Smokefree Marketing Campaign Strategy:

2012-2015

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Foreword

Tobacco use remains one of our most significant public health challenges. Every year smoking kills nearly 80,000 people in England[1]. Half of all regular smokers *who continue to smoke* will eventually be killed by their smoking[2].

The burden of smoking goes beyond smokers themselves. There is an increasing body of evidence demonstrating a wide range of serious illnesses in those regularly exposed to other people's smoke. Children and babies are particularly at risk[3].

Around 1,260 people are admitted to hospital every day because of smoking-related sickness[4] – this is 1 in 20 of all hospital admissions[5]. We must do everything we can to encourage smokers to stop.

The public-health White Paper *Healthy Lives, Healthy People: Our strategy for public health in England* set out the Government's long-term vision for improving public health in England. The White Paper signalled a radical shift in the way we tackle public health challenges, with a real focus on addressing lifestyle-driven health problems, which are responsible for so much of the burden of disease today.

However, while many individuals would like to lead healthier lives, changing behaviour is extremely challenging, often requiring not just individual motivation but sustained support from friends, family and society. In addition, while the majority of smokers want to quit, smoking is highly addictive. Once people start, many find it extremely hard to stop, despite their best intentions.

Government can play an important role in helping people by creating environments that promote quitting and by helping to bring about cultural changes that make it less attractive for people to start smoking. *Healthy Lives, Healthy People: A Tobacco Control Plan for England* sets out how a comprehensive tobacco-control strategy can help to achieve this.

This tobacco-control marketing strategy outlines the role social marketing can play in supporting other tobacco-control measures, including reminding smokers of the health harms of smoking and their reasons for wanting to quit, prompting people to make quit attempts and providing products to help them quit, as well as signposting them to the most effective forms of quitting.

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[1] http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking/statistics-on-smoking--england-2012

[2] Doll, R. (1994) Mortality in relation to smoking

[3] Royal College of Physicians (2005) Going Smokefree: the medical case for clean air in the home and workplace

[4] http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking/statistics-on-smoking--england-2012

[5] http://www.ic.nhs.uk/news-and-events/news/about-1260-hospital-admissions-a-day-due-to-smoking-new-figures-show

Mass-media campaigns will continue to play an important role in tobacco-control marketing because of their proven effectiveness. In addition, we will increasingly use a wider range of channels, including those the Government already owns. We will make the most of the opportunities offered by digital channels and social media, and we will engage a wide range of partners to help us at a national and local level. Individuals, local communities, local authorities, healthcare professionals, schools, businesses, civic institutions and voluntary organisations all have a part to play. By working together we can make a real difference by helping tackle tobacco use, supporting smokers to quit and so improving public health.

Anne Milton, MP

Parliamentary Under Secretary of State for Public Health

Executive summary

0.1 Smoking remains the primary cause of preventable death in England. Over 80,000 smokers die each year as a result of smoking-related disease[6].

0.2 There is a wealth of national and international evidence to show that social marketing can successfully motivate and support smokers to stop. The new approach described in this document builds on our overall social marketing strategy, which aims to protect the public from serious health threats and harms.

0.3 The good news is that two-thirds of England's 8 million smokers already tell us that they want to give up the habit. The majority have already tried to stop and most have managed to do so for days or weeks at a time. However, recent evidence suggests that motivation to quit and quit attempts are both in decline. This may be at least partly due to the stress and uncertainty created by the current economic climate, which causes people to put off making any significant commitment to change, including a quit attempt.

0.4 The role of the national marketing campaign will therefore be to remind smokers why they need and want to stop, triggering immediate quit attempts nationally within the smoking population and signposting people to information to help them make more effective quit attempts. Our messaging will not be anti-smoker, but it will be anti-smoking.

0.5 The central communication programme will evolve to move beyond emotional harm, to address the physical health harm caused by smoking and to undermine smokers' low sense of personal risk associated with their habit. Our work will also extend to cover second-hand smoke in the home and family car, and smoking in pregnancy.

0.6 In future, the national marketing team will focus on doing those things that can only be done at a national level, or that it is more cost-efficient to do once. This will include, for example, mass-media advertising to reinforce smokers' motivation to stop and to trigger significant numbers of quit attempts, and negotiating national partnerships.

0.7 We will work with a range of national and local partners and with health professionals to ensure they are aware of the important role they can play in prompting quit attempts, and in directing people to services which improve their chances of stopping.

0.8 We will encourage local partners to join up with and amplify national marketing initiatives and ensure they have timely access to relevant information and materials that they can use and adapt for their own local activity. In addition,

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[6] National Statistics/NHS Information Centre *Statistics on Smoking: England, 2011*

local areas will increasingly take responsibility for encouraging smokers to use local stop-smoking services, as well as for marketing around specific local audiences and issues.

1. Purpose of this document

1.1 This document sets out a new marketing strategy for the Smokefree tobacco-control marketing campaign in England. It is a companion document to *Healthy Lives, Healthy People: A Tobacco Control Plan for England* and *Changing Behaviours, Improving Outcomes: A New Social Marketing Strategy for Public Health.* It describes how marketing resources will support the national ambition to reduce smoking prevalence. It is a three-year strategy, covering the period from January 2012 to April 2015.

1.2 The strategy is intended for those working with the Department of Health, local authorities and Public Health England, and their appointed agencies, with an interest in using social marketing approaches to reduce tobacco use. This includes the NHS, local stop-smoking services, local networks such as tobacco alliances, and other local and national partners with an interest in smoking cessation and tobacco control – for example, non-governmental organisations (NGOs) and commercial partners.

1.3 While this is a marketing document, we have tried to avoid the use of 'marketing speak', and we hope that what we have written will be accessible to a lay reader. A glossary of common marketing terms is included in Annex E.

1.4 The strategy has been developed in consultation with leading academics and practitioners in the fields of health, psychology, smoking cessation and marketing, NGOs with an interest in tobacco control and reducing the health risks caused by smoking, and national and local partners.

2. Context: the overall strategy for tobacco control in England and the new public-health social marketing strategy

A new approach to marketing in health

2.1 Following on from the recent White Paper *Healthy Lives, Healthy People: Our strategy for public health in England,* a new three-year social marketing strategy for public health was published in April 2011. Titled *Changing Behaviour, Improving Outcomes: A New Social Marketing Strategy for Public Health*, this document sets out a new approach to social marketing to help influence health-related behaviours. It draws on learning from existing successful marketing programmes such as Smokefree and Change4Life, as well as new insights from behavioural sciences, while aiming to be more efficient and innovative in the way we use public resources.

2.2 The new marketing approach across the board in health behaviours will be different in that:

- There will be fewer social marketing programmes in total, prioritising those where there is evidence of effectiveness
- With the exception of smoking (and, when appropriate, health-protection campaigns such as the response to a flu pandemic), we propose to end central single-issue campaigns, instead taking a life-course approach, through which a trusted brand will deliver support on all topics that are relevant to a person at that stage of life
- More will be done at a local level; the centre will do only those things that it is best placed to do. Emerging insights from the behavioural sciences will be explored to enhance existing programmes and design radically different marketing initiatives. Community, charity, civic and commercial partners will be encouraged to do more
- Paid-for mass-media channels are proven to be effective and will remain important due to the scale of the task. However, we will always seek efficiencies and, where appropriate, will shift the balance towards those channels the Government already owns, such as government websites
- There will also be a step-change in the way we use new technologies, including social media
- Where our campaigns enter into frequent and regular communications with people, we will test ways of migrating these to digital channels

- We will work with the Cabinet Office to pilot a 'payment by results' approach in our agency relationships where appropriate

2.3 The strategy prioritises four programmes for ongoing national marketing activity:

- Smoking cessation
- Change4Life
- A new programme to tackle risk-taking behaviours in younger people
- A new programme to improve the health of older people

2.4 Smokefree will remain a single-issue campaign for a number of reasons:

- The significant health harms caused by smoking and the importance of this public health issue
- The scale of the behaviour-change task – on smoking we are seeking *cessation*, as opposed to *moderation* in other areas of health
- The nature of the behaviour-change task – we are seeking to achieve change in a highly addictive behaviour
- Clear evidence for the effectiveness of this approach in the past

The policy context

2.5 *Healthy Lives, Healthy People: A Tobacco* Control *Plan for England* was published in March 2011 and set out the Government's plans to support efforts to reduce smoking rates over the next five years, within the context of the new public health system.

