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The European Tobacco Control Report 2007

WORLD HEALTH ORGANIZATION
EUROPE

The European Tobacco Control Report

2007

THE EUROPEAN TOBACCO CONTROL REPORT 2007

ABSTRACT

The *European tobacco control report* describes the tobacco control situation and the status of tobacco control policies in the WHO European Region as at late 2006; reviews progress following the adoption of the European Strategy for Tobacco Control (ESTC) in 2002; and establishes a baseline for monitoring implementation of the WHO Framework Convention on Tobacco Control (FCTC) in the Region. The document presents an overview of the situation regarding tobacco use and related harm in the WHO European Region during the period 2002–2006 and of Member States' policy responses and implementation of national tobacco control measures in line with the recommendations of the ESTC. Reference is also made to the status of policies in countries in the light of the specific requirements of the WHO FCTC. Lessons learned and challenges faced during the policy-making process are illustrated by several short national, regional and subregional case studies attached to the Report.

Keywords

SMOKING – adverse effects – prevention and control
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HEALTH PROMOTION
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TOBACCO INDUSTRY – legislation
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Summary

The WHO Regional Committee for Europe adopted the European Strategy for Tobacco Control (ESTC) in 2002 *(1)*. The ESTC followed three consecutive regional action plans spanning the period from 1987 to 2002 and was developed at the request of the WHO European Ministerial Conference, Warsaw, in February 2002. Since 2002 there have been substantial developments in international tobacco control. In May 2003, the Member States of WHO adopted the Framework Convention on Tobacco Control (WHO FCTC) – the first global public health treaty *(2)*. The WHO FCTC entered into force in February 2005 and the first Conference of the Parties was convened from 6 to 17 February 2006 to outline and promote its implementation. Simultaneously, several Member States updated their policies and legislation, commissioned new surveys and strengthened their national capacity in tobacco control.

The European tobacco control report 2007 reflects on the above developments. The report was prepared by the WHO Regional Office for Europe in collaboration with the WHO European network of national counterparts and experts, with valuable input from WHO Headquarters, the European Commission and international partners such as the European Network of Smoking Prevention.

The purpose of the report is threefold: to describe the tobacco control situation and tobacco control policies in the WHO European Region as at late 2006; to review progress with the implementation of the ESTC since its adoption in 2002; and to establish a baseline for monitoring progress with the implementation of the WHO FCTC in the Region.

The document presents an overview of the situation regarding tobacco use and related harm in the Region during the period 2002–2006, and of Member States' policy responses and implementation of national tobacco control measures in line with the recommendations of the ESTC. The lessons learned and challenges faced during the policy process are also illustrated by 15 short national, regional and sub-regional case studies which are attached to the Report.

Smoking prevalence data are derived from information provided by WHO national counterparts and international sources, together with comparable prevalence estimates provided by the WHO Headquarters Infobase database *(3)*. Data confirm recent observations that the tobacco epidemic is being generally curbed in the Region, but not in all countries and at different rates. According to available data, at the end of 2005 smoking prevalence (current daily cigarette smokers, population weighted, age and year standardized) was estimated at around 28.6% (40.0% among males and 18.2% among females) as compared with 28.8% (40.9% among males and 17.8% among females) in 2002.

In most western European countries, smoking prevalence among men and women has in general stabilized or is decreasing. Overall prevalence has, however, reached a level from which it will be difficult for it to show a further decrease unless substantially stronger measures are implemented. Smoking prevalence has also started to decrease in some countries in the eastern part of Europe, although generally it is only stabilizing among men, with no clear overall trends, and in some cases, a slight rise in prevalence among women is being recorded.

Among young people aged 15 years, the prevalence of weekly smoking is on average 24% (24% in boys and 23.5% in girls). In many western European countries the prevalence of smoking

among 15-year-old girls exceeds that of 15-year-old boys. In eastern Europe, smoking among 15-year-old boys tends to be higher than among girls.

The overall positive trends in male smoking prevalence are now reflected in a Region-wide fall in the standardized death rates for lung cancer among men, whereas lung cancer among women is still increasing. Tobacco remains the leading contributor to the disease burden in more than half of the European Member States, and one of the three leading contributors in the absolute majority. Tobacco also poses considerable economic costs. According to World Bank estimates, tobacco-related health care costs range from between 0.1% to 1.1% of gross domestic product (GDP) in different countries.

Of particular concern is the growing concentration of smoking in the lower socioeconomic groups observed throughout the Region. This is leading to a widening gap in current and future health outcomes. Smoking remains a major contributory factor to the gap in mortality and healthy life expectancy between the most and least advantaged.

Between 2002 and 2006, most Member States made significant progress in relation to banning advertising, increasing the size of health warnings, strengthening product regulation and, to a certain extent, raising taxes on tobacco. The price of tobacco products rose by an average annual rate of 6.8% above inflation between 2001 and 2005 in the European Union (EU) countries – good progress when compared to the previous annual rate of increase of 2.7%. The data are less encouraging in the countries in the eastern part of the Region where, in some cases, tobacco became cheaper over this period. Most countries still do not earmark tobacco taxes for tobacco control.

Since 2002, major developments have also occurred in the area of smoke-free policies. Several countries have introduced bans on smoking in public places which for the first time extended to bars and restaurants. These restrictions were led by the example of Ireland and Norway (2004). Nearly 20 countries have passed stricter laws covering smoking in bars and restaurants, and currently, nearly two thirds of countries have bans or restrictions on smoking in most indoor public places – a substantial improvement since 2001.

Recent years have also been characterized by significant and increasing public support for strong tobacco control policies and action at both national and international levels. Smokers as well as nonsmokers are now in favour of tougher controls.

Since 2002, 24 Member States have reinforced legislation on direct advertising by either passing new laws or implementing existing provisions. EU Directive 2003/33/EC *(4)* totally banned advertising in the press, on the radio and in the sponsorship of sporting or cultural events with cross-border effect from 31 July 2005. Advertising remains less regulated in the Commonwealth of Independent States (CIS), although there has been notable progress in most countries since 2002.

There have also been significant developments in the regulation of tobacco products. Since December 2002, EU Directive 2001/37/EC *(5)* has required EU tobacco manufacturers to disclose the nature and quantities of all the ingredients used in tobacco products. In 2006, 32 countries and, in particular, the EU are regulating the levels of tar at 10 mg per cigarette, nicotine at 1 mg and carbon monoxide at 10 mg in cigarettes, a decrease compared with the 2001–2002 levels of 12 mg of tar and carbon monoxide per cigarette and 1.2 mg of nicotine per cigarette. The CIS countries and those in south-eastern Europe (SEE) in the main still set higher levels: 1.2–1.4 mg for nicotine and 12–16 mg for tar per cigarette.

In 2002 the average size of warning labels was less than 10% of each large surface of the pack. This has now been increased more than threefold in the 32 countries that have transposed or adopted EU Directive 2001/37/EC *(5)*. In the 14 other Member States (mainly CIS and SEE countries), health warnings are still usually less than 10% of the largest surface. Misleading descriptions on tobacco packs are prohibited in EU countries and in some SEE and CIS countries.

There has been marked progress in restricting the sale of tobacco products to minors. Currently 34 countries ban the sale of tobacco products to young people aged under 18 years and 10 countries to young people aged under 16 years. Despite these bans, tobacco is still widely available to young people throughout the Region. Forty Member States ban the sale of single or unpacked cigarettes and 32 ban the distribution of free samples. Compliance with laws on age restrictions appears to need improvement in the majority of countries.

Most countries provide information and education on the harm caused by tobacco. Information is generally disseminated through public awareness campaigns or school programmes.

There are still some major weaknesses in policy in many countries, particularly concerning restrictions on indirect advertising, the introduction of smoking cessation in the national health care system and, above all, in combating smuggling. In the western part of the Region the fight against smuggling has had some success, especially in reducing the supply of illegal tobacco products. Progress has also been reported by some SEE countries.

The Region, in general, has made a significant contribution to the negotiation and entry into force of the WHO FCTC. By 15 December 2006, 40 countries in the WHO European Region and the European Community had become Parties to it.

All this has been carried out against the backdrop of strong resistance by the tobacco industry to control or regulation justified by public health concerns. In parts of the European Region where smoking prevalence is stabilizing, attempts to maintain the rates of tobacco use and to increase profits have become a major preoccupation of the industry.

The Regional Office has supported Member States and international partners in strengthening and coordinating policies throughout the Region through surveillance, capacity-building, review and update of legislation, the promotion of intersectoral links, and so on. Particular highlights have included support with the development of national action plans, updating of legislation, implementation of internationally standardized surveys, capacity-building projects focusing on CIS and SEE countries, information campaigns such as World No Tobacco Day, organization of the work of the national counterparts network, and updating and extending the European tobacco control database *(6)*.

In conclusion, although smoking prevalence has in general stabilized in the WHO European Region and is decreasing in some countries, it does not yet present a clear diminishing trend. WHO Member States need to continue and in many cases accelerate their implementation of the baseline recommendations outlined in the ESTC. Governments and society need to use the current momentum to create a turning-point in combating the tobacco epidemic in the Region. *The European tobacco control report* outlines a number of additional areas where, by strengthening controls, European Member States could make a considerable contribution to reducing the significant health burden associated with tobacco consumption.

Introduction

The European Strategy for Tobacco Control (ESTC) was adopted by the Regional Committee for Europe in 2002 *(1)*. The first progress report on the ESTC was due in 2006.

In May 2003, the Member States of WHO adopted the Framework Convention on Tobacco Control (WHO FCTC) – the first global public health treaty *(2)*. There have been many developments since the adoption of the treaty at global, regional and national level. The WHO FCTC entered into force in February 2005, and the first Conference of the Parties was convened from 6 to 17 February 2006 to outline and promote its implementation. In recent years several Member States have updated their policies and legislation, undertaken new surveys and strengthened their national capacity in tobacco control.

The purpose of this review is threefold:

- to describe the tobacco control situation and tobacco control policies in the WHO European Region as at late 2006;
- to review progress on the implementation of the ESTC since its adoption in 2002; and
- to establish a baseline for monitoring progress on the implementation of the WHO FCTC in the Region.

The report provides a general overview of tobacco use and tobacco-related harm in the Region from 2002 to 2006, and outlines Member States' policy responses in the form of national tobacco control measures in line with the recommendations contained in the ESTC. Reference is also made to the status of policies in countries in the light of the specific requirements of the WHO FCTC.

Part 1 contains an analysis of tobacco use and its health consequences in the Region, followed by an analysis of tobacco control policies at the national and international levels in Part 2. The report concludes with some observations on the progress made, the remaining challenges and the next steps in this important of area of public health in the Region. The lessons learned and challenges faced during the policy process are illustrated by several short national, regional and sub-regional case studies in Annex 1.

This report is of particular importance in ensuring that, as stipulated by the Regional Committee, the ESTC is a continuing process subject to regular review and strategic modification, as necessary.

Background

Europe was the first WHO Region to launch a regional action plan on tobacco. In 1987 the First European Action Plan on Tobacco 1987–1992 called for a comprehensive approach, including restrictions on the production, distribution and promotion of tobacco; pricing policies; protection for nonsmokers; health promotion and health education programmes; smoking cessation training for professionals, and practical help with giving up smoking *(7)*. It also urged countries to monitor and evaluate these measures. In 1988, the First European Conference on Tobacco Policy (held in Madrid) set out directions in a Charter for a Tobacco-free Life, supported by 10 detailed strategies for achieving a tobacco-free Europe.

In 1992, 37 proposals designed to strengthen Member States' commitment and capacities were incorporated in the Second Action Plan for a Tobacco-free Europe 1992–1996 *(8)*. This new strategy document emphasized the importance of building alliances to support tobacco control

policies. It set out priorities for the promotion of a smoke-free environment, nonsmoking behaviour among young people and cessation activities. The Action Plan recommended that Member States allocate more human and financial resources to these priorities and that there should be intensive cooperation among the countries of central, eastern and southern Europe. It recognized that tobacco-related problems were not only a European concern but very much also a global one, and that international safeguards were needed to ensure that they were not exported to other parts of the world.

To ensure that more effective action was taken than had been the case in previous years, the Regional Committee at its forty-seventh session adopted the Third Action Plan for a Tobacco-free Europe for the period 1997–2001 *(9)*. This new Action Plan set specific targets to be achieved in Member States in the areas of pricing, availability and advertising of tobacco, control of smuggling, product regulation, smoke-free environments, support for smoking cessation, and public education and information. It outlined the specific role that Member States should play by establishing adequately funded national intersectoral committees, drawing up country-based action plans, and carrying out effective monitoring of tobacco control measures. The Plan highlighted the role of integrational, intergovernmental and nongovernmental organizations, as well as of health professions, in forging effective partnerships for strengthening tobacco control in Europe.

At the end of 2001, according to the previous *European tobacco control report (10)*, approximately 30% of the adult population of the Region were regular smokers. The overall trend was relatively stable, with a slight decline after the mid-1990s. Almost no Member State showed a decrease in smoking prevalence among young people during the latter part of the 1990s. Among lower socioeconomic groups the trend was not encouraging, and there was no indication that the socioeconomic gradient in tobacco use was falling.

The standardized death rate for lung cancer among males had stabilized or was slightly decreasing in the central and western parts of the Region. The death rate among women was still increasing as they were in general exposed to tobacco later than men.

The ESTC was based on the lessons learnt from the assessment of the three consecutive Action Plans (1987–2001) *(10)* and from the evidence underpinning policy development and implementation at national, regional and global levels. It also took into account the guiding principles set out in the Warsaw Declaration for a Tobacco-free Europe (2002) *(11)*. The ESTC established strategic directions for action in the Region, to be carried out through national policies, legislation and international cooperation within the means and capacities of each Member State. It also identified the specific international tools and mechanisms that could be used and suggested a time-frame for implementation and monitoring. The structure and content were consistent with the strategic approach of the WHO FCTC, in whose negotiation European Member States were simultaneously actively involved.

The ESTC aimed to promote and facilitate the adoption at country level of comprehensive and multisectoral evidence-based policies to reduce the demand for and supply of tobacco products and to cut down the prevalence of tobacco use in all population groups. The principal target was to obtain a significant and realistic increase in the rates of people not taking up and of those stopping smoking, in order to at least double the average annual reduction of smoking prevalence in the Region which was standing at nearly 1%. The reduction in smoking rates was expected to vary from a significant fall in countries with a high smoking prevalence to a more moderate decrease in countries which had already achieved lower prevalence. The ESTC also aimed to assure the citizens' right to a smoke-free environment.

Process and data sources

This report has developed from a process of consultation, drafting and reviewing, involving the network of WHO European national counterparts, international experts, the WHO Regional Office for Europe, WHO headquarters and collaborating centres, and international partners such as the European Commission and the European Network for Smoking Prevention. The approach is based on the use of factual information followed by crosschecking that information against various additional sources to clarify different data or possible misinterpretations. Standard templates and questionnaires were developed to gather information on specific topics. An external expert group was established to provide guidance and assistance in the preparation and drafting of the report.

The process for writing and the structure of the Report were presented, commented on and reviewed during the First Expert Meeting held in Copenhagen on 24 January 2005. A questionnaire addressing issues not covered by existing survey instruments (for example, the level of enforcement of current regulations and legislation) was drafted at the Second Expert Meeting held in Paris on 11 May 2005.

The outline of the process for reviewing the ESTC was agreed during a meeting of national counterparts for the ESTC held in Paris from 12 to 14 May 2005. A drafting committee comprising national counterparts from seven countries (Armenia, France, Ireland, Serbia and Montenegro,[1] Spain, Sweden and Switzerland) was designated at that meeting to work in close collaboration with the Regional Office. The initial draft was reviewed during a meeting of the drafting committee held in Dublin on 3 and 4 November 2005 at the invitation of the Irish Office for Tobacco Control. This first draft was then reviewed and amended by experts and drafting committee members, in anticipation of further review by the meeting of national counterparts held in Dublin on 10 and 11 April 2006, kindly hosted by the Irish Ministry of Health and the Children and the Irish Tobacco Control Office. The cross-checking of data, incorporation of comments and reflection of new policy developments continued until November 2006.

The data used in this document were drawn extensively from the WHO European Database on Tobacco Control established in 2001, as part of the development of a global tobacco control surveillance system *(6)*. The database is based on information provided by the WHO national counterparts in the Regional Survey for Country-specific Data and on other internationally recognized sources. The information was made available in the first edition of the *WHO European country profiles on tobacco control (12)* and in an electronic database. It has been updated on a continuing basis and the data have been cross-checked with different sources and with the national counterparts for tobacco control.

The questionnaire drawn up by the expert group for the WHO European Report on Tobacco Control Policy and reviewed by the national counterparts for the ESTC was designed to check the accuracy of existing information and to provide additional information on national tobacco control policies and facilitate comparisons with the measures recommended by the ESTC. The questionnaire was sent to the national counterparts for the ESTC in June 2005, and by April 2006, 40 of the 52 Member States had responded (Andorra, Armenia, Austria, Belarus, Belgium, Bulgaria, Bosnia and Herzegovina, Croatia, the Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Georgia, Germany, Hungary, Iceland, Ireland, Italy, Kazakhstan, Kyrgyzstan,

[1] Serbia and Montenegro became two separate Member States of WHO in September 2006. Throughout this report they are referred to as either one country or two countries according to the dates of the references or data. Where, prior to September 2006, separate data are available for either or both of the entities, they are shown as Serbia and Montenegro (Serbia) or Serbia and Montenegro (Montenegro).

Latvia, Lithuania, Malta, the Republic of Moldova, Netherlands, Norway, Poland, Portugal, Russian Federation, Sweden, Serbia and Montenegro, Slovakia, Slovenia, Spain, The former Yugoslav Republic of Macedonia, Ukraine, the United Kingdom and Uzbekistan).

This report also draws on presentations of national practices made during two Meetings of National Counterparts for the ESTC in Helsinki, Finland (1–2 August 2003) and in Paris, France (12–14 May 2005). Other important sources of data include the WHO Global InfoBase *(3)*, WHO Regional Office for Europe programmes and networks, including its Health for All (HFA) database *(13)* and the WHO Health Behaviour in School-aged Children study *(14,15)*, the European Commission *(16)* (in particular the ASPECT Report on Tobacco or Health in the European Union *(17)*), the World Bank *(18)* and other international and nongovernmental organizations, especially the European Network for Smoking Prevention (ENSP) *(19)*.

To facilitate analysis, countries were grouped according to the Regional Office's usage:

- the European Union (EU) countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom prior to 1 May 2004, plus Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia since 1 May 2004;
- the south-east European (SEE) countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Republic of Moldova,[2] Romania, Serbia and Montenegro, The former Yugoslav Republic of Macedonia;
- the Commonwealth of Independent States (CIS): Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

In a comprehensive exercise such as this, some of the information gathered could be inconsistent or conflicting. Whenever this happened, alternative sources were used to compare the data and decisions as to the most appropriate data to use were made on a case-by-case basis in cooperation with national counterparts for the ESTC.

[2] The Republic of Moldova is included with both the SEE and the CIS countries in order to maintain the integrity of the data relating to the SEE grouping.

PART 1

TOBACCO CONSUMPTION AND TOBACCO-RELATED HARM

Summary

In the WHO European Region smoking prevalence is estimated at around 28.6% (40% among males and 18.2% among females). There are, however, wide disparities in different parts of the region. In most western European countries, the smoking prevalence in men and women has in general stabilized or is decreasing, but the picture is not so homogenous in the eastern part of the region. In some eastern European countries, the smoking prevalence is starting to fall, although in general it shows a slight upward trend in women and is stabilizing among men. Among young people aged 15 years, the prevalence of weekly smoking is on average 24% (24% in boys and 23.5% in girls). In many western European countries, the prevalence of weekly smoking in 15-year-old girls exceeds that of boys of the same age. In eastern European countries the prevalence of weekly smoking in boys tends to be higher than that of girls. The new data confirm the observations of the 2002 *European report on tobacco control policy* that the tobacco epidemic is being curbed in some parts of the Region. However, many countries, particularly in the CIS, need to do more to achieve an annual 2% reduction in smoking prevalence as suggested by the ESTC.

Since the last *European report on tobacco control policy* was published in 2002, the standardized death rate for lung cancer among men across the European Region has fallen but those for women have increased.

Smoking remains a major contributory factor to the gap in mortality and healthy life expectancy between the most and least advantaged. The growing concentration of smoking in the lower socioeconomic groups observed throughout the Region is leading to a widening gap in current and future health outcomes. Although the absolute number of socioeconomically disadvantaged people may be diminishing in some countries, the persisting relative gap emphasizes the need to address the social and economic factors which have an impact on smoking.

Prevalence of tobacco use

One of the principal objectives of the ESTC was to obtain a significant and realistic reduction in smoking prevalence in the Region and to at least double the average annual reduction rate, which was standing at nearly 1%.

Smoking prevalence among adults

The smoking prevalence data in this report derive from the information provided by national counterparts together with comparable estimates provided by the WHO Global InfoBase *(3)*. Infobase estimates for the prevalence of tobacco consumption are based on a standardization of survey data in the different Member States, sometimes a composite of several different surveys in one country, with the aim of obtaining a global picture of current and future smoking prevalence patterns. The InfoBase draws on a wide variety of sources. Adjustments are made to the initial estimates to take account of urban/rural criteria, survey year and age (the InfoBase methodology is presented in Annex 3). At the time of this report it was possible to derive estimates for 41 of the 52 countries in the WHO European Region.[3] As these are estimates there may be differences between the figures shown in Fig. 1 and 2 (and in Annex 2) and the best available national prevalence data as confirmed through the network of national counterparts (Annex 4).

[3] In some cases further clarification is required of data and for this reason Infobase estimates for some countries have not been included in this report.

The definition of smoking status for the reported data is "current daily cigarette smoker" in the group aged 15 years and over. Data are adjusted for 2002 and 2005. Aggregated data from the InfoBase were used to estimate comparable smoking prevalence data for the male, female and overall population of each country. Data provided by countries and verified through the network of national counterparts for the ESTC are presented in Annex 4. The limitations on the InfoBase are similar to those with any database, namely the availability and quality of data and common definitions. The InfoBase nevertheless serves as an important tool for encouraging investment in the collection of reliable national data on which to base intercountry comparisons.

Current status

The overall adult daily estimated smoking prevalence (population-weighted) has stabilized at around 28.6% in the Region. The estimated average smoking prevalence among males is 40%: in 14 (mostly eastern European) countries there is a higher prevalence rate of male smoking, while in 12 (mostly western European) countries the male smoking prevalence is below 30% (Fig. 1). The estimated average female smoking prevalence in the Region is 18.2%: in 24 (mostly western European) countries the prevalence rate is higher, while in 8 eastern European countries it is below 10% (Fig. 2).

Gender differences

Fig. 3 depicts the percentage differences between male and female smoking prevalence estimates in the Region in 2005. In all but two countries (Iceland and Sweden), smoking prevalence is higher among men than among women. Data from Georgia show the widest gender gap – 46.9%, followed by five eastern European countries with a gender difference of more than 40% (Armenia, Belarus, Kyrgyzstan, Republic of Moldova and Russian Federation). A small difference between male and female smoking prevalence of less than 10% can be found in 18 (mostly western European) countries (Fig. 3).

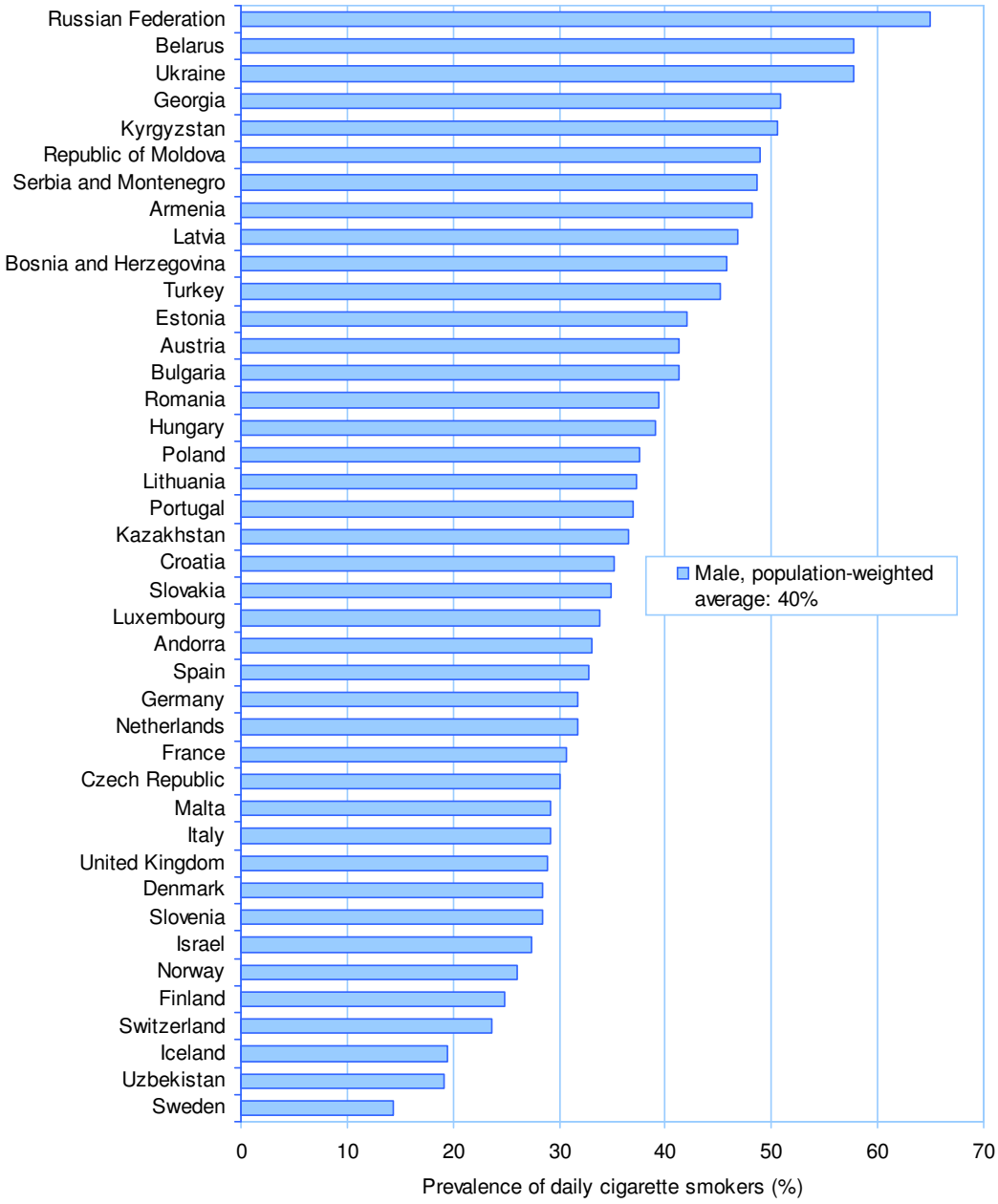
Changes in smoking prevalence

Estimates for male and female smoking prevalence for 2002 and 2005 are available for 41 countries. Only relative differences of more than +/-10% have been taken into account as noteworthy changes when comparing data for these two years.

Since the 2002 *European report on tobacco control policy*, smoking prevalence among the male population has in general stabilized across the Region. A notable decrease has been reported for Sweden (16.3% to 14.4%), Iceland (22.8% to 19.4%) and Israel (31.5% to 27.4%), but in most countries in the Region male smoking prevalence did not show a significant change between 2002 and 2005. Female smoking prevalence has notably decreased in Iceland (22.8% to 19.7%) and increased in Ukraine (15.5% to 18.7%). In all other countries, there was no significant change in female smoking prevalence although slight increases were observed in many CIS and SEE countries.

Fig. 4 shows the average population-weighted smoking prevalence estimates in the Region in 2002 and 2005. Total smoking prevalence did not change notably (28.8% in 2002 as compared to 28.6% in 2005). Smoking prevalence among males and females has also not changed notably during the period although there was a slight downward trend among men (40.9% in 2002 as compared to 40% in 2005) and a slight upward trend among women (17.8% in 2002 as compared to 18.2% in 2005).

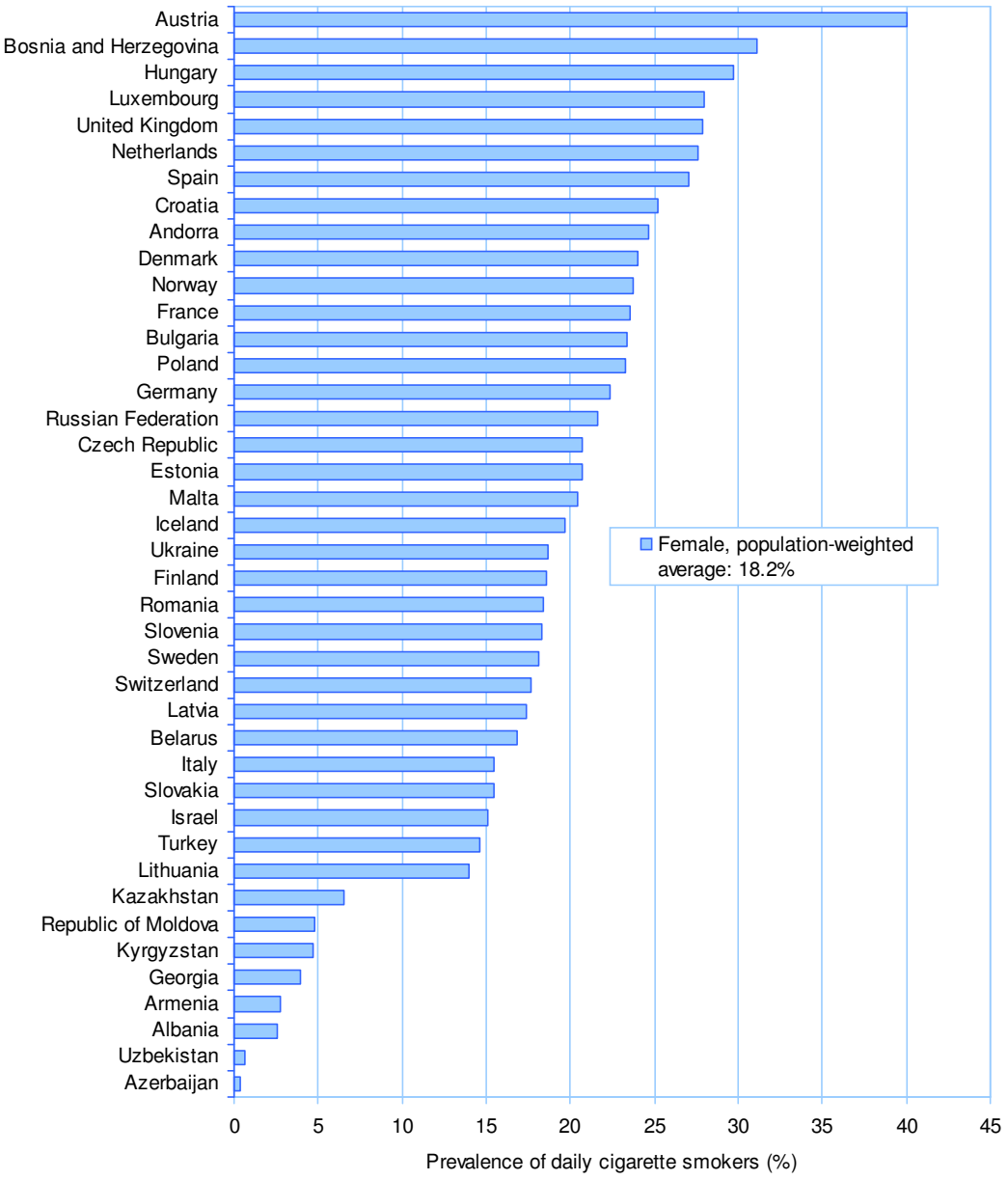
Fig. 1. Male daily smoking prevalence estimates, 2005



Note. Fig. 1 does not reflect the use of smokeless tobacco.
Source: WHO Global InfoBase *(3)*.

This overall regional pattern does, however, hide varying sub-regional trends. In the EU plus the three European Economic Area countries (Iceland, Norway and Switzerland), there was no notable change in the average smoking prevalence among the overall, male and female populations (Fig. 5). A slight downward trend could be observed in the total (26.1% in 2002 as compared to 25.4% in 2005) and in the male (31.7% in 2002 as compared to 30.3% in 2005) populations.

Fig. 2. Female daily smoking prevalence estimates, 2005

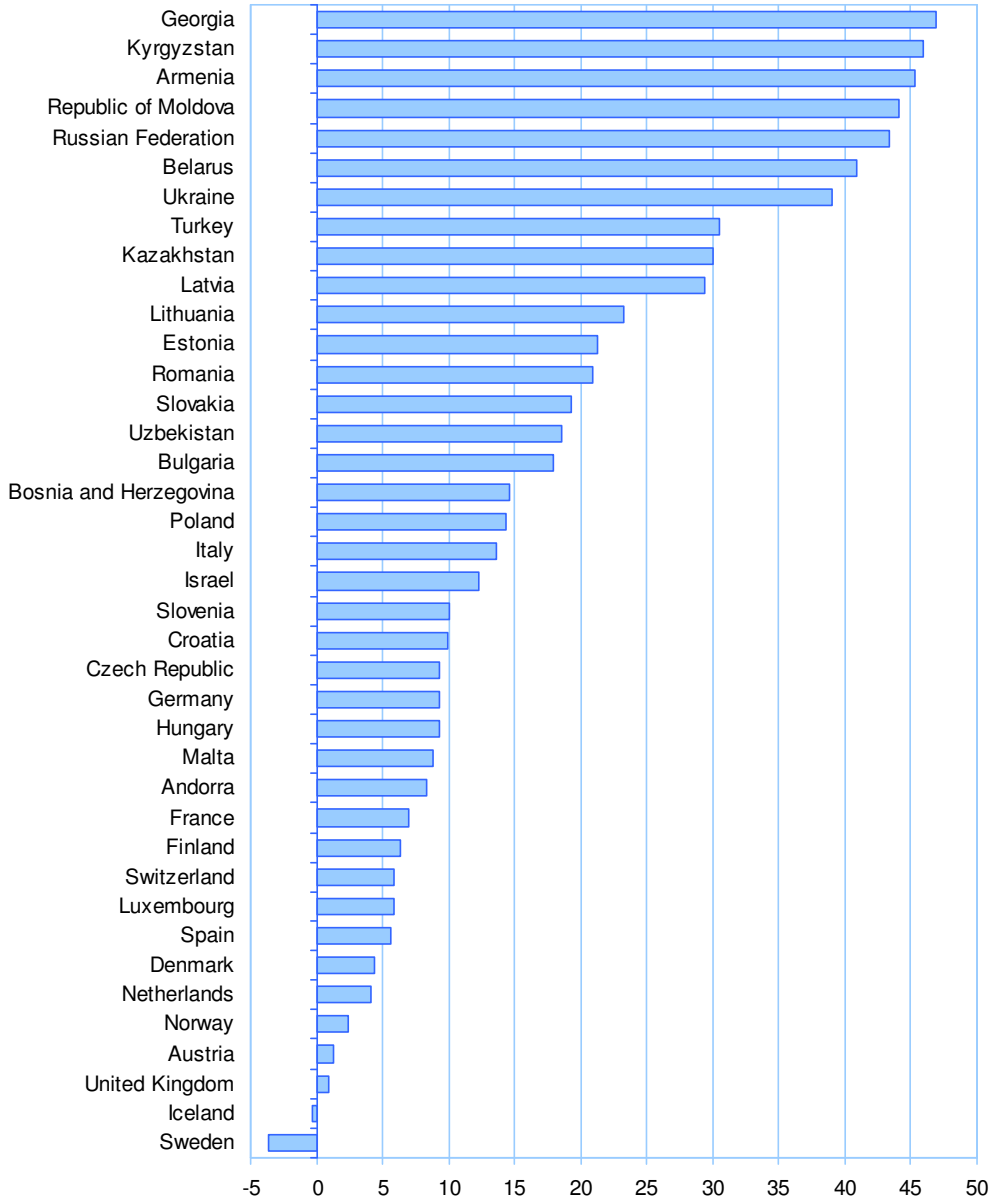


Source: WHO Global InfoBase *(3)*.

