National NGO Forum Response to:

Department of Health on the future of tobacco control

The National NGO Forum welcomes the opportunity to comment on this consultation document. The NGO Forum is submitting a joint response on behalf of all member organisations but individuals and member organisations have been encouraged to do their own organisational responses.

NGO Forum background

The NGO Forum was established to help improve public health and reduce health inequalities across the UK. It does this by bringing together public health experts from non-governmental organisations (NGOs) and government policy makers.

The NGO Forum was established in 1999 and has been managed by the RSH since April 2006 under a contract with the Department of Health. The Forum currently includes approximately 100 national NGOs, comprising of the major health charities (e.g. Diabetes UK, British Heart Foundation, etc), professional associations (e.g. Faculty of Public Health, Chartered Institute of Environmental Health), advocacy organisations (e.g. UK Public Health Association), NGOs who create practical changes to the built environment (e.g. Sustrans) as well as organisation who focus on particular health topics or particular groups in the population.

(Appendix A contains a full list of NGO Forum members)

Part A: Reducing smoking rates and health inequalities caused by smoking

Question 1: What smoking prevalence rates for all groups (children, pregnant women, routine and manual workers and all adults) could we aspire to reach in England by 2015, 2020, and 2030, and on what basis do you make these suggestions? What else should the Government and public services do to deliver these rates?

The rate of smoking prevalence in the general population to could be reduced by at least 15% by 2015 and to 19% amongst lower socio-economic classes and marginalised groups. NGO Forum members feel it is important the government puts most effort into narrowing the gap between lower socio-economic and marginalised groups before 2020 to ensure those most at risk receive the most resources. By 2020, fewer than one in ten of the population should still be smoking, and by 2030 the figure should fall to fewer than one in 20.

We believe that these challenging targets are possible on the basis of recent trends which have shown an annual decline of around 0.4% of the population

per annum, and on the evidence from other jurisdictions when comprehensive tobacco control strategies have been implemented such as California.[1]

We believe the success of banning smoking in public places has already begun to change opinion and that these challenging targets can be met by a concerted effort from all interested stakeholders to work with each other to help continue current positive trends.

The Government needs to continue to provide resources, funding and health campaigns to ensure that effective tobacco control measures are in place and it may require further expansion of these measures in new ways or to new areas in order to ensure the targets are met.

Question 2: What more do you think could be done to reduce inequalities caused by tobacco use?

It is essential to use all the methods that are known to work successfully, expand and roll out programmes that have worked in spearhead areas, find ways (possibly via the voluntary sector) of reaching into communities and building trust before beginning smoking cessation programmes. It is known that High tobacco prices due to sustained increases in taxation are the best way of reducing smoking. However this is undermined by smuggled tobacco, mainly bought by poorer smokers.[2] Tougher action is needed to stop smuggling [see answers to Qs 4 & 5 below.]

Poorer, more disadvantaged smokers also tend to be more heavily addicted and need greater support to quit successfully. The introduction of a harm reduction strategy would be particularly helpful to poorer smokers who are unable to quit. [See answers to questions 13-17]

It is also important that while look at the issues of nicotine addiction this is not done in isolation, those most at risk of smoking and least likely to quit may also be at risk of other addictive behaviours. There is need for further research for those people who have multiple poor health behaviours to find the best way to provide effective interventions that do not merely address their smoking but other health issues.

Question 3: Do you think the six-strand strategy should continue to form the basis of the Government's approach to tobacco control into the future? Are there other areas that you believe should be added?

We believe that the six-strand strategy has been effective to date and should continue to be the basis of the future of tobacco control. The United Kingdom has led the world in many areas and achieved a great deal, particularly with respect to: helping people who want to quit, banning tobacco advertising and promotion, and reducing exposure to second-hand smoke.

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[1] California Tobacco Survey (CTS) Reports. http://ssdc.ucsd.edu/tobacco/reports/

[2] A YouGov poll commissioned by ASH found that 1 in 5 poorer smokers buy smuggled tobacco compared to only 1 in 20 of the most affluent smokers. (Fieldwork undertaken 20-25 Feb 2008. Total sample size was 3,329 adults, weighted to represent all GB adults aged 18+.)

It is possible to achieve more by spending more on targeted campaigns, investment in social marketing for smoking cessations services, reducing ways in which tobacco can be marketed (especially to young people), increased regulation of tobacco products and reducing their supply and availability.