2.6 The Plan builds on the achievements in tobacco-control policy over many decades and sets out a comprehensive package of evidence-based action that will be implemented at national level to support local areas in decreasing rates of tobacco use.

2.7 The Plan is built around the internationally recognised strands of comprehensive tobacco control:

- Stopping the promotion of tobacco to young people and adults
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second-hand smoke
- Implementing an effective tobacco-control communications strategy

National ambitions

2.8 In the Tobacco Control Plan, the Government set three national ambitions to focus tobacco-control work across the whole system:

- To reduce adult (over 18 years) **smoking prevalence** in England to 18.5% or less by the end of 2015, equating to around 210,000 fewer smokers a year
- To reduce rates of regular smoking among **15-year-olds** in England to 12% or less by the end of 2015
- To reduce rates of smoking throughout **pregnancy** to 11% or less by the end of 2015 (measured at time of giving birth)

2.9 These ambitions are not targets; rather, they represent an assessment of what could be delivered as a result of the national actions described in the Plan, together with local areas and regions implementing evidence-based best practice for comprehensive tobacco control. The new approach to public health delivery in England means that local areas will decide on their own priorities and ways of improving health in their communities in line with the evidence base.

Scope and aims of this strategy

2.10 We will focus the marketing strategy where it can have the greatest effect, contributing to the first and by far the broadest ambition: **to reduce smoking prevalence in England**.

2.11 We will also carry out some targeted activity with pregnant women who smoke and their partners. This will support the third ambition: to reduce smoking rates in pregnancy.

2.12 A separate marketing strategy for young people is in development, as set out in *Changing Behaviour, Improving Outcomes: A New Social Marketing Strategy for Public Health*. This will take a cross-public-health approach to tackling risky health behaviours in young people, including the uptake of smoking, and will contribute towards the second ambition. Tackling youth uptake is, therefore, beyond the scope of this strategy.

3. Context: smokers and smoking

The harms of smoking

3.1. Smoking is still the number-one cause of premature death and preventable disease in England today. It is estimated that smoking caused over 80,000 deaths in England in 2010[7]. Around half of all regular smokers who do not give up are eventually killed by a smoking-related illness. Deaths from smoking are more numerous than the next six most common causes of preventable death combined[8].

3.2. Smoking is harmful not only to people who smoke but also to the people around them. Tobacco smoke contains thousands of chemicals, many of them carcinogenic or toxic. There is no safe level of exposure to second-hand smoke.

3.3. Smoking also has a huge impact on the NHS and wider society. In 2009, some 462,000 hospital admissions in England among adults aged 35 and over were attributable to smoking[9]. Treating smoking-related illnesses was estimated to have cost the NHS £2.7 billion in the year 2006/07, and wider society around £13.74 billion a year[10].

Who smokes?

3.4 There are over 8 million smokers in England. While smoking rates have declined over recent decades, 20.5% of adults still smoke, and since 2007, overall smoking rates among adults in England have declined only very slowly[11].

3.5 The population of smokers is in constant flux. This can be illustrated by the 'smoking pipe' model[12], which uses data from multiple sources to estimate, in a given year, the number of smokers entering the 'pipe' (whether through taking up smoking or relapsing) and leaving it (by quitting or dying).

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[7] National Statistics/NHS Information Centre: *Statistics on Smoking: England, 2011*

[8] Drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse. Source: NHS Information Centre: *Statistics on Smoking: England, 2011*

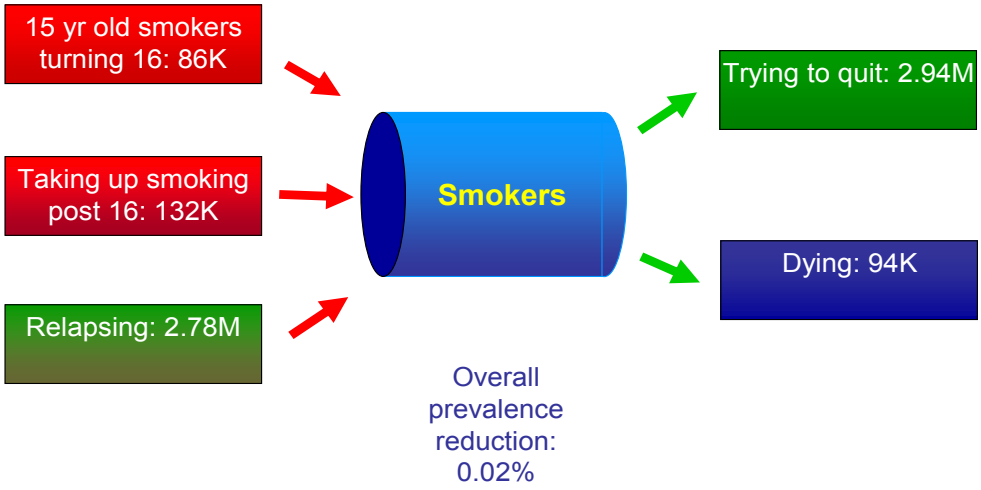
[9] National Statistics/NHS Information Centre: *Statistics on Smoking: England, 2011*

[10] Nash and Featherstone (2010) Cough Up: Balancing tobacco income and costs in society

[11] ONS IHS (Office for National Statistics, Integrated Household Survey) data to June 2011

[12] West, R. *The 'Smoking Pipe Model'* (www.smokinginengland.info)

Smoking Pipe Model 2011



www.smokinginengland.info

3.6 There is a strong association between smoking and occupation. Nearly half of all smokers in England, more than 4 million people, work in a job defined as routine and manual[13].

3.7 Smoking is correlated with income, and accounts for approximately half of the difference in life expectancy between the lowest and highest income groups[14].

3.8 There are also variations in smoking rates by region, gender, age, ethnicity, life stage, working status and mental health status. For further information, see the list of sources in the footnote[15].

Smoking initiation

3.9 Smoking is an addiction that is largely taken up in childhood and adolescence, and the highest rates of smoking are among young adults. Around 26.2% of people aged 16-24 smoked in 2009[16]. While smoking rates have reduced considerably in recent years, this remains a serious issue. An estimated 320,000 young people under the age of 16 try smoking each year in England, and around 6% of pupils aged 11-15 were regular smokers (defined as one

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[13] ONS GLF (Office for National Statistics, General Lifestyle Survey) 2009

In 2009 smoking prevalence was twice as high among people in routine and manual occupations (30%) as it was among those in managerial and professional occupations (15%)

[14] Department of Health (2011) Healthy Lives, Healthy People: A Tobacco Control Plan for England, paragraph 2.13

[15] ONS GLF (Office for National Statistics, General Lifestyle Survey) 2009, National Statistics/NHS Information Centre: *Statistics on Smoking: England, 2011* and HSE 2004, or http://www.ons.gov.uk/ons/dcp171778_227150.pdf

[16] ONS GLF (Office for National Statistics, General Lifestyle Survey) 2009

cigarette a week) in 2009[17]. Almost two-thirds of current and ex-smokers started smoking regularly before the age of 18, with 40% starting before the age of 16[18].

People who take up smoking earlier tend to smoke more heavily and for longer as the habit becomes more ingrained.

3.10 Smoking is also socially contagious. Friends, siblings, partners and communities influence smoking uptake and cessation. For married couples in particular, smoking cessation in one partner decreases the chances of the other partner smoking by 67%[19].

Quitting

3.11 Stopping smoking helps prevent smoking-related illnesses and helps people live longer, whatever their age when they quit. Around two-thirds of smokers say that they would like to stop[20]. However, smoking is highly addictive and, for the large majority of people, quitting successfully can take many attempts. Most smokers will have already tried and failed.

3.12 Most quit attempts fail at an early stage, usually within the first few days. Only 25% of unaided quit attempts last more than the first week and less than 5% last for more than six months. The risk of relapse is very high in the first few weeks but becomes much lower after this. If a smoker can make it through the first crucial weeks, then their chances of being permanently smoke-free improve significantly. A smoker able to abstain for the first four weeks is five times more likely to succeed in the long term than when they started[21].