In the CIS, a slight increase in smoking prevalence among females can be observed (13.7% in 2002 as compared to 14.7% in 2005) but no notable changes among males (56.8% in 2002 as compared to 56.7% in 2005) or in the total adult population (33.2% in 2002 as compared to 33.7% in 2005) (Fig. 6).

In the SEE countries, there was no notable change in the estimated average smoking prevalence in the overall, male and female populations. A slight downward trend could be observed among males (44.5% in 2002 as compared to 44.1% in 2005) and a slight upward trend among females (15.4% in 2002 as compared to 16.1% in 2005) (Fig. 7).

Fig. 3. Difference between male and female daily smoking prevalence estimates, 2005 (%)

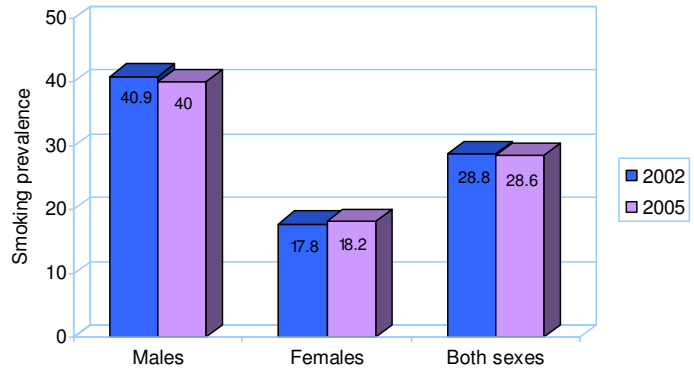


Source: WHO Global InfoBase *(3)*.

Prevalence of "smokeless" tobacco products

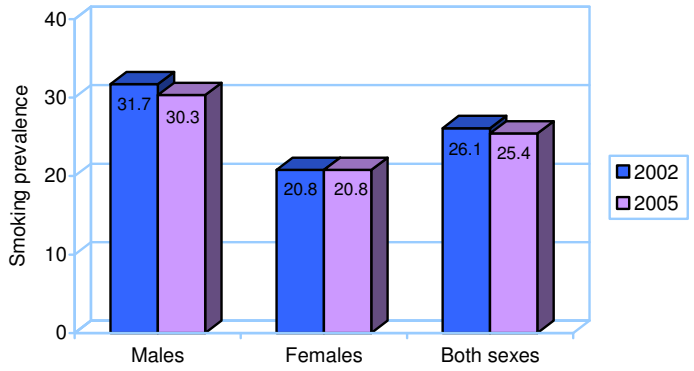
The consumption of oral non-combustible products, which are highly addictive and can cause cancer of the head, neck, throat and oesophagus as well as many serious oral and dental conditions, remains widespread in Scandinavian countries *(20)*. In 2004, the daily snus (oral smokeless tobacco) prevalence rate reached 23.4% (+3.4% since 1997) among Swedish men and 2.8% (+1.9% since 1997) among women. In Norway the use of snuff increased significantly during the same period, reaching 8% among men in 2004 (+3% since 1997), although fewer than 1% of Norwegian woman use snuff daily *(21)*. Meanwhile, Nasvay (another form of smokeless tobacco product) is widely used in CIS countries such as Kyrgyzstan and Uzbekistan: in 2005 over 40% of the rural male population was using it.

Fig. 4. WHO European Region: average population-weighted smoking prevalence estimates, 2002 and 2005



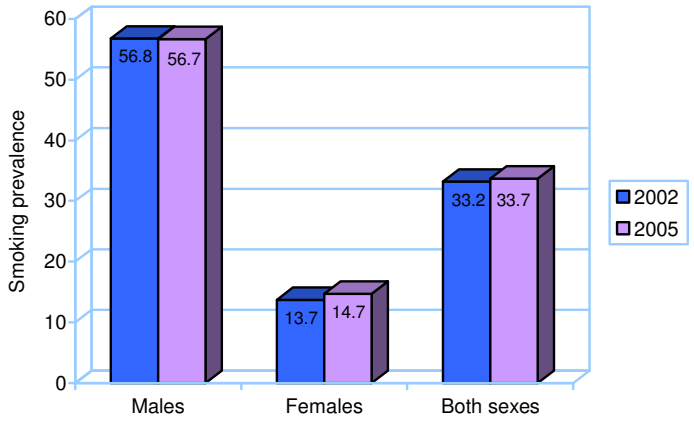
Source: WHO Global InfoBase *(3).*

Fig. 5. EU plus European Economic Area countries: average population-weighted smoking prevalence estimates, 2002 and 2005



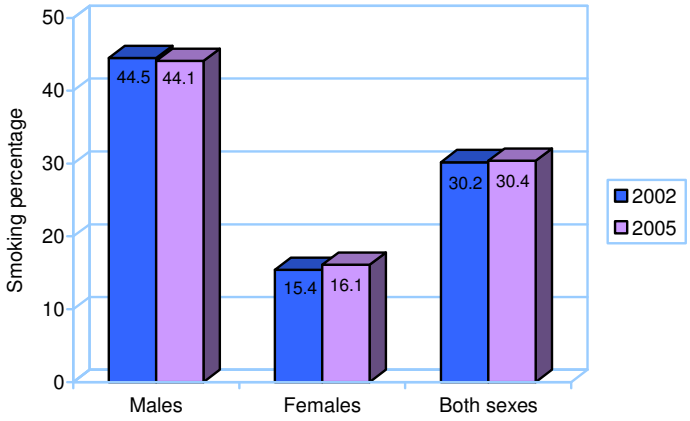
Source: WHO Global InfoBase *(3).*

Fig. 6. CIS: average population-weighted smoking prevalence estimates, 2002 and 2005



Source: WHO Global InfoBase *(3).*

Fig. 7. SEE countries: average population-weighted smoking prevalence estimates, 2002 and 2005



Source: WHO Global InfoBase *(3)*.

Smoking prevalence among young people

The analysis of smoking prevalence among young people is based on the WHO Health Behaviour in School-aged Children (HBSC) study, a unique cross-national research study conducted every four years: 1993/1994, 1997/1998 *(14)* and 2001/2002 *(15)*. The 2005/2006 survey has recently been launched in 41 countries and regions and no comparable data are yet available. Information based on a second survey instrument, the Global Youth Tobacco Survey (GYTS) *(22)*, was also used in the preparation of this report. The GYTS was developed by the US Centers for Disease Prevention and Control (CDC) and WHO and has been carried out in a large number of countries in the European Region (Table 1). With more and more countries carrying out and repeating the GYTS, comparisons should be possible in the next two to three years (Annex 3 provides more technical information on both instruments).

Current status

According to the HBSC study, weekly smoking prevalence rates were on average 2% among 11-year-olds, 8% among 13-year-olds, and 24% among 15-year-olds. In general, smoking prevalence rates increased more steeply between the ages of 11 and 13 years than between 13 and 15 years. The results of the HBSC and GYTS studies show that weekly smoking prevalence rates in 15-year-old boys were especially high (>30%) in some eastern European countries (Belarus, Estonia, Georgia, Latvia, the Russian Federation, Slovakia and Ukraine). The highest smoking prevalence rates (>30%) among 15-year-old girls were found mostly in western European countries such as Austria, the Czech Republic, Finland and Spain. The lowest smoking prevalence rates among 15-year-old boys (<15%) were in Albania, Bosnia and Herzegovina, Greece, Kazakhstan, Kyrgyzstan, Serbia and Montenegro, Sweden and Turkey. Smoking prevalence rates among girls were especially low in Armenia (0.5%) and below 10% in a number of other countries, particularly in the east of the Region (Albania, Bosnia and Herzegovina, Georgia, Greece, Kazakhstan, Kyrgyzstan, Republic of Moldova and Turkey). An overview of smoking prevalence rates among young people in the WHO European Region obtained by the HBSC and GYTS is provided in Table 1.

Table 1. Smoking prevalence (at least one cigarette per week) in 15-year-old boys and girls (%), 1997/1998, 2001/2002 and 2001/2004

Country	HBSC				GYTS 2001/2004		
	1997–1998		2001–2002				
	Boys	Girls	Boys	Girls	Year	Boys	Girls
Albania					2004	10.6	5.4
Armenia					2004	15.8	0.5
Austria	30	36	26.1	37.1			
Belarus					2004	33.2	23.8
Belgium	28	28	21.3	23.5			
Bosnia and Herzegovina					2003	10.8	7.5
Bulgaria					2002	28.7	26.4
Croatia			23.2	24.9	2002	18.6	16.7
Czech Republic	22	18	28.7	30.6	2002	29.9	32.8
Denmark	20	28	16.7	21.0			
Estonia	24	12	30.4	18.2	2002–2003	31.8	23.0
Finland	25	29	28.3	32.2			
France	28	31	26.0	26.7			
Georgia					2003	31.8	6.3
Greece	18	19	13.5	14.1	2003	16.3	9.5
Hungary	36	28	28.2	25.8	2003	24.1	27.4
Ireland	25	25	19.5	20.5			
Israel	24	13	16.9	11.6			
Italy			21.8	24.9			
Kazakhstan					2004	14.5	9.0
Kyrgyzstan					2004	10.2	2.9
Latvia	37	19	28.9	21.1	2002	30.2	22.1
Lithuania	24	10	34.9	17.9	2001	29.0	20.5
Malta			16.9	17.4			
Netherlands			22.5	24.3			
Norway	23	28	20.1	26.6			
Poland	27	20	26.3	17.0	2003	20.8	14.3
Portugal	19	14	17.6	26.2			
Republic of Moldova					2004	21.7	4.9
Romania					2004	16.8	12.8
Russian Federation	24	22	27.4	18.5	2003	39.9	28.8
Serbia and Montenegro					2003	12.4	15.7
Slovakia	28	18			2003	31.3	28.8
Slovenia			29.5	29.7	2003	24.2	28.8
Spain			23.6	32.3			
Sweden	18	24	11.1	19.0			
Switzerland	25	25	25.4	24.1			
The former Yugoslav Republic of Macedonia			14.6	12.7	2003	15.2	7.3
Turkey					2003	12.9	5.0
Ukraine			44.6	22.8	2004	41.0	22.2
United Kingdom	25	33	21.1	27.9			

Note. Dark grey fields signify a relative increase of more than 10% in smoking prevalence; light grey fields signify a decrease of more than 10% in smoking prevalence between the survey periods 1997/1998 and 2001/2002.

Source: HBSC 1997/1998 *(14)*, HBSC 2001/2002 *(15)* and GYTS 2001–2004 *(21)*.

Gender differences

The prevalence of weekly smoking among 15-year-old girls was higher than that of 15-year-old boys in 18 mainly western European countries of the 28 that implemented the HBSC study in 2001/2002 (Austria, Belgium, Croatia, the Czech Republic, Denmark, Finland, France, Greece,

Ireland, Italy, Malta, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden and the United Kingdom). In Austria, Belgium, Norway, Sweden and the United Kingdom, this difference was even greater than in the late 1990s. In the remaining 10 (mainly eastern European) countries (Estonia, Hungary, Israel, Latvia, Lithuania, Poland, the Russian Federation, Switzerland, The former Yugoslav Republic of Macedonia and Ukraine), smoking prevalence in girls was lower, but in at least half of these 10 countries, it was catching up and, in two countries (Czech Republic and Hungary), even overtaking smoking prevalence in boys. The GYTS data in general confirmed the pattern of higher rates of smoking prevalence among boys than girls in eastern Europe (except in Serbia and Montenegro). Countries for which there were GYTS data include Albania, Armenia, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Greece, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, the Russian Federation, Slovakia, The former Yugoslav Republic of Macedonia, Turkey and Ukraine. The differences in prevalence rates between boys and girls were highest in Armenia, where the prevalence among girls was the lowest (0.5%) whereas among boys it had reached 15.8%. The gender gap is also wide in Georgia, where boys smoked five times more often than girls, the Republic of Moldova (four times), Kyrgyzstan and Turkey (three times) and Albania, Lithuania and Ukraine (twice as often).

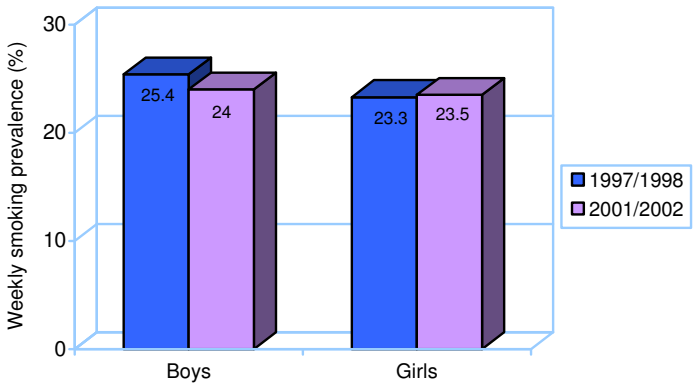
Changes in smoking prevalence

Twenty-one countries implemented the HBSC both in 1997/1998 and 2001/2002.

A comparison of the results from those two surveys shows that weekly smoking prevalence rates in 15-year-old boys decreased in 11 (mostly western European) countries of the 21, increased in 5 countries and remained stable in 4. The picture among 15-year-old girls is quite similar: weekly smoking prevalence rates decreased in 10 out of the 21 countries, increased in 6 and remained stable in 5.

A calculation of the averages from these two HBSC surveys shows that the average weekly smoking prevalence among 15-year-old boys (25.4% and 24.0%) and girls (23.3% and 23.5%) did not change significantly between the two periods (Fig. 8), although a slight downward trend in boys and a slight upward trend in girls can be noticed.

Fig. 8. Weekly smoking prevalence in boys and girls aged 15 years
1997/1998 and 2001/2002



Source: HBSC 1997/1998 (22 countries) *(14)* and 2001/2002 (19 countries) *(15)*.

Age of starting to smoke

The 2001/2002 HBSC showed the average age at which 15-year-old weekly smokers reported smoking their first cigarette, cigar or pipe. Among boys in this age group, the figures ranged from an average age of 10.8 years in Lithuania and 10.9 years in the Czech Republic and Estonia, to an average of 13 years in Greece and 13.2 years in Israel. The corresponding figures for girls ranged from 11.7 years in Austria to 13.6 years in Italy and 13.7 years in Israel and Greece. In most countries, boys generally started to smoke earlier than girls. The largest gender gaps in age of starting to smoke were found in Estonia, Lithuania and Ukraine, where girls started to smoke on average almost two years later than boys.

Socioeconomic differences

Differences between countries

There is growing evidence of strong links between poverty, sustainable development and tobacco use *(23)*. The countries with the lowest gross national product (GNP) per capita, mostly in the eastern part of the European Region, had male smoking prevalence rates of over 50% compared with an average of 34% in wealthier countries. The death rate as a result of smoking among males aged 35–69 years is higher in the countries with the lowest GNP.

Differences within countries

In most European countries, and certainly those where the epidemic has been long established, poor and less educated people are more likely to smoke than the rich and/or better educated. Moreover, smokers are becoming more and more concentrated among the lower socioeconomic groups. This concentration is particularly significant in high-income countries but it is also observed in middle-income countries, notably among men. For example, in 2002, in the EU member states the top two groups in terms of smoking (daily and occasional smokers) were unemployed people (54%) and manual workers (51%) compared with an overall population average of 35% *(24)*. In the United Kingdom in 1998, smoking prevalence among manual workers was in relative terms 49% higher than among non-manual workers; there was no significant change by 2003, when the gap was 48% *(25)*.

In the mid-1970s, approximately 35–40% of male smokers were concentrated in the lower socioeconomic groups. This proportion has now increased to 60–65% in the western countries for which data are available. A similar rising trend is observed for women but at a slower speed.

In 2003, in Ireland 60.4% of male and 59.0% of female smokers were classified as manual workers, unemployed or dependent on the state (together representing around one third of the adult population). By 2005 there had been a slight decrease but the prevalence picture remained almost unchanged: 57.8% among men and 56.2% among women. In France in 2003, the smoking prevalence gap between those with a university degree and those with only a primary education was as high as 60%, while the difference in prevalence between those with the highest and lowest incomes was around 30%. Wider differences were observed in the Nordic countries: in Iceland in 2004, smoking prevalence among those with a university degree was half (10.1%) that of those who had not completed secondary school (21.6%). In Spain in 2003, the difference in smoking prevalence according to professional status was around 44.4% for men and 10.1% for women between the highest and lowest professional groups. Similar trends have been noted in Denmark and Sweden *(21)* and Finland *(26)*.

In the eastern part of the Region, the impact of socioeconomic determinants, particularly the effect of income, is more varied. In the former Soviet Union, higher education was not a guarantee of a higher income and income distribution was substantially more equal than in the west. However, education was important for people's perception of their own social status and commanded high prestige *(27)*. For instance in Armenia, Belarus, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation and Ukraine, smoking prevalence is generally lower among men with a higher education and (very recently) to a certain extent among those economically better off and with stronger social support. For women, with the exception of place of residence, no major factor to explain smoking has been clearly identified. Smoking prevalence among women living in rural areas tends to be lower than among those living in urban areas, which is thought to reflect the stronger marketing and easier availability of cigarettes in urban areas. In the Russian Federation, where smoking prevalence among women is the highest in the CIS, educational achievements also tend to be inversely associated with smoking, although this is not as significant as for men *(28)*.

Cumulative exposure to socioeconomic disadvantages is a known factor for increasing the risk of smoking among men. Recent studies in the western part of the Region suggest that the risk is also important for women, especially young single mothers. For example, studies in the United Kingdom have shown that 46% of women in the group aged 18–49 years who leave school without qualifications are smokers *(24)*. Within this group, of those whose current or last job was semi-skilled or unskilled, 50% are smokers. When the group is further narrowed down to those who are also reliant on social housing, prevalence rises to 67%. When the additional disadvantage of living on means-tested benefits is included, prevalence rises to 73%.

In the United Kingdom, single mothers with dependent children who receive income support have a smoking prevalence of 57% compared with the average of 26%. In Sweden, a similar pattern can be observed among single mothers. Patterns of smoking and inequalities persist among women in pregnancy across Ireland, the Nordic countries and the United Kingdom (countries where data are available). In these countries, cessation rates during pregnancy fall from 70% among women in the most advantaged circumstances to around 40% among women in the poorest circumstances.

Children from less-advantaged families are more exposed to the risks of environmental tobacco smoke than those from more affluent backgrounds because of their parents' smoking habits. In the United Kingdom, for instance, 54% of the children in the lower socioeconomic groups were exposed to tobacco smoke in the home compared with 18% in professional households *(24)*.

Tobacco-related harm

Summary

Since the last *European report on tobacco control policy* was published, the standardized death rate for lung cancer among men in the whole European Region has decreased while there has been a slight increase among the female population. Smoking has been identified as a major contributor to the gap in mortality and healthy life expectancy between those most in need and those most advantaged. Tobacco is the leading contributor to the disease burden in more than half of the European Member States and is among the three leading contributors in the absolute majority of countries.

Burden of disease attributable to tobacco use

The *World health report 2002 (29)* estimated that in the WHO European Region smoking is the second most important risk factor, accounting in 2000 for 12.3% of the total years of life lost due to premature mortality and years lived in disability (DALYs), which equates to about 18.6 million years of life lost (Table 2).

Table 2. Proportion of seven leading risk factors in the burden of DALYs in the WHO European Region, 2000

Risk factor	Total DALYs (%)
1. High blood pressure	12.8
2. Tobacco	12.3
3. Alcohol	10.1
4. High blood cholesterol	8.7
5. Overweight	7.8
6. Low fruit and vegetable intake	4.4
7. Physical inactivity	3.5
Total	59.6

In 2002, tobacco was the leading contributor to the burden of disease in 31 Member States of the European Region (particularly in the western part of the Region), the second in 8 and the third in 6 (Table 3) *(30)*.

Table 3. Rank and proportion of the burden of DALYs attributable to tobacco by country, 2002

Country	Rank	DALYs (%)	Country	Rank	DALYs (%)
Albania	1	9.2	Latvia	3	12.0
Andorra	1	11.2	Lithuania	3	11.5
Armenia	1	12.3	Luxembourg	1	11.3
Austria	1	11.0	Malta	3	9.7
Azerbaijan	2	6.9	Monaco	1	10.4
Belarus	4	11.6	Netherlands	1	16.7
Belgium	1	15.8	Norway	1	11.8
Bosnia and Herzegovina	1	14.7	Poland	1	16.6
Bulgaria	2	12.4	Portugal	2	10.4
Croatia	1	15.8	Republic of Moldova	4	9.7
Cyprus	2	5.6	Romania	2	13.1
Czech Republic	1	15.5	Russian Federation	3	13.4
Denmark	1	17.7	San Marino	1	11.0
Estonia	3	11.9	Serbia and Montenegro	2	15.3
Finland	3	7.7	Slovakia	2	12.2
France	1	12.4	Slovenia	1	13.7
Georgia	4	9.2	Spain	1	12.3
Germany	1	13.7	Sweden	2	8.0
Greece	1	12.9	Switzerland	1	10.7
Hungary	1	20.9	Tajikistan	8	2.3
Iceland	1	12.6	The former Yugoslav Republic of Macedonia	1	11.1
Ireland	1	11.8	Turkey	1	7.0
Israel	1	6.1	Turkmenistan	5	5.1
Italy	1	12.0	Ukraine	3	12.8
Kazakhstan	1	13.4	United Kingdom	1	14.2
Kyrgyzstan	1	6.6	Uzbekistan	7	3.1

Tobacco-related mortality

The *World health report 2002* estimated that throughout the European Region tobacco was the leading risk factor for premature mortality, causing about 1.6 million deaths *(29)*.

Current status

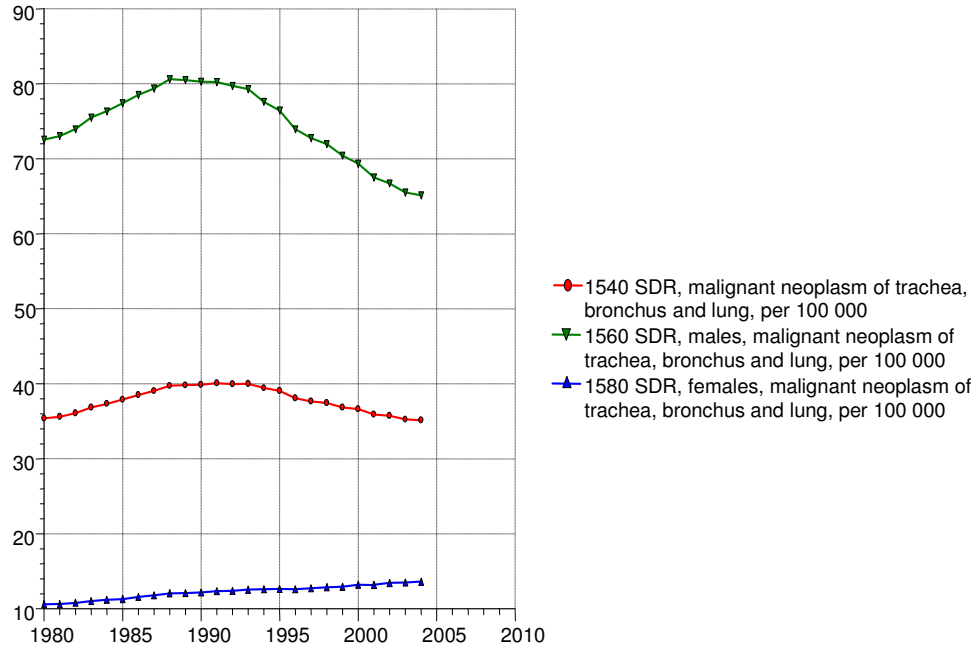
Changes in mortality from cancer of the trachea, bronchus and lung may be used as a marker of past trends in a population's exposure to tobacco smoke. Standardized death rates for all ages per 100 000 have been used to illustrate trends across the Region as well as trends for the male and female populations *(13)*.

After a peak in mortality in the late 1980s and early 1990s, death rates have been falling throughout the Region although to a different extent in the various areas. According to the most recent available data (2004), the average mortality rate for the whole Region was 35.2 per 100 000 inhabitants *(13)*.

Gender differences

In the Region, overall mortality rates from cancer of the trachea, bronchus and lung are generally much lower among women than among men. For example in 2004, the female standardized death rate was 13.8 per 100 000, as compared to 65 per 100 000 in the male population *(13)*. The Region has been experiencing a favourable trend of falling death rates from these cancers in the male population since the early 1990s (Fig. 9).

Fig. 9. Standardized death rates (SDRs) per 100 000 inhabitants, cancer of the trachea, bronchus and lung, all ages, males and females, from 1980

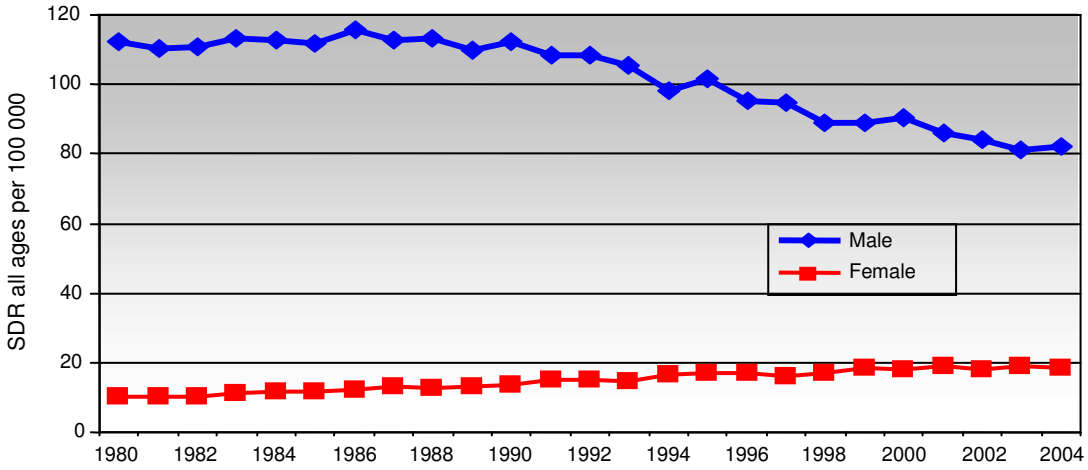


Source: WHO European HFA database, 2006 *(13)*.

Considering the time lag between smoking behaviour and manifestation of disease and the relatively recent development of the tobacco epidemic among women, it is of grave concern that mortality from cancer of the trachea, bronchus and lung in the female population is steadily rising in the Region (Fig. 9).

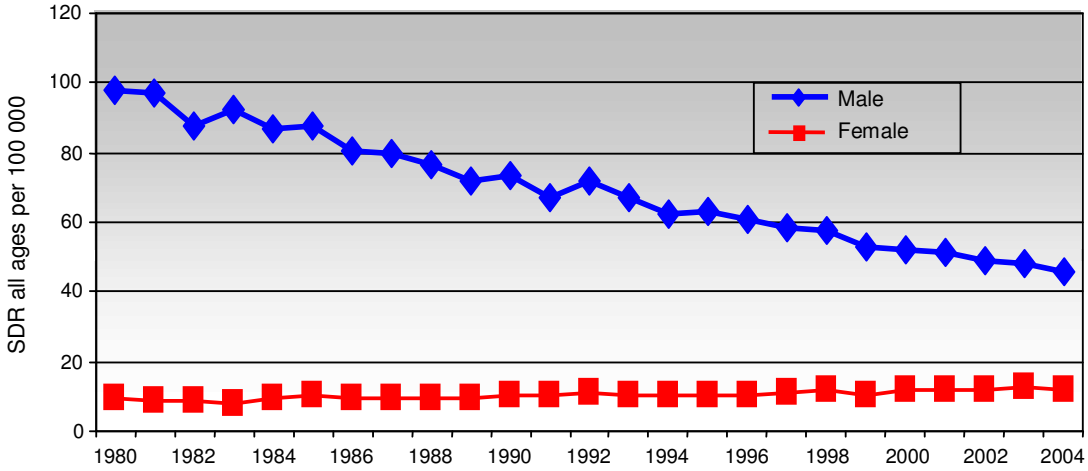
Falling death rates due to trachea, bronchus and lung cancer in the male population of the WHO European Region since the mid-1990s imply that trends in smoking prevalence among men have been curbed in many countries since at least the early 1980s. Female mortality trends, although rising at different rates in the Region, in general reflect increasing smoking prevalence rates among women since at least the early 1980s. Four countries (the Czech Republic, Finland, the Netherlands and the United Kingdom) have been selected to demonstrate the different male and female mortality trends (Fig. 10–13).

Fig. 10. Standardized death rates (SDRs) per 100 000 inhabitants, cancer of the trachea, bronchus and lung, all ages, male and female, Czech Republic, 2005



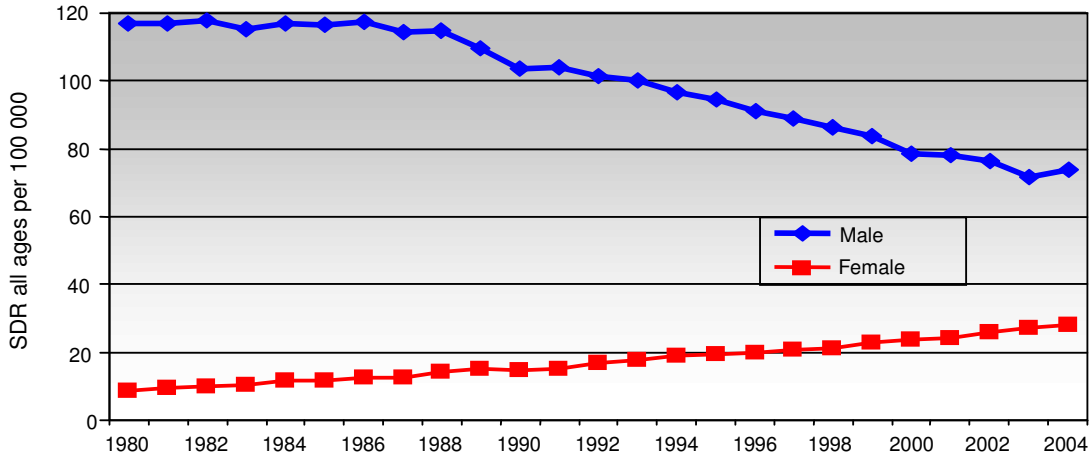
Source: WHO European HFA database, 2005 *(13)*.

Fig. 11. Standardized death rates (SDRs) per 100 000 inhabitants, cancer of the trachea, bronchus and lung, all ages, male and female, Finland, 2005



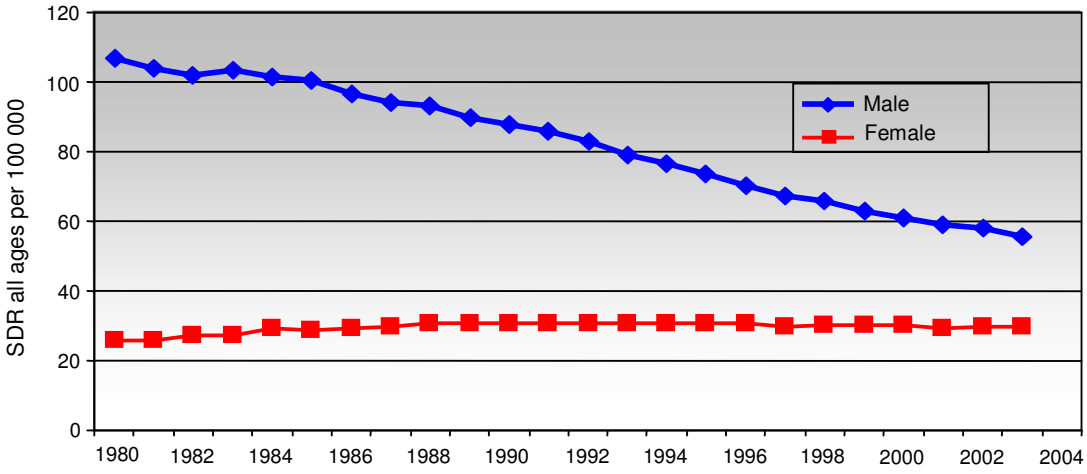
Source: WHO European HFA database, 2005 *(13)*.