In addition, a harm reduction strategy would help those smokers who are either reluctant to quit or find it particularly hard to do so, and would help reduce health inequalities. [See answer to Q17.]

Question 4: How can collaboration between agencies be enhanced to contribute to the inland enforcement against illicit tobacco?

An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of tobacco smuggled by criminal gangs, with new tougher targets for a continued reduction in the market share of smuggled cigarettes and hand-rolled tobacco. It is important that this is seen as a key area of work and dealt with seriously rather then being assumed to low-level and under resourced and under-policed.

It is essential that new Borders Agency must work closely with HMRC and the Treasury to create a new and improved anti-smuggling strategy and ensure that cracking down on smuggling of illicit tobacco continues as priority for the Government and is promoted a priority within law enforcement.

NGO Forum members support the proposals as set out in paragraphs 2.38 – 2.39. However, the UK Government should promote the creation of a strong illicit trade protocol as part of the international treaty on tobacco – the Framework Convention on Tobacco Control. We believe it is important that the UK should also sign the EU anti-smuggling agreements, in line with all other EU Member States.

Question 5: What more can the Government do to increase understanding about the wider risks to our communities from smuggled tobacco products?

There should be more investment in media campaigns and use of social marketing to convince the public to report illegal tobacco sales and to demonstrate the dangers caused by smuggled tobacco, its links into criminal behaviour and how cheap smuggled tobacco undermines other tobacco control measures.

One measure would be to ensure that information about the scale of smuggling is easily accessible to both interested organisations and members of the public so that can see success of anti-smuggling strategy or press for increased measures if the strategy is not achieving its aims.

Part B: Protecting children and young people from smoking

Question 6: What more do you think the Government could do to:
a. reduce demand for tobacco products among young people?

b. reduce the availability of tobacco products to young people?

Many NGO Forum members work with young people in a variety of ways to improve their well-being. We naturally support any measures that are likely to reduce (or stop them starting) smoking amongst young people. However we note that there is little evidence to show that measures targeted specifically at young people have much benefit. Indeed, youth smoking prevention campaigns (particularly those initiated by the tobacco industry) can be can be counter-productive. [3] [4]

We believe that a comprehensive tobacco control strategy aimed at the whole population is the best way to reduce demand for tobacco products among young people. The introduction of campaigns that reduce the appeal of tobacco products, ensure it is seen as not part of a cultural norm and decrease starting or experimentation with smoking should be developed.

Key measures to reduce the availability of tobacco products to young people include:

- banning sales of tobacco from vending machines,
- increasing price through taxation and
- stronger measures to curb smuggling

If the licensing of the sale of tobacco were reintroduced with a penalty for anyone who sells tobacco illegally to underage smokers and this results in having their licence removed it would both strengthen control of underage sales and help retailers by enabling unlicensed sales of tobacco to be tackled more effectively (for example in street markets or car boot sales).

Question 7: Do you believe that there should be restrictions on the advertising and promotion of tobacco accessories, such as cigarette papers?

Yes. The advertising of tobacco accessories such as cigarette papers or lighters can act as a prompt and reminder about smoking which can be especially difficult for those in the process of giving up smoking.

In recent years there has been a rise in the proportion of smokers using hand-rolled tobacco: from 12% in 1996 to 22% in 2006.[5] It is noteworthy that when the Tobacco Advertising and Promotion Act was implemented Imperial Tobacco chose to place advertisements for Rizla cigarette-rolling papers at the point of sale since they did not require health warnings. Imperial has also used the Rizla brand to sponsor motor racing, thereby maintaining a link between sport and smoking, despite UK and European law which has outlawed tobacco sponsorship of sponsorship of sport.[6]

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[3] Landman, A., Ling, P., & Glantz, S. Tobacco industry youth smoking prevention programs: Protecting the industry and hurting tobacco control. Am J Public Health 2002; 92 (6): 917-930.
[4] Wakefield, M. et al. Youth responses to anti-smoking advertisements from tobacco-control agencies, tobacco companies, and pharmaceutical companies. J Applied Social Psychol 2005; 35 (9): 1894-1911.
[5] Smoking-related Behaviour and Attitudes, 2006. Office for National Statistics, 2007
[6] Good, G. Presentation at UBS Tobacco conference. 1 December 2006 http://www.imperial-tobacco.com/files/financial/presentation/011206/ubs_transcript.pdf

Question 8: Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is your preferred option?