Motivation to quit

3.13 In 2011 two-thirds (67%) of people who smoke said that they wanted to stop – a significantly smaller proportion than the 74% who reported that they wanted to quit in 2007[22].

3.14 Tracking research suggests that, although there has been a decline in motivation across all smokers (driven by routine and manual smokers, who account for almost half of all smokers), the decline has been particularly

[17] National Statistics/NHS Information Centre: *Statistics on Smoking: England, 2010*

[18] ONS GLF (Office for National Statistics, General Lifestyle Survey) 2009 *Smoking and drinking among adults: A report on the 2009 General Lifestyle Survey*, Robinson, S. and Harris, H.

[19] Christakis and Fowler (2008) *New England Medical Journal*

[20] West, R. (Jan 2012) *Smoking Toolkit Study*, www.smokinginengland.info

[21] West, R. and Stapleton, J. (2008) The clinical and public health significance of treatments to aid cessation

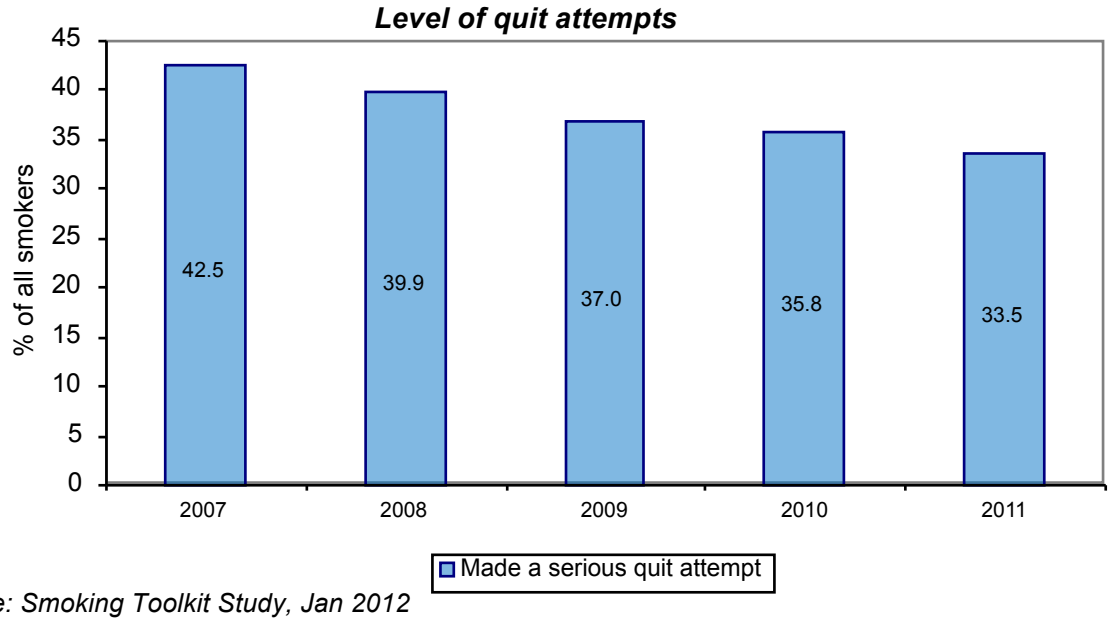
[22] West, R. *Smoking Toolkit Study,* www.smokinginengland.info

marked in groups we have not specifically targeted with marketing campaigns – for example, younger smokers, under the age of 25[23].

Source: Smoking Toolkit Study, Jan 2012

Quit attempts

3.15 The Smoking Toolkit Study suggests the number of quit attempts being made is also in gradual decline over the longer term. In recent years, there has been a year-on-year decline in the proportion of smokers making quit attempts, from 42.5% in 2007 to 33.5% in 2011[24]. The average number of quit attempts made by smokers each year has similarly been falling, from 0.65 in 2007 to 0.50 in 2011.



Source: Smoking Toolkit Study, Jan 2012

[23] TNS Tobacco tracking study, Nov 2011

[24] West, R. *Smoking Toolkit Study*, www.smokinginengland.info

3.16 Possible contributors to the decline in motivation and quit attempts include the impact of the Smokefree legislation, which may have brought forward quit attempts, and the impact of the current economic environment. Motivation to quit may also have been affected by the change in the balance of investment in campaigns since the introduction of the Smokefree legislation in 2007; a larger proportion of expenditure was subsequently invested in campaigns that aimed to promote ways to stop.

Summary

This evidence suggests our marketing should:

- **Address the decline in motivation to quit and the corresponding reduction in quit attempts**
- **Support people when they try to stop smoking, to improve their chances of success**

4. Audience insights

4.1 We are fortunate to have a wealth of insight about smokers and how to support them to stop.

- ***We should be anti-smoking, not anti-smoker.*** In past research, people who smoke have reported a sense of persecution. Smoking is an addiction – many smokers wish they had never started but find it incredibly difficult to stop.
- ***It is vital to offer constructive support for smokers who want to stop – not just information.*** People who smoke do not research the market for help with quitting, and offering 'products' such as the Quit Kit can create a huge response. Peer support also appears to be motivating for quitters and online forums such as the Smokefree Facebook page are proving to be an increasingly popular source of support.
- ***Boosting confidence in quitting is imperative.*** People who smoke ***fear quitting*** and lack confidence in their own ability to stop. Although desire to quit features widely in conversation, this is strongly undermined by abundant stories of failure, difficulty and loss from quitting by other smokers (or ex-smokers attempting to make smokers feel better about their habit or failure).
- ***The consequences of smoking must be described in immediate and irrefutable terms***. People who smoke are familiar with the long-term health risks of smoking and find it very easy to find ways to dismiss the messages as not relevant to them personally[25].
- ***We need to provide reasons to stop NOW.*** While the vast majority of smokers want to quit, it is all too easy to put off stopping until another day, so we need to provide triggers for people to make a quit attempt **now**. Of particular note is the concept of 'the right time' to quit, often reinforced by ex-smokers: 'It was just the right time for me'. This seeds the idea of a magical moment to be expected at some future point and can drive a 'wait and see' rather than 'quit now' attitude.
- ***Linking the act of smoking to the damage it inflicts is powerful***. For example, one of the most impactful and memorable campaigns of recent years is the iconic 'fatty cigarette' advertising, developed by the British Heart Foundation. The campaign graphically depicted the effects of smoking on the arteries by showing the fat deposits caused by smoking coming out of the end of a cigarette. This campaign used an emotional rather than rational argument, designed to trigger a Pavlovian response, linking cigarette smoking with disgust.

[25] ***Extreme health harms, for example,*** such as picture warnings on packs, are easy to dismiss. 'I would never let myself get like that.' Statistical arguments based on probability of risk are easy to challenge: 'If 50% of smokers are killed by smoking, then that means half aren't.'

4.2 To understand the attitudes of smokers in England today, new research[26] was needed to update our understanding and assess how marketing might be used to influence them. Our new research showed some significant shifts in attitudes, beliefs and behaviours, including:

- ***Lower perceived personal risk of the health harms*** arising from smoking, and limited awareness of detail (particularly, but not exclusively, for younger people). This appears to have resulted from a lack of 'voice' in this area in recent years, but also from the development of a wide range of counter-arguments that are used to reduce the sense of personal risk. These include the belief that:
  - Smoking can be mitigated for by a healthier approach to other areas of life, such as exercise, healthy eating, or limiting alcohol intake
  - Only those with underlying poor health, or multiple or congenital disorders, are at risk from smoking.
- ***Limited connection of illness and smoking*****.** Many failed to recognise symptoms in themselves or others in their wider social circle.
- ***Support for smoke-free legislation and the rise of 'responsible' smoking*****.** Before the smoke-free legislation was introduced, many smokers felt uneasy about the proposed law. Now that the legislation has been implemented successfully, the majority of people say that they support it. However, smoke-free legislation has altered the context of smoking in England. Smokers say that they feel under less pressure to stop, as there is now less tension with non-smokers. Smokers also feel that they now smoke in a "responsible" way, which protects others from their second-hand smoke. Unwittingly, smoke-free legislation may have helped smokers to feel less worried about using tobacco and may have eased some of the tension and pressure to quit.
- ***Low perceived risk to others.*** In terms of second-hand smoke, all smokers – even those who are already modifying their behaviour – underestimate the harm to others.
- ***Flexible rules.*** Smokers may not always be honest with themselves about their smoking habits. This is particularly true for second-hand smoke, where adult reported behaviour differs significantly from children's reported experience. A wide range of flexible rules have been identified: for example, some may claim to keep a smoke-free home but consider the kitchen an outside space or smoke inside when it rains.