Fig. 12. Standardized death rates (SDRs) per 100 000 inhabitants,
cancer of the trachea, bronchus and lung, all ages, male and female, Netherlands, 2005



Source: WHO European HFA database, 2005 *(13).*

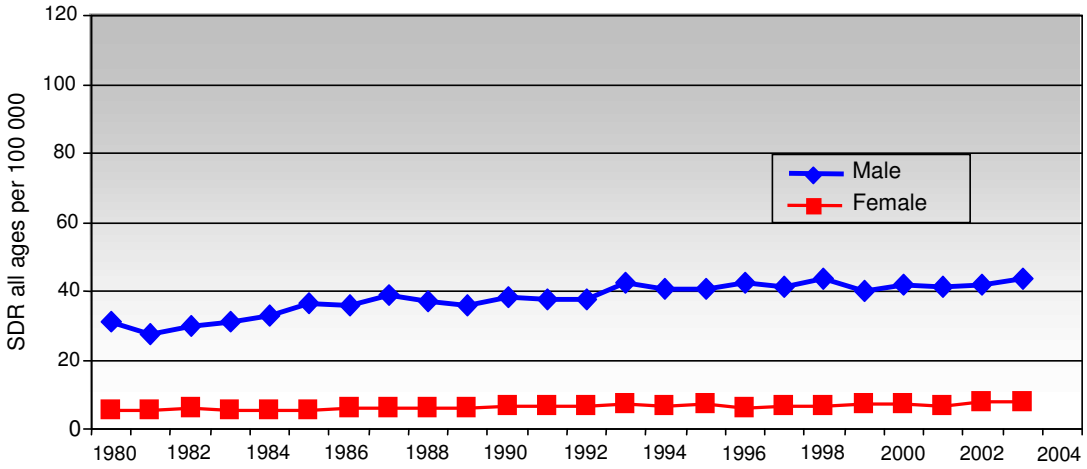
Fig. 13. Standardized death rates (SDRs) per 100 000 inhabitants,
cancer of the trachea, bronchus and lung, all ages, male and female, United Kingdom, 2005



Source: WHO European HFA database, 2005 *(13).*

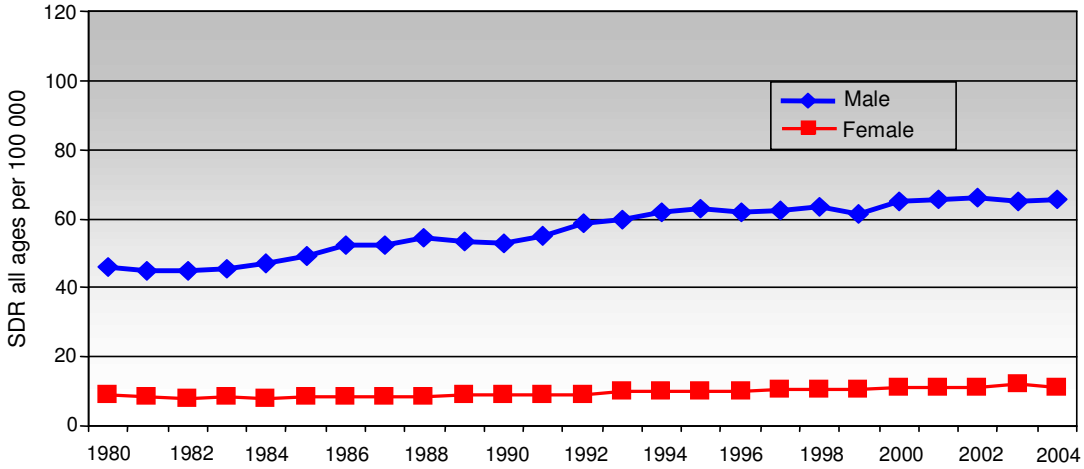
In other European countries, for example Portugal and Romania, both male and female death rates from cancer of the trachea, bronchus and lung per 100 000 are rising. In these countries, the population's exposure to smoking is either still rising among women as well as men, or has merely fallen very recently, and because of the time lag between smoking and morbidity and mortality rates, lower mortality rates (Fig. 14,15) which reflect smoking behaviour have not yet become apparent.

Fig. 14. Standardized death rates (SDRs) per 100 000 inhabitants,
cancer of the trachea, bronchus and lung, all ages, male and female, Portugal, 2005



Source: WHO European HFA database, 2005 *(13).*

Fig. 15. Standardized death rates (SDRs) per 100 000 inhabitants,
cancer of the trachea, bronchus and lung, all ages, male and female, Romania, 2005



Source: WHO European HFA database, 2005 *(13).*

Socioeconomic differences in mortality

In all countries with available data, the rates of premature mortality, particularly among men, are higher among those with lower levels of education or income. Smoking has been identified as a major contributory factor to the gap in mortality and also in healthy life expectancy between those most in need and those most advantaged. Data from France, Poland and the United Kingdom show that smoking is responsible for more than half of the difference in adult male mortality between those with the highest and lowest socioeconomic status. In the United Kingdom, premature deaths from lung cancer are five times higher among men in unskilled manual work compared with those in professional work *(24)*. Comparable figures are available in France and Poland (for males aged 20–44 years). Similar gaps according to education level

have recently been reported in Finland (Helsinki), Norway (Oslo) and the Russian Federation (Moscow and St Petersburg), with the differences widening noticeably after about 1990 in the two Russian cities *(31)*.

Among men, the concentration of smoking in the lower socioeconomic groups observed throughout the Region is leading to a widening gap in future health outcomes. As underlined during the EU Presidency Summit on Tackling Health Inequalities (London 17–18 October 2005), no significant reduction in the socioeconomic gradient has been observed in countries where the prevalence has been reduced. Although the absolute number of people exposed to socioeconomic disadvantages could be diminishing in some countries, the persisting relative gap emphasizes the need for the Region to move beyond general tobacco control policies to tackle the different social and economic factors related to smoking *(32)*.

Tobacco-related costs

The estimates of health care costs related to smoking cited in World Bank publications range from 0.1% to 1.1% of the gross domestic product (GDP) *(33)*. Studies recently conducted in the WHO European Region suggest that these costs could be even higher. The direct and indirect costs of smoking in the EU were estimated to range from €97.7 to 130.3 billion in 2000, corresponding to between 1.04% and 1.39% of the EU GDP *(17)*. Available data show that the costs are more substantial in the new EU member states, where the burden of disease and the death rates related to smoking are higher. For example, studies in Hungary concluded that the cost of smoking represented 2.7% to 3.2% of GDP in 1996 and 1998, respectively, while in Finland and France the estimated costs were between 1.1% and 1.3% of GDP *(30)*. In Sweden it was estimated that the total costs arising from health care and productivity losses for smoking were SKr 26 billion in 2001 – compared with the national contribution to international aid (21 billion) or to the functioning of the judicial institutions (23 billion) *(34)*.

PART 2

TOBACCO CONTROL POLICIES

Measures to reduce the demand for tobacco products

Price and taxation policies

Summary

On average, the price of tobacco products rose by an annual 6.8% above inflation between 2001 and 2005 in the EU countries – good progress when compared to the previous annual rate of increase of 2.7%. The trend is not promising in the CIS and SEE countries, however, as in many countries tobacco products became cheaper over this period. According to the information available for 35 countries,[4] tobacco products became less affordable in 13 countries but more affordable in 20 countries.

No major convergence of the price and tax burden on cigarettes, fine-cut tobacco, pipe tobacco and cigars has been achieved in the Region. In the EU, hand-rolled cigarettes are still half the price or less than manufactured products, despite tax increases. There is no major initiative to harmonize taxation of tobacco products in the other WHO European Member States, although a recent trend towards harmonization with the EU framework has been observed in some SEE countries, and some coordination (albeit limited to the taxation of imported tobacco products) is due to be introduced in the CIS.

Most countries still do not earmark tobacco taxes for tobacco control or for public health in general.

Background

Raising taxes on tobacco products is considered to be one of the most effective components of a comprehensive tobacco control strategy *(35,36)*.

The ESTC recommended that strategic national action should include:

- *maintaining high prices and taxes for tobacco products;*
- *raising taxes in order to bring the price of tobacco products above the average rates of inflation and income growth, to ensure their constantly decreasing affordability;*
- *prohibiting all tax-free and duty-free sales of tobacco products;*
- *allocating and sustaining a significant part of government revenues, including those from tobacco taxes, to funding national tobacco control programmes;*
- *harmonizing taxation and prices of all tobacco products to discourage the substitution of one tobacco product by another.*

Different objectives were suggested for Member States in 2002 according to their progress with tobacco control:

- *countries that had relied mainly on the impact of legislation and information should make public health concerns the explicit cornerstone for sustained and regular increases in tobacco taxes;*

[4] Armenia, Azerbaijan, Austria, Belgium, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, Slovakia, Slovenia, Spain, Sweden and the United Kingdom.

- *countries that had developed a set of comprehensive measures and multisectoral strategies should above all sustain the progress made in terms of tax increases, and to engage in internal cooperation in particular for coordinating taxation policies and combating counterfeiting, smuggling and cross-border sales.*

Price and tax variations

The price variation indicator is expected to reflect tax variations, since an increase in the price of tobacco products mainly results from an increase in taxes. In order to take into account the impact of inflation, a real annual price variation was calculated by taking the annual percentage difference of the tobacco products price index and discounting inflation measured by the annual percentage difference of the general consumer price index (excluding tobacco products, when possible). Table 4 presents the data for the countries where information was available.

Table 4. Annual price variation of tobacco products in real terms (%), 1997–2005

Country	31.12.1997–31.12.2001	31.12.2001–31.12.2005	Countries	31.12.1997–31.12.2001	31.12.2001–31.12.2005
Albania	-2.1	-0.4	Italy	+0.9	+6.1
Armenia	+14	-5.4[a]	Kyrgyzstan	- 0.2	- 2.6[a]
Austria	+1.5	+2.4	Latvia	+1.9	+5.3
Azerbaijan	-8.9	-2.4[a]	Lithuania	–	+7.9
Belgium	+1.6	+3.5	Luxembourg	+1.6	+1.8
Bulgaria	-2.1	+21	Malta	–	+7.9
Croatia	–	+1.4	Netherlands	+2.6	+6.3
Cyprus	+5.8	+14.8	Norway	+7.3	+7.6
Czech Republic	0	0	Poland	+4.3	+1.9
Denmark	-1.1	-3.2	Portugal	+1.8	+2.8
Estonia	+5.3	+5.5	Republic of Moldova	+3.5	-3.8
Finland	+0.7	-1.1	Romania	–	+ 2.9
France	+3.8	+13.1	Russian Federation	–	- 6.2[a]
Germany	+1.6	+11	Slovakia	+1.6	+10.7
Greece	+3.1	+1.5	Slovenia	0	+9.3
Hungary	+0.5	+11.8	Spain	+4.7	+2.3
Iceland	+4.8	+5.7	Sweden	+2.9	+0.7
Ireland	+3.2	+4.1	United Kingdom	+7.2	+0.3
Israel	+4.1	+5.2			

[a] Until June 2005 instead of December 2005.
Source: Data provided by national counterparts.

On average, from 2001 to 2005 the price of tobacco products rose by an annual rate of 6.8% above inflation in the EU countries *(37)*, which was good progress when compared to the previous annual rate of increase of 2.7% observed in the same group of countries during the period 1997–2001. Cyprus, France,[5] Germany, Hungary, Lithuania and Slovakia managed a greater increase. However, real prices increased by less than 3% annually in Austria, Greece, Luxembourg, Poland, Spain and the United Kingdom over the same period. Prices were almost stable in Sweden and even fell in Denmark and Finland. The prices of cigarettes and rolling tobacco followed similar trends. In the CIS and SEE countries (apart from Bulgaria) there was an unpromising trend towards cheaper tobacco products (Table 4) *(38)*.

[5] At the end of 2003 the French Government signed an agreement with licensed tobacconists freezing the taxation of tobacco products until late 2007.

In the EU countries where excise duties are over 57% of the retail price and total taxes often exceed 75% when value-added tax (VAT) is included (Table 5), taxes and prices have followed parallel trends. With prices and taxes being in general proportional to each other, the increases/decreases in the retail price of tobacco were higher when the tax increases/decreases were the highest.

Table 5. Structure of taxation for tobacco products (%), 2005[a]

Country	Specific excise	Ad valorem excise	Total excise	VAT	Total tax
Albania	41.70	–	41.70	16.7	58.3
Austria	15.70	43	58.70	16.67	75.37
Belgium	3.87	53.76	57.63	17.36	74.99
Bosnia and Herzegovina	49.0	–	49.0	16.7	67.7
Bulgaria (filtered cigarettes)	15.93	31.80	47.73	16.67	64.4
Croatia (2003)	n.a	n.a	49.1	18.0	67.1
Cyprus	14.55	44.50	59.05	13.04	72.09
Czech Republic	27.27	24.00	51.27	15.97	67.24
Denmark	41.07	13.61	54.68	20.00	74.68
Estonia	28.05	26.00	54.05	15.25	69.30
Finland	7.38	50.00	57.38	18.03	75.41
France	6.03	57.97	64.00	16.39	80.39
Germany	37.00	25.29	62.29	13.79	76.08
Greece	3.67	53.83	57.5	15.97	73.47
Hungary	31.27	27.00	58.27	16.67	74.94
Ireland	42.01	18.32	60.33	17.36	77.69
Italy	3.75	54.74	58.49	16.67	75.16
Latvia	34.50	14.80	49.35	15.25	64.60
Lithuania	25.33	15.00	40.33	15.25	55.59
Luxembourg	9.88	47.14	57.02	13.04	70.06
Malta	9.42	51.40	60.82	15.25	76.07
Netherlands	36.53	20.56	57.09	15.97	73.06
Norway	56.1	–	56.1	20.0	76.10
Poland	25.68	31.30	56.98	18.03	75.01
Portugal	38.04	23.00	61.04	17.36	78.40
Republic of Moldova	7.7	–	7.7	16.7	24.4
Romania	22.72	30.00	52.72	19.00	71.72
Russian Federation	n.a	n.a	8 to 20		n.a
Serbia and Montenegro (Montenegro)	10.0	26.0	36.0	20.0	56.0
Slovakia	31.43	23. 00	54.43	15.97	70.39
Slovenia	14.84	42.71	57.55	16.67	74.22
Spain	7.29	57.00	64.29	13.79	78.08
Sweden	10.00	39.20	49.20	20	69.20
Switzerland[b]	29.7	25.0	54.7	7.06	62.6
United Kingdom	40.89	22	62.89	14.89	77.79
Uzbekistan (2003)	–	45.0	45.0	17.0	62.0

[a] The tax structure is presented as a percentage of the retail selling price, all taxes included. For the EU countries the structure has been updated as at 1 January 2006 *(39)*.
[b] Includes 0.87% for the Growers' Prevention Fund.

The relationship between tax and price is more variable in the CIS and south-eastern Europe. In countries where the total amount of taxes was below 50%, significant increases in excise duty observed since 2002 have often been counterbalanced by a cut in price by the tobacco industry. For example, in the Russian Federation, despite tax increases of 70% in 2003–2004 and 75% more recently, cigarettes are actually cheaper than in 2002. According to the Ministry of

Finance, since the excise is tied to the release price rather than to the retail price, cigarette manufacturers have been lowering their release prices from between 5% and 35%.

Affordability[6]

Real price increases do not necessarily mean that tobacco products are becoming less affordable. Variations in income also have to be taken into account. Fig. 16 presents information on the affordability of tobacco products. In order to take account of variations in income level, the real price index of tobacco products has been discounted by the changes in income estimated according to variations in gross domestic product per capita calculated at a constant price by the United Nations Development Programme *(40)*.

In general, in countries where annual price increases were above 5% the domestic affordability of tobacco products has declined. Information available for 35 countries shows that although affordability declined in 13 (particularly in Cyprus, France, Israel, Kyrgyzstan, Malta, Norway Slovakia and Slovenia) it increased in 20 countries: Armenia, Azerbaijan, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, Greece, Hungary, Ireland, Latvia, Lithuania, Luxembourg, Poland, Portugal, Romania, Russian Federation, Spain and the United Kingdom (Fig. 16).

The level of affordability has important implications for governments who should adjust their taxation policies on tobacco products according to inflation but also in accordance with increases in income.

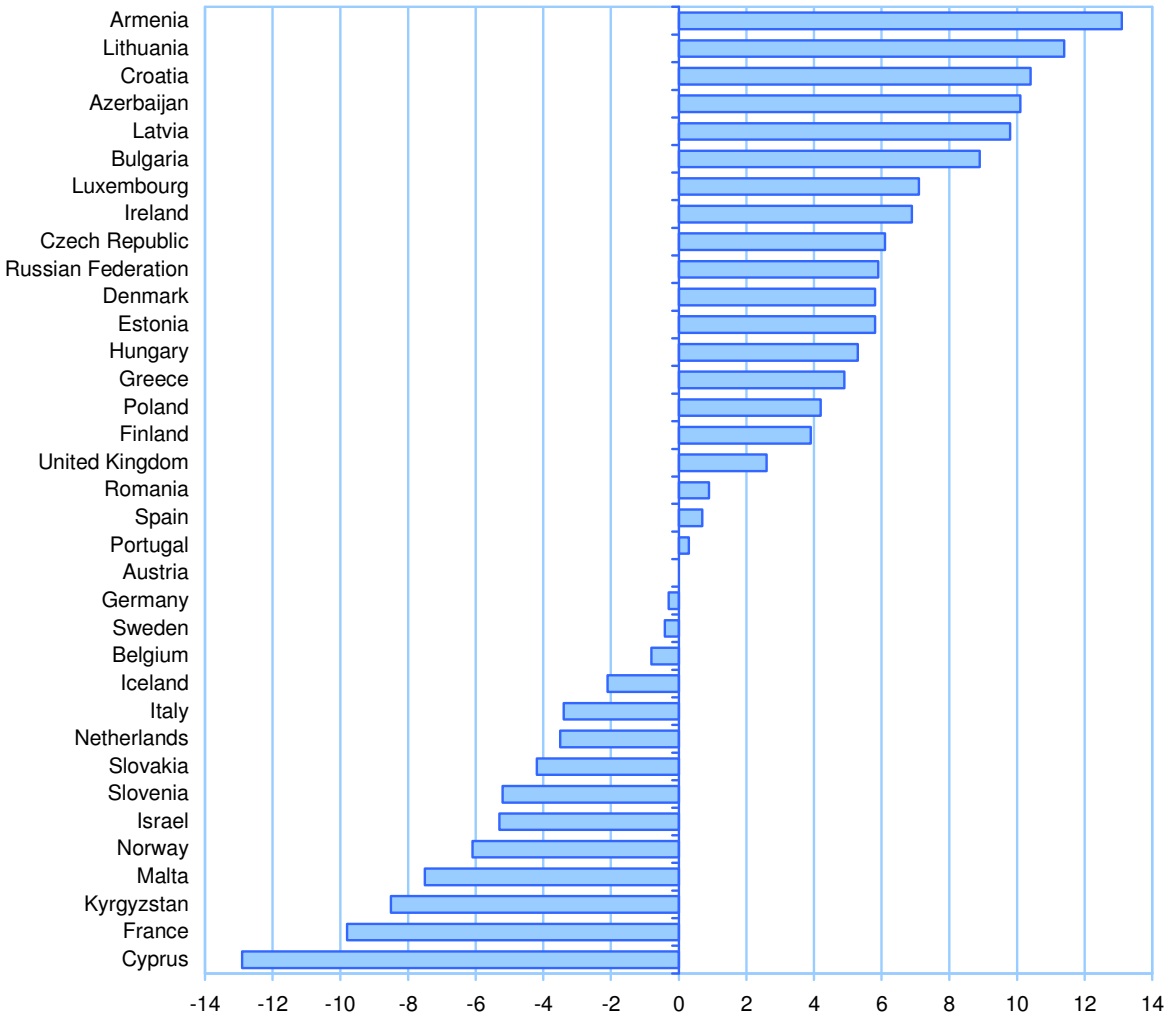
Tax-free and duty-free sales of tobacco products, movement of duty-paid products

Since 2002, no countries have prohibited all tax-free and duty-free sales of tobacco products. In the EU private individuals are still free to purchase tobacco products for their own use in any EU country of their choice and to transport them personally to another EU member state without paying duty again and with almost no limit on quantity. Although all the original 15 EU member states that share borders with the new member states do restrict quantities, cross-border shopping has not diminished as the new member states still have low levels of taxation. Between the new EU member states and some bordering countries such as Belarus, the Russian Federation (Kaliningrad) and Ukraine, cross-border shopping has increased.

In order to reduce this shopping, most EU member states have been granted a derogation to apply the same quantitative limits on tobacco products brought into their territories from the new EU member states as those applied to imports from third countries.

[6] Since data are not consistently available, the changes in tobacco affordability are limited to 2001–2003. Some new EU member states substantially increased their duties on tobacco in 2004 and 2005, so conclusions drawn on the basis of data from 2001 and 2003 should be treated with caution.

Fig. 16. Affordability: average annual change in relative income price of tobacco products, 2001–2003



Source: WHO Tobacco Free Initiative.

Earmarking of tobacco tax revenues for funding national tobacco control programmes

According to the available data, 12 countries (Austria, Estonia, Finland, France, Greece, Iceland, Poland, the United Kingdom and, since 2002, Belarus, Romania and Switzerland) have introduced an earmarking tobacco tax mechanism. Serbia and Montenegro (Serbia) introduced an earmarking mechanism in 2005. Bulgaria was expected to do so in 2006. The countries that use such funds for tobacco control and health promotion are Poland, Finland and Iceland (which earmark 0.5%, 0.75% and 0.9% of tobacco taxes, respectively), Serbia and Montenegro (Serbia) (which earmarks 1 csd per pack of cigarettes to preventive action) and Switzerland (which earmarks 2.6 Swiss cents per pack of cigarettes). Romania uses the funds to finance health promotion activities, including those in tobacco control areas such as awareness-raising campaigns, the Quitline, and training in and treatment for smoking cessation.

Harmonization of taxation and prices of tobacco products

In the EU since 2002, the regime for cigarette taxation established in 1972 has been modified in accordance with Directive 2002/10/EC *(41)*. In addition to the 57% minimum excise incidence rule, which failed to achieve significant convergence in tax levels, new rules were established requiring a minimum excise burden of €95 per 1000 cigarettes, which meant either applying a specific regime or the former regime of 57% rate plus a specific excise of €60 per 1000 cigarettes (€64 from July 2006 onwards).

At present almost all EU countries comply with this new regime. The Czech Republic, Greece, Slovenia and Spain have, however, negotiated a transition period up to 31 December 2007; Hungary, Poland and Slovakia until 31 December 2008, and Estonia, Latvia and Lithuania until 31 December 2009. Italy, Luxembourg, the Netherlands and Portugal are temporarily operating below the minimum burden.

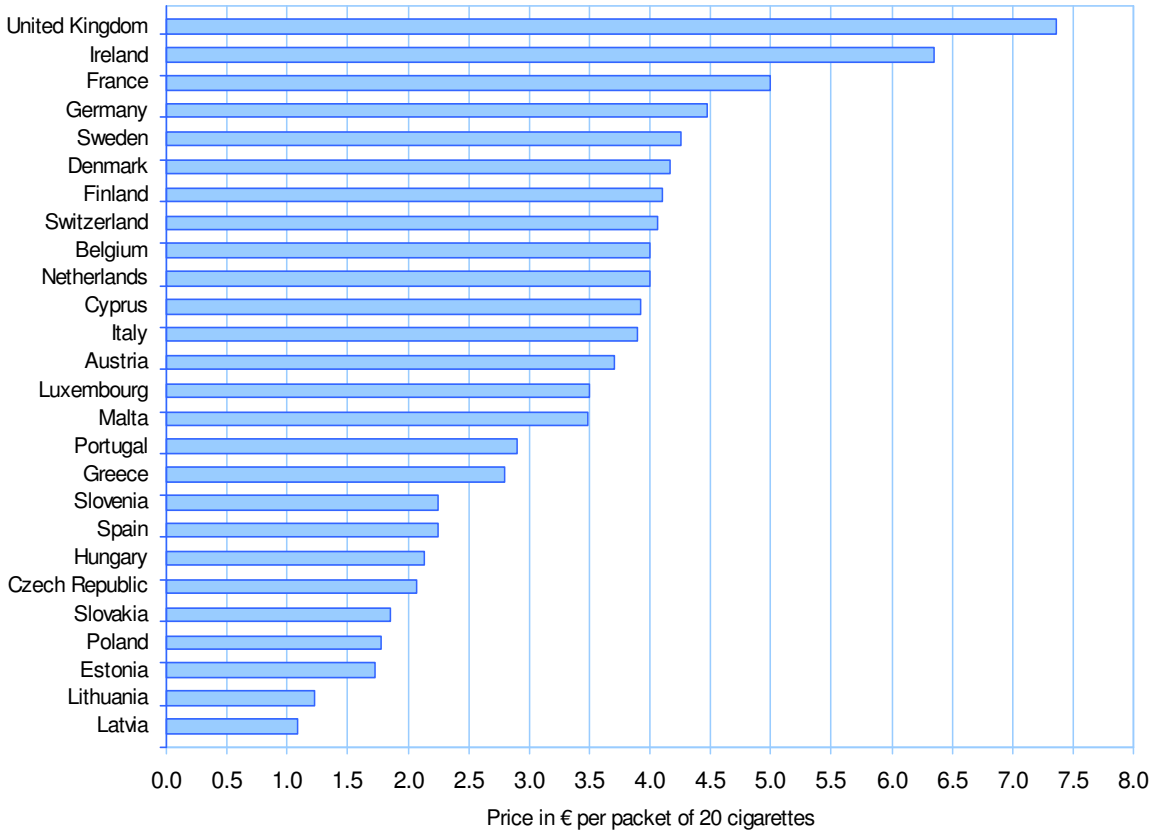
In order to increase convergence between the minimum rates of tax on cigarettes and other tobacco products, Directive 2002/10/EC has also gradually increased the minimum percentage rates for rolling tobacco from 30% to 39.36% and the minimum specific amount from €25 to €32 per kg as from1 July 2004. A minimum excise rate for cigars of 5% of the retail selling price inclusive of all taxes or €11 per 1000 items or per kg was also introduced. The minimum excise rate for pipe tobacco was adjusted for inflation to 20% of the retail selling price or €20 per kg (the Czech Republic and Estonia have derogations). Despite these increases, hand-rolled cigarettes are still half or less than half the price of manufactured products. This is far from the 33.33% difference envisaged in 2002 by most member states. On average, the total tax yield on hand-rolling tobacco is actually approximately 44% of the average total tax yield on cigarettes.

Such a difference has been used by the German tobacco industry when introducing, in response to the 2003 tax increases, new cheap cigarettes presented as “tobacco sticks” (roll “make your own” tobacco) in order to benefit from the lower tax on loose tobacco (tobacco sticks cost on average 20% less than usual cigarettes). Between 2003 and the end of 2005, sales of singles or sticks accounted for almost one fifth of the cigarette market with a consequent reduction in the impact of tax increases on smoking prevalence. On 10 November 2005 the European Court of Justice ruled that this initiative by the German tobacco industry was illegal and classified tobacco sticks as cigarettes *(42)*.

Although Directive 2002/10/EC has had a visible impact on increases in excise taxes on cigarettes, fine-cut tobacco, pipe tobacco and cigars in the 10 acceding countries (which had the lowest rates in 2002), it has not resulted in a major convergence in the price and tax burden between the 25 EU member states. In terms of purchasing power parity (PPP), the difference between the most popular price cigarette in the United Kingdom and Lithuania is 4 : 1, greater than the difference observed between the United Kingdom and Spain (3 : 1) before the 2004 enlargement (Fig. 17). The difference in the tax burden expressed in PPP is even higher, €230 per 1000 cigarettes in the United Kingdom compared to less than €25 in Latvia and Lithuania (Fig. 18).

As stipulated by Directive 2002/10/EC, a review of the structure and rates of excise duty on tobacco products is under way and a proposal for revision will be put forward no later than 31 December 2006. The proposal should reflect the wider objectives of the Treaty related to public health considerations (Art. 152) and the provisions following the ratification of the WHO FCTC. Unfortunately, owing to the length of the negotiated transition periods, no major convergence and price increases could realistically be expected before 31 December 2009.

Fig. 17. Retail sale price of the most popular price cigarettes (pack of 20) in the European Union, January 2005



Source: Confédération des Débitants de Tabac de France, 2006 (www.lelosange.fr/confe/article.php?id_article=7, accessed 11 September 2006).

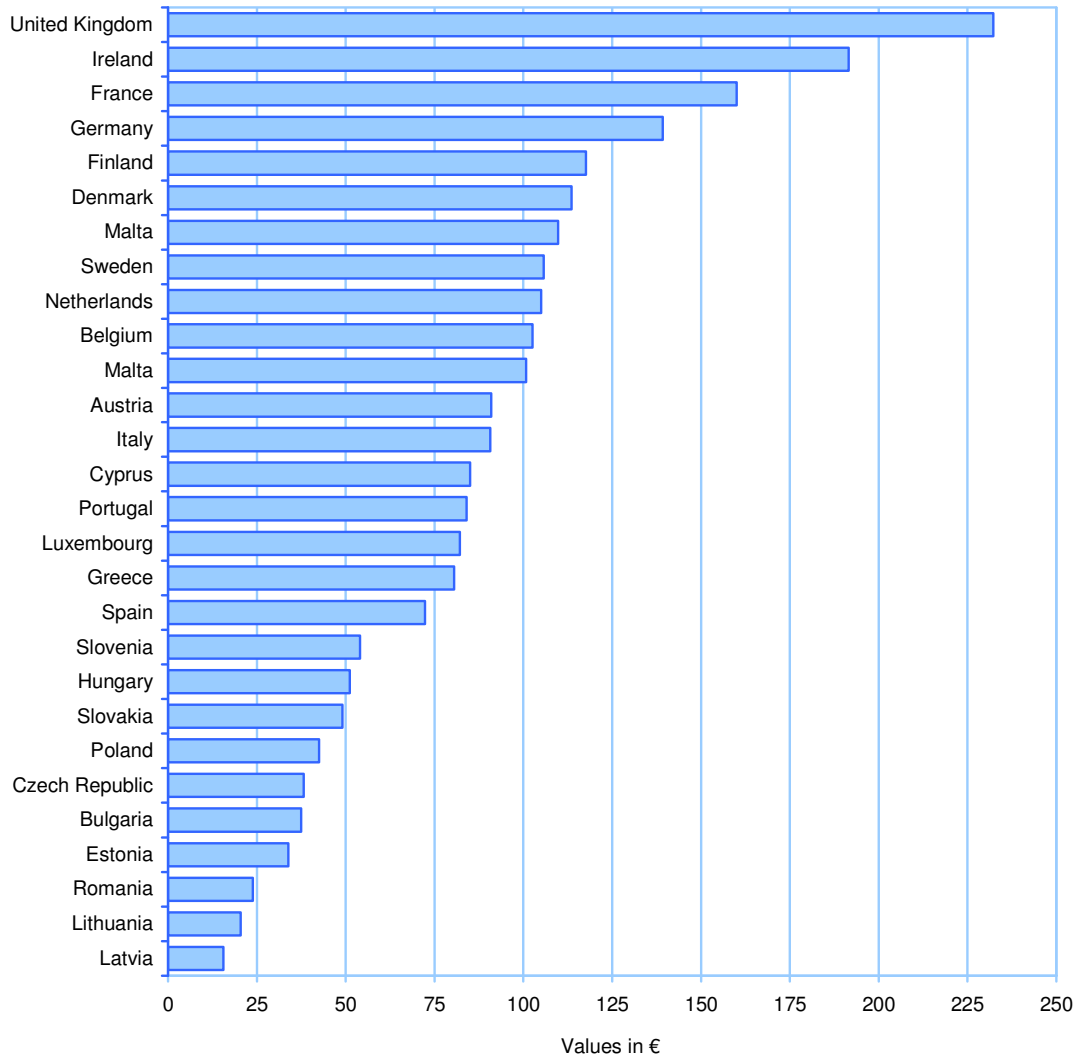
In the other WHO European Member States (apart from Bulgaria and Romania, which have tax regimes similar to the EU) no major initiative has been developed to harmonize the taxation of tobacco products. A study of the price level indices carried out in some SEE countries (Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro and The former Yugoslav Republic of Macedonia) during 2003 showed that tobacco products were relatively cheaper in these countries than they were in the EU taken as a whole *(43)*. There has recently been a trend towards harmonization with the EU framework observed in those countries, and the CIS countries are due to start coordinating the taxation of imported tobacco products.

Exposure to tobacco smoke (passive smoking, environmental tobacco smoke)

Summary

The regulation of smoking in public places has become more restrictive in the WHO European Region. On 29 March 2004 a major development occurred in Ireland when smoking bans in public places were extended for the first time in the Region to pubs, bars and restaurants as well as all workplaces. Since then, legislation banning smoking in all indoor premises, including bars and restaurants, has been passed in Italy, Malta, Norway, Spain, Sweden and the United Kingdom.

Fig. 18. Tax burden on cigarettes in € per 1000 cigarettes, 3 October 2005



Note. Malta appears twice in Fig. 18 because the excise tax structure is 51.4% of the retail price + Lm 7.30 per 1000 cigarettes but not less than Lm 43.30 (or €100.84) per 1000 cigarettes.
Source: Excise duty tables. Part III – Manufactured tobacco. Brussels, European Commission, 2006 (ref 1.022) (www//europe.eu.int/comm./taxation_customs/, accessed 2 December 2006).

Since 2002, a number of Member States (mainly in the EU) have introduced bans on smoking in health care, educational and government facilities and in indoor workplaces and offices. A smaller number of Member States, mainly in the eastern part of the Region, have introduced or reinforced restrictions in the same settings. In particular, a large majority of countries (70%) have enforced bans – complete or with completely separated rooms – on smoking in health care and educational facilities. Smoking in government facilities, workplaces and cultural institutions is also banned in a smaller number of countries (60%). Since 2002, 14 Member States have passed complete bans on smoking in taxis, 13 in trains and 12 in buses. Five Member States, mostly in the eastern part of the Region, have introduced partial restrictions in some settings, particularly on trains. By the end of 2005, 80% of the countries had enforced a ban on smoking in buses, 70% in taxis but fewer than 50% on trains.

Background

The accumulation of evidence on the risks and health consequences of involuntary exposure to environmental tobacco smoke emphasizes the need for stronger regulation to protect nonsmokers, particularly children. There is also evidence that smoke-free legislation will help current smokers to stop smoking and reduce the average consumption of tobacco by those that continue to smoke *(44)*.

The ESTC recommended that strategic national action should include:

- *introducing or strengthening legislation to make all public places smoke-free, including public transport and workplaces;*
- *banning smoking indoors and outdoors in all educational institutions and their premises for children up to the age of 18 years, and indoors in all other educational institutions;*
- *banning smoking in all places of health care delivery and their indoor and outdoor premises;*
- *banning smoking at all public events arranged indoors and outdoors;*
- *banning or severely restricting smoking in restaurants and bars, to protect owners, employees and clients from serious damage to their health;*
- *classifying environmental tobacco smoke as a carcinogen to protect the rights of workers (nonsmokers and smokers), particularly those working in smoking environments, and to speed up the banning of smoking in all workplaces.*

It was also suggested that Member States review and strengthen the mechanisms for enforcing their legislation and increase compliance through comprehensive information campaigns and litigation.

Restrictions on smoking in public places

Smoking is increasingly being regulated in public places in the WHO European Region. This trend has moved from restrictions on smoking in specific institutions, such as schools and hospitals, to separating smokers and nonsmokers in a larger number of places and finally to legislation banning or restricting smoking in public places, including workplaces. The main reasons for these developments are the increasing evidence about the risks of environmental tobacco smoke and growing public support among both smokers and nonsmokers for regulation *(45)*. In general, public support increases after such bans. In Norway, for instance, public support increased from 54% before the introduction of new legislation banning smoking in bars and restaurants to 76% 16 months after it entered into force *(46)*.