The NGO Forum believes that the introduction of further controls is an important measure in reducing the 'normality' of tobacco products in the UK. Point of sales displays often dominate large areas of retail environments and could be seen as advertising in their own right. We think that all tobacco products should be removed from display.

There has been considerable speculation in the retail trade press about the cost to the retail trade of this measure. However, evidence from Canada shows that the tobacco industry paid for cigarette displays and, once they were banned, the companies continued to pay retailers for the tobacco storage units.[7] The tobacco industry has the means and resources to assist tobacco retailers in managing similar changes in the UK. Moreover, we believe that the tobacco industry should be required to disclose to the Government the amount of money it spends on marketing its products, as is the case in Canada.

Question 9: Do you believe that there should be further controls on the sale of tobacco from vending machines to restrict access by young people? If so, what is your preferred option?

We believe that the best choice is Option 3: A total ban on the sale of tobacco products from vending machines.

Even though vending machines are not a major source of cigarette sales, due to their open and unsupervised nature a disproportionate number of young people under the legal minimum age to buy tobacco obtain cigarettes from this source. The latest survey conducted when the legal age for purchasing tobacco was 16, found that 17% of 11-15 year old smokers reported that vending machines are their usual source of cigarettes. [8]

If there was a ban on the sale of tobacco products from vending machines would make it harder for underage and younger people to purchase cigarettes. This would be in agreement with a total ban on tobacco sales from vending machines that has been recommended by the World Health Organisation.

Question 10: Do you believe that plain packaging of tobacco products has merit as an initiative to reduce smoking uptake by young people?

Yes. Although no jurisdiction has yet implemented a law requiring plain packaging, research suggests that it would help deter young people from taking up smoking because smoking would lose its appeal. [9]

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[7] Anti-tobacco troopers won't butt in - The Gazette (Montreal), 19 May 2008

[8] Fuller, E. Smoking, drinking and drug use among young people in England 2006. NHS Information Centre, Leeds, 2007.

[9] Cunnigham, R. & Kyle K. The case for plain packaging. Tobacco Control 1995; 4: 80-86

There is evidence from around the world to show that the tobacco industry uses branding in general and pack design in particular to:

- Target young people
- Maximise display space (some members of brand families are virtually indistinguishable on taste alone yet the number of variants has increased dramatically in recent years).
- Communicate misleading messages (it would be illegal for manufacturers to claim products were "low tar" "light" or less harmful yet all these are communicated by the colour of sub-brand packaging)

Tobacco companies invests considerable resources in making tobacco packaging alluring and eye-catching, as this is now one of the few methods currently available to the industry to market its products to new and existing smokers. [10] Industry analysts believe that plain packaging would have a significant negative impact on cigarette sales. [11]

Question 11: Do you believe that increasing the minimum size of cigarette packs has merit as an initiative to reduce smoking uptake by young people?

We are not aware of any evidence that shows that an increase in the minimum pack size would reduce smoking by young people. The NGO Forum recommends that research in undertaken on this subject and it is reviewed as results become available and any necessary changes are undertaken at that time.

Question 12: Do you believe that more should be done by the Government to reduce exposure to second-hand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.

There is more could be done by Government, concerned organisations and individuals to reduce children's exposure to second-hand smoke.

- Run further media campaigns targeted at parents/carers about the health effects of second-hand smoke, particularly in enclosed places such as the home and motor vehicles.
- Commission research into effective ways of helping parents to stop smoking and to prevent children's exposure to smoke if parents do not stop smoking. (This links to the harm reduction approach outlined in question 17.)
- Work with voluntary groups in disadvantaged communities, health trainers, and pharmacists to ensure they have the resources and knowledge to help spread the message about the dangers of second-hand smoke.

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[10] Wakefield, M. The cigarette pack as image: new evidence from tobacco industry documents. Tobacco Control 2002; 11:i73-i80 http://tobaccocontrol.bmj.com/cgi/content/full/11/suppl_1/i73

[11] Material new risk appears: UK government suggests plain packaging. Citigroup, 2 June 2008

- Ensure that the stop smoking services are adequately funded and continue to be targeted towards disadvantaged smokers and other groups such as parents.
- Ensure that services aimed at pregnant women are also inclusive of expectant fathers.

Part C: Supporting smokers to quit

Question 13: What do you believe the Government's priorities for research into smoking should be?

