- *It is cross-curricular and centred around a spiral curriculum.*

The syllabus contains the following themes:

- *Building self-esteem*
- *Eating for health*
- *Caring for the body*
- *Physical activity for health*
- *Staying healthy*
- *Keeping safe*
- *Relating to others*
- *Finding out about helping agencies*
- *Having a role in community health issues*

The syllabus builds on these themes, giving areas of work for the following year groups: 5–8, 8–10, 12–14 and 14–16.

One of the most interesting facts about the syllabus was the novel way it was introduced into schools. It did not just land on headteachers' desks. Schools chose a year from 1985 to 1990 in which to become 'designated'. This meant that the Health Education Co-ordinator whom all New Zealand schools have in post received training to bring the syllabus into the school.

Deciding priorities

The training covered the content, but more importantly how to set up a consultation process with parents and the wider community. These courses were run by the Department of Education for groups of teachers, who were then responsible, with support, for running training within their own areas.

The idea of consultation is that everyone concerned with a school should decide what its priorities are within the framework of the syllabus. One school that I visited decided that *Self-esteem*, *Relating to others*, and *Keeping safe* were their three priorities. It was decided to do something from these every year and spread out the teaching of the other themes between the year groups.

The potential of the New Zealand syllabus is enormous. The fact that it is a core subject gives it the sort of profile that health deserves. It is very well worked out, with the benefit of 12 years' consultation. It stresses the positive view of health, concentrating on the attitudes and skills required to help children choose a healthier lifestyle. The mechanism for ensuring that the school works with the local community to make the syllabus relevant to the children is inspired.

Low status

Compare this with the arrival of the *Curriculum Guidance 5: Health Education* document in English and Welsh schools last year. It came amidst all the other National Curriculum initiatives. The lack of priority was signalled by that and by the fact that it is a non-statutory cross-curricular theme.

There are no units to back up *Curriculum Guidance 5*. The ideas to support the guidelines must come from the teachers themselves or from the health education projects.

Disbanded

However, many of these positive approaches to health education in New Zealand have been overshadowed by the enormous changes that have taken place in education, outlined in a document called *Tomorrow's Schools*. The major ones include:

The Department of Education becoming the Ministry of Education.

Education Boards (similar to LEAs) being disbanded.

Schools becoming self-financing and governing with increased power in the hands of Boards of Trustees (our governing bodies).

The setting-up of a Review Board to check on the implementation of Ministry policies.

In terms of health education, this has been a disaster. There is no one in the Ministry with a Health Education brief, and there are no longer any local advisers in the subject. This means that health education training is only available in a very *ad hoc* way.

There are a few trainers who are funded through other agencies, and Initial Teacher Training Colleges are providing a very few courses. In both cases schools are having to provide funding, and I met a number of teachers who were paying for the 'privilege' of attending courses out of their own money.

The other thing that is happening is that materials are being used in schools without any in-service. This tends to mean that the full potential of packs, and often the underlying ethos, can easily be overlooked. There is a great deal to be learned from the negative effects on health education of the changes in the education system. The developments in England and Wales are very similar to those in New Zealand — just a little further behind.

One of the Department of Health posters: 'The positive position of remaining or becoming Smokefree is stressed.'

Transferable skills

Many of the skills taught in smoking education are transferable to all areas of health. These include increasing the children's self-esteem and improving their decision-making abilities. These are fostered by the *Self-esteem* and *Relating to others* sections of the health syllabus. More specific knowledge-based work on smoking comes into *Caring for the body*.

Community health also contains a section on forming smoking policies in schools. However, much of that has been overtaken by the Smokefree Indoor Environments Act, whereby schools, along with all other workplaces, have to produce a smoking policy.

There were some interesting teaching materials available to support the health syllabus, including two skills-based drug education packs: *Reaching Out* for primary schools and the *Alcohol and Drug Project* for secondary schools.

The Smokefree pack

On the smoking issue there was nothing to match the practical fun approach of the *My Body* project. However, there were some interesting ideas in the *Snokefree* pack.

Smokefree was written in 1988 by the National Heart Foundation and the Department of Education. It is written for the 9–12 age group, and aims to develop skills as well as instilling into children the positive advantages of remaining Smokefree. It is given free to schools through funding by the Heart Foundation.

The pack has a wonderful starter activity that I would love to try with children here. It finds out the children's perceptions of smoking before any formal work is done. It is based on a postbox idea. A number of boxes are provided by the teacher with a question attached. Teachers can produce their own questions or follow recommended ones, such as:

- *List the reasons why people choose to be smokefree.*
- *How could you help a friend to remain smokefree?*
- *How many people in the class do you think are smokefree?*

The children anonymously write their responses to these and post them into the boxes. Each box is then allotted to a group of children who sort out the answers and feed back the results to the rest of the class. From this starting-point, the pack goes on to encourage children to see the advantages of being smokefree and the things that will challenge their stance on this. The tape can be used to trigger role play. Refusal skills are practised in this manner.

The final section, which once again could add a lot to work taking place in Britain, is for the children to make up questionnaires to use with staff and students in the school, parents, and the community. This can then form the basis of discussion for a school smoking policy. For a policy to come about through the children's own work would make it so much more relevant.

Training the teachers

Initial teacher training in New Zealand is excellent. It could provide a wonderful model for colleges in this country. Many students training to become teachers here receive no mention of the word 'health'. In New Zealand, all students receive a considerable amount of well-balanced health education.

For all students, the following areas are covered:

- *The content and delivery of the health education syllabus.*
- *Looking at other health education projects (Auckland had a copy of the first edition of the 'My Body' project).*
- *The involvement of the community in school health education.*
- *Finding out what health agencies there are to help teachers and pupils.*
- *All students have to receive instruction and become proficient in the use of First Aid.*

There are other skills-based topics in the course as well.

The benefits of students studying health education at college are enormous. They are familiar with the processes involved and can build them into their teaching style. This is so much better than having to assimilate them if and when they meet them on in-service courses.

How we could benefit

It might be helpful to recap on the most exciting developments that I saw in New Zealand and from which I feel we could derive most benefit.

The smoking legislation as it stands at the moment is far-reaching and well-considered. It would be thrilling to see something similar in place here. The benefits to the smoking figures, particularly of young people, brought about by the end of advertising and promotion, is great. The protection for all from passive smoking is also of such value.

The positive promotion of a 'Smokefree' country appealed to me greatly. It complements the messages that are to be given through smoking education in schools.

I feel it is so vital that health education is seen as a priority in schools. It is unlikely that there will be the luxury of its being included as a core subject in England and Wales.

The provision of training for teachers in health education, both at the initial training stage and at in-service, are vital for the development of their skills and for bringing out the full potential of all materials.

Multi-cultural health promotion must become a priority and be fully considered if all people are to be given equal access to good health.

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