The first session of the Conference of the Parties to the WHO FCTC that was held in Geneva from 6 to 17 February 2006 decided, among other things, to start developing guidelines for protection from exposure to tobacco smoke (Article 8 of the WHO FCTC). These guidelines, or at least a progress report, should be presented to the second Conference of the Parties planned for the first half of 2007.

A large majority (70%) of countries in the WHO European Region had enforced bans (absolute or in physically separated rooms) on smoking in health care and educational facilities. Smoking in government facilities, workplaces and cultural institutions was also banned in a smaller number of countries (60%).

For a long time, throughout the Region an exception to smoke-free legislation was made for the hospitality sector, for which a large majority of countries had either provided for the establishment of areas for nonsmokers or else not restricted smoking in restaurants and bars at all. On 29 March 2004, a major development occurred in Ireland when smoking bans were extended for the first time in the European Region to pubs, bars and restaurants. On 1 June 2004, Norway became the second country in Europe to impose a countrywide ban on smoking in all public places, including all restaurants and bars.

By October 2006, seven countries (Ireland, Italy, Malta, Norway, Spain, Sweden and the United Kingdom (Scotland)) had introduced smoke-free bars and restaurants and more countries were planning to do so. The legislation varies in its comprehensiveness. The most comprehensive European smoke-free legislation has been introduced in Ireland and the United Kingdom (Scotland), where smoking in workplaces, including bars and restaurants, is prohibited although hotel rooms, prisons and psychiatric hospitals which are considered personal accommodation are exempted. Norwegian smoke-free legislation provides the same protection in bars and restaurants as in Ireland but is less strict in other workplaces, where designated smoking-rooms are allowed. Italian, Maltese and Swedish legislation provides for smoke-free workplaces, including bars and restaurants, but permits the possibility of designated closed and ventilated smoking-rooms. A complete ban on smoking at the workplace, excluding bars and restaurants and with the possibility of designated and ventilated smoking-rooms, has recently been implemented in Belgium, the Netherlands and Spain.[7] A smoking ban in restaurants with designated closed and ventilated smoking-rooms will come into force in 2007 in Belgium and Estonia and a total ban, like that in Ireland and Scotland, will come into force in Lithuania and the other parts of the United Kingdom in 2007. In Denmark, Finland,[8] the Netherlands, Portugal and Slovenia, continuing political and public debates could pave the way for future bans on smoking in the hospitality sector; the French law in this respect will come into force in 2008. Moreover 14 countries, particularly in the eastern part of the Region, have introduced stronger restrictions.

In 2006, Finland and Germany are still the only European countries to classify environmental tobacco smoke as carcinogenic.

Developments in legislation and restrictions on smoking in public places are summarized in Table 6.[9] A ban provides effective protection from environmental tobacco smoke by imposing a total ban on smoking. In some countries the term “ban” is used although smoking may be permitted in physically separated areas rather than totally banned. These are explained by a footnote in the case of countries for which information was available.

[7] In Spain the ban in the hospitality sector is only partial since bars and restaurants under 100 m^2 are exempt, although in venues larger than 100m^2 a total ban applies unless physically separated areas for smoking are established.

[8] The amendment of the tobacco law regarding smoking bans in pubs and restaurants is going through the Finnish Parliament. The amendment will allow for the voluntary designation of smoking-rooms.

[9] In Table 6 and the relevant calculations, Serbia and Montenegro have been counted as two Member States so as to reflect the position in October 2006, even though the legislation was enacted before they separated.

Table 6. Regulation of smoking in public places, October 2006

Country	Health care facilities	Educational facilities	Government facilities	Restaurants	Pubs and bars	Indoor workplaces and offices	Theatres and cinemas
Albania	Voluntary agreement	Voluntary agreement	Voluntary agreement	No restriction	No restriction	Voluntary agreement	Voluntary agreement
Andorra	Ban	Ban	Ban	No restriction	No restriction	No restriction	Ban
Armenia	Ban	Ban	Restriction	Restriction	Restriction	Restriction	Restriction
Austria	Ban	Ban	Ban	Voluntary agreement	Voluntary agreement	Ban	Ban
Azerbaijan	Ban	Ban	Restriction	Restriction	Restriction	Restriction	Ban
Belarus	Ban	Ban	Ban	Restriction	Restriction	No restriction	Restriction
Belgium	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Bosnia and Herzegovina	Ban	Ban	Ban	Ban	Restriction	Ban	Ban
Bulgaria	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Croatia	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Cyprus	Ban	Ban	Ban	Restriction	Restriction	Restriction	Ban
Czech Republic	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Denmark	Restriction	Restriction	Restriction	No restriction	No restriction	Restriction	Restriction
Estonia	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Finland	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
France	Ban	Ban	Ban	Restriction	Restriction	Restriction	Ban
Georgia	Restriction	Restriction	Restriction	Restriction	Restriction	Restriction	Restriction
Germany	Voluntary agreement	Restriction	No restriction	Voluntary agreement	Voluntary agreement	Ban	No restriction
Greece	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Hungary	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban[a]
Iceland	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Ireland	Ban[b]	Ban	Ban	Ban	Ban	Ban	Ban
Israel	Ban	Ban	Ban	Restriction	Restriction	Ban	Restriction
Italy[c]	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Kazakhstan	Ban	Ban	Ban	Restriction	Restriction	Restriction	Ban
Kyrgyzstan	Ban	Restriction	Restriction	No restriction	No restriction	No restriction	No restriction
Latvia	Restriction	Ban[d]	Restriction	Restriction	Restriction	Restriction	Restriction
Lithuania	Ban	Ban	Ban	Restriction	Restriction	Restriction	Ban
Luxembourg	Ban	Ban	No restriction	No restriction	No restriction	No restriction	Ban
Malta[c]	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Montenegro	Ban	Ban	Ban	Restriction	Restriction	Restriction	Restriction
Netherlands	Ban	Ban	Ban	Voluntary agreement	Voluntary agreement	Ban	Ban
Norway	Ban	Ban	Ban	Ban[e]	Ban	Ban	Ban
Poland	Restriction	Restriction	Restriction	Restriction	Restriction	Restriction	Restriction
Portugal	Ban	Ban	Voluntary agreement	Voluntary agreement	Voluntary agreement	Voluntary agreement	Ban
Republic of Moldova	Ban	Ban	Restriction	No restriction	No restriction	Restriction	Restriction
Romania[c]	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Russian Federation	Restriction	Restriction	Restriction	No restriction	No restriction	Restriction	Restriction

Country	Health care facilities	Educational facilities	Government facilities	Restaurants	Pubs and bars	Indoor workplaces and offices	Theatres and cinemas
Serbia	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Slovakia	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Slovenia	Ban	Ban	Ban	Restriction	Restriction	Ban	Restriction
Spain[f]	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Sweden[c]	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Switzerland	Restriction	Restriction	Restriction	No restriction	No restriction	Restriction	Restriction
The former Yugoslav Republic of Macedonia	Ban	Ban	Ban	Restriction	Restriction	Ban	Ban
Turkey	Restriction	Restriction	Restriction	No restriction	No restriction	Restriction	Restriction
Turkmenistan	Ban	Ban	Ban	No restriction	No restriction	Ban	Ban
Ukraine	Restriction	Restriction	Restriction	No restriction	No restriction	No restriction	Restriction
United Kingdom[g] Scotland	Voluntary agreement Ban	Voluntary agreement Ban	Voluntary agreement Ban	Voluntary agreement Ban	Voluntary agreement Ban	Voluntary agreement Ban	Voluntary agreement Ban
Uzbekistan	Restriction	Restriction	No restriction	No restriction	No restriction	No restriction	Restriction

[a] Except for the bar.
[b] Except for prisons, psychiatric hospitals and homes for the elderly.
[c] Smoking is banned in all enclosed public spaces. It is allowed in areas specially arranged for smoking which comply with the terms specified in the legislation.
[d] Except for universities and colleges which have only a partial restriction.
[e] Separate smoking rooms are allowed, but not in bars and restaurants, any other place food is served, or in most educational facilities.
[f] Only a partial ban since bars and restaurants under 100 m^2 are exempted.
[g] The complete ban entered into force in March 2006 in Scotland, will enter into force in Northern Ireland in April 2007 and in England in August 2007. In Wales the law is still being drafted.
Note. Shading indicates that the legislation entered into force during 2002–2006.

According to the information available from the countries listed in Table 6, a large number of countries (mainly in the EU) have enforced bans in health care, education and government facilities and in indoor workplaces and offices since 2002. A smaller number of Member States (mainly in the eastern part of the Region) have introduced or reinforced restrictions in the same settings.

- 21 Member States have strengthened their legislation in health care facilities (18 by passing bans and 3 by introducing restrictions, mainly in the eastern part of the Region);
- 23 Member States have reinforced their legislation in educational facilities (21 by enforcing bans and 2 by introducing restrictions);
- 24 Member States have strengthened their legislation in government facilities (19 by enforcing bans and 5 by introducing restrictions, mainly in the eastern part of the Region);
- 24 Member States have strengthened their legislation in indoor workplaces and offices (17 by enforcing bans and 7 by introducing restrictions, mainly in the eastern part of the Region);
- 23 Member States have strengthened their legislation in theatres and cinemas (17 by enforcing bans and 6 by introducing restrictions, mainly in the eastern part of the Region);
- 20 Member States have strengthened their legislation in restaurants, pubs and bars (7 by enforcing bans, 10 by introducing restrictions and 1 through voluntary agreement).

Although the majority of WHO European countries regulate smoking in public places, either by legal measures or by voluntary agreements (in a few), enforcement levels vary considerably.

In order to gain a more objective picture, a question on the level of enforcement was included in the questionnaire sent to national counterparts as part of the preparations for this report. The results should, however, be interpreted with caution as the answers regarding the effectiveness of enforcement measures were often based on personal opinions. Compliance with restrictions on smoking in public places was reported as high in 55% of the countries, medium in 30% and low in 15% of the countries.

Compliance is particularly strong in countries of the western part of the Region where legislation has been introduced recently and incorporates specific mechanisms for enforcement and heavy penalties for infringement. Popular support for the ban has also tended to increase following its introduction, which has resulted in a certain degree of self-enforcement. In Italy, according to figures presented by the Ministry of Health one year after the ban came into force (January 2006), 9 out of 10 people were in favour of the ban and 87.3% considered that it was well respected. It was estimated that cigarette sales had declined by over 5.7%. In Ireland, where 40 dedicated environmental health officers for tobacco control are supported by an additional 400 environmental health officers and a further 100 inspectors from the Health and Safety Authority, compliance with the smoke-free workplace legislation is also very high: 94% of all workplaces inspected under the National Tobacco Control Inspection Programme were smoke-free, 92% of all workplaces inspected by the Health and Safety Authority were smoke-free and 93% of all hospitality workplaces inspected were smoke-free (see Annex 1, case study). Similarly high levels of compliance with smoke-free workplace legislation have been reported in Norway *(47)* and Sweden.

Recent evidence shows that high compliance with the smoke-free workplace legislation results in a reduction in exposure to second-hand smoke in enclosed workplaces.

Restrictions on smoking in public transport

By the end of 2005, 80% of countries in the WHO European Region had enforced a ban on smoking in buses and 70% in taxis but fewer than 50% in trains (Table 7). In general, the responding counterparts have reported a higher level of compliance than for restrictions in other public places.[10]

Since 2002, 14 Member States have passed complete bans on smoking in taxis, 13 in trains and 12 in buses. There are no significant differences between the eastern and western parts of the Region in this regard. Five Member States, mostly in the eastern part of the Region, have introduced partial restrictions in some settings, particularly in trains.

Exposure of 13–15-year-olds to tobacco smoke

To estimate exposure to tobacco smoke in private places and outside home, the answers to the following GYTS question were used: "During the past seven days, have people smoked in your presence at home/in places other than in your home?" *(21)*. On average, in the 25 countries participating in the GYTS, exposure to environmental tobacco smoke is very high: 79% of the 13–15-year-olds reported that they were exposed to tobacco in their homes and 84% outside home, although the figures were even higher in some countries (Table 8).

[10] In Table 7 and the relevant calculations, Serbia and Montenegro have been counted as two Member States so as to reflect the position in October 2006, even though the legislation was enacted before they separated.

Table 7. Restrictions on smoking in public transport, October 2006

Country	Buses	Taxis	Trains
Albania	Voluntary agreement	Voluntary agreement	No restriction
Armenia	Ban	No restriction	Ban
Andorra	Ban	Ban	Ban
Austria	Ban	Ban	Ban
Azerbaijan	Restriction	Ban	Restriction
Belarus	Ban	Ban	Restriction
Belgium	Ban	Ban	Ban
Bosnia and Herzegovina	Ban	Ban	Ban
Bulgaria	Ban	Ban	Restriction
Croatia	Restriction	Restriction	Ban
Czech Republic	Ban	Ban	Restriction
Denmark	Restriction	No restriction	Restriction
Estonia	Ban	Ban	Ban
Finland	Ban	Ban	Ban
France	Ban	Ban	Restriction
Georgia	Restriction	Restriction	Restriction
Germany	Voluntary agreement	No restriction	Voluntary agreement
Greece	Ban	Ban	Ban
Hungary	Ban	Ban	Ban
Iceland	Ban	Ban	not available
Ireland	Ban	Ban	Ban
Israel	Restriction	Restriction	Restriction
Italy	Ban	Ban	Ban
Kazakhstan	Ban	Ban	Restriction
Kyrgyzstan	Ban	Ban	Restriction
Latvia	Ban	Ban	Ban
Lithuania	Ban	Ban	Ban
Luxembourg	Ban	No restriction	Restriction
Malta	Ban	Ban	n/a
Montenegro	Ban	Ban	Ban
Netherlands	Ban	Ban	Ban
Norway	Ban	Ban	Ban
Poland	Ban	Ban	Restriction
Portugal	Ban	Ban	Restriction
Republic of Moldova	Ban	Ban	Ban
Romania	Ban	Voluntary agreement	Ban
Russian Federation	Ban	Ban	Restriction
Serbia	Ban	Ban	Restriction
Slovakia	Ban	Ban	Ban
Slovenia	Ban	Ban	Restriction
Spain	Ban	Ban	Ban
Sweden	Ban	Ban	Ban
Switzerland	Voluntary agreement/ban	Voluntary agreement/ban	Voluntary agreement/ban
The former Yugoslav Republic of Macedonia	Ban	Ban	Ban
Turkey	Restriction	Restriction	Restriction
Turkmenistan	Ban	Ban	Ban
Ukraine	Ban	Ban	Restriction
United Kingdom	Ban	No restriction (ban in Scotland)	Ban
Uzbekistan	Ban	Ban	Restriction

Note. Shading indicates that the legislation entered into force during 2002–2006.

Table 8. Prevalence of exposure to tobacco smoke in 13–15-year-olds (%)

Country	Survey year	Exposure at home	Exposure outside home
Albania	2004	84.8	80.6
Armenia	2004	91.4	85.1
Belarus	2004	75.3	90.1
Bosnia and Herzegovina Federation of Bosnia and Herzegovina Republika Srpska	 2003 2003	 96.7 96.2	 91.5 91.1
Bulgaria	2002	67.7	75.7
Croatia	2003	94.9	91.1
Czech Republic	2002	41.1	74.5
Estonia	2003	80.6	90.7
Georgia	2003	95.0	93.8
Greece	2004 (regional)	91.1	94.3
Hungary	2003	84.0	92.8
Kazakhstan	2004	72.7	71.8
Kyrgyzstan	2004	64.4	64.9
Latvia	2002	59.0	71.3
Lithuania	2005	43.1	64.6
Poland	2003	86.7	90.4
Republic of Moldova	2004	62.3	96.7
Romania	2004	90.4	81.5
Serbia and Montenegro (Serbia)	2003	97.4	91.3
Slovakia	2003	79.5	85.7
Slovenia	2003	65.9	89.0
Tajikistan	2004	51.5	69.7
The former Yugoslav Republic of Macedonia	2003	91.9	80.2
Turkey	2003	81.6	85.9
Ukraine	2005	70.1	84.4

Advertising, promotion and sponsorship

Summary

Since 2002, 24 Member States have reinforced their legislation on direct advertising either by passing new bills or by implementing existing provisions. In the EU countries, advertising in the press or on the radio and sponsorship of events or activities involving or taking place in several member states or otherwise having cross-border effects, such as Grand Prix races, and all other European sporting or cultural events were fully banned on 31 July 2005.

As at June 2006, 44 countries had enforced a complete ban on tobacco advertising on national and cable television and radio, while 34 had a complete ban on tobacco advertising in local printed magazines and newspapers with 12 having partial restrictions. Advertising on billboards and outdoor walls is banned in 38 countries and in the cinema in 30 countries. The situation for advertising at points of sale is more varied. It is banned in 14 countries (most of the time product information is allowed with restrictions), partially restricted in 18 and not restricted in 15.

There has been some progress since 2002 regarding promotion, sponsorship, brand-sharing and all other forms of indirect advertising, which have become the most significant part of the tobacco industry's advertising. Since then, 8 countries (mostly in the EU) have adopted a total ban on all forms of indirect advertising and 12 countries have introduced restrictions on some forms of indirect advertising. Advertising remains less regulated in the CIS, particularly in the Russian Federation.

Background

According to the evidence, a fully comprehensive ban, covering all media and all forms of advertising (direct or indirect), promotion, sponsorship and use of product brand names or characteristics contributes to the reduction of tobacco consumption and lessens the social desirability of smoking, particularly among young people *(48)*. Article 13.2 of the WHO FCTC has fixed a period of five years after entry into force of the Convention for each Party to undertake the appropriate legislative, executive and/or administrative measures to achieve such a comprehensive ban (Article 13.3 allows Parties to have restrictions instead of a comprehensive ban).

The ESTC recommended that strategic national action should include:

- *prohibiting all forms of direct and indirect advertising for tobacco products and smoking, including promotion, "brand-stretching" and sponsorship;*
- *adopting national measures and imposing appropriate regulatory restrictions to ensure that tobacco advertising, promotion and sponsorship do not promote a tobacco product by any means that are false, misleading or deceptive or that are likely to create an erroneous impression about its characteristics, health effects, hazards or emissions.*

It was also suggested that Member States ban indirect advertising and cooperate effectively at the integrational and intergovernmental levels to phase out cross-border advertising.

Direct advertising

Since 2002, 24 Member States have reinforced their legislation on direct advertising either by passing new bills or by implementing existing provisions (Table 9).[11]

The adoption by the European Parliament and Council in 2003 of Directive 2003/33/EC *(4)* banning tobacco advertising and sponsorship with a cross-border dimension in all EU member states was an important development. The deadline for this to be adopted into countries' national legislation was 31 July 2005, when advertising in the press and on the radio and sponsorship (including any free distribution of tobacco products) of events or activities involving or taking place in several member states or otherwise having cross-border effects, such as Grand Prix races, and all other European sporting or cultural events were fully banned.

As at October 2006, 44 countries had a complete ban on tobacco advertising on national and cable television and radio, while only Belarus and Kyrgyzstan still have partial restrictions.[12] The data for local printed magazines and newspapers are also encouraging: 34 countries have a complete ban on tobacco advertising and 12 have partial restrictions. Advertising on billboards and outdoor walls is fully banned in 38 countries and in the cinema in 30 countries. Belarus, Georgia, Germany, Greece, Kyrgyzstan, Republic of Moldova, Romania, the Russian Federation, Switzerland and Ukraine still have limited restrictions on one or two of these media. The situation for advertising at points of sale is more varied across the Region: it is banned in 14 countries (most of the time a partial ban since product information is allowed with restrictions), partially restricted in 18 and not restricted in 15.

[11] In Table 9 and the relevant calculations, Serbia and Montenegro have been counted as two Member States so as to reflect the position in October 2006, even though the legislation was enacted before they separated.
[12] Montenegro has reported that according to the law on tobacco control, advertising of tobacco products is forbidden. No further details are available.

Table 9. Legislation on direct advertising of tobacco products, October 2006

Country	National television	Cable television	National radio	Local printed magazines, newspapers	Billboards, outdoor walls	Points of sale, kiosks	Cinema
Albania	Ban	Ban	Ban	Ban	No restriction	No restriction	Partial restriction
Armenia	Ban	Ban	Ban	Partial restriction	Ban	Partial restriction	Partial restriction
Austria	Ban	Ban	Ban	Ban	Ban[a]	Partial restriction	Partial restriction
Azerbaijan	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Belarus	Partial restriction	Partial restriction	Partial restriction	Partial restriction	Partial restriction	No restriction	Partial restriction
Belgium	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Bosnia and Herzegovina	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Bulgaria	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Croatia	Ban	Ban	Ban	Ban	Ban	No restriction	Partial restriction
Czech Republic	Ban	Ban	Ban	Ban	Ban	No restriction	Ban
Denmark	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Estonia	Ban	Ban	Ban	Ban	Ban	ban	Ban
Finland	Ban	Ban	Ban	Ban	Ban	ban	Ban
France	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Germany	Ban	Ban	Ban	No restriction	No restriction	No restriction	Partial restriction
Georgia	Ban	Ban	Ban	Partial restriction	Partial restriction	No restriction	Partial restriction
Greece	Ban	Ban	Ban	No restriction	No restriction	No restriction	No restriction
Hungary	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Iceland	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Ireland	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Israel	Ban	Ban	Ban	Partial restriction	Ban	Partial restriction	Partial restriction
Italy	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Kazakhstan	Ban	Ban	Ban	Partial restriction	Ban	No restriction	Ban
Kyrgyzstan	Partial restriction	Partial restriction	Partial restriction	Partial restriction	Ban	No restriction	No restriction
Latvia	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Lithuania	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Luxembourg	Ban	Ban	Ban	Partial restriction	Ban	Ban	Ban
Malta	Ban	Ban	Ban	Ban	Ban	No restriction	Ban
Montenegro[b]							
Netherlands	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Norway	Ban	Ban	Ban	Ban	Ban	Ban	Ban

Country	National television	Cable television	National radio	Local printed magazines, newspapers	Billboards, outdoor walls	Points of sale, kiosks	Cinema
Poland	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Portugal	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Republic of Moldova	Ban	Ban	Ban	Ban	Ban	No restriction	Partial restriction
Romania	Ban[c]	Ban	Ban	Partial restriction	Partial restriction	Partial restriction	Partial restriction
Russian Federation	Ban	Ban	Partial restriction	Partial restriction	Partial restriction	No restriction	Partial restriction
Serbia	Ban	No restriction	Ban	Ban	Ban	No restriction	Ban
Spain	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Slovakia	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Slovenia	Ban	Ban	Ban	Ban	Ban	No restriction	Ban
Sweden	Ban	Ban	Ban	Ban	Ban	Ban	Ban
Switzerland	Ban	Ban	Ban	Partial restriction	Partial restriction	Partial restriction	Partial restriction
Tajikistan	Ban	Ban	Ban	Ban	Ban	No restriction	No restriction
The former Yugoslav Republic of Macedonia	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Turkmenistan	Ban	Ban	Ban	Ban	Ban	No restriction	No restriction
Turkey	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Ukraine	Ban	Ban	Ban	Partial restriction	Partial restriction	Partial restriction	No restriction
United Kingdom	Ban	Ban	Ban	Ban	Ban	Partial restriction	Ban
Uzbekistan	Ban	Ban	Ban	Ban	Ban	No restriction	No restriction

Note. Shading indicates that the legislation entered into force during 2002–2006.
[a] From 1 January 2007.
[b] According to the law on tobacco control, advertising of tobacco products is forbidden. No further details are available.
[c] From 31 December 2006.

Since 2002, according to the data available:[11]

- 12 Member States have enforced a complete ban on advertising on national and cable television (Armenia, Azerbaijan, Bosnia and Herzegovina, Czech Republic, Georgia, Kazakhstan, Latvia, Malta, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia and Uzbekistan) and 14 a total ban on national radio (the same countries plus Spain and the United Kingdom);
- 13 Member States have enforced a ban on advertising in local printed magazines and newspapers (Austria, Azerbaijan, Bosnia and Herzegovina, Czech Republic, Denmark, Latvia, Malta, Netherlands, Serbia, Spain, Tajikistan, The former Yugoslav Republic of Macedonia and the United Kingdom);

- 17 Member States have enforced a ban on advertising on billboards and outdoor walls (Armenia, Austria, Azerbaijan, Bosnia and Herzegovina, Czech Republic, Denmark, Hungary, Kazakhstan, Kyrgyzstan, Malta, Netherlands, Serbia, Spain, Tajikistan, The former Yugoslav Republic of Macedonia, the United Kingdom and Uzbekistan);
- 10 Member States have enforced bans on advertising in cinemas;
- 10 Member States have strengthened their legislation on advertising at points of sale.

In 2006, taking account of the main national media (television, radio, press, billboards), 33 countries[11] have a total ban on tobacco advertisements compared to 18 in 2001. Progress is uniform through the Region: eight countries in the western part of the Region, three in the CIS and three in south-eastern Europe. Based on information from counterparts who responded to the WHO questionnaire, compliance with bans on direct advertising is high in 75% of the countries, and incomplete or low in 25%.

The first session of the Conference of the Parties to the WHO FCTC decided to start preparing a template for a protocol on cross-border advertising as provided for in Article 13.8. The template (or at least a progress report) should be presented to the second Conference of Parties due to be convened in the first half of 2007. The possible protocol would then, if adopted by the Conference of Parties, become part of international law and hence binding on those Parties to the WHO FCTC that decide to accede to that protocol.

Indirect advertising

Regarding promotion, sponsorship, brand-sharing and all other forms of indirect advertising, which represent a significant part of the tobacco industry's advertising, the overall picture demonstrates some progress since 2002. Since then, 8 countries (mostly in the EU) have adopted a total ban on all forms of indirect advertising and 12 countries have introduced restrictions on some forms of indirect advertising.

Education, information and public awareness

Summary

Thirty-three Member States have reported that information and/or education on the addictive nature and the health hazards of tobacco use is part of a national programme for schools. National public awareness campaigns exist in 39 Member States. Although there has not been a major increase in education and information activities, important mass-media campaigns were launched at international level by the European Community and at country level in Finland, France, Ireland, Italy, Netherlands, Norway, Serbia and Montenegro, Sweden, Switzerland and the United Kingdom.

Background

Evidence suggests that continuous and intensive information and education programmes increase the social acceptance of tobacco control policy measures *(49)*.

The ESTC recommended that strategic national action should include:

- *developing and implementing effective and appropriate basic curricula and training programmes on tobacco control for policy-makers, health professionals, students, educators and other relevant persons;*

- *facilitating and strengthening education, training and public awareness campaigns, including counter-advertising;*
- *ensuring that the general public, notably children, young people and vulnerable groups, are fully informed about the health risks, addictiveness and social costs of tobacco consumption and exposure to tobacco smoke, and about the benefits of smoking cessation and tobacco-free lifestyles;*
- *endeavouring to promote the participation of public agencies, nongovernmental organizations and civil society in the development of strategies for tobacco control; proper links between the efforts of nongovernmental organizations and health professionals should be ensured.*

It was also suggested that information and training should be used to reinforce the impact of other tobacco control measures, although they were seldom effective on their own. Special attention should also be paid to not involving the tobacco industry in information campaigns, particularly those targeting young people.

National campaigns

Thirty-three Member States have reported that appropriate education on the addictive nature and the health hazards of tobacco use is part of a national programme for schools (Table 10).[13] There are national public awareness campaigns in 39 Member States. During this period important national campaigns were launched in particular by France, Italy, Netherlands, Norway, Serbia and Montenegro, Sweden, Switzerland and the United Kingdom. Nearly 70% of Member States (37) encourage participation by public agencies, nongovernmental organizations and civil society in the development of strategies for tobacco control.

World No Tobacco Day

WHO Member States started World No Tobacco Day in 1987 to draw global attention to the tobacco epidemic and the preventable death and disease it causes. This yearly celebration on 31 May informs the public of the dangers of using tobacco, the business practices of tobacco companies, what WHO is doing to fight the tobacco epidemic and what people around the world can do to claim their right to health and healthy living and to protect future generations. Since 2000, the majority of European Member States have celebrated World No Tobacco Day annually. In many Member States, there are national nonsmoking days in addition to World No Tobacco Day.

WHO World No Tobacco Day awards are presented annually to people or institutions that have made an outstanding contribution to tobacco control. The list of award-winners for 2002–2006 is in Annex 5.

In 2002, the aim of the World No Tobacco Day campaign was to clean sport of all forms of tobacco, tobacco consumption, exposure to second-hand smoke and tobacco advertising, promotion and marketing. WHO was joined in the campaign by a wide range of international partners including the CDC, the International Olympic Committee, the Fédération Internationale de Football Association (FIFA) and Olympic Aid, as well as national and local sports organizations.

[13] In Table 10 and the relevant calculations, Serbia and Montenegro have been counted as two Member States so as to reflect the position in October 2006, even though the data refer to the time before they separated.

Table 10. Information, education and public awareness campaigns, October 2006

Countries	Education about the addictive nature and health hazards of tobacco use in schools	Public awareness campaigns and/or counter-advertising	Participation of public agencies, nongovernmental organizations and civil society in the development of tobacco control strategies	Participation in annual World No Tobacco Day campaign	National nonsmoking day
Albania	Yes	Yes	Yes	Yes	
Andorra	Yes	No	No	Yes	
Armenia	Yes	Yes	Yes	Yes	Yes
Austria	Yes	Yes	Yes	Yes	
Belarus	Yes	Yes	No	Yes	Yes
Belgium	Yes	Yes	Yes	At regional level	
Bosnia and Herzegovina Federation of Bosnia and Herzegovina Republika Srpska	 No Yes	 No Yes	 Yes Yes	 Yes Yes	
Bulgaria	At regional level	Yes	Yes	Yes	Yes
Croatia	Yes	Yes	Yes	Yes	Yes
Czech Republic	Yes	Yes	Yes	Yes	Yes
Denmark	Yes	Yes	Yes	Yes	No
Estonia	Yes	Yes	No	Yes	Yes
Finland	Yes	Yes	Yes	Yes	
France	At regional level	Yes	Yes	Yes	
Georgia	Yes	At regional level	Yes	Yes	Yes
Germany	At regional level	Yes	Yes	Yes	
Hungary	Yes	Yes	Yes	Yes	
Iceland	Under revision	Yes	Yes	Yes	
Ireland	Yes	Yes	Yes	Yes	Yes
Italy	At regional level	Yes	Yes	Yes	
Kazakhstan	Yes	Yes	Yes	Yes	Yes
Kyrgyzstan	Yes	Yes	Yes	Yes	
Latvia	Yes	Yes	Yes	Yes	No
Lithuania	Yes	Yes	Yes	Yes	
Malta	Yes	Yes	No	Yes	
Montenegro	Yes	Yes	Yes	Yes	No
Netherlands	Yes	Yes	Yes	Yes	
Norway	Yes	Yes	Yes	Yes	
Poland	Yes	Yes	Yes	Yes	Yes
Portugal	Yes	Yes	Yes	Yes	Yes
Republic of Moldova	At regional level	At regional level	At regional level	Yes	Yes
Romania	Yes	Yes	Yes	Yes	Yes
Russian Federation	No	Yes	Yes	Yes	
Serbia	Yes	Yes	Yes	Yes	Yes
Slovakia	At regional level	Yes	Yes	Yes	Yes
Slovenia	Yes	Yes	Yes	Yes	Yes
Spain	No	Yes	Yes	Yes	
Sweden	Yes	Yes	Yes	Yes	Yes
Switzerland	Yes	Yes	Yes	Yes	
The former Yugoslav Republic of Macedonia	Yes	Yes	Yes	Yes	
Turkey	No	No	Yes	Yes	
Ukraine	No	No	Yes	Yes	
United Kingdom	Yes	Yes	Yes	Yes	Yes
Uzbekistan	Yes	Yes	Yes	Yes	Yes

Tobacco-free sports events were organized all over the world, including at the 2002 Salt Lake City Winter Olympic Games in the United States. FIFA joined forces with WHO, establishing a Memorandum of Cooperation to ensure that the 2002 FIFA World Cup was tobacco-free. The kick-off of the 2002 FIFA World Cup, in Seoul, Republic of Korea coincided with World No Tobacco Day on 31 May. Athletes, sports organizations, national and local sports authorities, school and university sports teams, sports media and those interested in physical activity were invited to join the campaign. According to the information available, a majority of countries in the European Region participated and organized activities on World No Tobacco Day 2002.

In 2003, the theme for World No Tobacco Day was "Tobacco-free film and fashion". WHO called upon the entertainment industry, in particular the world of film and fashion, to stop promoting a product that has devastating effects on public health and to start promoting a tobacco-free society. According to the information available, a majority of countries in the Region reported that they had organized activities on this theme on World No Tobacco Day. Commissioner David Byrne from the European Commission was honoured with the WHO Director-General's award.

"Tobacco and Poverty: a Vicious Circle" was the theme for World No Tobacco Day in 2004. The theme focused on the poverty-causing and poverty-sustaining aspects of tobacco, as well as the exploitative labour practices in this sector of economic activity. Many countries in the European Region participated in the 2004 World No Tobacco Day. Mr Micheál Martin, T.D., Minister for Health and Children, Ireland, was honoured with the WHO Director-General's award.

In 2005, World No Tobacco Day focused on the role of health professionals in tobacco control. For many reasons, health professionals have a very important role to play. They are in contact with many people on a regular basis. They have the opportunity to help people change their behaviour and can give advice, guidance and answers to questions related to the consequences of tobacco use. This can be very supportive for patients who wish to stop. Health professionals can also be outstanding role models for nonsmoking. The global launch took place in London, highlighting the important role that health professionals have played for many years in tobacco control in the United Kingdom. According to the information available, 31 countries contributed to the success of the 2005 World No Tobacco Day and organized activities around the theme.

Quit & Win

Quit & Win *(50)* is an international smoking cessation competition organized every second year by the National Public Health Institute of Finland and supported by the WHO countrywide integrated noncommunicable disease intervention (CINDI) programme. Adult daily smokers who have smoked for at least one year can register for the contest. The goal is to abstain from smoking for a specified period of four weeks in May. At the end of this period, every country selects one winner who receives a national prize (abstinence is verified by a witness and by a biochemical test). Among the national winners, there is a raffle for one international prize of US$ 10 000 and six regional prizes (according to the six WHO regional offices) of US$ 2500. One year after the competition, there is a follow-up survey on a random sample of at least 300 participants in order to assess abstinence rates and evaluate the effectiveness of the campaign.

The International Quit & Win contest is an increasingly popular smoking cessation intervention. It was launched in 1994 with the participation of 13 countries and since then the competition has taken place every other year. In the fifth campaign in 2002, almost 670 000 smokers took part in the Quit & Win contest in 76 countries worldwide, including 35 countries and altogether 340 223

participants from the WHO European Region. In 2002, the international super prize (US$ 10 000) went to the WHO European Region: the winner was the national winner of Germany.