- Research to further understand and overcome the barriers to using medicinal nicotine or other pharmacotherapies
- Research to improve the identification, referral and retention in treatment of pregnant smokers
- Studies to examine the impact of interventions and policies on different social groups.
- The use of tobacco amongst ethnic minority groups
- Studies to examine the efficacy of different prevention approaches including mass media interventions on young people
- Research to ensure optimum access to accredited smoking cessation services, deploying these across the broadest range healthcare professionals and settings
- Research into the role of other forms of nicotine replacement and harm reduction strategies
- Research into how to prevent experimentation and first steps towards addiction by young people
- Research into pack sizes and if eliminating the availability of small quantities is likely to reduce uptake of smoking amongst young people.

Question 14: What can be done to provide more effective NHS Stop Smoking Services for:
- *smokers who try to quit but do not access NHS support?*
- *routine and manual workers, young people and pregnant women – all groups that require tailored quitting support in appropriate settings?*

Stop smoking services are very cost effective and combined with the use of pharmacotherapies can increase a smoker's chances of quitting four-fold compared to using willpower alone. However, take up by smokers wanting to quit is still low with only 3% to 6% of smokers making use of the services per year. If attendance was raised to 10% of smokers, it is estimated that the population long-term quit rate could be increased by 0.5%. [12] Therefore, there is huge scope for improving the services and making them more attractive to people seeking help in stopping smoking.

Models used by health promotion and community development that involve working in and with the communities most at risk should be examined to see what lesson can be learned and applied to smoking cessation services.

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[12] West, R. The Smokers Toolkit Study. www.smokinginengland.info

Hospitals, medical and dental surgeries and other healthcare clinics should be required to monitor smoking rates of patients and to give all smokers brief advice to quit, access to stop smoking medicines and referral to stop smoking services. Smoking rates of people leaving hospital should also be monitored. In addition, smoking cessation should be included in the Standards for Better Health set by the Healthcare Commission.

The cost of purchasing stop smoking aids can be a barrier to use, as can the limited availability of these products. Although some versions of NRT are now on general sale, availability is still largely limited to pharmacies and supermarkets. Meanwhile tobacco products are widely available from many outlets such as corner shops, garage forecourts, supermarkets, pubs, vending machines in licensed premises, and specialist tobacconists. In order to help smokers who want to quit without NHS support, stop smoking aids should be made more widely accessible but with the necessary checks to ensure the pure nicotine products are being used safely. There is widespread public support for such as policy. According to a YouGov poll, 76% of adult smokers in England said they supported making NRT easier to access. [2]

There should be publicity campaigns to ensure that smokers who feel unable to afford NRT are aware that it can be obtained free for those on limited incomes and in receipt of state benefits.

Social marketing campaigns targeted at particular social groups should be used to assist those who find it most difficult to quit.

Question 15: How can communication and referral be improved between nationally provided quit support (such as the website and helplines) and local services?

It is important that these services are made much more attractive to people who want to stop smoking and that there is continual support and promotion of their availability. To achieve better communication and referral it would be important to invest in the selection, training, assessment and supervision of specialists; the implementation of treatment protocols, and high quality administrative support for services.

It is essential that any mass media health campaigns are closely co-ordinated and local and community-based initiatives are given the resources to promote local services and have the capacity, knowledge and skills to respond to national campaigns.

Question 16: How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?

All health professionals should be trained to offer opportunistic stop smoking advice and referral to the stop smoking services, particularly to disadvantaged smokers who are likely to be in most need of help and ongoing support. Public Health consultants locally are key facilitators in engaging established

professionals and, thereby, in introducing accredited smoking cessation services to a greater range of clinical settings (e.g. dental surgeries).

Health trainers and other community initiatives must be trained and supported to give initial stop smoking advice and knowledge about appropriate services for referral.

When possible it is important that all community support workers are given appropriate training to ensure they have the skills, knowledge and ability to provide brief stop smoking advice, especially if they work in disadvantaged communities.

Smoking cessation should be included as part of the medical training for all health and social professionals.
The health and social care workforce should be encouraged and supported to give up smoking themselves.

There should be more outreach with services being set up in places where people are likely to see them, such as in workplaces, shopping centres, leisure facilities and schools.

Better use could be made of existing social networks including faith groups to reduce smoking prevalence.

The NHS smoking quitline should appear on all tobacco packaging.