[26] Jones, J. (Define Insight) State of the Nation Qualitative Research, 2011

Summary

This evidence suggests our marketing should:

- **Support smokers, not victimise them**
- **Focus on the emotional and irrefutable, not the extreme or rational**
- **Revisit health harms**
- **Not reinforce the idea of responsible smoking**

5. The role for marketing

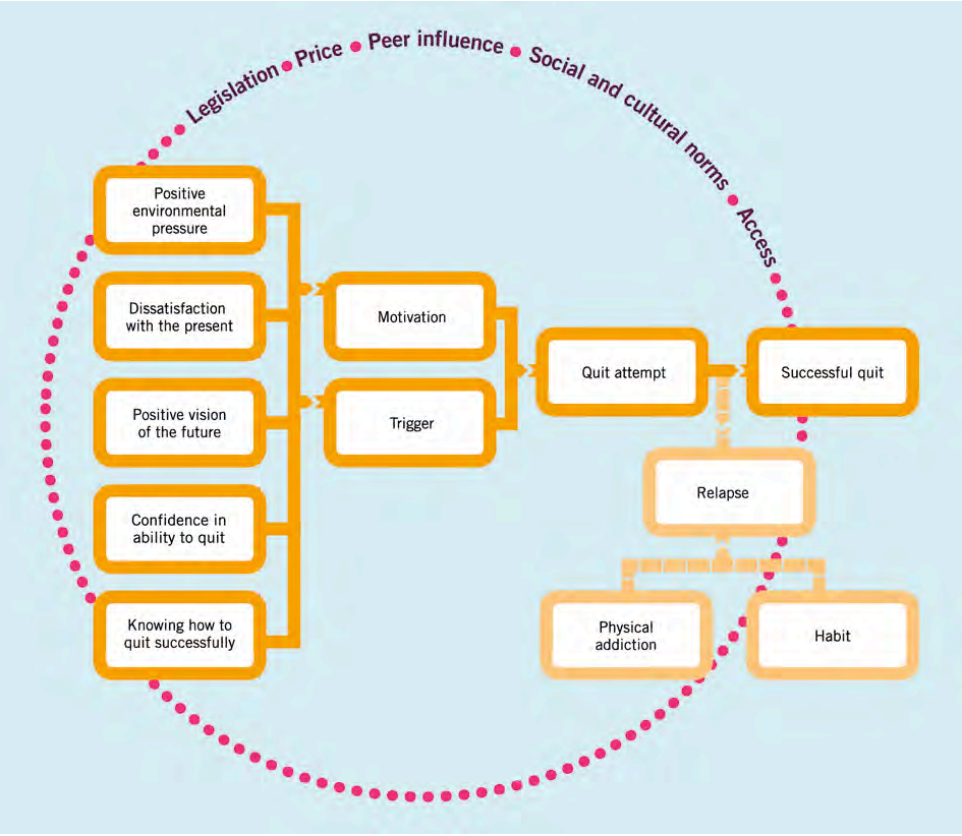
Tobacco-control marketing and behaviour change

5.1 There is a strong international evidence base for the impact of tobacco-control marketing on reducing smoking prevalence. This is also the case in England[27].

5.2 As well as mass-media approaches, we should look to learn from new ideas emerging from behavioural economics and social psychology, popularised by books like *Nudge*, which are starting to influence mainstream marketing. In 2010, the Cabinet Office produced its MINDSPACE report, which provided a toolkit for using behavioural insights in government.

The behavioural model

5.3 For the previous 2008-10 tobacco-control marketing strategy, extensive work was carried out on the conditions required for successful behaviour change. These are summarised in the behavioural model below[28]. We believe these conditions remain the same and are still relevant to this new marketing strategy.



[27] West, R. University College London. 'The role of mass media campaigns in evidence-based tobacco control.' Published in All Party Parliamentary Group on Smoking and Health Inquiry into the effectiveness and cost effectiveness of tobacco control: Submission to the 2010 Spending Review and Public Health White Paper Consultation Process

[28] See Tobacco Control Marketing and Communications Strategy 2008-10 for full details

Conditions required for successful behaviour change

5.4 The role for marketing in influencing these conditions includes:

- **Positive environmental pressure.** The introduction of the smoke-free legislation in 2007 played an important role in creating the environment for change, but there is potential to use marketing to go further to help de-normalise smoking and normalise quitting in communities.
- **Dissatisfaction with the present**, i.e. knowing the risks of smoking and believing these are relevant to you. Smokefree campaigns have and will continue to create dissatisfaction with the present – for example, by focusing on the health harms from smoking or the impact that smoking has on loved ones in the 'here and now'.
- **Positive vision of the future**, i.e. being able to see oneself as a non-smoker in the future and imagine a life free from cigarettes. Smokefree support materials adopt a positive tone, helped by the 2009 activity to refresh the Smokefree brand. This positioned Smokefree as a positive force to help all smokers quit for good, while retaining a realism that appeals to the target audience.
- **Confidence in ability to quit.** Marketing activity can increase smokers' confidence in their ability to quit by adopting a positive tone. For example, over 60% of those who received a Quit Kit reported that it gave them more confidence in their own ability to quit smoking[29].
- **Knowing how to quit successfully.** Marketing has a key role to play in presenting the different support options available and signposting smokers to the options most likely to improve their chances of quitting successfully.
- **Motivation and triggers.** PRIME theory[30] highlights the need for triggers as well as motivations for quitting. Research has found that "*Triggering action even among groups which claim low or no motivation can be successful*" (Pisinger et al, 2005). This is borne out by results from our marketing activity – for example, the Quit Kit was successful in prompting quit attempts among the 57% of recipients who were not planning a quit attempt prior to receiving the kit[31]. Advertising may act as one trigger, but there is the opportunity to use a broader range of triggers (for example, advice from a healthcare professional) to greater effect.

Making the biggest difference with national marketing

5.5 We have modelled the effects of a number of possible scenarios to help inform the focus for marketing activity, including triggering more quit attempts in the

[29] HPI Quit Kit evaluation research, 2010

[30] PRIME theory is a theory of motivation developed by Professor Robert West at University College London. More information on PRIME theory can be found at: http://primetheory.com

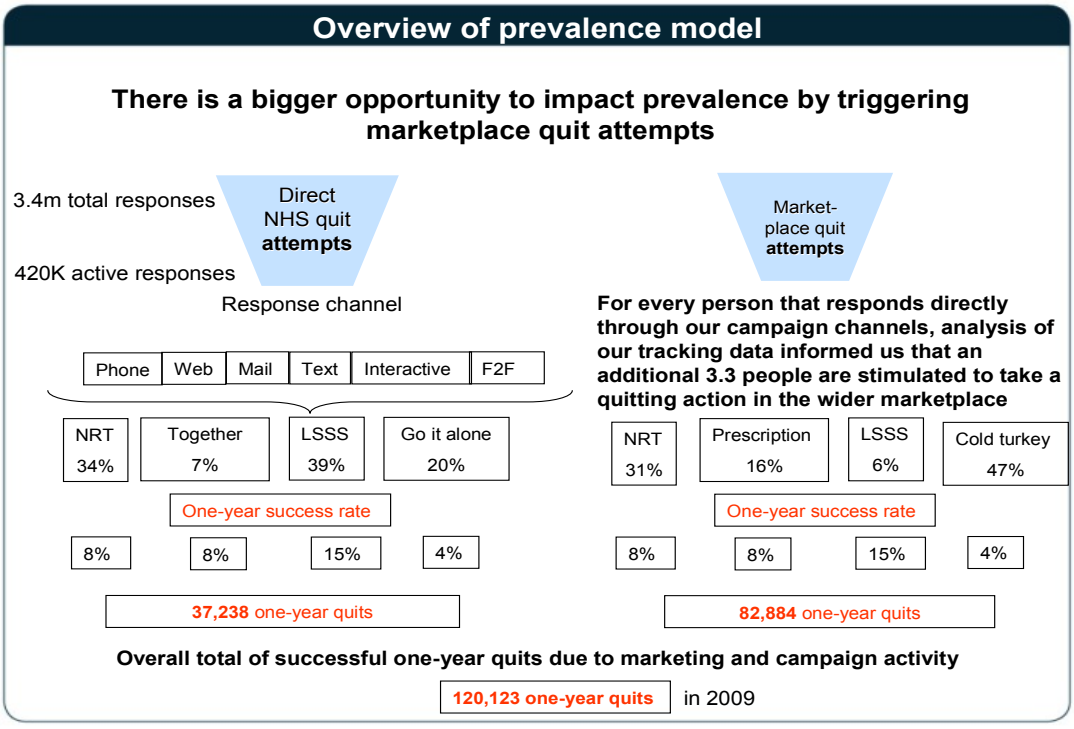
[31] HPI Quit Kit evaluation research, May 2010

smoking population, making quitting more successful by directing more quitters to the NHS, and reducing the uptake of smoking[32].