In the sixth Quit & Win contest in 2004, the number of participants in the European Region reached 380 471 people from 34 countries: Albania, Armenia, Austria, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Estonia, Finland, Germany, Greece, Hungary, Ireland, Italy, Kazakhstan, Latvia, Lithuania, Malta, Netherlands, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey and Ukraine. Research shows that the cessation rate after four weeks remains relatively constant (15–25%) among participants regardless of their number *(51)*.

EU information and communication campaigns

In 2002, in the framework of a strengthened comprehensive and multisectoral tobacco control policy, the EU embarked on an important antismoking publicity campaign targeting teenagers in the EU. Between 2002 and 2004 the EU spent €18 million on the "Feel Free to Say No" campaign. Evaluation has shown that through this campaign more than a billion contacts with its target audience were made *(52)*.

In order to help the Commission define the criteria for the development of future campaigns a European Conference on Tobacco Youth Prevention and Communication was organized in Rome from 13 to 15 November 2003. Attended by 212 public health and media experts from 32 countries, the Conference adopted recommendations on the most effective mass media strategies for preventing young people from smoking.

The EU has earmarked €72 million from the Community Tobacco Fund for the new information campaign "HELP: For a Life Without Tobacco" *(53).* The campaign planned for 2005–2008 covers the key tobacco control themes agreed during the 2003 Rome Conference: prevention, cessation and passive smoking. Adolescents (15–18-year-olds) and young adults (aged 18 to 30 years) in the 25 EU countries are the main target groups. The campaign started in May 2005 with three advertisements aimed at preventing young people from taking up smoking, helping those who already smoke to give up, and promoting tobacco-free environments to reduce the dangers of passive smoking. Each of the three advertisements ends with a reference to "HELP" internet site and a national quitline number.

The results of the recent post-campaign test showed that over half the young people aged under 25 years surveyed in the 25 EU countries had seen the advertisements and the vast majority (83%) of them liked the campaign. The results also showed a good understanding (88%) of the messages behind the advertisements, and two thirds of young nonsmokers declared that the advertisements could deter them from starting to smoke. The results also provide feedback on the impact that the advertisements had on smokers, of whom 61% said that they made them think about their smoking, and 64% responded that they made them think about the impact of their smoking on nonsmokers.

Smoking cessation

Summary

Half of the Member States for which information is available implemented national programmes for prevention, diagnosis and treatment of tobacco dependence as part of primary health care. Quitlines have been set up in 29 Member States, a substantial increase since 2002. As in 2002, training for health professionals in smoking cessation techniques is reported to be taking place in a large number of countries. Nicotine replacement therapy products are available, most of the time over the counter. Bupropion is available in 36 countries. Nicotine replacement therapy and buproprion are still not reimbursed by national health care systems apart from (partially) in Belgium, Cyprus, Denmark, France, Ireland and the United Kingdom. An increasing number of Member States introduced training in smoking cessation as part of the basic curriculum for health professionals.

Background

Smoking cessation is an important component of tobacco control policy. Evidence shows that brief advice and behavioural support are effective in motivating smokers to quit, and that the use of nicotine replacement therapy increases the rate of success.

The ESTC recommended that strategic national action should include:

- *implementing age- and gender-based promotional and educational programmes aimed at encouraging the cessation of tobacco use;*
- *developing and integrating best practices in the treatment of tobacco dependence and prevention of relapse (i.e. behavioural support, counselling services, "quitlines" and routine advice on cessation of tobacco use) into national health programmes, plans and strategies, including those for primary health care, alcohol and drugs control, reproductive health, tuberculosis control, etc.;*
- *establishing and strengthening programmes of training in smoking cessation techniques for health professionals, including physicians, nurses, dentists and pharmacists as well as teachers and community and social workers;*
- *establishing in health care facilities programmes for diagnosis, medical advice and treatment of tobacco dependence, with a priority focus on primary health care.*

It was also suggested that Member States pay particular attention to funding training and cessation services and increase the affordability of treatment for low-income smokers, including treatment either at reduced cost or free of charge.

Treatment services, quitlines and training for health professionals

Twenty-three Member States reported that they had introduced promotional and educational smoking cessation programmes aimed at encouraging the cessation of tobacco use.[14] Twenty-one Member States are implementing national programmes for prevention, diagnosis and treatment of tobacco dependence as part of primary health care. In 10 additional countries, such programmes are implemented at a subnational level. There are still no Region-wide standards to determine the content and extent of promotional and educational programmes, so effectiveness probably differs widely within the Region (Table 11).

[14] In Table 11 and the relevant calculations, Serbia and Montenegro have been counted as two Member States so as to reflect the position in October 2006, even though the data refer to the period before they separated.

Table 11. Smoking cessation as part of educational, national health and health care programmes, October 2006

Country	Age- and gender-based promotional and educational programmes encouraging cessation of tobacco use	National health programme includes treatment of tobacco dependence and prevention	Primary health care programme includes prevention, diagnosis and treatment of tobacco dependence
Albania	Yes	Yes	Yes
Andorra	No	No	No
Armenia	At regional level	No	At regional level
Austria	No	Yes	Yes
Belarus	At regional level	No	At regional level
Belgium	At regional level	Yes	Yes
Bosnia and Herzegovina Federation of Bosnia and Herzegovina Republika Srpska	 No Yes	 No Yes	 Yes Yes
Bulgaria	At regional level	Yes	No
Croatia	Yes	No	At regional level
Czech Republic	No	Yes	Yes
Denmark	Yes	No	No
Estonia	Yes	Yes	Yes
Finland	Yes	Yes	Yes
France	Yes	No	Yes
Georgia	At regional level	Yes	Planned
Germany	At regional level	No	No
Hungary	No	Yes	At regional level
Iceland	No	No	At regional level
Ireland	Yes	Yes	Yes
Italy	Yes	Yes	At regional level
Kazakhstan	At regional level	Yes	Yes
Kyrgyzstan	Yes	No	At regional level
Latvia	Yes	Yes	Yes
Lithuania	Yes	Yes	Yes
Malta	Yes	No	Yes
Montenegro	Yes	Yes	Yes
Netherlands	No	No	No
Norway	Yes (age), regional level (gender)	Yes	Yes
Poland	At regional level	Yes	At regional level
Portugal	Yes	Yes	Yes
Republic of Moldova	At regional level	No	No
Romania	No	Yes	No
Russian Federation	At regional level	Yes	Yes
Serbia	Yes	Yes	At regional level
Slovakia	At regional level	No	No
Slovenia	Yes	No	At regional level
Spain	Yes	No	Yes
Sweden	Yes	Yes	Yes
Switzerland	Yes	No	At regional Level
The former Yugoslav Republic of Macedonia	No	Yes	No
United Kingdom	Yes	Yes	Yes
Uzbekistan	Yes	No	Yes

One basic element for an effective smoking cessation policy is that the treatment of tobacco dependence is an integral part of the national health programme of a country. This is reported to be the case in 25 Member States, although no information is available on the extent of treatment programmes. The United Kingdom remains one of the few countries with a comprehensive national programme which is regularly evaluated. Around 530 000 people set a date to stop smoking through National Health Service "stop smoking" services in England in 2004/2005. When they were followed up four weeks later, 56% were still not smoking. Success rates increased with age, from 39% of those aged under 18 years to 66% of those aged 60 years and over *(54)*.

Quitlines have been set up in 29 Member States. Since 2002, Austria, Croatia, Cyprus, the Czech Republic, Kazakhstan, Latvia, Lithuania, Portugal and Slovakia have established such lines and Armenia and Spain are planning them (Table 12).

Table 12. Quitlines and availability of smoking cessation treatment, October 2006

Country	Quitlines	Availability of nicotine replacement therapy	Reimbursement of nicotine replacement therapy by national health care system	Availability of bupropion or comparable medication	Reimbursement of bupropion therapy by national health care system
Andorra	No	Over the counter	No	On prescription	Yes
Armenia	Planned	Over the counter	No	Over the counter	No
Austria	Yes	Nasal spray on prescription, all other over the counter	No	On prescription	No
Belarus	At regional level	Over the counter and on prescription	No	Not available	No
Belgium	Yes	Over the counter	Yes, pregnant women	On prescription	No
Bosnia and Herzegovina Federation of Bosnia and Herzegovina Republika Srpska	 No No	 Over the counter Over the counter	 No No	 Over the counter Over the counter	 No No
Bulgaria	No	Over the counter	No	On prescription	No
Croatia	Yes	Over the counter	No	On prescription and over the counter	No
Cyprus	Yes	Over the counter	Yes, with funding limitation	On prescription	No
Czech Republic	Yes	Over the counter	No	On prescription	No
Denmark	Yes	Over the counter	Yes, in some counties	On prescription	No
Estonia	Yes	Over the counter	No	On prescription	No
Finland	Yes	Regular retail shops/over the counter/on prescription	No	On prescription	No
France	Yes	Over the counter	Yes, with limitations	On prescription	Yes, with limitations
Georgia	Yes	Over the counter	No	Not available	NA
Germany	Yes	Over the counter	No	On prescription	No
Greece	No	Over the counter	No	On prescription	No
Hungary	Yes	Over the counter	No	Not available	NA

Table 12, continued

Country	Quitlines	Availability of nicotine replacement therapy	Reimbursement of nicotine replacement therapy by national health care system	Availability of bupropion or comparable medication	Reimbursement of bupropion therapy by national health care system
Iceland	Yes	Over the counter	No	On prescription	No
Ireland	Yes	Over the counter	Yes, with limitations	On prescription	Yes, with limitations
Italy	Yes	Over the counter	No	On prescription	No
Kazakhstan	Yes	Over the counter	No	On prescription	No
Kyrgyzstan	No	Over the counter	No	Not available	NA
Latvia	Yes	Over the counter	No	On prescription	No
Lithuania	Yes	On prescription	No	On prescription	No
Malta	Yes	Over the counter	No	On prescription	No
Netherlands	Yes	Over the counter	No	On prescription	No
Norway	Yes	Over the counter	No	On prescription	No
Poland	Yes	Over the counter	No	On prescription	Free in some cessation clinics
Portugal	Yes	Over the counter	No	On prescription	No
Republic of Moldova	No	Over the counter	No	Not available	NA
Romania	Yes	Not available	No	On prescription	Pilot programme to make buproprion available to smokers
Russian Federation	No	Over the counter	No	Not available	No
Serbia	No	Over the counter	No	Over the counter	No
Slovakia	Yes	Over the counter	No	On prescription	No
Slovenia	Yes	Over the counter	No	On prescription	No
Spain	Planned	Over the counter	No	On prescription	No
Sweden	Yes	Over the counter	No	On prescription	Yes
Switzerland	Yes	Inhaler on prescription, all others over the counter	No	On prescription	No
The former Yugoslav Republic of Macedonia	No	Over the counter	No	Not available	NA
Ukraine	No	Over the counter	No	On prescription	No
United Kingdom	Yes	Over the counter and on prescription	Yes	On prescription	Yes
Uzbekistan	No	Over the counter and on prescription	No	Over the counter and on prescription	No

According to the available information, products used in nicotine replacement therapy are available over the counter in 42 Member States. Only six countries in the Region (Belgium, Cyprus, Denmark, France, Ireland and the United Kingdom) partially reimburse these products by their national health care systems, in general limited to those on lower incomes and/or those aged over 65–70 years. According to the information available, bupropion is available in 36 countries but not available in 7 (mostly eastern European) countries (Table 12).

Health professionals have a critical role to play in reducing tobacco use. Even brief and simple advice from health professionals can have a substantial increase on smoking cessation rates.

Therefore, one of the strategies to reduce the number of smoking-related deaths is to encourage the involvement of health professionals in counselling for the prevention and cessation of tobacco use. Nineteen Member States reported that training in smoking cessation is an integral part of the basic curriculum for medical students, and in even more countries for nursing, dental and pharmaceutical students (Table 13).

Table 13. Training of health professionals in tobacco control and smoking cessation

Country	Medical students	Nurses	Students of dentistry	Students of pharmacy	Postgraduate training for doctors
Albania	Yes	Yes	Yes	Yes	Yes
Armenia	At local level	At local level	No	No	Yes
Austria	Yes	Yes	Yes	Yes	Yes
Belarus	At regional level	At regional level	No	No	At regional level
Bosnia and Herzegovina Federation of Bosnia and Herzegovina Republika Srpska	 Yes Yes	 Yes Yes	 Yes Yes	 Yes Yes	 Yes Yes
Belgium	At regional level	At regional level	At regional level	At regional level	At regional level
Bulgaria	No	At regional level	No	No	At regional level
Croatia	At regional level	At regional level	No	No	At regional level
Cyprus	No	No	No	No	No
Czech Republic	Yes	Yes	At regional level	No	Yes
Estonia	No	No	No	No	Yes
Finland	Yes	In preparation	No	No	Yes
Georgia	No	No	No	No	Planned
Germany	No	No	No	No	At regional level
Greece	No	Yes	No	No	At regional level
Hungary	Yes	Yes	Yes	Yes	Yes
Iceland	Yes	Yes	Yes	Yes	No
Ireland	Yes	Yes	Yes	Yes	Yes
Italy	No	No	No	No	No
Kazakhstan	Yes	Yes	Yes	Yes	Yes
Kyrgyzstan	Yes	Yes	No	No	Yes
Latvia	Yes	Yes	Yes	Yes	Yes
Lithuania	No	No	Yes	Yes	Yes
Malta	Yes	At national level	Yes	Yes	No
Norway	Yes	Yes	No	No	No
Poland	At regional level	Yes	No	No	Yes
Portugal	No	No	No	No	Yes
Republic of Moldova	No	No	No	No	No
Romania	Yes	No	Yes	No	Yes
Russian Federation	Yes	Yes	Yes	Yes	Yes
Serbia	No	No	No	No	Yes
Slovakia	At regional level	No	No	No	Yes
Slovenia	Yes	Yes	Yes	Yes	Yes
Spain	No	No	No	No	No
Sweden	Yes	Yes	Yes	Yes	Yes
Switzerland	No	No	No	No	Yes
The former Yugoslav Republic of Macedonia	Yes	Yes	Yes	Yes	Yes
Uzbekistan	Yes	Yes	Yes	Yes	Yes

Twenty-five countries reported that they had post-graduate training for doctors in tobacco control and smoking cessation at national level, but there is incomplete information on the content, quality and amount of training that health professionals receive and whether they are informed about evidence-based guidelines on smoking cessation. Six countries referred to training at post-graduate training for doctors at regional level.

The European Network of Quitlines (ENQ)

The European Network of Quitlines aims to bring together experienced and newer quitlines across Europe to develop code of practice tools and policy recommendations on smoking cessation. In addition, it aims to ensure that all European member quitlines have access to the best training, advice and support in counselling protocols, evidence-based cessation programmes, technological advice and web-based interventions.

Membership of the network has grown from 6 partners at its inception in 2000 to 25 in 2005. All members actively participate in a series of training groups and seminars every year to share development and best practice. In 2004, the *European guide to best practice for quitlines* was published in English, French and German and has received widespread acclaim *(55)*.

The network is currently focusing on a pan-European research project led by the Dutch Centre STIVORO. The ESCHER project was conceived in 2002 during the first ENQ training seminar held in The Hague, where the need for more scientific research data on the quality and effectiveness of European quitlines was identified. The research aims to evaluate the effectiveness of the European quitlines, to assess which factors influence success and to discover what kind of assistance is sought and received by which kind of smokers. It also attempts to explore the cost-effectiveness of the quitlines and to evaluate the impact of the quitline phone numbers on cigarette packets.

In conjunction with the Finnish Public Health Institute KTL, the network is also conducting a second research project with the aim of establishing best practice in the internet provision of smoking cessation assistance across Europe. The project will result in guidelines for internet-based smoking cessation and the development and promotion of a smoking cessation expert web tool.

More recently, the network has been supporting the new pan-European campaign “HELP: For a life without tobacco” by providing practical, accredited advice and support to smokers seeking help as a result of the campaign.

Product control and consumer information

Summary

In 2006, 32 countries and, in particular, the EU are regulating the levels of tar (10 mg per cigarette), nicotine (1 mg per cigarette) and carbon monoxide (10 mg) in cigarettes, a decrease compared with the 2001–2002 levels of 12 mg of tar and carbon monoxide per cigarette and 1.2 mg of nicotine per cigarette. The CIS and SEE countries (except Bulgaria, Croatia, Georgia, Montenegro and Serbia) still set higher levels: 1.2–1.4 mg for nicotine and 12–16 mg for tar.

While the average size of warning labels used to be less than 10% of each large surface of the pack, it has increased by more than 200% in the 32 countries that have transposed or adopted the EU Directive 2001/37/EC. In the 14 other Member States (mainly CIS and SEE countries), health warnings are still usually less than 10% of the largest surface. Misleading descriptions on tobacco packs are also prohibited in the EU countries and in some SEE and CIS countries.

Since December 2002, Directive 2001/37/EC has required EU tobacco manufacturers to disclose all the ingredients and their quantities used in tobacco products. Unfortunately there have been problems in gathering this information. Apart from seven countries which have started to implement a similar procedure, regulation of the disclosure of the contents of tobacco products has not changed in the remaining Member States, notably not in the CIS.

Background

More accurate assessment is required of the content of tobacco products and stronger regulation of the substances being delivered to smokers. Through visible, specific and unequivocal health warnings, consumers should be adequately informed so that they understand the risks.

The ESTC recommended that strategic national action should include:

- *adopting standards for the regulation of tobacco products, including standards for the testing and measuring, design, manufacture and processing of such products, and cooperating in the development and harmonization of such standards;*
- *introducing and enforcing measures for the disclosure of tobacco products by all manufacturers, including details of major ingredients and additives and the major constituents of tobacco smoke, as well as of their toxicity, carcinogenicity and addictiveness, and promoting the availability of clear and meaningful information to the public;*
- *banning the terms "low tar", "light", "ultra light", "mild" or any other similar confusing term that has the aim or the direct or indirect effect of conveying the impression that a particular tobacco product is less harmful than others; steps should also be taken to ensure that tobacco packaging and labelling does not otherwise promote a tobacco product by any means that are false, misleading or deceptive;*
- *ensuring that each unit, packet or package of tobacco products carries a strong health warning, in accordance with international and integrational agreements;*
- *ensuring that these warnings provide clear information about the toxic contents of the tobacco product, specifically tar, nicotine and carbon monoxide, including actual measurements of smoke yields; appear in the principal language or languages of the country in whose territory the product is on sale; and progressively occupy not less than 40% of the front and 40% of the back of tobacco packages.*

In Article 11, the WHO FCTC fixed a period of three years after its entry into force for adopting and implementing the provisions on packaging and labelling of tobacco products.

The adoption of EU Directive 2001/37/EC of June 2001 concerning the manufacture, presentation and sale of tobacco products has had a major impact on the regulation of tobacco products in the WHO European Region *(5)*. The Directive not only affected new legislation in the 25 Member States and in the candidate countries Bulgaria and Romania but also influenced legislation in Croatia, Georgia, Iceland, Israel, Norway, Serbia and Montenegro and Switzerland. The Directive has also had positive implications across the Region and globally, since it applies to cigarettes exported to countries outside the EU.

Measurements

In order to harmonize the testing and measurement of the emissions and contents of tobacco products, Directive 2001/37/EC opted for the relevant International Standards Organization (ISO) methodology to be carried out by approved laboratories. In addition to the EU member

states, seven other countries have decided to apply the ISO system. In February 2006, the European Commission published a list of approved testing laboratories notified by member states as required by the Directive *(56)*. In its first report on the implementation of Directive 2001/37/EC, the Commission noted the criticism of the ISO standards but said that it did not propose to use new methods until there was solid evidence about another method *(57)*. The WHO FCTC Conference of Parties at its first meeting in February 2006 decided to start drawing up guidelines for implementing Article 9 of the WHO FCTC concerning the testing and measuring of the contents and emissions of tobacco products from the public health perspective.

The absence of certified testing laboratories, particularly in the CIS countries, is still a major obstacle.

Tar, nicotine, carbon monoxide yields

In 2006, 33 countries – the EU member states (with the exception of Greece) plus Bulgaria, Croatia, Georgia, Iceland, Israel, Norway, Romania, Montenegro, Serbia[15] and Switzerland – have reported that they are regulating the levels of tar (10 mg per cigarette), nicotine (1 mg per cigarette) and carbon monoxide (10 mg). These yields represent a decrease compared to 2001–2002, when tar and carbon monoxide were regulated at 12 mg per cigarette and nicotine at 1.2 mg per cigarette.

The remaining CIS and SEE countries are still regulating the yields at significantly higher levels: 1.2–1.4 mg for nicotine and 12–16 mg for tar.

Use of misleading terms

According to available data, the use of misleading terms such as "low tar", "light", "ultra light" and "mild" is banned in most countries of the European Region but not in Albania, Bosnia Herzegovina or the CIS countries, apart from Georgia and the Republic of Moldova.

Health warnings

Health warnings are required by all countries of the Region. In general, countries have specific requirements regarding the content, location, languages, area to cover, colours and font size. Since 2002, the size of warning labels has increased by more than 200% in the 33 countries that have transposed or adopted legislation similar to EU Directive 2001/37/EC. While the average figure used to be less than 10% of each large surface of the pack, it now stands at a minimum of 30% of the external area with a general warning and of 40%, with 14 rotating additional warnings on the other side of the pack. Additionally the tar, nicotine and carbon monoxide yields are printed on one side and take up at least 10% of the external area. The different areas for warning labels to be covered are increased according to the number of official languages. The size is also increased by the black border surrounding the text, which is excluded from the minimum requirement.

In May 2005, the European Commission approved 42 pictograms or colour images combining the texts of the additional warnings with an image, and encouraged member states to adopt them as rotating health warnings *(58)*. In April 2006, further technical specifications were adopted. Belgium was expected to become the first EU member state to introduce pictorial warnings in 2007.

[15] Levels will gradually be reduced to comply with EU regulations by 2011.

In the 14 other WHO Member States, mainly CIS and SEE countries, the size and content of health warnings remain in general less than 20% of the largest surface.

Regulation of the disclosure of tobacco products

Since December 2002, tobacco manufacturers in the EU have been required under Directive 2001/37/EC to notify to member state authorities all the ingredients in each brand name and type of cigarette and the quantities used in tobacco products. The EU member states are obliged to submit this information to the Commission and disseminate this data to the public, taking due account of any information on specific product formulae that constitute a trade secret. However, there have been problems in gathering this information. As indicated in the first report on the implementation of Directive 2001/37/EC, there is no common reporting format, neither is there the capacity to analyse the data either at member state or EU level. The initial assessment made by the European Commission Directorate-General for Health and Consumer Protection indicates that the amount and quality of the data from the member states to the Commission vary greatly. In general, the industry provides information according to "a quantity not exceeded" template instead of being exhaustive, as required by the Directive. Furthermore, the regulatory initiatives of some countries, for instance the Netherlands, are being legally challenged by the industry. The Court of The Hague decided on 21 December 2005 that the Dutch State had correctly implemented Directive 2001/37 in its national legislation. The Court dismissed most claims from the industry, which has, however, launched an appeal.

To support the disclosures of tobacco products, the Commission is facilitating and coordinating the development of harmonized data collection methods based on a common EU format. In future the EU registration, evaluation and authorization of chemicals (REACH) procedure – a system aimed at ensuring greater safety in the manufacture and use of chemical substances – could also have a role in improving the process for evaluating and authorizing such substances.

Apart from in the EU member states and candidate countries, the regulation of tobacco products has not significantly changed in the remaining WHO Member States, especially the CIS.

Measures to reduce the supply of tobacco products

Illicit trade

Summary

In the western part of the Region the fight against smuggling has had some success, especially in reducing the supply of illegal tobacco products. On 9 July 2004 the European Community with 10 EU member states concluded with Philip Morris International a twelve-year agreement valid throughout the whole of the EU which included a system to combat future cigarette-smuggling and counterfeiting and ended all litigation between the parties in this area. Progress has also been reported by some SEE countries. No data are available for assessing the situation in the CIS.

Background

Apart from representing a threat to public health by encouraging tobacco consumption, smuggling deprives governments of tax revenues and reinforces criminal organizations and corruption. The size of the price differentials between duty-paid and duty-free tobacco products and corruption *(60)* has led to an increase in smuggling throughout the Region since the early 1990s.

The ESTC recommended that strategic national action should include:

- *adopting appropriate measures to ensure that all packages of tobacco products sold or manufactured carry the necessary markings and product information which will allow the products to effectively be tracked and traced;*
- *monitoring and collecting data on the cross-border trade in tobacco products, including illicit trade, and exchanging information among relevant national authorities and international bodies;*
- *enacting and/or strengthening the corresponding legislation and penalties.*

Smuggling is a supply-driven process, fed by the industry which supplies the duty suspended cigarettes. In the western part of the Region the fight against smuggling has had some success, especially in reducing the supply of illegal tobacco products.[16] In the EU the number of cigarettes seized fell from 8.1 billion in 2000 (1.9 billion in the United Kingdom and 6.2 billion in the rest of Europe) to 2.6 billion in 2003 (1 billion in the United Kingdom and 1.6 billion in the rest of Europe) *(61)*.

Philip Morris agreement

Reducing the supply of illegal cigarettes was also a key issue in the negotiations between the EC and Philip Morris International. On 9 July 2004 the European Commission (EC) and 10 EU member states concluded with Philip Morris International a twelve-year agreement valid throughout the whole of the EU. This included a system to fight future cigarette-smuggling and counterfeiting, ended all litigation between the parties in this area, and stressed the importance of controlling the supply chain and export practices in order to gain effective control of the illegal trade *(62)*. The EC and the 10 EU member states will receive substantial payments over a number of years. The amount of the payments will vary based on a number of factors and could total approximately US$ 1.25 billion. The agreement on payments is of crucial importance. For each container of 10 million Philip Morris International cigarettes seized in the ten countries party to the agreement – the company has to pay €1.5 million. When 90 million Philip Morris International cigarettes have been seized in the ten countries, the company has to pay five times as much or €7.5 million for each container of 10 million cigarettes seized. The agreement is in line with the principle that "the key to controlling cigarette-smuggling is to control tobacco manufacturing and its exporting practices." *(63)*. It could provide a baseline for a protocol to Article 15 of the WHO FCTC, for which the first session of the Conference of the Parties decided to start preparing a template.

Other tobacco companies have not been keen to accept the obligations of the agreement between Philip Morris International and the EU. British companies, such as Imperial Tobacco and Gallagher prefer memoranda of understandings, which are generally vague, short, without penalties and not legally binding in the same way as the Philip Morris International-EU agreement. British American Tobacco (BAT) is also not willing to accept the obligations of the Philip Morris International agreement, but has made proposals to accept an export bond system which would require that any person wanting to move manufactured tobacco products in commercial quantities from one country to another has to post a bond in the form of a bank guarantee or similar instrument in a specified format and provided by an approved institution. While BAT's proposal is not legally binding as the Philip Morris International agreement is, it acknowledges financial responsibility for control of the export of their cigarettes.

[16] In Spain for instance (one of the few countries in the world which has combated smuggling efficiently), success has not been due to controlling distribution at street level, but to reducing the amount brought into the country at "container" level through intelligence, customs activity and cooperation and technology.

Challenges posed by counterfeit cigarettes

In 2000–2001, while most of the seizures were of genuine products they were actually mainly of counterfeit items. In the United Kingdom, 25% of the legal cigarette market and 54% of the cigarettes seized in 2003–2004 were counterfeit. The control of counterfeit cigarettes is even more difficult than the control of "genuine smuggled cigarettes" *(64)*. The origin of smuggled cigarettes can be detected, but the origin of counterfeit cigarettes can only be discovered through close collaboration with the country where they are produced. An estimate of counterfeit trade is difficult to make, but it is certain that the market share of counterfeit cigarettes is rising in many countries, not just in the United Kingdom. Recognizing counterfeit cigarettes at the time of seizure is an additional problem. Most counterfeit cigarettes have health warnings or tax stamps on the pack and are not recognized as fake by smokers. In most countries, customs authorities rely on the tobacco industry to determine whether a product is genuine or counterfeit, which can take a considerable time and impede effective control of the trade in counterfeit products. The need for independent identification of counterfeit cigarettes is self-evident. In Brazil, Malaysia and the United States (California), for instance, markings are required on the pack which allow enforcement officials to detect easily counterfeit cigarettes. There is a need for effective control of the worldwide trade in both genuine smuggled and counterfeit cigarettes.

International cooperation to combat illicit trade

To facilitate the procedure for the exchange of data, an agreement was signed in 2003 between the World Customs Organization (WCO) and the European Anti-Fraud Office (OLAF) with the aim of improving cooperation. In future, there was be a technical option for information relating to seizures of smuggled cigarettes in the EU to be transferred automatically from the OLAF Anti-Fraud Information System (AFIS)/Ciginfo to the WCO Customs Enforcement Network system. This would help to keep the analysis of global trends and the global picture of illicit cigarette trafficking up to date and assist enforcement targeting activity in the WCO's 162 member countries. It would also make life much more difficult for the smugglers and assist in bringing them to justice. Customs services around the world could now have access to the most current information on methods of concealment and other *modus operandi* used by cigarette traffickers in the EU.

Progress has also been reported by some SEE countries. In Bulgaria and Serbia and Montenegro the number of cigarettes seized fell by almost 70% between 2001 and 2004. The illegal markets have been slightly reduced or stabilized albeit at very high levels in Albania (50–40%), Bosnia and Herzegovina (45–35%) and The former Yugoslav Republic of Macedonia (30–35%).

No data are available for assessing the situation in the CIS. It is estimated that 30% of cigarettes consumed in Uzbekistan are smuggled. In the Russian Federation, the illegal exports of genuine and counterfeit cigarettes mostly to CIS and Baltic countries have fallen slightly since the introduction of new measures by the State Customs Committee in 2003. Other measures to combat national consumption of smuggled or counterfeited cigarettes are starting to have some impact according to national authorities, although the Russian Federation remains the main European illegal market according to volume (20–30% of the total market).

Availability of tobacco to young people

Summary

Since 2002, 14 countries have introduced age restrictions on the sale of tobacco products. Currently 34 countries ban the sale of tobacco products to young people aged under 18 years and

10 countries to young people aged under 16 years. The majority of Member States ban the sales of single or unpacked cigarettes and the distribution of free samples, and close to half of the Member States ban sales from vending machines – a notable increase since 2002. Notwithstanding these bans, tobacco is still widely available to young people throughout the Region. Compliance with laws on age restrictions appears to need improvement in the majority of countries.

Background

Restricting the availability of cigarettes to young people is an important element of tobacco control policy. In particular, there is some evidence that restricting access to vending machines, small packs or single cigarettes can be effective.

The ESTC recommended that strategic national action should include:

- *prohibiting tobacco sales to and by persons under the age of majority as determined by domestic law;*
- *requiring all sellers of tobacco products to request young purchasers to provide appropriate evidence of having reached the age of majority as determined by domestic law;*
- *banning sales through vending machines, self-service displays, mail order and electronic sales, sales of single or unpacked cigarettes, and distribution of free samples of cigarettes;*
- *licensing of retailers so far as possible within the means at the country's disposal.*

In the eastern part of the Region, GYTS data on minors' access to tobacco show that the age restrictions, even those recently introduced, are far from being fully enforced. In almost all the countries that had age restrictions when the GYTS was conducted, more than two thirds of the current smokers aged 13–15 years who bought their cigarettes in a shop had not been refused during the previous 30 days despite their youth. The range of non-compliance (percentage of those who had not been refused during the previous 30 days) varied from 93% in Slovenia to 55.9% in Belarus (Table 14).

Age restrictions

Since 2002, 14 new countries have introduced age restrictions for the sale of tobacco products (Table 15).[17] Currently 34 countries ban sales to young people aged under 18 years and 10 countries ban sales to those aged under 16 years. But despite these bans on the sale of tobacco products to minors, tobacco is still widely available to young people throughout the Region.

The answers from the responding counterparts show that compliance with laws on sales restrictions needs to be improved in the majority of countries.

[17] In Table 15 and the relevant calculations, Serbia and Montenegro have been counted as two Member States so as to reflect the position in October 2006, even though the data refer to the period before they separated.

Table 14. Access to cigarettes by 13–15-year-olds in countries with a minimum buying age

Country	GYTS year	Minimum buying age	Percentage of current smokers who usually bought their cigarettes in a shop	Percentage of these who had not been refused during the previous 30 days
Belarus	2003	18	47.5	55.9
Bulgaria	2002	18	65.1	75.7
Croatia	2002	18	56.3	88.7
Czech Republic	2002	18	49.1	71.8
Hungary	2003	18	65.3	76.2
Republic of Moldova	2003	18	66.6	76.0
Romania	2004	18	62.9	73.0
Russian Federation	2004	18	69.4	75.3
Slovakia	2003	18	54.0	78.9
Slovenia	2002	15	64.6	93.0
The former Yugoslav Republic of Macedonia	2002	18	63.7	74.5

Restrictions on impersonal modes of sale

In addition to age restrictions, some countries have introduced regulation of impersonal modes of sale (Table 15). Twenty-two countries reported that they ban the sale of tobacco products through vending machines (10 since 2002) and 18 in self-service displays (5 since 2002). Forty Member States (13 since 2002) ban the sale of single or unpacked cigarettes and 32 (8 since 2002) ban the distribution of free samples, while a few countries have banned or restricted mail order and electronic sales. A majority of countries have restrictions on duty-free sales of tobacco products and licence requirements for retail sales.

