gies requiring international cooperation such as global funding to promote alternative livelihood or to enforce the removal of tobacco subsidies. It can also fund activities of international organizations such as the WCO and the Interpol in their anti-smuggling drive.
Conclusion: There is a higher probability of reaching international consensus on the manner of raising funds if the objective and the criteria for raising additional funds are clearly defined but each state is allowed to choose from a variety of options to impose a levy. In this case, the bone of contention would be on the amount of contribution from each state so as to achieve equity. Further study on the elements that contribute to equity is required.
The availability of additional funds for global coordination activities accelerates the denormalization of the tobacco industry and promotes inter-sectoral cooperation at the country level especially in developing nations.

OP025
TOBACCO TREATMENT PROTOCOL IN TERTIARY CARE HOSPITALS – THE WAY FORWARD IN TOBACCO CONTROL IN LMICS

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Background: In India, amongst the strategic approaches for an effective tobacco control, the health system's approach to deliver tobacco treatment is lacking. One such solution is to have a tobacco-treatment protocol (TTP) in hospitals. Besides assisting country in the "O" component of MPOWER, it can also help the member countries to fulfil their commitment to the Article 14 of the FCTC (Framework Convention on Tobacco Control).
Objective: It is to assess if the model of tobacco treatment protocol can be realized in an Indian setting through a framework: (1) Concurrence from management; (2) Establishing a working group; (3) Empowerment along with communication with all to ensure their buy-in; (4) A high visibility to the campaign; (5) Close monitoring of the implementation; (6) A formal declaration after (a) evaluation of its efficacy by an external agency and (2) replication by other hospitals in the existing health system.
Method: The TTP comprised of: Screen, Ask, Advise, Treat or Refer and Follow-up: 1) The hospital reception screens patients for any tobacco use (SCREEN); 2) The screen-identified patients receive consultation, in addition to their management for the primary ailment (ASK, ADVISE, TREAT or REFER); 3) The interventions are – "minimum (~3 minutes)" or "brief (for ~10 minutes)"; Intensive (for ~30–40 minutes; for addicts or habitual users; and those less confident or have relapsed frequently in past, etc.); the last intervention is done through the in-house Tobacco Cessation Clinic (TCC); 2) Those requiring and willing are prescribed cessation medication and/or NRT; All screened patients are followed-up through the calls made on their cell phones after 6 months of their first report to the hospital.
Result: The program has completed 4 and a half months till date. Within the first quarter: 1. The enrolment of tobacco users on monthly basis averages to ~9.54% of the total patients seen in the hospital – new and follow up (468 out of 4902). About 9% of these have received doctors' consultation. In telephonic follow up, a quit success of ~40% has been observed.
Conclusion: Despite challenges and barriers at all levels, and its brief duration of actual implementation, this exercise in human behaviour modification of health workers and patients alike appears implementable; and, effective too. Its replication in the health systems should lower their tobacco burden by increasing quit rates in LMICs.

OP031
CHARACTERISTICS OF TOBACCO RETAILERS IN NEW ZEALAND

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Background: New Zealand (NZ) does not require tobacco retailers to be licensed or registered, and any type of outlet is permitted to sell tobacco. Consequently, tobacco is retailed widely yet it is not known how many outlets sell tobacco or where they are located. Smokefree Enforcement Officers (SEOs), based within District Health Boards, are responsible for enforcing legislation which prohibits point-of-sale tobacco displays and promotion, and sales of tobacco to minors. To monitor retailer compliance with smoke-free legislation, SEOs are required to manually compile and maintain databases of tobacco retailers in their region.
Objective: This research aimed to describe the number and types of tobacco retail outlets in NZ, to examine how SEOs identify tobacco retailers, and to examine the distribution of outlets according to neighbourhood deprivation, proximity to secondary schools, and the extent to which tobacco is sold alongside alcohol.
Method: The names and physical addresses of known tobacco retail outlets were obtained from SEOs throughout NZ. Geographic Information System software was used to map tobacco retail outlets, neighbourhood socioeconomic deprivation and secondary schools. Descriptive statistics, simple linear regression and logistic regression were used to examine the relationship between tobacco retailers, neighbourhood deprivation and proximity of retail outlets to schools.
Result: A total of 5,008 tobacco outlets were identified, giving a density of 1 outlet per 617 people or 1 outlet per 165 smokers. One-half of secondary schools had a tobacco retail outlet within a 500 m walking distance. Tobacco retail outlets were more densely located in areas of higher socioeconomic deprivation. A third of all tobacco outlets had a licence to sell alcohol and 13% of tobacco retailers were on-licensed premises (e.g. bars), where alcohol is purchased for consumption.
Conclusion: This study indicates the widespread retail availability of tobacco in New Zealand, and the ease of access to tobacco retail outlets by secondary school students and people living in lower socioeconomic neighbourhoods. Our research highlights the need to investigate policies to decrease the retail availability of tobacco in New Zealand, and mandate registration to enhance enforcement of smoke-free legislation. This will help achieve the government's goal of becoming a smoke-free nation by 2025.