5.6 This modelling suggested that **triggering more quit attempts** by smokers would have the biggest impact on reducing smoking prevalence.

5.7 In recent years we have focused on triggering action by driving people to respond to us through our own direct channels (e.g. the Smokefree website and helplines). We have also focused on making quitting more successful by directing people to NHS quitting support, such as the local stop-smoking services, either directly through mass-media advertising or via follow-up communications – for example, the customer relationship management (CRM) programme. Modelling has shown this is an effective way to trigger increased quit attempts.

5.8 However, we recognise that the majority of smokers choose to quit without the support of local stop-smoking services. To have the most impact we need to focus on the volume opportunities to **stimulate the whole market for quitting**, including triggering quit attempts in the majority of smokers who attempt to quit 'cold turkey' without support. This is illustrated in the overview of the prevalence model below:



F2F – face to face
NRT – nicotine replacement therapy
LSSS – local stop-smoking service
Source: Smoking Prevalence Model, Fuel, 2010

[32] Fuel. Individual to population modelling, 2010

5.9 The primary role for national marketing communications is, therefore, to act as *an immediate trigger* to quitting. Professor Robert West argues that:

"The decision to stop smoking can always be put off to another day and statistics about death rates do not necessarily capture the imagination and motivate action. It is all too easy to put uncomfortable thoughts about smoking out of one's mind. Mass media campaigns have a potentially important role in acting as an immediate trigger to quitting as well as maintaining feelings of concern about smoking through imagery and offering hope by promoting effective methods of stopping[33]."

[33] West, R. University College London. 'The role of mass media campaigns in evidence-based tobacco control.' Published in All Party Parliamentary Group on Smoking and Health Inquiry into the effectiveness and cost effectiveness of tobacco control: Submission to the 2010 Spending Review and Public Health White Paper Consultation Process

6. The new marketing strategy

6.1 To contribute to reducing smoking prevalence in England, the overarching marketing objective is to: **Trigger immediate quit attempts at a population level**.

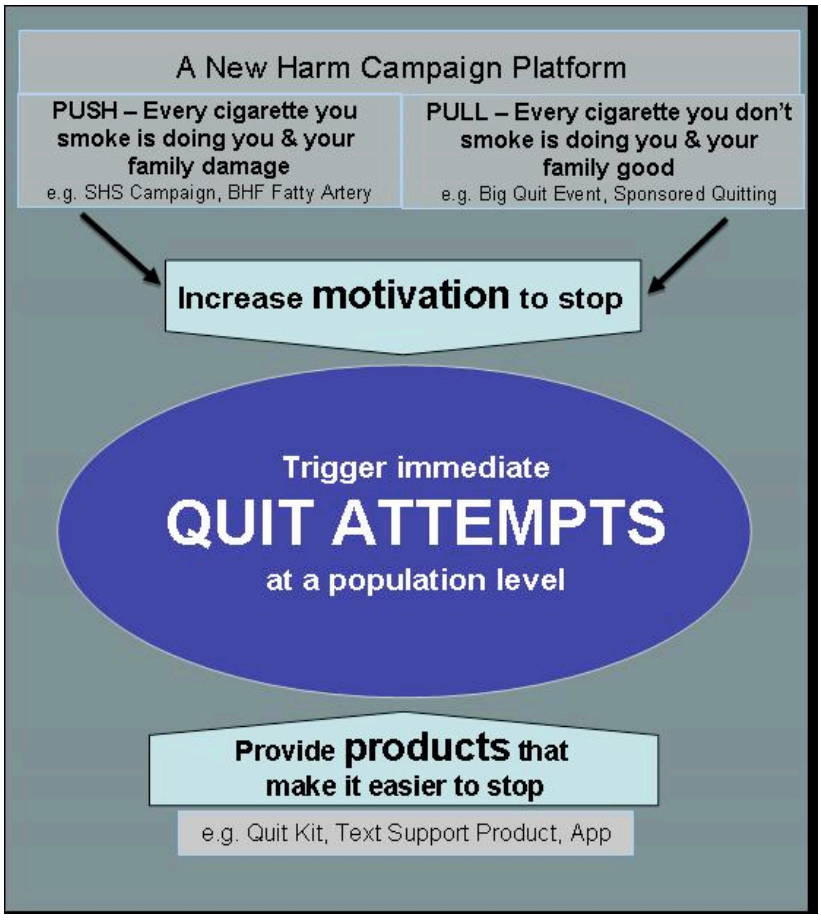
To do this we need to:

1. *Boost* smokers' motivation to quit. This will be the overall focus of our marketing activity and our approach to motivation will include both push and pull elements:

a) **Push** – campaigns that highlight the damage every cigarette is doing to you and your family – by reminding people of the harms of smoking and addressing their low sense of personal risk.

b) **Pull** – providing new opportunities to quit with campaigns that highlight the positive impacts of every cigarette not smoked for smokers and their loved ones.

2. *Support* quit attempts by helping people to quit successfully – by providing products to support them and signposting them to further help and support.



Boosting smokers' motivation to quit

6.2 We know that marketing can stimulate motivation to quit and that, for smokers, *really* wanting to quit is linked to taking action to quit.

6.3 Two-thirds of smokers report that they want to quit, with 44% saying they *really* want to quit[34]. However, all the evidence suggests that smokers are making fewer quit attempts and that quitting smoking is losing salience as an issue. Our focus will therefore be on maintaining the importance of quitting at the forefront of people's minds, reminding them of their reasons for wanting to quit and triggering them to make a quit attempt *now*.

6.4 Previously we ran separate campaigns aimed at reinforcing smokers' motivation to quit and direct-response campaigns to trigger action. With reduced budgets for marketing, we will combine these two campaign strands so that all motivation advertising carries a call to action – for example, to visit the Smokefree website for more information or to pick up a Quit Kit from a pharmacy.

6.5 Recent research[35] has shown that there have been worrying declines in smokers' perceptions of the harms of smoking and that they have a low sense of personal risk.

6.6 Coupled with this, smokers put off quitting because they believe it is going to be too hard.

6.7 Our task, therefore, is to redress the balance and show that smoking is more harmful than you think and that quitting need not be as hard as you think.

6.8 Recent campaigns have focused on the undeniable, immediate emotional harm smoking causes to the relationship with your family. We will evolve this current campaign platform beyond emotional harms to address physical health harms and to address people's low sense of personal risk.