Table 15. Bans or restrictions on the sale of tobacco products by various means, October 2006

Country	Age restrictions	Vending machines	Self-service displays	Mail order or electronic sales	Sale of single or unpacked cigarettes	Duty-free tobacco products	Free sample of cigarettes	Licensing of retail sale
Albania	No	No restriction	No restriction	No restriction	No restriction	No restriction	No restriction	No
Andorra	18	Partial restriction	Partial restriction	No restriction	Ban	No restriction	Partial restriction	No
Armenia	18	Partial restriction	Partial restriction	No restriction	Ban	Partial restriction	Partial restriction	Yes
Austria	16	Partial restriction[a]	No restriction	No restriction	Ban	Partial restriction	Ban	Yes
Azerbaijan	No	Ban	No restriction	No restriction	Ban	No restriction	Ban	No restriction
Belarus	18	Ban	Ban	No restriction		Partial restriction	Partial restriction	Yes
Belgium	16	Ban	Ban	Partial restriction	Ban	Partial restriction	Ban	Yes
Bosnia and Herzegovina	18	Ban	Ban	No restriction	Ban	No restriction	Ban	No

Table 15, continued

Country	Age restrictions	Vending machines	Self-service displays	Mail order or electronic sales	Sale of single or unpacked cigarettes	Duty-free tobacco products	Free sample of cigarettes	Licensing of retail sale
Bulgaria	18	Ban	Ban	No restriction	Ban	No restriction	Ban	Yes
Croatia	18	Ban	Partial restriction	Partial restriction	Ban	Partial restriction	Ban	No
Cyprus	18	Ban	Ban	No restriction	Ban	No restriction	Ban	Yes
Czech Republic	18	Partial restriction	Ban	Ban	Ban	Partial restriction	Ban	No
Denmark	18	No restriction	Data not available	Partial restriction	Ban	Partial restriction	Ban	No
Estonia	18	Ban	No restriction	No restriction	Ban	No restriction	Ban	Yes
Finland	18	Partial restriction	Partial restriction	No restriction	Ban	Partial restriction	Ban	No
France	18	Ban	Ban	Ban	Ban	Partial restriction	Ban	Yes
Georgia	18	No restriction	No restriction	No restriction	Ban	No restriction	No restriction	No
Germany	16	Voluntary agreement	No restriction	No restriction	Ban	Partial restriction	Ban	No
Greece	No	Data not available	Data not available	Data not available	Ban	Partial restriction	Partial restriction	Yes
Hungary	18	Ban	No restriction	No restriction	Ban	Partial restriction	Ban	Yes
Iceland	18	Ban	Ban	No restriction	Ban	No restriction	Ban	Yes
Ireland	18	No restriction	Ban	No restriction	Ban	Partial restriction	Ban	No
Italy	16	Restriction	Ban	Restriction	Ban	Partial restriction	Ban	Yes
Kazakhstan	18	Ban	Ban	Ban	Ban	No restriction	No restriction	No
Latvia	18	Ban	No restriction	No restriction	Ban	No restriction	Ban	Yes
Lithuania	18	Ban	No restriction	No restriction	Ban	No restriction	Ban	Yes
Malta	18	No restriction	No restriction	No restriction	Ban	No restriction	Ban	No
Netherlands	16	Partial restriction	No restriction	No restriction	Ban	Partial restriction	Ban	No
Norway	18	Ban	No restriction	Partial restriction	Ban	No restriction	Ban	No
Poland	18	Ban	No restriction	No restriction	Ban	No restriction	No restriction	Yes
Portugal	16	Partial restriction	No restriction	No restriction	Ban	Partial restriction	Partial restriction	No
Republic of Moldova	18	No restriction	No restriction	No restriction	Ban	No restriction	No restriction	Yes
Romania	16	Ban	Ban	No restriction	Ban[b]	Partial restriction	Ban	No
Russian Federation	18	Ban	No restriction	No restriction	Ban	No restriction	No restriction	No
Serbia	18	Ban	Ban	No restriction	Ban	Partial restriction	Ban	Yes
Slovakia	18	Ban	Ban	Ban	Ban	Ban	Ban	Yes
Slovenia	15	Ban	Ban	No restriction	Ban	No restriction	Ban	Yes

Country	Age restrictions	Vending machines	Self-service displays	Mail order or electronic sales	Sale of single or unpacked cigarettes	Duty-free tobacco products	Free sample of cigarettes	Licensing of retail sale
Spain	18	Partial restriction	Ban	Ban	Ban	Partial restriction	Ban	Yes
Sweden	18	Partial restriction	Ban	Partial restriction	Ban	Partial restriction	Ban	No
Switzerland	No	No restriction	No restriction	No restriction	Ban	No restriction	No restriction	No
Tajikistan	18	No restriction	No restriction	No restriction	No restriction	No restriction	No restriction	No
The former Yugoslav Republic of Macedonia	16	No restriction	No restriction	No restriction	No restriction	No restriction	No restriction	Yes
Turkey	18	No restriction	No restriction	No restriction	Ban	No restriction	Ban	Yes
Turkmenistan	18	No restriction	No restriction	No restriction	No restriction	No restriction	No restriction	No
Ukraine	18	No restriction	No restriction	No restriction	No restriction	No restriction	Ban	Yes
United Kingdom	16	Partial restriction	No restriction	No restriction	Ban	Partial restriction	Ban	No
Uzbekistan	18	No restriction	No restriction	No restriction	No restriction	No restriction	No restriction	Yes

Note. Shading indicates that the legislation entered into force during 2002–2006.
[a] From 1 January 2007.
[b] From 31 December 2006.

Tobacco subsidies

The ESTC recommended that strategic national action should include:

- *promoting alternative economic activities to tobacco production; and*
- *gradually transferring subsidies for tobacco-growing to other activities.*

The gradual decrease and elimination of subsidies to tobacco production remain important objectives in the overall spectrum of tobacco control measures. Major progress has been noted in recent years in the EU where, in 2004, the Council of Ministers decided that aid would be fully decoupled from tobacco production after a four-year transition period starting in 2006. During these four years, at least 40% of the tobacco premiums are to be included in the decoupled single payment for farmers, although Member States may decide to retain up to 60% as a coupled payment, i.e. still linked to production *(65)*.

In 2005 the EU contributed almost €1 billion to tobacco production, but as a result of the reform, the 2006 budget for raw tobacco production was to be set at only one third of the 2005 level. Although the EU still supports tobacco growers, it has decided that this aid should not stimulate tobacco production (decoupling).

After the four-year transition period, from 2010 onwards, tobacco aid will be completely de-linked from production. Some 50% will be transferred to the single payment scheme and the remaining 50% will be used for programmes in tobacco-producing regions within the rural development policy (EC 864/2004) *(65)*. Contributions to the Community Tobacco Fund will be 4% of coupled tobacco payments in respect of the 2006 harvest and 5% in respect of the 2007 harvest. In 2006–2007 the Fund will only finance information concerning the harmful effects of tobacco

consumption: EC regulation No 2182/2002 applies, laying down the conditions for the use of the Community Tobacco Fund with regard to information programmes and measures to promote a switch of production *(66)*. This Regulation provides that funding should be divided appropriately between two main objectives: aiding tobacco producers to convert to other crops and implementing antismoking information programmes. Funding to the Community Tobacco Fund increased from 2% of the premium paid to tobacco growers in 2002 to 3% in 2004. The Commission, with the assistance of a scientific and technical committee, is responsible for the management of the Fund as regards the information programmes. The funding for health projects has increased from €3 million in 2000 to €14.4 million in 2005; in 2007 an amount of €16.9 million is foreseen.

The WHO FCTC

The WHO FCTC was unanimously adopted by the World Health Assembly in May 2003. It is the first globally binding public health treaty, and as such has crucial importance for international action against the tobacco epidemic and for global public health in general.

The negotiation process and the European coordination mechanism

Starting in 2000 and increasingly since 2002, the European Region has been actively involved in the negotiations for the WHO FCTC. In preparation for the fifth session of the Intergovernmental Negotiating Body (held from 14 to 25 October 2002 in Geneva), four major consultations were held at the sub-regional level, in collaboration with the Regional Office, to facilitate the review of the Chairperson's proposed text, intergovernmental exchange of views and positions, and the possible coordination of positions for the next round of negotiations.

The sub-regional consultative meeting of SEE countries (Sofia, 30–31 August 2002) was hosted by the Ministry of Health of Bulgaria in collaboration with the Regional Office, and attended by delegations from eight countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, The former Yugoslav Republic of Macedonia, Turkey and Yugoslavia). It was followed by the consultative meeting of Member States in the CIS (Moscow, 6–7 September 2002), hosted by the Ministry of Health of the Russian Federation and attended by delegates from 11 countries (Azerbaijan, Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Uzbekistan and Ukraine). The third sub-regional consultative meeting was hosted by Estonia (Tallinn, 9 September 2002) for the Member States in the Baltic region (Estonia, Latvia, Lithuania).

All three sub-regional meetings reviewed and in general supported the Chairperson's text and the proposed working method. The meetings also developed a consensus on the majority of issues and provided a platform for the sub-regional groups, particularly those representing the CIS and the Baltic States, to speak with a consolidated voice during the sessions of the Intergovernmental Negotiating Body. This was a valuable contribution to building support for strong tobacco control measures during the negotiation process. A parallel mechanism was in place among the EU and accession countries which facilitated coordination and consensus-building in the Region.

The sub-regional consultations were followed by a Region-wide coordination meeting organized by the Regional Office (Helsingør, Denmark, 23–24 September 2004), which brought together representatives of 40 countries before the fifth session of the Intergovernmental Negotiating Body. Overall, the participants supported the Chairperson's text and the proposed method of work for the fifth session. They also identified points of general agreement and issues that needed further discussion. The chairperson of the consultative meeting wrote to the Chairperson of the Intergovernmental Negotiating Body listing the major issues for further debate and

endorsing the proposed method of work. Finally, in order to promote European coordination before the final stage of negotiations, the Regional Office facilitated the organization of two consultative meetings in Geneva (6–7 February and 16 February 2003) prior to the sixth session of the Intergovernmental Negotiating Body (Geneva, 17–28 February 2003).

Generally speaking, the coordination both at sub-regional and Regional levels played an important role in ensuring a strong and coordinated voice from the European Region in the negotiations and adoption of the FCTC.

Status of the WHO FCTC

The WHO FCTC entered into force on 27 February 2005, on the ninetieth day after the deposit of the fortieth instrument of ratification in the United Nations headquarters, the depository of the treaty, in New York. Norway was the first country in the world to deposit the ratification instrument on 16 June 2003, and 16 other European Member States (Armenia, Denmark, Finland, France, Germany, Hungary, Iceland, Latvia, Lithuania, Malta, Netherlands, San Marino, Slovakia, Spain, Turkey and the United Kingdom) were among the first 40 contracting parties (Table 16). The European Community ratified the WHO FCTC on 30 June 2005.

Table 16. Status of the WHO FCTC in the WHO European Region, 15 December 2006

Country	Date of signature	Date of ratification	Country	Date of signature	Date of ratification
Albania	29/06/2004	26/04/2006	Lithuania	22/09/2003	16/12/2004
Andorra			Luxembourg	16/06/2003	30/06/2005
Armenia		29/11/2004	Malta	16/06/2003	24/09/2003
Austria	28/08/2003	15/09/2005	Monaco		
Azerbaijan		01/11/2005	Montenegro		23/10/2006
Belarus	17/06/2004	08/09/2005	Netherlands	16/06/2003	27/01/2005
Belgium	22/01/2004	01/11/2005	Norway	16/06/2003	16/06/2003
Bosnia and Herzegovina			Poland	14/06/2004	15/09/2006
Bulgaria	22/12/2003	07/11/2005	Portugal	09/01/2004	8/11/2005
Croatia	02/06/2004		Republic of Moldova	29/06/2004	
Cyprus	24/05/2004	26/10/2005	Romania	25/06/2004	27/01/2006
Czech Republic	16/06/2003		Russian Federation		
Denmark	16/06/2003	16/12/2004	San Marino	26/09/2003	07/07/2004
Estonia	08/06/2004	27/07/2005	Serbia	28/06/2004	08/02/2006
Finland	16/06/2003	24/01/2005	Slovakia	19/12/2003	04/05/2004
France	16/06/2003	19/10/2004	Slovenia	25/09/2003	15/03/2005
Georgia	20/02/2004	14/02/2006	Spain	16/06/2003	11/01/2005
Germany	24/10/2003	16/12/2004	Sweden	16/06/2003	07/07/2005
Greece	16/06/2003	27/01/2006	Switzerland	25/06/2004	
Hungary	16/06/2003	07/04/2004	Tajikistan		
Iceland	16/06/2003	14/06/2004	The former Yugoslav Republic of Macedonia		30/06/2006
Ireland	16/09/2003	07/11/2005	Turkey	28/04/2004	31/12/2004
Israel	20/06/2003	24/08/2005	Turkmenistan		
Italy	16/06/2003		Ukraine	25/06/2004	06/06/2006
Kazakhstan	21/06/2004		United Kingdom	16/06/2003	16/12/2004
Kyrgyzstan	18/02/2004	25/05/2006	Uzbekistan		
Latvia	10/05/2004	10/02/2005			

Source: WHO Tobacco Free Initiative (http://www.who.int/tobacco/framework/countrylist/en/, accessed 15 December 2006).

By 15 December 2006, 168 countries worldwide had signed the WHO FCTC and 142 countries had ratified it. In the WHO European Region, 40 countries and the European Community are currently parties to the WHO FCTC.

The Conference of the Parties

The first session of the Conference of the Parties to the WHO FCTC took place from 6 to 17 February 2006 in Geneva. The European Community and all the states where the WHO FCTC had entered into force had the right to participate in the Conference with voting rights. Other states, including signatories to the WHO FCTC, were able to participate as observers. Nongovernmental organizations in official relations with WHO and intergovernmental organizations also participated as observers at the first session.

The first Conference of the Parties adopted the following decisions:

- to establish the permanent secretariat of the Treaty within WHO, located in Geneva; parties agreed on a budget of US$ 8 million for its functioning during the next two years, funded through voluntary assessed contributions;
- to create working groups that will begin to develop protocols (legally binding instruments) in the areas of cross-border advertising and illicit trade, and to develop guidelines (non-binding instruments) to help countries establish smoke-free places and effective ways of regulating tobacco products;
- to assess the progress made in implementing the measures required by the Treaty through a pilot reporting questionnaire agreed by the Parties during the first session of the Conference;
- to establish an ad hoc group of experts that will study economically viable alternatives to the growing and production of tobacco, with a view to making recommendations on diversification initiatives for countries whose economies are heavily dependent on tobacco production.

The Conference of the Parties also elected the Chairperson and the secretariat that will ensure continuity of the work between the sessions of the Conference. The secretariat is comprised of one representative from each WHO region (Austria represents the European Region).

The role of the WHO European Region Member States and of the European Community has been important in preparing the WHO FCTC guidelines both on the protection of exposure to tobacco smoke (Article 8) and on the product regulation (Article 9). In both cases two of the three key facilitators have come from the Region: Finland and Ireland for the Article 8 guidelines and Norway and the European Community for the Article 9 guidelines. Norway has also been acting as one of the three reviewers for Article 8 guidelines and France for Article 9 guidelines. The Regional Office is collaborating closely with Member States in this process. It has also facilitated the nomination of experts for the development of protocols to the WHO FCTC and given the necessary support.

Region-wide action

In accordance with the Warsaw Declaration for a Tobacco-free Europe and with the strategic directions of the ESTC, the WHO Regional Office for Europe has strengthened its work in:

- promoting Region-wide political commitment to tobacco control
- supporting capacity-building in countries
- strengthening international coordination, and
- facilitating information exchange and promoting technical cooperation.

Below are some important elements in the progress made with regard to these strategic directions.

Facilitating Region-wide political commitment

The Regional Office organized a high-level ministerial conference for tobacco control in February 2002. The Conference, hosted by the Polish government, provided strong support to the Framework Convention process and called for the development and adoption of the European Strategy for Tobacco Control. The Warsaw Declaration for a Tobacco-free Europe has since been providing political guidance for strengthening action against the tobacco epidemic in the Region.

Tobacco control has been brought into the mainstream of other WHO European high-level political processes such as the WHO European Ministerial Conference on Environment and Heath (Budapest, 23–24 June 2004) and the Children's Environment and Health Action Plan for Europe. Other important developments in this direction were the high level meeting of WHO and the EC with the focus on putting tobacco on to the development agenda, and bringing tobacco control into the mainstream of the Stability Pact Social Cohesion framework. A large number of Member States and international organizations are simultaneously involved in this process.

The adoption by the Regional Committee of the European Strategy for Child and Adolescent Health and Development in 2005 and the European Strategy on Noncommunicable Diseases Prevention and Control in 2006 provides a major framework for integrating tobacco control policies in overall preventive and control activities.

The Regional Office has also worked to raise awareness and build commitment to the WHO FCTC. The extensive intergovernmental coordination process in 2002 and early 2003 (see above) has continued following the adoption of the WHO FCTC. High-level intersectoral meetings have been organized jointly with the governments of the Czech Republic (January 2004), Serbia and Montenegro (May 2004), Kyrgyzstan (Bishkek, December 2003, with the participation of five central Asian republics – Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) and Bulgaria (Sofia, September 2005, with the participation of eight SEE countries – Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Republic of Moldova, Romania, Serbia and Montenegro and The former Yugoslav Republic of Macedonia). The consultations have been followed by signature and/or ratification of the WHO FCTC by half of the participating governments within a very short period of time.

International support for building national capacity

The adoption of the ESTC in 2002 and the WHO FCTC in 2003 provided international instruments and gave added impetus to the development of national policies and legislation. The Regional Office has since provided technical support to 18 countries, particularly those in the eastern part of the Region, in the development and adoption of national action plans, strategies and programmes for tobacco control. The Office has also provided support for 12 countries in

the review of national legislation required under the WHO FCTC; some of these are currently updating their legislation.

Support to national policies

Biennial collaborative agreements between the Regional Office and health ministries serve as a major instrument in providing technical support to Member States in various public health policy areas. During 2002–2005, tobacco was part of biennial collaborative agreements in 17 countries of central and eastern Europe, with most activities focused on development of national action plans, review of legislation, capacity-building, and information campaigns such World No Tobacco Day. The Office has also supported the creation of national tobacco control resource centres in seven countries.

Capacity building

The following four major capacity-building projects were undertaken in 2002–2005 aimed at both the government and civil society levels.

The Regional Office provided support, both financial and technical, to 15 nongovernmental organizations from different parts of the Region. These organizations were working under a WHO umbrella initiative entitled "Channelling the Outrage". The project aimed to strengthen capacity and advocacy for the WHO FCTC and tobacco control in general. The second phase of the initiative entailed the organization of a regional capacity-building workshop for civil society networks (Romania, May 2004) and the creation of the Russian version of GlobaLink that has provided major support to capacity-building and networking in the CIS.

In collaboration with the Tobacco Control Resource Centre of the British Medical Association, WHO organized a workshop for organizations representing health professionals which was attended by representatives of 18 countries (Edinburgh, October 2004). This has been followed up by training workshops for health professionals in ten countries, and in most cases has been complemented by the creation of coalitions of health professionals for tobacco control.

The Regional Office, in collaboration with the government of Belarus, convened a capacity-building workshop on tobacco control for representatives of the CIS countries in Minsk from 10 to 12 March 2004. The workshop, attended by (for the most part) three representatives from each of the 11 participating countries, addressed intersectoral policies with a focus on the health, economic and legislative aspects of tobacco control. The workshop helped to highlight the importance of intersectoral policies and supported collaboration at country level between the public health and the economic and legal sectors. Preparations have recently started for a second meeting of the CIS countries, to be held in early 2007, focusing on the ratification and implementation of the WHO FCTC.

A project entitled "Public Health Capacity Building for Strengthening Tobacco Control in South-East Europe" was launched in 2005 as part of the Stability Pact Initiative for Social Cohesion. The project involves the nine south-east European countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia (the project leader country), Montenegro, Republic of Moldova, Romania, Serbia and The former Yugoslav Republic of Macedonia) and is supported by the Government of Norway. The Regional Office provides technical and organizational support. The first phase of the project (1 April 2005–31 March 2006) focused on generating political support at intersectoral level for the WHO FCTC. The intergovernmental consultation in Sofia (28–29 September 2005), followed by intersectoral meetings at the national level, helped to build greater awareness of and collaboration as regards the WHO FCTC and its ratification in half of the participating countries.

The second phase started with a planning meeting in Zagreb on 30 and 31 Mach 2006. The focus of that meeting was on intersectoral capacity-building for tobacco control. A major intercountry training workshop for representatives of the health, economic, legal and other relevant sectors was held in October 2006, hosted and supported by Slovenia. It was due to be followed by national training workshops in late 2006 and early 2007. Two additional phases of the project in the next two to three years will focus on public information campaigns and strengthening smoking cessation services in countries.

Strengthening international coordination

The Regional Office, in coordination with WHO headquarters, has worked towards strengthening international interagency cooperation at the global, regional and national levels. The United Nations Interagency Task Force for tobacco control, involving more than 10 organizations such as WHO, the International Labour Organization, the United Nations Children's Fund, the United Nations Development Programme, the World Bank, the International Monetary Fund and others, is an important mechanism for promoting international coordination. The Regional Office has collaborated with the World Bank to provide technical advice and conduct studies on the economic aspects of tobacco control in selected countries. Consultations have been held with the International Labour Organization to ensure the reflection of respective international conventions in the Regional Office's policy paper on legislating for smoke-free workplaces. The development of protocols and policy guidelines as part of the WHO FCTC is now also opening up new opportunities for substantial international collaboration, particularly with the EC, the International Labour Organization, the ISO and the WCO.

There has also been collaboration with several other international organizations. With the EC this has included coordination of positions for the WHO FCTC as well as for the design of recommended health warnings and the recent EU youth information campaigns. Under the United Kingdom's EU Presidency in 2005, issues concerning the illicit trade in tobacco products were addressed as part of the Presidency's Policy Summit on Inequalities and Health. The Council of Europe has been the major partner for the Stability Pact for Social Cohesion Initiative which is now hosting the south-east Europe tobacco control project, among several other public health programmes. The Tobacco and Cancer Group of the International Agency for Research on Cancer has provided input and advice for this report. The Agency has recently undertaken major reviews of the carcinogenic effects of smokeless tobacco and the side stream tobacco smoke. The ENSP coordinated action to support the adoption of the WHO FCTC (for example, letter-writing campaigns to urge national governments to ratify the Convention before the end of 2004). The ENSP also assisted the Regional Office in the implementation of the "Channelling the Outrage" project in support for nongovernmental organizations and the World No Tobacco Day campaign, as well as contributing to Region-wide action by providing advocacy and support for the implementation of EU directives, national smoke-free legislation and the recent HELP campaign. The European Network on Young People and Tobacco contributes to the reduction of tobacco use among young people through Europe-wide collaboration, information exchange and programme-building, particularly through the Smoke-free Class Competition, the largest school-based smoking prevention programme in the Region, that attracted 28 000 classes and 700 000 pupils from 17 countries in the 2004/2005 campaign *(67)*.

Information exchange, technical cooperation and monitoring

Documentation for technical support and guidance

To provide guidance and support to Member States, three technical documents have been prepared as envisaged in the ESTC and at the request of the European network of national counterparts:

- *WHO European strategy for smoking cessation policy,* in 2003 *(51)*;
- *Taxation of tobacco products in the WHO European Region: practices and challenges*, in 2004 (in collaboration with the Heidelberg WHO collaborating centre) *(36)*;
- *Legislating for smoke-free workplaces*, in 2006 *(68)*.

In liaison with WHO headquarters, special attention has been given to the production and dissemination of two important comprehensive publications for the development of national capacity for tobacco control: *Tools for advancing tobacco control in the 21st century: success stories and lessons learned (69)* and *Building blocks for tobacco control: a handbook (70)*.

The network of national counterparts

The network of national counterparts for the ESTC is an important intergovernmental mechanism for international cooperation in the Region. Meetings of the network have been held since the adoption of the ESTC in Helsinki (August 2003), Paris (May 2005) and Dublin (April 2006), hosted respectively by the governments of Finland, France and Ireland. The meeting in Helsinki focused on the implementation of the ESTC, the policy papers required in some specific areas to complement the ESTC, and a review of the WHO FCTC process after its adoption in May 2003. The main focus of the meeting in Paris was to agree the process for developing this report on the review of the WHO FCTC process following its entry into force in February 2005, as well as particular discussions on taxation policies and combating illicit trade. The meeting in Dublin focused on reviewing and reaching an agreement in principle on the draft of this report and reviewing the WHO FCTC process following the first session of the Conference of the Parties, held in February 2006. The meetings of national counterparts have also reviewed policy developments in the Region and in countries, as well as other issues such as the preparations for World No Tobacco Day and surveillance and capacity-building initiatives.

The role of other WHO programmes and networks

Several WHO Regional Office programmes, in addition to Tobacco-free-Europe, have contributed to the implementation of the ESTC.

Throughout the history of the WHO European Healthy Cities programme tobacco control has been a continuous priority. Progress on tobacco control was reviewed in 1997/1998, 2001/2002 and in 2005. At present, more than 90% of healthy cities have in place tobacco education and smoking prevention programmes, programmes specifically targeted at children and young people, and policies on smoke-free public places (either local policies or implementation of national policy). Over 85% of cities have established cessation programmes. The number of cities banning tobacco advertisements has risen from 25% in 1998 to 44% today. The majority of cities implement their tobacco control programmes and policies through intersectoral processes, which make links to city-wide strategies and plans. Where tobacco control policies exist, the majority prioritize children, young people and women and have a focus on equity.

The European Network of Health Promoting Schools, a tripartite project launched by the Regional Office, the European Commission and the Council of Europe, is targeting one of the

major health determinants – education. Schools implementing health-promoting schools principles are tackling tobacco education from many angles. Their activities are now showing good results in terms of delaying the onset of tobacco use and facilitating cessation. The approach used by health-promoting schools includes planning for the programme through data collection, implementation of a comprehensive programme, and monitoring and evaluation. It is important to note that the terms used in tobacco education usually refer to nonsmoking as the norm, rather than to anti-tobacco or antismoking activities. Components of a tobacco education programme in a health-promoting school may include the creation of a safe and supportive school environment; ongoing measures to foster tobacco control and nonsmoking among adults; and the development of skills and knowledge through a health education curriculum. Health-promoting schools also link the specific topic of tobacco use to more general areas such as mental health promotion, life skills education, and prevention of the use of other substances.

The EuroPharm Forum is a network comprising national pharmaceutical associations and the WHO Regional Office for Europe. The tobacco-related activities of the EuroPharm Forum are coordinated by the task force "Pharmacists against smoking". This task force informs national organizations about activities in Europe, collects information about the results of pharmacists' involvement in nonsmoking work and shares knowledge between members of the task force. The national pharmaceutical associations take part in national tobacco control activities and local community pharmacies take care of individual cessation programmes, group cessation programmes, community-based programmes like Quit & Win and health information for local inhabitants.

Important contributions have also been received from other programmes and networks such as noncommunicable diseases, the CINDI programme (tobacco control as part of integrated preventive policies, capacity-building, Quit and Win competitions, etc.) and public health services (for the South-east European Tobacco Control Project).

WHO collaborating centres for tobacco control

Since 2002, the network of WHO collaborating centres addressing tobacco control policies has been reinforced by the designation of three new centres. The WHO collaborating centre for tobacco control in Heidelberg, Germany, is focusing on several areas such as smoking cessation and the role of health professionals, smoking prevalence, the economic aspects, the burden of passive smoking on children, and advocacy and communication, with a particular emphasis on developing documentation and a web site targeted at the public and experts. Two other recently established centres have tobacco as an important part of their agenda among other closely related topics (the collaborating centre on noncommunicable diseases and health promotion in Moscow, Russian Federation, and the collaborating centre on the promotion of healthy lifestyles in Almaty, Kazakhstan).

Information and monitoring

As stated in the ESTC, the Regional Office has developed a WHO European database on tobacco control that serves as the basis for a WHO European monitoring system.[18] The database is an integral part of the Global Information System on Tobacco Control (GISTOC), the network of online databases developed and maintained by the WHO regional offices with overall coordination by WHO Tobacco Free Initiative (TFI) at headquarters. One of the key features of GISTOC is the provision of information on tobacco use and tobacco control legislation and regulations in a comparable format.

[18] Tobacco control database *(6)*.

The European database on tobacco control covers five main areas: smoking prevalence, legislation, economics, cessation and general policy. It is updated regularly on the basis of regular cross-checking of data against different sources and with the national counterparts for tobacco control. The information was made available in the first edition of the WHO European country profiles on tobacco control and in an electronic database in 2002. In 2003, a special section on tobacco control legislation, incorporating texts of national and EU laws and regulations, was included in the electronic database. In 2004, a section on tobacco economics and mortality for tobacco-related causes was added. In 2005/2006 the database underwent a major update, in particular in relation to the publication of this report, and was redesigned to incorporate a statistical package for data analysis. The European database has long been acknowledged as the most advanced among the WHO regional tobacco databases in terms of its comprehensiveness, the coverage of countries and the tools for analysis. The Regional Office hosted a global workshop in 2003 in Copenhagen to share the experience gained with this database and to support other regions in developing their databases.

Developments in the standardization of data

Instruments to promote the international standardization of data have been developed and made available by CDC and WHO. These instruments are designed to obtain country health information and facilitate international comparisons. The Regional Office has been actively collaborating with CDC in several areas, most notably in the GYTS and Global Health Professional Survey. In the WHO European Region, 26 countries have now completed the school-based GYTS survey of students aged 13–15 years, which is designed to gather internationally comparable data on youth smoking prevalence and on different policy areas of tobacco control – knowledge and attitudes, media and advertising, young people's access to tobacco products, inclusion of the prevention of tobacco use in the school curriculum, exposure to environmental tobacco smoke and cessation of tobacco use. Eight countries have now also completed the Global Health Professional Survey, the recently launched survey that collects information on tobacco use, knowledge and attitudes regarding tobacco, and school curricula on the harmful effects of tobacco from third-year students attending medical, dental, nursing and pharmacy schools.

Thirty European countries are participating in the World Health Survey, a global instrument designed to monitor functioning, disability, and health interventions. The Survey addresses risk factors, including smoking.

The Regional Office has been advocating for some time the development of internationally comparable surveys of the adult population. To this effect, the Regional Office supported a global consultation between partners and experts in 2006, in collaboration with the CDC and WHO TFI, and will pilot the proposed surveillance instrument in the Region in 2007.

Other policy issues

Intersectoral coordination, funding, plans and programmes of action

In the WHO European Region, 38 Member States have national coordinating committees for tobacco control. Most of the committees established in the eastern part of the Region are still not adequately funded.

Thirty Member States reported that they had national action plans on tobacco control with specific targets. Different sources of information suggest that the majority of countries have

some gender and age orientation with elements of school programmes, primary health care and smoking cessation interventions and training for teachers. Armenia, Bulgaria, Cyprus, Latvia, Lithuania and Turkey have adopted national action plans during the last three years.

Developments in EU tobacco control policy

Since 2002 the European Community has particularly reinforced its comprehensive tobacco control policy, characterized by a three-stage approach:

- adoption and implementation of legislative measures *(16)*;
- support for smoking prevention and cessation activities;
- inclusion of tobacco control in a range of other Community policies (for example, agricultural, taxation and development policies).

As a result of its reinforced commitment to tobacco control and sustained activities and efforts the EC is establishing itself as a major player in tobacco control at a global level. In particular, it has played a major role during the negotiating and ratifying process for the WHO FCTC. The European Community signed the WHO FCTC 8 June 2003 and ratified it on 30 June 2005.

Adoption and implementation of legislative measures

In December 2002 the Court of Justice confirmed the validity of the Tobacco Products Directive 2001/37/EC. Three years later the provisions regarding maximum tar, nicotine and carbon monoxide yields, labelling of all tobacco products and product descriptions were incorporated into all legislation of the 25 EU member states. In May 2005 the EC introduced 42 pictorial warnings in line with Directive 2001/37/EC. Belgium was the first Member State to announce that it would introduce pictorial warnings and several other Member States have plans to do so. Two working groups were set up in the autumn of 2005 to address the need to collect data on tobacco ingredients in a harmonized way and to enhance laboratory cooperation.

On 31 July 2005, Directive 2003/33/EC relating to the advertising and sponsorship of tobacco products entered into force and was due to be transposed by the EU member states. In order to enforce this Directive 2003/33/EC the EC sent “reasoned opinions” and letters of formal notice to several Member States in 2006 (see section on product control and consumer information).

The EC has prepared a consultation paper on smoke-free environments which will be sent to the European Parliament, EU member states and all stakeholders for comments as to the best way to tackle passive smoking in Europe. This will launch an open public debate on the issue and the outcome of this dialogue will lay the ground for the direction of further EU action.

Support for smoking prevention and cessation activities

Two EC antismoking campaigns targeting young people and young adults: “Feel free to say no to tobacco” and “HELP – For a life without tobacco” – were launched in EU countries in November 2002 and May 2005, respectively.

Inclusion of tobacco control in a range of other Community policies

Directive 2002/10/EC on the structure and rates of excise duty applied to manufactured tobacco is due to be reviewed no later than 31 December 2006 in order to optimize the functioning of the internal market and to achieve public health objectives, particularly those linked to the WHO FCTC.

During the discussions of the High Level Round Table on Tobacco Control and Development Policy, held in Brussels on 3 and 4 February 2003 and organized in cooperation with WHO and the World Bank, the EC expressed its support for tobacco control as a force for development. It is determined to assist those countries that make tobacco control a priority by using existing instruments for cooperation in development.

A Community Fund for Tobacco Research and Information has been set up and financed from the proceeds of a deduction in the aid granted to tobacco growers.

In the area of agricultural policy, a decoupling of aid tobacco and production has been started. In 2004 the Council decided that full decoupling would be implemented after a four-year transition period, starting in 2006. During these four years, at least 40% of the tobacco premiums must be included in the decoupled single payment for farmers. Member states may decide to retain up to 60% as a coupled payment, i.e. still linked to production. After the four-year transition period, from 2010 onwards, tobacco aid will be completely delinked from production. Some 50% will be transferred to the single payment scheme and the remaining 50% will be used for programmes in tobacco-producing regions within the rural development policy *(65)*.

The tactics of the tobacco industry

In order to protect their market, cigarette manufacturers have, since the early 1950s, been putting up increasingly strong resistance to any control or regulation justified by public health concerns. In parts of the European Region where smoking prevalence is stabilizing, attempts to maintain the rates of tobacco use and to increase their profits have become a major preoccupation of the tobacco industry.

In the eastern part of the Region, the tobacco transnationals have been harnessing the benefits of transition, acquiring previously state-owned companies and attempting to encourage new smokers to take up the habit and seriously influencing tobacco control policies. Some of the tactics used by the tobacco companies to recruit new smokers, particularly among women and young people include opposition to meaningful restrictions in tobacco marketing and promotions, to tax and price increases to maintain the low costs of cigarette products and to clean indoor air legislation and regulation in order to maintain the social acceptability of smoking when the demand for smoke-free environments is rapidly increasing.

Whenever possible, tobacco companies have tried to control the agenda by shifting the discussion from the health and economic benefits of tobacco control. The approaches developed and coordinated throughout the Region by transnational tobacco companies include the denial of scientific evidence about the harm from tobacco use and exposure to environmental tobacco smoke, lobbying and exerting influence on the public and legislators, corruption and electioneering, and litigation *(71)*.

Corporate social responsibility

Recently, tobacco companies have also engaged in major public relations efforts to present themselves as socially responsible *(72,73)*. WHO has stated that corporate social responsibility and tobacco companies are an “inherent contradiction” *(74)*. While some companies have several company-wide corporate social responsibility reports (BAT, for example, has reports for Cyprus, France, Germany, Hungary, Poland, the Russian Federation and Uzbekistan on its web site), others incorporate their definitions and principles into a broader company strategy *(75)*. For

example, the web site of Altria (the parent company of Philip Morris International) shows that the company contributed, in 2005, to hunger relief efforts through donations to a London-based group *(76)* and that it provided donations to several humanitarian international agencies *(77)*, in addition to contributions in the United States, its headquarters country.