Part D: Helping those who cannot quit

Question 17: Do you support a harm reduction approach and if so can you suggest how it should be developed and implemented?

The members of the NGO Forum do support the harm reduction approach. People are free to smoke but it is important to find ways of reducing the harm caused by smoking whilst allowing people to use nicotine in a way that will not endanger their health. Nicotine is relatively safe but little has been done to promote longer term use of nicotine replacement therapy as an alternative to smoking for those who are unable to quit. Although the Medicines and Healthcare Regulatory Agency (MRHA) has taken steps to increase the accessibility of NRT much more needs to be done. This includes widening the range of healthcare professionals who can prescribe NRTs, such as dentists[13].

The Government should take a lead in encouraging the development and promotion of pure nicotine products (which like the current medicinal products on the market only contain nicotine and not any other tobacco products) as an alternative to smoking. This should include educational campaigns to raise awareness of the relative safety of nicotine, as currently a significant proportion of smokers and health professionals believe that nicotine can

[13] Tobacco Cessation Strategies – Should Dentists Be Allowed to Prescribe NRT and Zyban ? British Dental Association 2002.

cause smoking-related diseases such as cancer. [14] Such an approach will be particularly attractive to more deprived smokers who tend to be more heavily addicted to nicotine and so find it harder to quit, thereby helping to reduce health inequalities.

[14] Siahpush M, McNeill A, Hammond D, and Fong GT. Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey. Tobacco Control 2006; 15: iii65 - iii70.

Appendix A

MEMBER ORGANISATIONS

	Organisation	Website
1	Asthma UK	www.asthma.org.uk
2	Action for Blind People (ABP)	www.actionforblindpeople.org.uk
3	Action on Smoking and Health (ASH)	www.ash.org.uk
4	African HIV Policy Network (AHPN)	www.ahpn.org
5	Age Concern (AC)	www.ageconcern.org.uk
6	Alcohol Concern (AC)	www.alcoholconcern.org.uk
7	Alliance for Better Food & Farming (SUSTAIN)	www.sustainweb.org
8	Association for the Study of Obesity (ASO)	www.aso.org.uk
9	Association of Directors of Public Health (ADPH)	
10	Association of Directors of Social Services (ADSS)	www.adss.org.uk
11	Barnardo's	www.barnardos.org.uk
12	Black Health Agency (BHA)	www.blackhealthagency.org.uk
13	British Dental Association (BDA)	www.bda-dentistry.org.uk
14	British Dental Health Foundation (BDHF)	www.dentalhelpline.org.uk
15	British Dietetic Association (BDA)	www.bda.uk.com
16	British Flouridation Society (BFS)	www.bfsweb.org
17	British Heart Foundation (BHF)	www.bhf.org.uk
18	British Medical Association (BMA)	www.bma.org.uk
19	British Nutrition Foundation (BNF)	www.nutrition.org.uk
20	Brook Centres	www.brook.org.uk
21	Cancer UK	www.cancerindex.org/clinks44.htm
22	Chartered Institute of Environmental Health (CIEH)	www.cieh.org.uk
23	Child Poverty Action Group (CPAG)	www.cpag.org.uk
24	Clubs for Young People (CYP)	www.clubsforyoungpeople.org.uk
25	Commission for Racial Equality (CRE)	www.cre.gov.uk
26	Community Action Network	
27	Community Development Exchange (CDX)	www.cdx.org.uk
28	Community Health Involvement & Empowerment Forum (CHIEF)	www.chiefcic.com
29	Community Practitioners & Health Visitors Association (CPHVA)	www.msfcphva.org
30	Community Service Volunteers (CSV)	www.csv.org.uk