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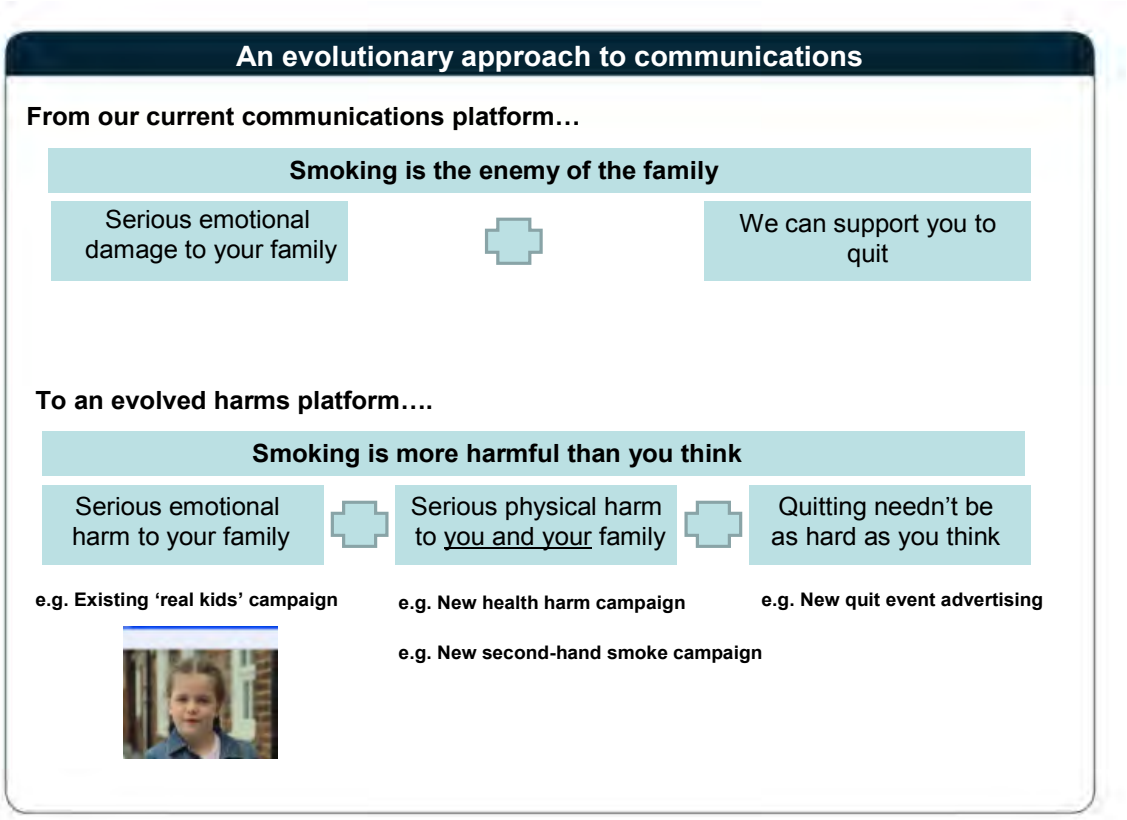
[34] West, R. *Smoking Toolkit Study,* www.smokinginengland.info

[35] Jones, J. (Define Insight) State of the Nation Qualitative Research, 2011
TNS Smokefree tracking study, Nov 2011. Tendency to lower levels of agreement with 'I worry about the effects that smoking has on my health' in full year 2010/11 compared with 2009/10



A new 'push' motivational campaign platform: a 'harms' approach

6.9 This will involve a return to health-harms messaging, including the harms of second-hand smoke. It will, however, be important that campaigns dramatise the harm that smoking is doing in the here and now, rather than just in the future, to provide a reason for people to quit ***now***.

6.10 Research shows that the most powerful advertising always appeals strongly on an emotional level. Even in such rational territory as health harms, emotional appeal remains important. Research also suggests that harms messaging needs to be multi-layered and draw together:

- *Serious consequences* that smokers care to avoid (death, reduced quality of life, pain and suffering)
- Relevance to personal risk through compelling *facts*
- And *hidden harms* (since these can't be evaluated and rejected) which have a particularly strong impact when *linked to currently experienced symptoms*

6.11 The research suggests that, as previously, ***family remains a key hook*** when considering health harms. Many smokers with families are still motivated to modify their behaviour to reduce or avoid damage to their family.

6.12 Our overall proposition here will be that every cigarette you smoke is doing you and your family harm.

A new 'pull' campaign platform: providing new opportunities to stop

6.13 In addition to creating a sense of dissatisfaction with the present, our work will create a positive vision of stopping. Given that most smokers have tried to stop before and may be anxious that trying to stop again will lead to failing again, we will explore ways to address the barriers to quitting.

6.14 We will explore opportunities to create additional triggers to stop, e.g. by creating a new seasonal trigger in autumn to encourage people to make a quit attempt, or to have another go at quitting if they have tried before and been unsuccessful. We hope to begin to reposition quitting more positively as something which smokers should keep attempting and learning from until they are successful.

6.15 We will also aim to debunk smokers' belief that there is a 'magical moment' to quit by encouraging them to quit ***now***.

6.16 Insight research suggests the following quitting communication opportunities:

Quitting communication opportunities

Factor encouraging inertia on quitting	**Messaging or intervention opportunities**
Inability to visualise the quit process	• Providing how-to information with a 'flexible' map, expected steps and information on positive progress
High likelihood of failure in the quitting experience	• Focusing on quitting 'challenge' for set periods of time, e.g. 1 month. Breaking quitting down into more 'manageable chunks'
Inability to plan individual steps to take to start and manage a quit attempt	• As above, plus addressing the idea of a 'magic moment' to quit by planning the right time for you to quit • Direct encouragement and facilitation of individual planning
Widespread belief on the part of smokers that GPs have nothing to offer	• Suggesting contact with and facilitating proactive communication by GPs to capitalise on their position of high trust and expertise
Widespread belief that NHS support is not useful/for me	• Reframing and developing products and service delivery to better meet needs

Supporting people to quit successfully

6.17 While we want to stimulate a significantly increased number of quit attempts, it is also important that we continue to support people in making *effective* quit attempts.

6.18 We know that the majority of smokers choose to quit 'cold turkey', without support from the NHS, and that packaging support into 'products' can help stimulate quit attempts and improve quitting success, as well as encourage smokers who would not have considered NHS support previously to take it up.

6.19 The success of the Quit Kit[36] demonstrates the huge potential for marketing-led innovation to engage smokers, stimulate quit attempts and encourage use of the NHS for support in quitting.

6.20 Our current Smokefree support offer includes the NHS Smokefree helpline, Smokefree website and Facebook page, the Together programme and the CRM programme, as well as support materials including the Quit Kit, quitting apps and an extensive range of information leaflets.

6.21 We will review our support offer in 2012/13 to ensure we are meeting the needs of our customers in the most efficient and effective way, because this offer accounts for a large proportion of the marketing budget. The review will include:

- Research with smokers/users of our existing offer to understand how well it meets their needs currently and whether it has helped them in their efforts to quit smoking
- A review of the role of the Smokefree helpline, as part of a wider review of public health helplines
- A review of the Together programme, and the Together Plus pilot programme, following the results of a randomised control trial
- A review of the Smokefree CRM programme, following the trial of a more streamlined CRM programme in 2011
- An ongoing review and rationalisation of Smokefree information leaflets, other materials and digital content to ensure these are useful, up to date and aligned with our campaigns
- New product development to include Smokefree home and car kits, more online support for quitters, more smartphone-enabled mobile content and SMS (text) support

6.22 To maximise opportunities, we will also look at synergies with other public health campaigns which target the same audiences – for example, exploring CRM opportunities and the possibility of behaviour 'swaps', where we

[36] See Annex D

encourage people to trade one behaviour for another, more positive behaviour.

Pregnant women who smoke

6.23 **In addition to work targeting all smokers, we will continue activity focused on pregnant women who smoke.** There are more than 700,000 births in England and Wales each year, and in England just over 13% of these mothers are currently recorded as being smokers at the time of delivery of their baby[37]. We will continue to reach out to pregnant women who smoke, as smoking during pregnancy can cause serious health problems for both mother and child and contributes greatly to health inequalities.

6.24 We will review and redevelop existing materials for midwives and other healthcare professionals who come into contact with pregnant women.

6.25 We will develop links with other health campaigns targeting the same audience, through the Start4Life campaign, to ensure a joined-up approach.

6.26 We will also explore the role for a public-facing communications campaign. This will build on learning from previous campaigns – for example, the need to target both pregnant women and their partners – and will incorporate new evidence where appropriate.

Channel strategy

6.27 The evidence base for effective mass-media campaigns within tobacco-control marketing is very strong and these campaigns will continue to play an important role. However, where applicable, we will continue to expand our use of owned and earned channels through government digital media properties and resources and through partnerships developed in relevant sectors, geographies and areas of mutual interest.