Tailoring tobacco control across different political, cultural and resource settings

OP003
ASSOCIATION BETWEEN BEING EMPLOYED IN A SMOKEFREE WORKPLACE AND LIVING IN A SMOKEFREE HOME IN LMICs

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Background: Smoke-free policies are known to be associated substantial health and economic benefits. Early arguments that smoke-free workplace policies would lead to shifting of smoking into the home have not been seen to hold true in high income countries.
Objective: We aimed to assess the impact of smoke-free workplace policy on living in smoke-free homes in low- and middle-income country (LMIC) settings.
Method: Country-specific individual level analysis was conducted using cross-sectional Global Adult Tobacco Survey data from fifteen LMICs (2008–2011). These LMICS included India, Bangladesh, Thailand, China, Philippines, Viet Nam, Brazil, Mexico, Uruguay, Poland, Romania, Russian Federation, Turkey, Ukraine and Egypt. For each country, our study population was GATS participants (≥15 years of age) working indoors but not in their homes. The number of study participants ranged from 1,174 in Romania to 12,561 in India. Adjusted odds ratios (AORs) and 95% CIs of living in smoke-free homes were estimated for participants employed in smoke-free workplaces vs. those employed in workplaces where smoking occurred, using multivariate logistic regression models. The covariates adjusted in the regression models included age, gender, place of residence, region (where available), education, occupation, current smoking, current smokeless tobacco use and number of household members.
Result: The percentage of participants employed in a smoke-free workplace reporting living in a smoke-free home was higher than among those employed in a workplace where smoking occurred in all 15 countries. The percentage of participants living in a smoke-free home and employed in a smoke-free workplace varied from 20% in China to 75% in Mexico. Overall, the percentage of participants living in smoke-free homes was higher in urban settings, among females, non smokers and highly educated participants, with exceptions in certain LMICs. AORs of living in smoke-free homes among participants employed in smoke-free workplaces (vs. those not employed in smoke-free workplaces) ranged from 1.12 [95% CI 0.79–1.58] in Uruguay to 2.29 [95% CI 1.37–3.83] in China. The point estimate was greater than two for China, Philippines and India. The association was insignificant in Uruguay and Mexico.
Conclusion: Despite country-specific differences, observed consistent association implies, enhanced implementation and enforcement of 100% smoke-free policies in LMICs is likely to bring about substantial additional health benefits by smoke-free norm spreading.

OP014
CHEAPER BY THE CARTON: EXAMINING PACIFIC PEOPLES USAGE AND SUPPLY OF DUTY-FREE TOBACCO

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Background: New Zealand is building a comprehensive tobacco control programme that includes working towards the goal of a smoke-free nation by the year 2025. In relation to this vision, the recent (2010–2012) and proposed (2013–2016) tax increases have resulted in a greater focus on the issue of duty free cigarettes. Given the frequent travel between NZ and Pacific Island countries the movement of Pacific peoples, which is now occurring at higher levels than at any time in the past, the risk that duty free tobacco sales pose towards undermining tobacco control interventions such as tax increases among Pacific Island communities is particularly high.
Objective: This qualitative research study involved focus group interviews with Pacific smokers and non-smokers regarding the buying and smoking/distributing of duty free cigarettes, whether it is being used as a strategy to circumvent tax increases in the price of cigarettes, and how this behaviour is viewed (positively or negatively) within the Pacific community. The latter is important given evidence that smuggling or distribution of cigarettes is often viewed positively within high prevalence disadvantaged communities.