	Organisation	Website
31	Consensus Action on Salt and Health (CASH)	www.actiononsalt.co.uk
32	Consumers Association (CA)	www.which.net
33	Continyou	www.continyou.org.uk
34	Council of Ethnic Minority Voluntary Sector Organisations (CEMVO)	www.cemvo.org.uk
35	Department of Health (DH)	www.dh.gov.uk
36	Diabetes UK	www.diabetes.org.uk
37	Drug Scope	www.drugscope.org.uk
38	Equalities National Council (ENC)	www.encweb.org.uk
39	Faculty of Public Health (FPH)	www.fph.org.uk
40	Faithworks	www.faithworks.info
41	Family Planning Association (FPA)	www.fpa.org.uk
42	Food Commission	www.foodcomm.org.uk
43	Forum for the Future	www.forumforthefuture.org.uk
44	Foyer Federation	www.giveusavoice.net
45	Help the Aged	www.helptheaged.org.uk
46	Homeless Link	www.homeless.org.uk
47	Institute of Rural Health (IRH)	www.rural-health.ac.uk
48	International Institute of Risk and Safety Management (IIRSM)	www.iirsm.org
49	Joint Council for Welfare of Immigrants (JCWI)	www.jcwi.org.uk
50	Kids' Cookery School	www.thekidscookeryschool.co.uk
51	Kings Fund	www.kingsfund.org.uk
52	Lesbian & Gay Foundation (LAGLO)	www.lgf.org.uk
53	Local Government Association (LGE)	www.lga.gov.uk
54	Medical Foundation for AIDS & Sexual Health (MEDFASH)	www.medfash.org.uk
55	Meningitis Trust	www.meningitis-trust.org
56	Men's Health Forum	www.menshealthforum.org.uk
57	Mental Health Providers Forum	www.mhpf.org.uk
58	MKC Trust	www.rokocancer,org
59	Muslim Council of Great Britain (MCB)	www.mcb.org.uk
60	National Aids Trust (NAT)	www.nat.org.uk
61	National Association for Mental Health (MIND)	www.mind.org.uk
62	National Asthma Campaign (Asthma UK)	www.asthma.org.uk
63	National Children's Bureau (NCB)	www.ncb.org.uk
64	National Energy Action (NEA)	www.nea.org.uk
65	National Healthy Living Alliance	www.healthylivingonline.org.uk
66	National Heart Forum	www.heartforum.org.uk

	Organisation	Website
67	National Society for Prevention of Cruelty to Children (NSPCC)	www.nspcc.org.uk
68	NHS Confederation	www.nhsconfed.net
69	No Smoking Day	www.nosmokingday.org.uk
70	Nuffield Trust	www.nuffieldtrust.org.uk
71	Nutrition Society	www.nutritionsociety.org
72	Obesity Awareness & Solutions Trust (TOAST)	www.toast-uk.org
73	One Parent Families (NCOPF)	www.oneparentfamilies.org.uk
74	Patient information Forum (PIF)	www.pifonline.org.uk
75	Patients' Association	www.patients-association.com
76	Pharmacy HealthLInk	www.rpsgb.org.uk
77	Refugee Council	www.refugeecouncil.org.uk
78	Rethink	www.rethink.org
79	Royal College of General Practitioners (RCGP)	www.rcgp.org.uk
80	Royal College of Midwives (RCM)	www.rcm.org.uk
81	Royal College of Nursing (RCN)	www.rcn.org.uk
82	Royal College of Physicians (RCP)	www.rcplondon.ac.uk
83	Royal Institute of Public Health (RIPH)	www.riphh.org.uk
84	Royal National Institute for Deaf People (RNID)	www.rnid.org.uk
85	Royal Pharmaceutical Society of Great Britain (RPSGB)	www.rpsgb.org.uk
86	Royal Society for the Prevention of Accidents (ROSPA)	www.rospa.org.uk
87	Royal Society for the Promotion of Health (RSPH)	www.rsph.org
88	Save the Children Fund UK (SCFUK)	www.scfuk.org.uk
89	Scarman Trust	www.thescarmantrust.org
90	Society for Health Education & Promotion Specialists (SHEPS)	www.promotinghealth.org.uk
91	Society of Local Authority Chief Executives and Senior Managers (SOLACE)	www.solace.org.uk
92	South Asian Health Foundation (SAHF)	www.sahf.org.uk
93	Stillbirth and Neonatal Death Society (SANDS)	www.uk-sands.org
94	Stroke Association	www.stroke.org.uk
95	Students in Mind	www.studentsinmind.org.uk
96	Sustainable Transport (SUSTRANS)	www.sustrans.org.uk
97	Terence Higgins Trust (THT)	www.tht.org.uk
98	The Day Care Trust	www.daycaretrust.org.uk
99	Trading Standards Institute (TSI)	www.tradingstandards.gov.uk
100	Unite the Union	www.amicustheunion.org
101	United Kingdom Public Health Association UKPHA	www.ukpha.org.uk

	Organisation	Website
102	Womens' Institute	www.womens-institute.org.uk
103	World Cancer Research Fund (WCRF)	www.wcrf.org.uk
104	YMCA England	www.ymca.org.uk

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