6.28 Our smoking audience has become increasingly technology enabled in recent years, using smartphones to access the internet and becoming increasingly active in social media such as Facebook. Digital channels will increasingly be used to help deliver our messages and will form a key strand of our 'always-on' strategy, through which we will maintain a constant dialogue with our audience and regularly refresh content and messages to maintain interest. We will further support the always-on strategy with search marketing, PR, digital online advisors and the telephone helpline.

Resource implications

6.29 With reduced budgets and a more holistic cross-campaigns approach, we will be reviewing our agency arrangements with a view to having fewer agencies

[37] Department of Health. *NHS IC Omnibus, 2010/11*. Smoking status at time of delivery data (England only)

in total, commissioned to deliver against the objectives within the broader public-health marketing strategy. This will have implications for our current communications and marketing suppliers, who have been working on single-issue campaigns. For example, we have already appointed single cross-campaigns agencies for communications planning and PR.

Budget

6.30 The budget for Smokefree marketing in 2011/12 was £15 million. The indicative budget for 2012/13 is £13.1m, including an allowance for running call centres and evaluation. Budgets for future years are to be confirmed.

Evaluation

6.31 There will be a robust evaluation plan for the Smokefree campaign each year, which will be devised in consultation with internal and external experts. This plan will set out in detail the evaluation objectives, methodology and data sources.

6.32 To help inform our evidence base, we will carry out further research and modelling. We envisage that this will include:

- Social influence modelling to inform campaign development and understand the potential impact of marketing activity on prevalence, including work around the social dynamics of quitting
- Research to understand usage and attitudes towards the support offering we provide to smokers
- Tracking research to continue to monitor motivation to quit, awareness and attitudes towards quitting, and actions taken as a result of campaigns

7. Key 2012-13 milestones

Our current marketing plans include:

7.1 **March–May 2012**

A motivational campaign focused on the harms that second-hand smoke can cause in the home and car. Smoking in indoor public places and workplaces is now a thing of the past; however, exposure to second-hand smoke at home and in private cars remains a significant cause of disease and death. The Government wishes to take a voluntary approach, as opposed to legislation, to persuade people to make their homes and cars smoke free.

The new campaign focuses around the harm that second-hand smoke does to children, to trigger quit attempts, and will offer smokers support to stop.

7.2 **September–November 2012**

A national quitting event/challenge that aims to create an increase in quit attempts in the autumn. We will explore insight-based ideas to communicate news, maximise participation through 'social norming' and support smokers with new products to help make stopping easier and more successful.

7.3 **January–March 2013**

A national new-year quitting campaign to capitalise on seasonal motivation to quit. We will explore the potential to use health-harms messaging to motivate smokers to make a quit attempt, as well as continuing to develop and optimise the Quit Kit. This kit has been proven to motivate smokers to quit, as well as increasing quitting success compared with those smokers who quit without support.

Additionally, throughout the year, we will support:

- Employers to help their employees to stop smoking
- Pregnant smokers to stop
- Healthcare professionals to engage smokers (see Annex C)
- NHS marketing at the local level
- An 'always-on' communication strategy providing NHS quitting advice and support (e.g. PR, search marketing, and the provision of the Smokefree website, helplines, Facebook page and online advisors)

Annex A: The Smokefree brand

A.1 We will continue to use the Smokefree brand, which was introduced in England in 2006 to support the introduction of the smoke-free legislation. The Smokefree brand is now widely recognised by our target audience, with 48% of all smokers recognising the Smokefree logo in January 2011[38].

A.2 The Smokefree brand was originally designed for use together with the NHS logo by NHS organisations and services. Now, with the changes in the public health system, there is a need to review how the Smokefree brand can be used and by whom.

A.3 We will begin this review in 2012/13 and will publish updated brand guidelines on the Smokefree Resource Centre once the review is complete. In the meantime, we would encourage all NHS organisations and services to continue to use the Smokefree brand.

A.4 As part of this review, we will explore whether there is further potential to develop the Smokefree brand. This could include enhancing community-led 'social-norming' initiatives – for example, creating smoke-free zones in children's play areas or around hospitals.

[38] TNS Smokefree tracking study, Jan 2011

Annex B: Target audiences

B.1 There are over 8 million smokers in England, two-thirds of whom report that they want to quit smoking. While we will aim to support all smokers to quit, we need to focus on the largest groups of smokers, as well as the groups where prevalence is highest, as this is where we can have the most impact with mass marketing.

B.2 However, we need to be mindful that we do this without exacerbating health inequalities. So, for example, we will continue to target pregnant women who smoke, because of the significant harms to mother and baby from smoking. We also believe there is a role for social marketing at a local level to target niche audiences, such as certain ethnic minority communities where there is a high prevalence of smoking or chewing tobacco, and we will provide resources where appropriate to support this.

B.3 A key target audience continues to be **smokers in routine and manual groups**, who make up nearly half of all smokers and who also have the highest smoking prevalence: 28% of those in routine and manual groups smoke, compared with 14% of those in professional and managerial groups[39]. Smokers in routine and manual groups can be considered to be the 'engine' that drives the reduction in smoking prevalence. The decline in motivation seen in our tracking data – in particular, the increase in those people not wanting to quit – is driven by smokers in routine and manual groups, and particularly by younger smokers in these groups.

B.4 Research with smokers in routine and manual groups shows that:[40]

- They started younger, smoke more and are more addicted than other smokers
- They have a short-term attitude to life and are focused on spontaneity and today rather than the future
- Their impression is that the majority of people smoke; there is high prevalence within their families and community, which provides a sense of belonging, and they may have a negative view of non-smokers
- Smoking is seen to fulfil many needs: stress relief (actual or anticipated), filling a gap, reward, relaxation and 'me time'
- In quitting they focus on the physical and do not recognise the emotional side
- They lack support in quitting and are generally less successful in their attempts

[39] ONS (Office for National Statistics), 2009. Routine and manual smokers make up 45% of the smoking population. Fuel Lead Generation Model

[40] Directions Research (2007). Report on routine and manual workers and smoking

Annex C: Working with others

Roles for national and local marketing teams

C.1 We will work with a range of national and local partners and with health professionals to ensure they are aware of the important role they can play in prompting quit attempts and in directing people to services which improve their chances of stopping.

National

C.2 In future, the national marketing team will focus on doing those things that can only be done at a national level, or that it is more cost-efficient to do once. This will include, for example, mass-media advertising to reinforce smokers' motivation to quit and trigger significant numbers of quit attempts, and the negotiating of national partnerships.

We will aim to minimise duplication and make the best use of resources by sharing messaging, research learnings, evaluation, best-practice guidance and other materials, such as templates, to ensure that partners have access to relevant information and materials that they can use and adapt for their own local activity.

Local

C.3 We will have an ongoing dialogue with local partners to understand local priorities and needs, and will encourage them to join up with and amplify national marketing initiatives where appropriate, as this is the most efficient and effective use of limited budgets. Some local areas may wish to consider joining together to deliver marketing activity on certain issues with a wider geographical relevance. Other key roles for local areas will include:

C.4 *Promoting local stop-smoking services*

Data shows that driving people to local stop-smoking services is best done at a local level. Local areas are best placed to know when they need to boost demand for their services to meet locally agreed targets and match marketing efforts to local service capacity.

C.5 *Working with ethnic minority groups*

Smoking prevalence is higher in certain ethnic groups – in particular, Bangladeshi men and Irish men and women. As these communities tend to be concentrated in certain geographical areas, we recommend that initiatives to address smoking in minority communities are best led locally.

Roles for other partners

National partners

C.6 We will build on existing work with other partners at a national level to achieve common goals to reach smokers with information and make it easier for them to quit successfully.

C.7 These partners include pharmacies, healthcare professionals and their representative bodies (such as the medical Royal Colleges), charities and NGOs, and other commercial-sector partners, such as retailers and employers.

C.8 Examples of recent successful partnerships include the distribution and promotion of the Quit Kit via pharmacy partners. Over 8,000 pharmacies took part in our most recent Quit Kit campaign, including major multiples such as Boots, Superdrug, Lloyds, Tesco, Sainsbury's, Asda and Morrisons, smaller chains such as Whitworths, Cohens and Rowlands, and many independent pharmacies. The campaign was supported and promoted by pharmacy representative bodies including the National Pharmacy Association, the Company Chemists' Association, the Royal Pharmaceutical Society of Great Britain, the Pharmaceutical Services Negotiating Committee and the Association of Independent Multiple Pharmacies. Major pharmaceutical companies also supported the campaign by helping promote the Quit Kits via their sales forces and assisting with distribution of the kits.