A look at specific corporate social responsibility activities developed by Philip Morris International shows that in addition to its "Youth Smoking Prevention" programmes developed throughout the Region, the company is financially involved in supporting a variety of initiatives and groups such as Children of Hope in Turkey *(78)* and the "Casa di accoglienza delle donne maltrattate", an agency to assist women who are victims of domestic violence in Italy *(79)*. The web site *(80,81)* sets out the company's support to charities but fails to agree with public health authorities on the harmful effects of environmental tobacco smoke. Japan Tobacco International's web site shows that the company supports a programme for the elderly in Romania, that in 2001 it won a "Corporate Citizen Award" *(82)* and that it is also involved in the restoration of Michailovsky Garden Railings in St Petersburg *(83)*. On the same web site, however, the company fails to agree with public health authorities on the deadly risks of cigarette smoking and exposure to environmental tobacco smoke *(84)*. BAT Germany's web site presents the social report for 2005 entitled *Responsibility through dialogue* describing its corporate social responsibility activities, such as youth smoking prevention, voluntary separation of smoking and nonsmoking areas and donations made to "community, civil society and other groups", and states that the company believes in "the provision of accurate, clear health messages about the risks of tobacco consumption", while at the same time denying the health hazards of exposure to environmental tobacco smoke and being vague about the health effects of smoking *(85)*. Similar statements about environmental tobacco smoke being an annoyance but not a health risk can be found in BAT's corporate brochures, web sites and social reports from other European countries, such as the Netherlands *(86)*, Switzerland *(87)* and BAT Nordic *(88)*.

The same web sites and reports also publicize the companies' involvement with the arts, education and community activities. The corporate social responsibility report on BAT Nordic web site discusses, for example, the funding of an annual Master's Thesis award with the marketing department of Helsinki School of Economics *(89)*, and funding for the Finnish Cultural Foundation.

Industry tactics regarding environmental tobacco smoke

Although several tobacco companies started to admit publicly some of the causal relationships between tobacco use and disease established since the 1950s, they have yet to acknowledge the harmful effects of exposure to environmental tobacco smoke *(90)*. Through analyses of industry documents, it is now known that the tobacco companies mounted a worldwide campaign to create controversy over the scientific evidence on the harmful effects of environmental tobacco smoke.

Using scientists, professors and others as consultants, the industry created a well-orchestrated public relations effort to delay the passage of clean indoor air legislation *(91)*. One particular European consultant became the focus of a case in the University of Geneva *(92)* and generated a discussion about the adequacy of institutions of higher learning in accepting tobacco industry funding, as well as issues of full disclosure of conflict of interest *(93–95)*. Papers have also looked at the industry's influence on science and policy in specific countries, for example, Germany, and questioned to extent to which the industry's influence has served as a barrier to advance tobacco control by biasing both scientific and public opinion *(96)*. Moreover, analyses

of industry documents allowed public health professionals to learn about research that the tobacco companies chose to withhold from the public *(97)*.

The tobacco industry is particularly concerned at the increase in legislation to protect against the harmful effects of environmental tobacco smoke. In addition to hiring scientists as consultants, several companies have: tried to influence the media on the issue of environmental tobacco smoke *(98)*, created links with the hospitality industry in order to delay the passage of comprehensive public smoking bans *(99)*, funded so-called smokers' rights movements and launched public opinion campaigns to promote mutual tolerance.

Despite the advance of public smoking bans in the Region, tobacco companies continue to promote their "Courtesy of Choice" programme in partnership with the International Hotel and Restaurant Association *(100,101)*. This programme seeks to "accommodate" smokers and nonsmokers with no regard to the health effects of environmental tobacco smoke. The tobacco companies, through their allies and other groups, have also tried to present ventilation technology as an alternative to bans, once again disregarding the scientific evidence showing that currently there is no ventilation technique that can address indoor air contamination by tobacco smoke *(102,103)*.

A report by the Smoke-free Partnership in Europe entitled *Lifting the smokescreen: 10 reasons for a smoke-free Europe* highlights the active role that the tobacco industry continues to play in opposing national smoke-free legislation through many of the above strategies: promoting accommodation and ventilation as a viable health solution, sponsoring studies that indicate significant economic losses in the wake of smoke-free legislation, and minimizing or denying the health effects of exposure to second-hand smoke *(49)*. This report offers scientific-based counter-arguments to assist policy-makers in protecting the public's health interests.

Marketing practices – What the documents say

As a result of researchers using the industry's documents, more details have become available about the tobacco companies' attempts to influence the European Community Directive of 1998 on tobacco advertising *(104)*. Research has also revealed that upon entry in Hungary, companies used their previously tested strategies of creating alliances and front groups to influence public opinion and decision-makers in order to evade marketing regulations *(105)*. Similarly, the documents showed how the influence of the tobacco industry in Finland might have contributed to slowing down the passage of tobacco control legislation in that country. However, Finland presents a success story where the industry's influence was defeated by the public health goal *(106)*. The issue of Formula 1 race exemptions in national legislation banning tobacco marketing demonstrates the tobacco companies' sustained interest in advertising. There is evidence that, national situation permitting, companies will continue to advertise aggressively in order to recruit new customers.

Another well-established alternative to bans or restrictions in marketing proposed by tobacco companies is the establishment of voluntary marketing codes. Such codes have been in existence for decades, one of the latest being the International Marketing Standards of 2001 *(107)*. Although it is not clear if the companies maintain their commitment to this Code, many of them have on their web sites versions of their voluntary marketing restrictions, all of which have been determined by public health professionals to be ineffective *(108)*. However, in countries with few regulatory restrictions the companies do not comply with their own code: advertisements still use young, attractive and successful people.

Youth smoking prevention programmes

In order to pre-empt the establishment of meaningful marketing restrictions, tobacco companies have enhanced the development of their own youth smoking prevention programmes. These programmes have been shown to be ineffective in preventing young people from smoking *(109–112)*. Nonetheless, tobacco companies take advantage of countries not well prepared to tackle tobacco control and often succeed in establishing financial partnerships and educational campaigns to gain the endorsement of government and nongovernmental authorities for its youth prevention programmes. Although public health does not gain, there are gains for tobacco companies both in terms of establishing themselves as "concerned" and "responsible" corporate citizens, as well as in avoiding or delaying legislation that could really have an impact on consumption and companies' profits. Companies launched, for example, advertising campaigns on television in countries as different as Portugal and the Russian Federation, with no apparent epidemiological impact on consumption.

Industry tactics tailored to different parts of the Region

Documentation from the industry have revealed that in countries where tobacco control is still growing and the public debate on the harmful effects of smoking is in its earlier stages, the industry concentrates on the widest possible range of targets (opinion leaders, the media, public opinion, politicians, civil servants, etc.). In general, after the period of investment and invasion of national markets, the objective has been to create confusion so as to delay public action and reduce the effectiveness of the proposed regulations. The documents show that in certain countries the tobacco companies have had access to high levels of the decision-making process and have been able, at least in the past, to influence decision-making in the area of tobacco control. Extensive research into the industry's documents has shown, for example, how BAT took advantage of the political transition in the CIS to ensure market share and favourable legislation *(113–116)*. There are several other examples of interference by the industry in European policies, for example, how Philip Morris prepared for possible EU restrictions on pesticide regulations and limitations that could affect the tobacco businesses *(117)*.

In the western part of the Region, where tobacco restrictions are most concentrated, the emphasis is on the state's excessive regulation of how people live their lives. Through the media and the funding of social studies, the industry encourages misleading debate suggesting that government control and regulation of personal behaviour is a restriction of individual liberties. The industry also denounces increases in taxes and the burden of bureaucracy.

Economic arguments to undermine tobacco control

The tobacco companies have developed strategies to limit the impact of proportional tax increases by introducing cheaper products (tobacco sticks in Germany) or even reducing the price of some existing products (beginning in 2006 in Spain). When it comes to smuggling and the loss of government revenues, information gathered in different countries shows that manufacturers adopt a passive attitude towards the surveillance of exports of their products. The industry documents have pointed to, at a minimum, a certain level of knowledge by cigarette manufacturers about the smuggling of their own products *(118–120)*. Individual governments and the European Commission have initiated legal proceedings against tobacco manufacturers on these issues. While tobacco smuggling rings are frequently dismantled in the Region, legal proceedings to establish tobacco companies' responsibilities continue. Two case studies in this report describe the latest developments in reaching agreement on counteracting smuggling with the industry by the European Commission and the United Kingdom, respectively (Annex 1, No. 2 and 14).

Industry tactics and the WHO FCTC

During the negotiations for the WHO FCTC, tobacco companies called for a dialogue through which they would try to demonstrate their "corporate responsibility". Evidence from the documents demonstrates that companies, once they realized that progress towards a global convention was inevitable, sought to influence it as much as possible *(121,122)*. The documents have revealed how three large multinational companies (BAT, Philip Morris International and Japan Tobacco International) considered the creation of a parallel regulatory body that would pre-empt the need for the WHO FCTC. In the aftermath of the approval and entry into force of the WHO FCTC, companies are now pushing for participation, dialogue and "reasonable" regulatory frameworks, i.e. that do not curtail their ability to market their products freely (or communicate with their consumers, as the industry tends to phrase it); that do not lead to a decline in the social acceptability of smoking and that maintain tobacco products at a price that is affordable to the largest possible number of consumers. Fortunately, with the growing implementation of the WHO FCTC, regulatory measures should become stricter. Nonetheless, the knowledge gained in studying the tobacco companies' behaviour is essential to inform future tobacco control activities.

Litigation

Litigation is not yet common in the European Region compared, for example, to the United States. The case initiated by the European Community and 10 EU member states supported by WHO *amicus curiae*[19] against major tobacco companies for involvement in illegal trade has been a significant development in this area. In January 2004, the New York Court of Appeals for the Second Circuit confirmed that the Community and EU member states were entitled to sue the companies for money laundering while the appeal for smuggling was rejected *(59)*. Six months later, in July 2004, a binding agreement was signed between Philip Morris International and the European Community ending the dispute but with important financial consequences (see section on measures to reduce the supply of tobacco products and Annex 1, case study). The Community is still suing the tobacco companies which are not parties to this agreement.

In order to enforce Directive 2003/33/EC on the advertising and sponsorship of tobacco products, the EC sent "reasoned opinions" (the last step in the infringement procedure before resorting to the European Court of Justice) in February 2006 to Germany and Luxembourg for failing to communicate to the Commission their national transposition measures for the Directive. In April 2006, the EC sent letters of formal notice (the first step in the infringement procedure) to four EU member states (the Czech Republic, Hungary, Italy and Spain) for allowing exemptions from the ban on tobacco sponsorship of cross-border events and activities, such as Formula 1 races and motorsport Grand Prix. Directive2003/33/EC does not recognize such exemptions.

Germany has challenged the validity of Directive 2003/33/EC in the European Court of Justice (Case C-380/03), the main issue being whether the internal market competence of the EU extends to banning tobacco advertising in the press. Judgment was expected by the end of 2006.

Twenty-one countries have reported various examples of litigation at national level, mainly by individuals/organizations aiming to protect people's right to a smoke-free environment. An increasing number of cases have, however, successfully challenged the implementation of

[19] Friend of the court, i.e. not a party to the litigation but present on the grounds that the decision will be in its interest.

advertising regulations and the right not to be exposed to environmental tobacco smoke. By comparison, individuals' claims for retrospective compensation based on exposure to environmental tobacco smoke have tended so far to be not very successful in the WHO European Region.

CONCLUSIONS

At the WHO European Ministerial Conference for a Tobacco-free Europe (Warsaw, 18–19 February 2002), Member States committed themselves to developing the ESTC and declared their strong support for a comprehensive WHO FCTC.

The 2002–2006 period has seen important progress in tobacco control policy in most Member States and in the Region as a whole. However, critical trends in smoking prevalence, particularly in vulnerable population groups, and weaknesses in the implementation of new policies require urgent attention. The available data show that the tobacco epidemic has in general stabilized, with more countries reaching the stage where smoking prevalence and tobacco-related harm are decreasing. The consequences are, however, still devastating for public health and countries need to strengthen their policies and work towards the objectives set out in the ESTC and the WHO FCTC.

The baseline recommendations for tobacco control in the WHO European Region are set out in the ESTC. In many cases these are reinforced by the provisions of the WHO FCTC. The analysis of recent data and developments provided in this report has led to the following conclusions, which are especially important for Member States and the Region as a whole.

Although smoking prevalence has in general stabilized in the WHO European Region, it does not present a clear diminishing trend. There are still wide disparities in different parts of the Region. In most western European countries, smoking prevalence has fallen to a point where not much further decrease can be expected unless substantially stronger measures are implemented. While in a few eastern European countries male and female smoking prevalence is starting to fall, in general it is still rising among women and just starting to stabilize among men. Moreover, in parts of the Region, particularly the CIS, smoking prevalence in men is substantially higher than the Regional average and shows no real signs as yet of decreasing. The countries thus need to continue and in many cases accelerate their implementation of the baseline recommendations outlined in the ESTC. There is also a strong need to develop international instruments and improve national surveillance and the monitoring of smoking prevalence, particularly through internationally comparable surveys of the adult population.

Recent years have also shown that there is significant and increasing public support in favour of national and international efforts to develop and strengthen legislation and regulations for tobacco control. It is not only a large majority of nonsmokers that support stronger measures: a majority of smokers too favour tougher controls. One important policy consideration is, therefore, that governments and society need to use the current momentum to create a turning-point in combating the tobacco epidemic in the Region. This also opens up opportunities for improving compliance with legislation through adequate and stronger (when necessary) enforcement mechanisms, penalties, comprehensive information campaigns and litigation.

Increased political commitment supported by strong public opinion has led to substantial changes in tobacco control policies in the last four years. One of the most visible improvements since 2004 has been the introduction of smoke-free legislation in all public places, including bars and restaurants. Most countries have also made progress in relation to banning advertising, increasing the size of health warnings on tobacco packaging, strengthening the regulation of tobacco products and, to a certain extent, increasing taxes on tobacco. The following are some specific points of policy, arising from the achievements and challenges of the past several years, to which consideration should be given to reinforce those already outlined in the ESTC:

- a total ban on smoking in all public places being the only feasible and effective way to prevent exposure to environmental tobacco smoke;
- the introduction of taxation mechanisms in order to set a minimum price for tobacco products;
- sustaining regular increases in tobacco taxes;
- providing adequate financial support for tobacco control which could be achieved in particular through earmarking mechanisms;
- exploring new or unfamiliar strategies, especially supply side measures such as substantially reducing the overall commercial availability of tobacco products (reduction of points of sale);
- holding to the principle that governments and public health authorities refuse offers of cooperation with the tobacco industry in framing their tobacco control policies.

The concentration of smokers among the lower socioeconomic groups observed throughout the Region, particularly in western countries, could lead to a widening gap in future health outcomes. Although the absolute number of people exposed to socioeconomic disadvantages may be diminishing in some countries, the persistence of a relative gap emphasizes the need for countries to extend tobacco control policies to broader policy interventions by targeting the different social and economic factors related to smoking. The following points need to be considered for future action:

- tobacco control policies tailored to reach vulnerable and lower socioeconomic groups, particularly through the introduction of innovative social marketing techniques;
- continued implementation and evaluation of effective programmes concerning tobacco dependence and cessation, in order to increase the rate of quitting especially among the lower socioeconomic and vulnerable groups;
- improvements in follow-up and prevention of relapse in the face of rising numbers of smokers going through cessation services or using nicotine replacement therapy products.

Challenges identified in previous European action plans still need particular attention, such as the fight against the illegal trade. While anti-smuggling measures seem to have achieved some results in the western part of the Region, there are further challenges from the increasing proportion of counterfeit products on the illegal market. An acceleration of Region-wide and sub-regional cooperation in this area, with its ever-greater cross-border character and impact, would substantially contribute to a strengthening of tobacco control measures in the Region.

The Region as a whole made a significant contribution to the negotiations and entry into force of the WHO FCTC. Forty Member States and the European Community have ratified and become Parties to the Convention. Tobacco control in Member States can certainly benefit from the coherence of national, regional and global action as a critical number of countries have already

ratified and started implementing the WHO FCTC. Further progress can be made through support for other countries in ratifying the Convention, establishing effective mechanisms for international collaboration, exchange of experience and reporting (particularly through the Conference of the Parties), and through exploring the synergy between achieving the Millennium Development Goals and tobacco control, in particular by introducing tobacco control into the global partnership for development.

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Annex 1

CASE STUDIES

1. Ratification of the WHO FCTC: the experience of Armenia
2. The Anti-Contraband and Anti-Counterfeit Agreement reached by the European Community with Phillip Morris
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1. Ratification of the WHO FCTC: the experience of Armenia

This case study presents the experience of Armenia in successfully promoting the ratification of the WHO FCTC by its Parliament. The case is particularly important in demonstrating the ratification of the first public health treaty in rather difficult circumstances, namely the absence of a strong tradition of tobacco control or of public and political support for it, and the fact that the government initially failed to sign the treaty by the internationally agreed deadline. The WHO FCTC is the first treaty initiated by the World Health Assembly, the governing body of WHO, and it aims to assist the participating countries in effectively and collaboratively countering tobacco use. Not all the countries participating in the Convention have ratified it. Despite a rather pro-tobacco climate in the country, the Armenian Ministry of Health has managed against the odds to get the WHO FCTC ratified by Parliament.

Situation prior to the policy initiative

Traditionally there has been a high prevalence of tobacco-smoking in Armenia, connected to the strong local tobacco industry with many tobacco brands famous throughout the former Soviet Union. According to the National Statistics Service, 67.5% of adult males and 3.1% of adult females were considered to be smokers in 2001. There has been an increasing trend in the percentage of smokers in recent years and high rates of mortality and disability resulting from smoking. Until the late 1990s, there was no anti-tobacco legislation.

In the late 1990s and early 2000s the Ministry of Health attempted to respond to the growing problem of tobacco consumption by taking the lead in raising awareness and developing legislation and national policy.

This presented a challenge since the climate at that time was not favourable to the anti-tobacco movement. The country had a long tradition of producing and consuming tobacco products and a significant part of the national economy was directly linked to the manufacture of and trade in tobacco. There was no anti-tobacco legislation, and both the media and the public were indifferent to the topic.

Launch, development and implementation

Under the growing influence of the WHO FCTC process, the country started to accelerate the development of a strategic approach to promote the anti-tobacco campaign. The initiative comprised simultaneous interventions at different levels primarily aimed at raising support among the major stakeholders in the system, namely policy-makers such as the government, parliament and presidential administration as well as the public, nongovernmental organizations and the media.

Between 2002 and 2004, a series of interventions were undertaken to develop and realize the strategy. In order to create an enabling environment a campaign was launched in the mass media, including on television, to raise public awareness of the negative consequences of tobacco consumption. During the campaign a special effort was made to involve key opinion-leaders such as influential journalists, respected professionals and popular representatives of show business and sports. A series of round-table discussions and seminars were held with the participation of policy-makers, members of Parliament and high-ranking officials to promote the ratification of the WHO FCTC by Parliament. Research studies conducted by professional groups and organizations were also actively supported in order to reveal the political, economic,

social and health impact from tobacco consumption, and an electronic tobacco control portal was created.

The implementation of the strategy aimed above all at the ratification of the WHO FCTC and involved a series of activities:

- the Ministry of Health translated the basic documents of the WHO FCTC into Armenian;
- in collaboration with the Ministry of Foreign Affairs, the provisions of the WHO FCTC were disseminated and clarified among other state structures and the National Assembly;
- the WHO FCTC document was presented to the Constitutional Court for consideration and advice;
- representatives of the Ministry of Health worked systematically to advocate with members of Parliament, ministers and government officials and high-ranking members of the Presidential administration;
- advocacy was sought from representatives of nongovernmental organizations who supported the idea as well as from international organizations, especially WHO.

Policy impact

Parliament ratified the WHO FCTC on 12 October 2004. Armenia was thus among the first 40 countries worldwide (the number of Parties required for the entry into force of the WHO FCTC) to ratify the Convention. The treaty became international law on 27 February 2005. The ratification was followed by a series of political measures to sustain and strengthen tobacco control in the country: adoption of the new tobacco control law, adoption of the government's national action plan, and provision, for the first time in many years, of substantial state funding for tobacco control activities. The ratification of the WHO FCTC as well as the introduction and implementation of tobacco control legislation provided the anti-tobacco coalition in the country with guidance and momentum to combat tobacco. A solid framework indicating the next steps and a sound legal basis have strengthened the position of the anti-tobacco forces. Further legislative and regulatory initiatives aiming at implementing the suggestions of the WHO FCTC have also been adopted.

Lessons and conclusions

The Armenian case clearly shows the importance of systematic and coordinated activity in successfully promoting action to counter tobacco. Even in an unfavourable context the adoption of a systematic approach has proved effective.

Continuity in pursuing a clearly defined aim (the ratification of the WHO FCTC) and consistency in following this aim during the implementation period proved to be invaluable for achieving a successful outcome. This also sets a precedent (rare in the WHO FCTC process) of a country ratifying the Convention without previously signing it – a potentially motivating case for the countries who for various reasons failed to sign the Convention before the deadline in 2004.

An anti-tobacco advocacy campaign needs to be well-orchestrated and centrally coordinated under the leadership of the Ministry of Health. To be successful it needs to involve a variety of stakeholders from different levels, including key opinion-formers.

2. The Anti-Contraband and Anti-Counterfeit Agreement reached by the European Community with Philip Morris

This case study provides an analysis of an intervention policy targeting tobacco smuggling through legally binding provisions agreed with a major tobacco manufacturer, Philip Morris International (PMI). The case study draws upon historical documents and oral and written testimony by tobacco manufacturers taken before the United Kingdom Treasury Sub-Committee from 2000 to 2005.[1]

Situation prior to the policy initiative

The member states of the European Union were losing hundreds of millions, if not billions, of Euros per year from the smuggling of authentic and counterfeit cigarettes.[2] As a result of an alarming increase in the trade in counterfeit goods, the customs services, member states and tobacco manufacturers established cooperative relationships in order to maintain orderly internal markets. The customs services introduced voluntary systems to raise concerns about particular customers and notified manufacturers of repeated seizures. In the United Kingdom, a yellow and red card system was introduced that identified customers where a serious risk was established that a high proportion of tobacco products were illegally entering the market.

To formalize this cooperation, memoranda of understanding were signed between member states and tobacco manufacturers to reinforce their cooperation in the fight against tobacco smuggling, particularly the large freight smuggling that dominates the large-scale illicit supply. These agreements were negotiated individually with different tobacco manufacturers and did not represent a standardized approach between members of the industry and member states. Key points addressed within the memoranda of understanding put the onus on manufacturers to:

- ensure that they supplied products only where a legitimate demand was established in the intended final market;
- identify supply routes of suspect export trade and refuse sales where the end sale (consumption) was in doubt;
- terminate relationships with customers who had been shown to have behaved improperly.

Launch, development and implementation of the policy

The EU and certain member states realized that memoranda of understanding were not an answer to the enormous problem of cigarette-smuggling. Thus, on 9 July 2004 the European Community, 10 EU member states and PMI signed a legally binding Anti-Contraband and Anti-Counterfeit Agreement.[3] The Agreement is more extensive in its provisions, scope and extent than any memorandum of understanding. Key differences are that it is legally binding, subject to specific enforcement mechanisms, and provides for substantial payments to the EU and 10 initial member states over 12 years, which may provide an additional source of funding for the fight against smuggling of authentic and counterfeit products. Additionally, the Agreement has

[1] Oral evidence presented by: HM Customs and Excise 2000-5 (17.10.2004), Philip Morris International (12.01.2005) and Chinese State Tobacco Monopoly Administration.
[2] Statement by Commissioner Michaele Schreyer in Brussels on 9 July 2004 at the signing of the Anti-Contraband and Anti-Counterfeit Agreement with Philip Morris International.
[3] To date, 14 additional member states have signed the Agreement.

extensive compliance protocols, customer oversight provisions[4] and product tracking and tracing provisions. Key features[5] of the Agreement are listed below:

- *sales and distribution practices* – all cigarettes will be sold, distributed, stored and shipped in accordance with legal requirements (Article 2);
- *anti-contraband and anti-counterfeit initiatives and procedures* – allow for the combat against the introduction, sale and distribution of contraband and counterfeit cigarettes within or through the territory of member states;
- *extra payments* – commitment by PMI to make substantial payments that could serve as additional funding for the fight against the smuggling of authentic and counterfeit cigarettes (Article 3);[6]
- *seizures payments* – substantial payments by PMI in the event of seizures in the EU provides a mechanism for effective policing by both PMI and member states' law enforcement authorities;
- *compliance protocols* – require PMI to exercise tight control and regulation of contractors, and to stop supplying them if they are found to be complicit in smuggling;
- *tracking and tracing protocols* – allow member states' customs services to identify smuggled cigarettes through the use of a central database so that they can be traced back to the contractor who bought them from PMI;
- *central database* – maintenance of a central database containing information useful in tracking products sold by PMI (Article 5);
- *resolving prior disputes* – mutual release of claims and the end to all prior disputes between parties (Article 9);
- *enforcement* – provisions for dispute resolution and enforcement of the Agreement in the future (Article 12);
- *review* – the Agreement will be reviewed annually; if proposed changes are not agreed by both sides there will be an independent arbitration process (Article 12);
- *life of the Agreement* – the Agreement remains in effect for 12 years and will be renegotiated two to three years before it ends.

Enablers and context

Until the Agreement was signed in July 2004, the intervention strategies initiated by member states had targeted specific areas and represented a piecemeal rather than a comprehensive and systematic approach. The Agreement provides a framework for a proactive and strategic approach coordinated among member states, the European Community, law enforcement agencies, customs services, regulatory bodies such as the European Anti-Fraud Office (OLAF) and Philip Morris.

The Agreement is a binding contract, and consequently the basis for it was very different from a non-binding memorandum of understanding. It resolves all past disputes; in particular, all civil

[4] These provisions are also described as "Know your customer" and "Contractor Relations".
[5] For full details of the agreement, see the European Anti-Fraud Office (OLAF) web site (http://europa.eu.int/comm/anti_fraud/index_en.html, accessed 28 November 2006).
[6] Over the course of the 12-year Agreement, payments could total approximately US$ 1.25 billion.

litigation between the parties to the Agreement was brought to an end. The Agreement does not constitute an admission of liability by any of the parties.

The Agreement contains several mechanisms designed to enhance cooperative efforts. One of these mechanisms is the cooperation that ensues after notification of a seizure by a member state to Philip Morris.[7] The Agreement requires Philip Morris to control smuggling of its brands produced anywhere in the world and seized within the EU. Payment by PMI in the event of a seizure in the EU provides a mechanism for effective policing and cooperation by both PMI and member states' law enforcement agencies. Additionally, these payments represent an additional source of funds that may be used to combat cigarette-smuggling.

The stipulations within the "Know Your Customer" and "Contractor Relations" provisions contribute to a comprehensive and global customer oversight programme designed to be a proactive, rather than a reactive, approach by PMI to prevent smuggling and money-laundering. Key stipulations include the requirement that representatives of Philip Morris visit each customer's place of operation and verify the business plan as well as the portfolio of potential customers.[8] Only approved purchasers can purchase Philip Morris cigarettes in line with retail demand for the intended market. If a company is found to be in non-compliance, it will be blocked from working with PMI for five years. Compliance reports are required on all contractors and are to be supplied to OLAF every year, as well as a full yearly audit and information on performance review mechanisms.

The tracking and tracing protocols provide for the creation of a comprehensive database of information for access by the European Community (OLAF), member states and PMI. Unique machine-readable markings on master cases enable law enforcement and customs to identify first and subsequent customers by querying PMI's database. The database is available 24 hours a day by nominated officials at OLAF and key agencies of each signatory member states. Contingency phone and fax numbers are available in the event that the database is not accessible. In this way, immediate investigations can occur that may result in additional seizures. In addition, multiple codes on packs and cartons provide for additional tracking of the product.

Another key enabling feature is the obligation on PMI to continue to carry out research and to supply yearly reports on new technologies in order to improve tracking and tracing. In this way, member states, customs and law enforcement agencies may have access to current and detailed information obtained by the latest technology.

Impact of the policy

The Agreement has provided a foundation for strong coordinated action between the European Commission (OLAF), national law enforcement authorities and Philip Morris to prevent smuggling and money-laundering. It represents an innovative approach due to its specific, measurable, achievable, relevant and timed targets, and the payments to be made by PMI if these targets are not met.

The Agreement is consistent with the provisions of Article 15 of the WHO FCTC regarding the illegal trade in tobacco products and constitutes a veritable working document for the preparation

[7] See Art. 4.01 of the Agreement.

[8] PMI is required to confirm customer details such as numbers of employees, date of birth, passport, tax regulation numbers, assessment of customers' ability to identify subsequent purchasers, investigation of sales plan, investigation of criminal records, full details of bank accounts through which payments are to be made, annual checks of invoice and payment details and identification of first and subsequent purchasers.

of specific protocols. The Agreement may serve as a model for agreements with other industry members.

Use of the PMI/EC Agreement as a model

The strict and legally binding control policies enunciated in the Agreement can serve a model for similar agreements with other members of the industry and in other areas of the world.

The appearance of multiple standards through inconsistent memoranda of understanding or significantly different agreements would undermine the effectiveness of this legally binding approach and create the possibility of conflicting or inconsistent obligations and applications covering a single industry participant or a single country or region. This lack of consistency would be detrimental to the effectiveness of the control mechanism.

Action on Smoking and Health (ASH) considers the PMI Agreement to be the "gold standard" against which all attempts by cigarette manufacturers to control excise tax fraud should be judged in the future.

Lessons and conclusions

The Agreement is an innovative approach for collective and strategic action by any country, including the member states, the European Community, law enforcement and regulatory agencies to control tobacco-smuggling and money-laundering.

It represents a systematic rather than a piecemeal approach that deals with products seized within the EU but produced anywhere in the world.

The stipulations for substantial additional payments to be made by PMI create financial mechanisms for policing and intervention, as well as cooperation and collective action between member states.

A comprehensive database and customer oversight programme created and enforced under the Agreement allows customs and law enforcement agencies to share information and act cooperatively toward additional seizures.

Compliance reports required of all contractors and supplied to OLAF every year, as well as full yearly audits and the established performance review process, are key components for monitoring and evaluating the ongoing effectiveness of this Agreement.

3. "HELP – For a life without tobacco": the launch of a new EU-wide antismoking campaign

The European Union (EU) has made the fight against smoking one of its top public health priorities. While adults today seem to be relatively well-informed about the harmful effects of smoking, young people remain less knowledgeable on the issue. This case study presents the development and launch of an ambitious information and awareness-raising campaign on the harmful effects of smoking by the European Commission (EC). The campaign is known as "HELP – For a life without tobacco" and it predominantly targets the younger generations in the

25 EU member states. The initiative has been proved challenging in view of the sheer size of the campaign and the regional and cultural differences between the EU member states.

Situation prior to the policy initiative

Tobacco-related diseases are the second largest avoidable cause of death worldwide, responsible for an estimated 4.9 million deaths every year. In Europe, however, they are the principal cause of death, where they are estimated to account for over 650 000 deaths every year in the 25 EU member states.[9] The effects of passive smoking are also of great concern,[10] and young people appear to be under-informed about the consequences of tobacco use. In view of this, EU countries have made several attempts at national level to combat the use of tobacco. Their efforts have, however, been fragmented and lacked coordination at European level. There have also been proposals for the EC to take a more active role in supporting anti-tobacco activity, with the need to define an added Europe-wide value. Thus there was a clear need for the EU to pave the way.

Responding to the challenge, the EC Directorate-General for Health and Consumer Protection decided to intervene by taking the leadership in launching a new anti-tobacco information campaign. "HELP– For a life without tobacco" is the second major EU-wide antismoking campaign run by the Commission. It builds on the experience of the first such campaign, "Feel Free to Say No", which ran from 2002 to 2004, while aiming to yield more fruitful results.

The "Feel free to say no" campaign

The first campaign ("Feel free to say no") was a three-year tobacco prevention campaign among young people and the media, covering 15 member states with a budget of €6 million a year.

There is much controversy about media-based youth prevention campaigns with regard to tobacco control, and the "Feel free to say no" campaign was immediately criticized by nongovernmental organizations working in tobacco control for not getting the right message across effectively.

The situation was more complex than that. An independent evaluation of the campaign carried out during the second year concluded that the teenagers participating in the focus groups appreciated the style of the campaign as easygoing and not moralizing. The anti-tobacco objective of the campaign was understood even if most elements of the campaign, taken separately, did not explicitly refer to tobacco, including the slogan "Feel Free to Say No". Adolescents also found smokers quite seductive: independent-minded people, questioning laws and morals, self-confident, sexually experienced, living in a tough world, members of a peer group; while nonsmokers were described as good girls and boys, conforming to adult authority, innocent and naive, uninitiated although active and responsible, sporting, keeping to a healthy diet and natural.

The evaluation concluded that the image of the nonsmokers after the campaign remained unchanged. Professional footballers in the television advertisement were seen as "compulsory" nonsmokers, and the fact that pop stars did not smoke was not judged credible by some. Some groups suspected manipulation, others reckoned that the advertisement was targeted at children. Moreover, what was shown on the screen seemed unrelated to real life. The theme of freedom appeared highly relevant to the teenagers, but rather than freedom from peers (saying no to

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[9] *Analysis of the Science and Policy for European Control of Tobacco (ASPECT) report.* Brussels, European Commission, 2004.

[10] Hill SE. Mortality among "never smokers" living with smokers. *British Medical Journal,* 2004, 328(7446):988–989.

them), the challenge was rather to become an autonomous adult, free from the influence of parents as well as free from any addiction.

In general, it was questioned whether added value at European level was optimized by launching media campaigns directed at young people, since to be effective at the micro-social level (where young people are most subject to influence) would require not only a much larger budget but also a fine-tuned social marketing approach sensitive to culture and language.

The lessons from the external evaluation were taken into account in the development of the second and third year of the "Feel free to say no" campaign, but the main achievement was the organization by the EC of a major conference on the subject.

The Rome conference

In the light of the "Feel free to say no campaign", the Commission organized, in collaboration with the Italian Presidency of the Council, a conference in Rome from 13 to 15 November 2003 where 212 public health and media experts from 32 countries presented the latest results, examined the pro and cons of the campaign and shared their views on it and on young people.

The output of this conference was a series of recommendations aiming to ensure that future EC campaigns would be developed in accordance with the latest scientific evidence available and come forward with innovative and consensus-driven solutions.

The call for tenders published in August 2004 which led to the "HELP – For a life without tobacco" was clearly based on the recommendations of the Rome conference

Launch, development and implementation

The "HELP – For a life without tobacco" campaign was developed for the EC by a consortium of health experts and communication and public relations professionals and launched in March 2005.[11] The EC has earmarked €72 million for the new campaign between 2005 and 2008. Adolescents (15–18-year-olds) and young adults (aged 18–30 years) are the main target groups.