Employers

C.9 Research suggests that smokers are more likely to seek support to quit if they are able to do so in work time. Communicating with smokers via their employers also provides the opportunity to reach out to smokers in environments inaccessible to commercial media. Recent partnership activity with employers has shown that they are an effective channel through which to reach smokers.

C.10 We will take a cross-campaigns approach to working with major employers, including employers of large numbers of routine and manual workers.

C.11 We will continue to provide information to raise awareness of national campaigns and to encourage employees who smoke to access support such as local stop-smoking services. We are currently redeveloping our employer pack and will promote this through the Smokefree Resource Centre.

Local partnerships

C.12 We will engage a wide range of local partners and supporters with an interest in the Smokefree campaign – for example, local authorities, the local NHS, tobacco alliances, healthcare professionals, schools, workplaces, local

businesses and others – to support local marketing efforts aimed at helping people stop smoking.

C.13 The main channel will be the Smokefree Resource Centre, which has recently been redeveloped to be more interactive and user-friendly. We will share campaign updates, messaging, research learnings, evaluation, best-practice guidance and other materials (for example, templates) to ensure that local partners have access to relevant information and materials that they can use and adapt for their own local activity.

C.14 Increasingly, we will take a cross-public-health approach to local partners, as we recognise that many partners will be interested in more than one public health area. This will help us build our supporter base; for example, we will contact supporters of other public health campaigns who may be interested in the Smokefree campaign and will encourage them to sign up to campaign updates.

Health and social care professionals

C.15 A conversation with a healthcare professional is one of the most important triggers for a smoker to make a quit attempt. This relationship is recognised in both the NHS Future Forum's *Every Contact Matters* report and in the Government's response to the report. We will build on work to ensure healthcare professionals have access to the latest evidence on the harms of smoking and the effectiveness of the various routes to quit, as well as ensuring that they are aware of the important role they can play in prompting quit attempts. This will support system changes, which aim to make it routine for all smokers to be offered a referral to support services to help them quit.

C.16 There is a huge opportunity to further engage GPs, in particular. Currently, fewer than half of GPs provide any advice to smoking patients: 57% of smokers reported that they received no advice to stop smoking from their GP, yet advice from a GP/healthcare professional is one of the top three triggers for a quit attempt[41].

C.17 Evaluation of previous campaigns promoting brief advice and referrals from GPs (e.g. the 'Ask, advise, act' campaign) shows that we have found it hard to engage GPs successfully or pitch materials at the right level for GPs. We will bear this in mind for future activity and will conduct a cross-campaign review of our approach to engaging GPs and other health professionals across public health issues to identify the approaches that are likely to have the most impact.

C.18 We will include a review of existing research with healthcare professionals to identify common themes and any knowledge gaps. This will result in a joined-

[41] West, R. *Smoking Toolkit Study,* www.smokinginengland.info

up, cross-issue approach with a clear plan – and this plan will be more effective because we will be coordinating, rather than competing, with other health issues.

C.19 We will engage healthcare professionals through a range of channels, including professional bodies such as the medical Royal Colleges, peer-to-peer communications, owned channels such as staff bulletins, and trusted media such as professional journals.

C.20 We will also build links with partners who are relevant to smoking cessation only (the UK Centre for Tobacco Control Studies, for example), to highlight the online training programme in smoking cessation which will shortly be available to GPs.

C.21 Additionally, we will share learnings from local pilot projects to help local stop-smoking services engage healthcare professionals and encourage referrals at a local level.

Annex D: The Quit Kit

D.1 The Quit Kit was developed specifically for 'cold turkey' quitters who choose to go it alone rather than use the support of the NHS.

D.2 Research showed that would-be quitters do not research all the support options available to them and that 'new news' could be an important trigger in prompting quit attempts. The research suggested that 'packaging' the idea of support into a new product, the Quit Kit, and presenting it as an easier way to quit had the potential to trigger large numbers of quit attempts.

D.3 The Quit Kit incorporated insights from research and behavioural economics to prompt quit attempts and introduce the idea of using NHS support. It offered 'a quit attempt in a box' to make it easier for smokers attempting to quit alone. The kit contained a mixture of practical tools and advice, as well as signposting quitters to the additional support available from the NHS, including local stop-smoking services.

D.4 The Quit Kit achieved a step-change in performance for tobacco-control marketing and communications. Nearly 500,000 orders were placed for the Quit Kit between January and March 2010 (a 500% increase versus the previous year's offer of a DVD showing the different ways of quitting) and cost-effectiveness increased by 400%. Over 90% of orders were from people who had not previously responded to national marketing. 40% of users reported that they would not have used the NHS for quitting support before[42], indicating the extent to which the Quit Kit successfully engaged people who wouldn't otherwise have considered the NHS.

D.5 The Quit Kit was refreshed and updated for use in 2011, based on customer insight, and a pharmacy partnership strategy was developed to facilitate delivery and increase interaction with the target market.

D.6 Follow-up research demonstrated that both versions of the Quit Kit had a strong impact on those who ordered it. In 2011, 70% of recipients made a quit attempt, with 56% reporting they were still not smoking at the time of follow-up[43].

D.7 A further positive effect of the Quit Kits was their impact on attitudes and beliefs, both about quitting and about the role of the NHS in supporting smokers to quit successfully. 63% of respondents agreed that the Quit Kit increased their motivation to quit and 56% agreed that it gave them more

[42] HPI Quit Kit evaluation research, 2010

[43] TNS Quit Kit evaluation research, 2011

confidence in their ability to quit (lack of confidence is a key barrier to quitting)[44].

D.8 83% of people reported that the Quit Kit demonstrated that the NHS understands the help they need to stop smoking and that it made them more likely to consider the NHS for quitting support in the future[45].

[44] TNS Quit Kit evaluation research, 2011

[45] HPI Quit Kit evaluation research, 2010

Annex E: Glossary of common marketing terms

Advertising – Communication in any medium (such as television, radio, newspaper or posters) that is funded by the advertiser and where the creative is supplied by the advertiser.

'Always-on' communication strategy – Maintaining a constant dialogue with the audience and being permanently accessible to the audience, usually via digital and PR channels.

Behavioural economics – The study of the effects of social, cognitive and emotional factors on the decisions, actions and activities of individuals and institutions, e.g. if we make cigarettes less visible in shops, fewer may be purchased.

Customer relationship management – The process of continuing dialogue with existing customers, for example to sustain beneficial behaviours. Customers have usually agreed to continue ('opted in' to) such dialogue. Can be paper-based (as when written communications are sent to an existing customer base) or electronic (for example, via email).

Digital engagement – Any contact with the target audience via the internet, including websites, emails and contact on social networking sites.

Direct marketing – Sending individual communication direct (for example, by letter) to a customer.

Marketing – The activity, set of institutions, and processes for creating, communicating, delivering and exchanging offerings that have value for customers, clients, partners and society at large.

Mass media – Communication channels with a broad reach, e.g. television, radio, press and outdoor media.

Media partnerships – Working with a media owner, such as a newspaper or television channel, to develop content. Can be paid-for (when the advertiser pays for advertising and receives editorial in addition) or non-paid-for (when the media owner supports the campaign pro bono).

Partnership marketing – Marketing activity where two or more organisations campaign together to support shared aims. Usually no money changes hands between them.

Population-level quits – Quits within the entire smoking audience, across the entire country.

Response – When a member of the target audience responds to a marketing campaign (for example, by going online to find out more information, calling a helpline or using a coupon).

Social marketing – The systematic application of commercial marketing concepts and techniques to achieve specific behavioural goals relevant to the social good. Should not be confused with social media marketing.

Social media – Media that promote social interaction, using new and accessible technologies (such as social networking sites).

Annex F: Acknowledgements, sources and contact details

This document was widely consulted upon and peer-reviewed by a range of stakeholders, including: leading academics and practitioners in health psychology, smoking cessation and marketing; NGOs with an interest in this field; and national and local partners. We would like to thank all those involved.

A list of source material is included throughout the document as footnote references.

For further information or to comment on this strategy, contact: smokefree@dh.gsi.gov.uk

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