A tool was devised to measure public opinion at the start and during the campaign. Prior to its launch, surveys were carried out in many European countries which showed that the public strongly favoured EU involvement in the fight against smoking. The data collected from the pre-test survey was used to give information to producers for the development of concepts for television and radio advertisements. A post-test assessment was also carried out to measure the standards for agreement among the member states with respect to the key attributes of the campaign and recognition of and approval rates for it.

The key objective of the campaign is for nonsmoking to become the new standard in the EU countries, while the three priorities of the campaign as defined by the EC are the prevention and cessation of smoking and tackling passive smoking.

The implementation of the campaign followed a multimedia approach, employing a range of integrated tools:

- a road-show to signal the launch of the campaign in each member state;

[11] *HELP Campaign Executive Summary, 17/01/2005* (SANCO/2004/FT/2004/01) (http://health21.hungary.globalink.org/help_logikaialap.pdf, accessed 28 November 2006).

- television advertisements: a full campaign spearheaded by three films, which were the subject of an unprecedented pre-testing exercise and more extensive post-test assessment;
- press releases and media coverage;
- the launch of an internet site;
- parallel Europe-wide events and discussion forums.

The overall process has proved fairly challenging. During the design and implementation stages significant barriers had to be overcome primarily related to:

- the size of the initiative, involving 25 countries and 460 million citizens, which has led to major difficulties in coordination and communication between all those involved;
- the considerable cultural variations and differences in perception between both individual countries and the different regions in the EU; this was clearly signalled in the pre- and post-test surveys which showed, as an example, that approval for the campaign fluctuated from 65% in the Nordic countries to 81% in the Mediterranean countries;
- the low level of member states' involvement in the programme and the sub-optimal level of coordination achieved in the implementation phase.

Enabling context

The campaign was carefully developed based on the advice and expertise of policy and health experts working in the area of the fight against tobacco. It incorporated the conclusions of existing European studies on the subject, used the experience of the first ("Feel free to say no") campaign and was based on the recommendations of the Rome conference.

In the early development stage, considerable efforts were directed at ensuring that national and local antismoking organizations across Europe were involved in the campaign. A partnership was developed with the European Network for Smoking Prevention (ENSP), Europe's largest antismoking network representing 530 organizations,[12] whose considerable expertise and know-how in the fight against tobacco was sought for the campaign.

Finally, at both the design and implementation stages, the programme encompassed a systematic and scientifically sound approach in assessing the potential impact prior to the launch of the campaign and measuring its effect afterwards. This was achieved by applying a qualitative tool in pre- and post-test surveys, which greatly enhanced the legitimacy of the initiative among the campaign partners and national representatives.

Impact of the policy

The process of bringing together 25 very different countries in the fight against tobacco has in itself been a substantial achievement and provides a base for coordinated action between the EC and EU member states.

From September to October 2005, a large-scale post-test survey was carried out by the market research company IPSOS in the 25 EU countries regarding the televised campaign which showed that:

[12] European Network for Smoking Prevention (www.ensp.org, accessed 22 August 2006).

- 48% of those aged under 25 years remembered seeing at least one of the three televised commercials of the HELP campaign;
- 83% of those aged under 25 years liked the HELP campaign;
- 81% of respondents thought that these commercials conveyed the message intended by the people behind the HELP campaign that "Smoking is absurd".

The campaign has been judged efficient and reached a satisfactorily high number of young people. It has proved popular, well-understood and with the capacity to trigger personal reflections on smoking. However, it is also clear that there needs to be greater awareness of it.

The post-test assessment has also revealed that the campaign has had further impacts:

- it has provided valid and relevant information to European citizens about the problem of tobacco;
- it has offered both personal and collective assistance to counter smoking;
- it has been complementary to national activities and communication operations and connected these activities to other European initiatives, setting them in a wider context and magnifying their local effects;
- it has supported and strengthened existing antismoking activities undertaken by the governments of EU countries and nongovernmental organizations;
- with the launch of the web site, it has created a European central point of reference concerning the provision of help and assistance with tobacco.

Lessons and conclusions

The first lesson to be drawn from the study has been the feasibility of setting up a communication campaign on the theme of tobacco throughout Europe. Despite the obvious difficulties, it has been possible to set up links and coordinate action between the EU member states.

"Think global act local" … As well as being a global unifying vision, it is also important to point out that linguistic and cultural adaptations have been necessary in implementing the programme. These were decided in cooperation with national partners to give member states flexibility in customizing the campaign to match local circumstances.

The role of the EC is as a facilitator. In that respect the campaign:

- has been adapted to suit the targeted areas of concern;
- co-exists harmoniously with national campaigns and communication activities in similar or different areas of the fight against tobacco;
- is developing over time with valuable contributions from health experts and nongovernmental organizations, thus building up "identity and awareness" capital.

Partnership with nongovernmental organizations and their active involvement in the design and execution phases have provided valuable insight and benefited the operation through their expertise and knowledge of the subject.

The weakest point has been the poor level of coordination and involvement of member states in the first year of the initiative. Future efforts should be concentrated on involving them more

actively. At the end of 2005, the EC invited representatives of the health ministries of the 25 member states to improve this coordination.

4. Taxation policy for tobacco control: the experience of France

This case analyses the utilization of taxation policy as a key instrument of an integrated public health policy on tobacco control. In particular, it explores the factors which led to the introduction of this policy and the contextual factors which influenced its development and execution.

Situation prior to the policy initiative

The consumption of tobacco products increased from the 1950s to 1980s and then remained stable until the early 1990s. It began to fall following the introduction of the Evin Law in 1991 (Fig. 1), although from the late 1990s to 2002 the decrease in consumption and sales of tobacco was not substantial. Between 1950 and 1991, empirical evidence indicated that the weak pricing policy that had been followed during that period resulted in relative prices falling and tobacco consumption moderately increasing (Fig. 2,3). Three main policy interventions aimed at controlling tobacco had been developed over this time with varying levels of success: the Veil Law (1976), which was the first attempt, produced moderate results, while the Evin Law (1991) and the Health Department Plan (1999–2002) had better results. These policies created an enabling environment for the introduction of a new strategy in 2003.

Fig 1. Sales and price of tobacco in France, 1950–2000

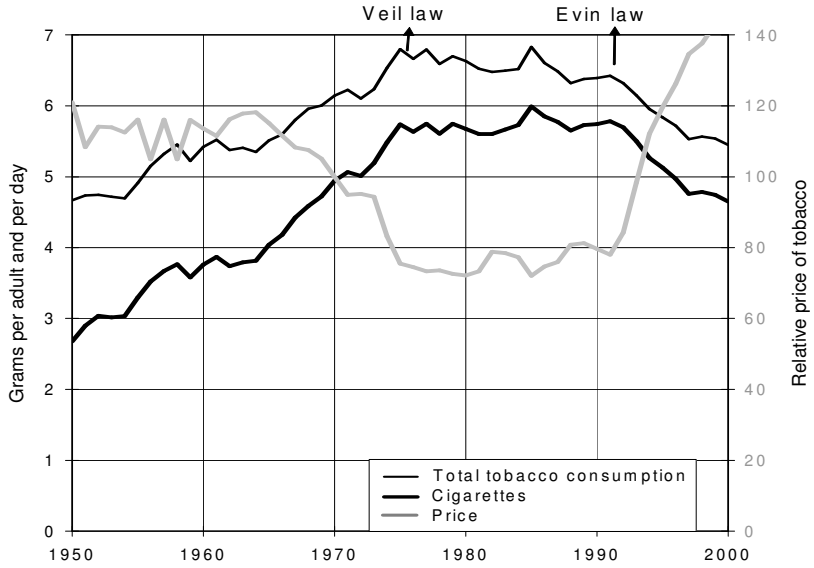


Fig. 2. Sales of cigarettes per person aged over 15 years, France, 1900–2000

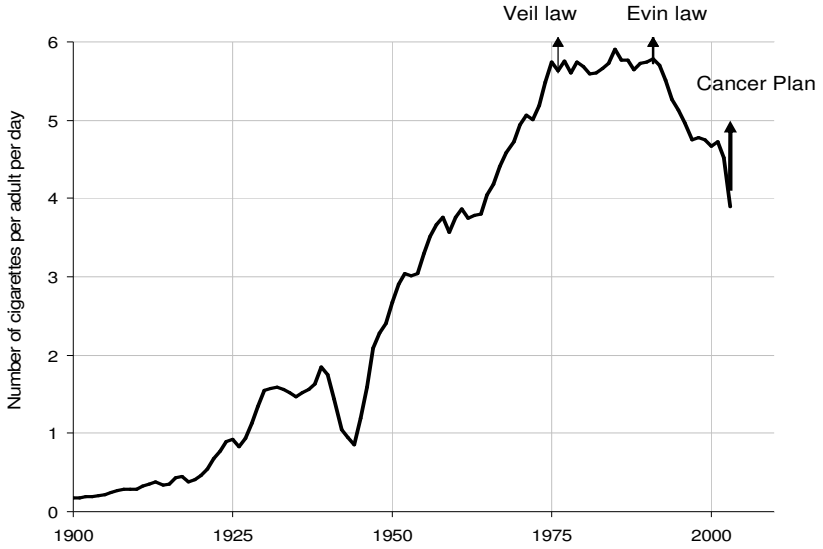
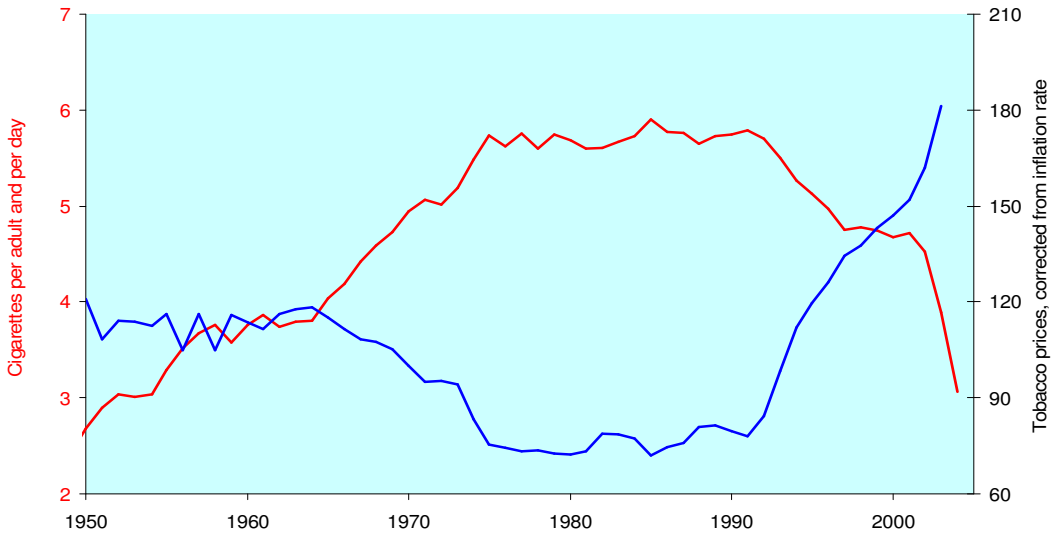


Fig. 3. An effective policy: evolution of prices and consumption of cigarettes, France



Source: Hill C, Laplanche A. Tabagisme et mortalité : aspects épidémiologiques. *BEH*, 2003, 22–23:98–100 (http://www.invs.sante.fr/beh/2003/22_23/beh_22_23_2003.pdf, accessed 30 November 2006).

The second milestone was the Health Department Tobacco Plan which promoted smoking cessation measures and policies to prevent secondary smoking. This plan launched the transfer of decision-making responsibility for taxes on tobacco and alcohol from the Ministry of Finance to the Health Department and allowed the use of pricing and taxation policies as powerful public health instruments to enhance tobacco control. The new approach enabled the Health Department to take full control of excise duty and taxes on tobacco products, rather than just the valued added tax, and thus gave it full control of pricing issues. New earmarked tobacco taxes were introduced and the revenues used to finance public health and social security activities.

Launch, development and implementation of the policy

In 2003, France introduced a new strategy, "The Cancer Plan", to combat tobacco. Aggressive taxation of tobacco products has been used as the major tool to control and reduce tobacco consumption within a multifaceted approach. This approach has involved a combination of taxation policy with enforcement of stringent anti-tobacco legislation (ban on advertising, ban on smoking in public places) and intensification of health education programmes emphasizing interventions for the prevention and cessation of smoking.

The launch of the Cancer Plan, as well as the preceding policies, had consequences for a wide range of stakeholders – tobacco companies, tobacconists, Ministry of Finance, Customs, the public. The development and implementation of policy were challenging and needed to be carefully managed.

To avoid or neutralize political pressures from various stakeholders such as the tobacco industry lobby, the Ministry of Finance, Customs and smokers, the Health Department had to develop a holistic approach in dealing with them.

The introduction of earmarked taxes was carefully planned and communicated to the public so as to galvanize public support for the imposition of tobacco taxes. The increase in taxation was justified by pointing to the proposed use of these tax revenues for financing public health and social security activities.

The Health Department had also to counter opposition from tobacco industry, which were clearly threatened by the tax increases and united to form a strong lobby. The Department countered this resistance in part by proposing to harmonize taxation on all tobacco products. This divided the interests of the tobacco companies, subject as they were to intense competition and conflicting interests between companies with a strong interest in cigarettes and those with interests in other tobacco products. The introduction of harmonized taxation ensured a further fall in the number of brands offered at low prices.

The new plan was also opposed by the Customs and the Ministry of Finance, which stood to lose revenue, and tobacco retailers, who were concerned about declining sales and the increased risk of cheap counterfeit products, given the high prices. The response of the Health Department was to develop close collaboration with the Ministry of Finance and the Customs, which helped to control the national tobacco market and fight smuggling. Cooperation between these Departments also ensured that strict controls on licensing of tobacco products were further enforced, the monopoly of circulation in the national market was maintained and the Customs were more active in monitoring tobacco products at the borders. The Health Department, Customs and Ministry of Finance also built alliances with the tobacco companies to fight illegal imports and tobacco smuggling. Collectively, these activities helped to reduce resistance and assisted in the execution of the policy.

Impact of the policy

Analysis of the relationship between tobacco prices and consumption from 1950 to 2003 clearly shows that the demand for tobacco, as measured by consumption, was sensitive to price. The substantial increases in tobacco prices that followed the Evin Law have led to a striking decline in tobacco consumption (Fig. 3). From 1993 to 2005, increases in tax rates were used to raise the prices of cigarettes annually by 5% in real terms. This strategy has been successful in reducing

the number of smokers, which fell by 6.5% in men and 5.8% in women between 1995 and 2003. The rate of decline among young smokers was even higher (over 10%). When the new 2003 strategy was implemented between January 2003 and January 2004, the price of cigarettes increased by 40% while sales fell by 33.5%, and the sales of medicines used to aid smoking cessation doubled and have remained at high levels.

Lessons learned

The Government has employed a multisectoral approach and involved the Ministry of Finance, Customs and the Ministry of Health, as well as the tobacco companies.

The approach to tobacco control was multifaceted and involved a combination of taxation policy with enforcement of stringent anti-tobacco legislation (ban on advertising, ban on smoking in public places) and intensification of health education programmes emphasizing interventions for the prevention and cessation of smoking.

Shifting the leadership role for taxation policies on tobacco to the Health Department from the Ministry of Finance – which is responsible for taxation issues in most countries - has been a main factor in increasing the effectiveness of the tobacco control policy .

A more comprehensive approach was adopted by combining effective, evidence-based interventions on the regulation and pricing of tobacco products with health promotion programmes.

Tobacco consumption has been shown to be sensitive to price increases, so pricing was a valuable instrument of anti-tobacco policy.

Conclusions

Based on the French experience some important conclusions should be drawn.

Control of tobacco taxation by the health authorities appears to be an effective public health policy instrument which can increase social acceptability by reducing demand but at the same time providing revenues to design and implement policies.

Multisectoral and comprehensive interventions are needed to control tobacco consumption effectively.

Giving departments/ministries of health leadership for taxation issues when these are related to public health interventions has proved effective.

Evidence indicates that increases in pricing are an effective intervention in tobacco control strategies. Interventions aiming to blunt demand through price increases do work.

5. Quit & Win Campaign: the experience in Germany

This case study presents the development and implementation in Germany of a smoking cessation campaign for adults known as “Quit & Win”, based on an innovative international smoking cessation competition organized every other year to reduce population tobacco use.

The Quit & Win competition was introduced in 1985 during the North Karelia Project in Finland as a new regionally-based antismoking campaign.[13] In 1994, the success of the Finnish experience led to the development of an international campaign in 13 countries, coordinated by the National Public Health Institute of Finland and supported by WHO as part of its Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme.[14] Since 1994, the competition has been held biennially, growing rapidly from 60 000 participants in 13 countries in 1994 to 700 000 participants in 73 countries in 2004 (Table 1).

Table 1. Number of countries and individuals participating in Quit & Win competitions, 1994–2006

Year	Countries	Smokers
1994	13	60 000
1996	25	70 000
1998	48	200 000
2002	69	426 000
2002	76	670 000
2004	71	700 000
2006	84	700 000

In 2004, a total of 359 019 smokers gave up smoking in the participating countries. The largest number of smokers participating in the competition were in Germany, where 90 184 people attempted to stop smoking.

Situation prior to the campaign

International experience has shown that the Quit & Win campaign could be carried out in different populations and cultures. It offers benefits both to individual smokers, who are given incentives and support to give up smoking, and to the organizers of the campaign, who get the opportunity to build coalitions with fellow organizers and activists, gain recognition for their activities, generate publicity for smoking-related issues and obtain assistance for smokers to quit.

In Germany, as in some other countries, the campaign was adopted countrywide and in 2000 the first nationwide smoking cessation campaign was implemented. Until then smoking cessation had not been a priority in the fight against tobacco and had not received much attention from health professionals and other relevant actors in the country. Consequently efforts were sporadic, fragmented and too weak to have an impact at national level, especially given the powerful tobacco industry in Germany which influenced policies against tobacco control measures to achieve one of the lowest tobacco prices in Europe.

Launch, development and implementation

Germany has participated in the Quit & Win campaign since 2000 with an initial turnout of 25 000 smokers, increasing to over 90 000 (about 0.5% of German smokers) in 2004. The

[13] The North Karelia Project began in 1972 as a project to prevent cardiovascular disease among residents of this province of Eastern Finland. The Finnish Heart Association coordinated the initial discussions with community representatives, national experts and representatives of WHO. Later, the programme expanded to include other noncommunicable diseases.

[14] The CINDI network comprises 29 participating countries (28 Member States of the WHO European Region and Canada) and three candidate countries.

German campaign, appropriately named “Rauchfrei” (smoke-free), is the biggest national quit-smoking campaign worldwide.

The launch of the campaign in Germany was designed and organized by the German Cancer Research Centre and has been largely supported by the Public Health Institute of Finland and the German Federal Centre for Health Education. Leading health nongovernmental organizations, such as the German Coalition against Smoking, have given strong support and cooperation and financial assistance has come from the Federal Government, which regarded the Campaign as a useful platform for conveying to the public messages on smoking cessation, passive smoking, tobacco taxation, tobacco advertising and under-age smoking.

The content of the campaign was adapted during the design phase to reflect the German context and strengthened with local innovations such as the introduction of the helper contest where participating smokers could nominate a helper – typically a nonsmoker – who helped to motivate the participants during the Campaign and who were also eligible to win the financial prizes offered to the participating smokers, provided the smoker they supported stopped smoking. This innovation gave additional support to participating smokers and broadened the audience to include nonsmokers.

A further innovation was the incorporation of media advocacy, involving media partners as well as partners from medical and educational fields, who provided support from own resources.

Various channels were used to promote the campaign. For example, in 2000, 2002 and 2004, 145 000 “action packets”, each containing 50 entry forms, posters and stickers, were sent to pharmacies, physicians, clinics, companies and educational facilities, which distributed them to a wide audience.

Advocacy in newspapers and magazines and on television and radio raised public awareness. The 2002 and 2004 campaigns were covered by around 1100 print articles with over 200 million copies of the printed material distributed. These campaigns also reached around 78.6 million viewers through 170 television reports. Further dissemination was achieved through 150 radio reports, 8 press conferences, 17 press releases and 27 press agency reports. In total, the Quit & Win Campaign was covered in 159 television and 101 radio programmes.

The internet was the most commonly used means for signing up participants. In 2004, 48 979 of the 90 184 participants signed up via the internet. The campaign web site was visited by over 1 million people the during the five-month campaign period. Internet service providers such as Yahoo™ and Google™ supported the initiative by installing banners and links to the campaign web site and by reporting it in weekly columns.

Impact of the campaign

Of the smokers who quit during the 2000, 2002 and 2004 campaigns, 30%, 22% and 32%, respectively, had managed to remain smoke-free one year after stopping, while 70% managed to abstain for one month: rates similar to those observed in campaigns in other countries. Overall, as a result of these three campaigns, an estimated 59 000 new former smokers had not relapsed one year after the campaign.

In addition to the measurable effects on public awareness of smoking, “Rauchfrei”, through its effective media advocacy which led to sustained and high-volume media coverage, contributed to creating the perception that smoking was not the norm and was socially unacceptable.

The German Quit & Win team succeeded in creating a large health communication network with several thousand organizations actively contributing to smoking cessation campaigns.

Lessons and conclusions

The Quit & Win campaign has been successfully implemented in Germany with high participation rates among smokers combined with high abstinence rates after the end of the competition, which has led to a substantial public impact. The campaign has also brought the importance of tobacco control higher up the public agenda.

The campaign was widely accepted by the public as it was perceived to have a positive stance towards smokers who wanted to stop rather than being a campaign against smokers. This positive approach also encouraged the engagement of journalists and helped to promote the campaign, which was critically important for media advocacy as there was no budget for advertising.

The campaign has proved to be a practical, cost-effective evidence-based method of smoking cessation for population-wide public health use, which can reach out to a large number of smokers at low cost. By inviting smokers to take the opportunity of trying to stop smoking for a limited period and nonsmokers to give them active support, it has brought both groups together in the fight against tobacco.

Critical success factors which have helped in the roll-out of the initiative in Germany have included the introduction of "helpers", the engagement of journalists and the wide support of the media.

The campaign has raised public attention about tobacco control issues and provided much-needed recognition for the anti-tobacco movement by generating positive publicity and media interest in smoking-related issues. It has created opportunities for coalition-building and helped in the development of partnerships and collaboration between government departments, nongovernmental organizations and commercial organizations active against tobacco.

The International Quit & Win office reported that 700 000 smokers in 84 countries participated in 2006.

6. Smoke-free workplaces: the experience of Ireland

This case study identifies key events over three decades that provided the foundation for the recent implementation of a comprehensive ban on smoking in enclosed workplaces. Widespread support galvanized employers, employees, managers, proprietors and the public and resulted in smoke-free laws that both protect health and are popular.

Situation prior to the policy initiative

Ireland began to implement tobacco control legislation in the late 1970s. The initial scope included:

- prohibitions and restrictions on advertising and sponsorship
- restrictions on the sale and marketing of tobacco products
- prohibitions and restrictions on smoking

- labelling and health warning provisions
- product specification and testing.

In 1988, the first legislation to include provisions to prohibit and restrict smoking in public places began to be published, and between 1990 and 1995 these provisions came into force. For the first time smoking was banned in schools, public offices, cinemas, theatres, buses, taxis and hairdressers. Designated no-smoking seating areas equal to half of the available seating were established on trains and ferries and in restaurants. Until then, a consensual approach was encouraged through a voluntary code on smoking in the workplace. By the late 1990s, the damaging effects of tobacco were broadly recognized as well as the need for a comprehensive integrated tobacco control policy.

Launch, development and implementation of the policy

In 2000, the publication of a parliamentary inquiry was used to launch a new national tobacco policy entitled "Ireland – A smoke-free zone: Towards a Tobacco Free Society". Protection of all citizens within enclosed workplaces was seen as a priority, and places not covered by existing legislation, such as bars and premises that allowed restricted smoking, were considered. The parliamentary committee recommended that smoking in the workplace should be prohibited, and statutory workplace health and safety plans were drawn up that incorporated protection from second-hand smoke.

During 2002, several key events occurred that formed the basis for the creation of alliances and a consensus within government and the scientific community. The Public Health (Tobacco) Act was passed by Parliament and established the Office of Tobacco (OTC) as an independent statutory body to lead the short- and longer-term strategy. The OTC was responsible for national implementation of the smoke-free law; local enforcement was carried out by environmental health officers (ECH) of the Health Service Executive. The Minister was empowered to make regulations banning or restricting smoking in specified places including licensed premises, registered clubs and workplaces.

The OTC commissioned an independent scientific working group to investigate the health risks associated with second-hand smoke. Their report, *The health risks of environmental tobacco smoke in the workplace*, concluded that the consensus amid the scientific community was that second-hand smoke in the workplace increased the risk of heart disease, cancer and respiratory diseases among non-workers. Further, workers such as pregnant smokers, bar staff and waiters were identified as being at increased risk. Legislation to protect workers was proposed, and in January 2003 the Minister announced his intention to ban smoking in all enclosed places.

A national debate occurred over the 15 months that followed this announcement, and the measure becoming law was featured weekly in the national and local media. Bars became the main focus of attention as publicans' organizations voiced their concern at anticipated vast job losses and the ruin of bar business. Opponents challenged the health evidence and proclaimed the law was unnecessary, unworkable and unenforceable. A critical factor for the success of the law was, however, widespread public support. A majority of the public (59%) supported the measure in the month following the announcement, and there was active support from the health and scientific community, nongovernmental organizations and a wide range of trade unions. The OTC and other members of the stop-smoking advocacy focused on:

- strengthening public awareness of the adverse health effects of tobacco smoke;
- building confidence in the enforceability of the legislation;

- countering misleading claims relating to economics, ventilation, separate areas and civil liberties.

The strategy of building compliance supported a systematic approach to implementation and represented a multifaceted approach between employers, managers, unions, advocacy groups and government. Within these constituencies, several key steps were implemented during the year prior to the workplace provisions becoming law:

- representatives of the hospitality industry, trade unions and enforcement agencies were involved in consultations to develop guidance for employers and managers;
- the OTC distributed such guidance to assist employers and managers to comply with their legal obligations and support the smooth implementation of the law;
- the Department of Health produced and disseminated public information materials to all workplaces; guidance and materials were distributed to all licensed premises and made available on the internet;
- television and radio advertising highlighted the health effects of second-hand smoke with the date that the law was introduced;
- a local smoke-free compliance telephone-line was established to provide the public with an alternative means to voice concerns and complaints if a satisfactory response was not provided by the person in charge of the premises, and complaints were passed to the relevant enforcement agency for investigation;
- environmental health officers proactively visited premises and worked in partnership with owners and managers before and after the introduction of the law;
- inspectors from the Health and Safety Authority also monitored compliance with the law as part of their general health and safety duties;
- provision was made for fines of up to €4000 to be levied on persons contravening the law, both smokers and the owner or person in charge;
- "No Smoking" signs were to be displayed at all times in premises, with the name of the person to whom a complaint may be made.

Impact of the policy

Since the smoke-free law was enacted, air quality has significantly improved: levels of carbon dioxide have decreased by 45% in nonsmoking bars and 96% of all indoor workers report that they work in smoke-free environments. Compliance has remained at over 90% and public support has grown to almost universal support:

- 93% of the population think that the law is a good idea, including 80% of smokers
- 96% think the law has been successful, including 89% of smokers
- 98% think that workplaces are healthier, including 94% of smokers.

Lessons and conclusions

A clear and consistent communications campaign was critical in alerting the public to the serious and harmful effects of second-hand smoke and the rationale for the law.

The active involvement of key stakeholders, particularly the trade unions, resulted in widespread support and a constituency that actively supported the protection of its members' health.

Publication of health evidence by an active coalition of partners informed the public and the media and was effective in countering misleading arguments.

A long lead time (15 months) prior to the introduction of legislation allowed for public education and encouraged a well-informed public debate.

Application of the law equally to all enclosed workplaces resulted in a law that was clear and understood by all parties, and enforcement facilitated compliance with the law. Employers were not therefore put to the expense of creating smoking areas.

Effective enforcement was key, beginning with mandatory signs showing the name of the person to whom a complaint could be made, and supported by a national statutory enforcement agency, an experienced and skilled inspection local inspection force and up to €4000 in fines for the smoker and owner of the premises not in compliance.

A key strategic step was highlighting the fact that hospitality venues are also places where people work, and that these workers are as vulnerable and as important as any other workers.

In addition to strict smoke-free legislation, high retail prices were found to be a highly effective means of reducing tobacco consumption among people on lower incomes and children. Taxation is 80% of the retail price and is reset each year.

7. Research on tobacco for strengthening national policy: the experience of Kyrgyzstan

This paper analyses the experience of Kyrgyzstan which, in spite of considerable resource constraints, carried out economic research on tobacco use and used the results to promote the ratification of the WHO FCTC and adoption of new tobacco control legislation.

Situation prior to the policy initiative

The sociocultural, economic and political changes which occurred in the period following independence in 1991 created a favourable environment for the tobacco industry, leading to considerable growth in the free trade in tobacco products, a substantial increase in tobacco advertising targeted at adolescents and young people and a significant increase in the number of tobacco promotion activities such as competitions and “invitation to smoke” events.

The Government was faced by financial constraints that limited the resources available for tobacco control. Other than a few limited studies, no system existed for the collection of data to monitor patterns or the prevalence of tobacco consumption.

During this period the tobacco industry was able to establish a strong lobby to resist tobacco control policy interventions. The first draft Law on the Control and Prevention of Smoking was developed at the end of 1999 but it was not until 28 December 2001, following significant efforts by the Ministry of Health and advocates of tobacco control, that the Law on Health Protection of the Population from the Hazardous Effects of Tobacco was adopted by Parliament. Even so, and despite objections by the Ministry of Health, representatives of both the local[15] and the

[15] OJSC Reemstma-Kyrgyzstan bought the exclusive rights for cigarette production in Kyrgyzstan for 10 years, according to Resolution of the Government of the Kyrgyz Republic No. 18 dated 10 January 1998, and according to

international tobacco industries participated in the discussions leading to the draft Law and actively resisted its adoption and implementation. A presidential veto in 2002 and rejection by the Government, despite approval of the proposal for a law in Government Resolution No. 265 of 12 May 2000, caused further delays. A special commission of the Legislative Assembly was set up to revise the Law so as to overcome the veto, which was not reversed until the end of 2004. The State Strategy and Action Plan on Tobacco Control, developed with support from WHO, have twice been rejected by the Government and are yet to be approved.

Launch, development and implementation

In 2004, the Ministry of Health asked the Regional Office for support in conducting research on the epidemiology and economics of tobacco use in Kyrgyzstan. Technical support was provided by WHO for the design of the research and development of the survey instruments to measure the prevalence[16] and economic aspects[17] of tobacco use. The research involved a nationally representative sample of 6000 people aged 15 years and over in 1936 households. In addition, a survey of schoolchildren aged 13–15 years as well as university students from the State Medical Academy was carried out using the Global Youth Tobacco Survey.[18] The answers of all respondents were verified with measurements of carbon monoxide levels.[19] Primary research was augmented by aggregation and analysis of the relevant routinely collected official data from the National Statistical Committee, the State Tax and Customs Inspectorate and the Ministries of Finance, Economy, Agriculture and Water Economy.

The research was postponed until the end of 2005 owing to the unstable political situation which led to the resignation of the President, election of a new President and appointment of the new Government.

The study results revealed a worsening picture in the prevalence of tobacco use (manufactured, cigarettes, etc.).

- In 2002, around 23% of the population aged 18 years and older used tobacco products[20] but in 2005 this figure increased to 26%. This increase was particularly marked in men: 47.5% in 2002 increasing to 54% in 2005.
- Prevalence in the rural areas (31%) was higher than in the cities (25%), especially for men (63% and 51%, respectively). For women the reverse was true: 74% of the women smokers lived in cities and the majority were aged 25–34 years.
- Most smokers (97.7%) preferred to smoke commercial cigarettes, especially cigarettes produced locally by OJSC Reemstma-Kyrgyzstan.

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the Law on the Ratification of the Agreement between the Government of the Kyrgyz Republic and Reemtsma Cigarettenfabriken GmbH, Hamburg, Germany, about Development of Cigarette Production in Kyrgyz Republic, No. 101 dated 24 July 1998. The Government shareholding is only 0.98%.

[16] National Epidemiological Study of Tobacco Use Prevalence (including Chewing Tobacco) among the population aged 15 years and older, carried out with a small grant from Research for International Tobacco Control, the International Development Research Centre, supported by the Canadian Tobacco Control Research Initiative and the American Cancer Society, 2005.

[17] Economic Study of Tobacco Control in Kyrgyzstan supported by the WHO Regional Office for Europe, 2006.

[18] Global Youth Tobacco Survey in Kyrgyzstan, supported by the WHO Tobacco-Free Initiative and the Office on Smoking and Health, US Centers for Disease Control, 2004.

[19] Prevalence of smoking among medical students. Medical students – how committed are they to promoting smoking cessation? Supported by a small grant from the Canadian Tobacco Control Research Initiative, the American Cancer Society, Cancer Research-UK, Research for International Tobacco Control, 2006.

[20] National CINDI Health Behaviour Survey among adults in Kyrgyzstan aged 18 years and older, supported by WHO and USAID, 2002. General sample of 8000 people, response rate 95%.

- Some 57.4% of the respondents smoked cigarettes with filters and 35.2% smoked cigarettes without. Only 5.3% of the respondents preferred "light" cigarettes.
- Surprisingly, 35% of the Medical Academy students smoked: this proportion increased to 44.8% after verification of the results of exhaled carbon monoxide levels.
- Worryingly, around 20% of the schoolchildren aged 13–15 years had tried tobacco products and 7.4% were regular smokers.

The analysis revealed that in the period 2000–2005, government tax revenues from profits of the tobacco industry accounted for 2.2% of the total tax take from industry, while revenues from excise tax accounted for 64.3%.[21] In 2004, the revenue from excise tax on tobacco product declined threefold compared with the levels in 2000, despite a small increase in the output of tobacco products.

Using the survey results on price elasticity of demand, economic modelling showed that a 50% increase in excise tax would increase government revenues from excise tax by the same amount but would only lead to an increase of 5% in prices of tobacco products.

In the five-year period 2000–2004 the number of people employed in the tobacco industry fell by 33%[22] (30% in OJSC Reemstma-Kyrgyzstan[23]).

The analysis revealed that in this period, 1041 people died as a result of fires related to cigarettes (37% of all fires). The financial cost of damage to property was around 80 million Kyrgyz som (approximately US$ 2 million).[24]

Impact of research findings on policy

The research results were widely distributed, particularly to politicians. The results gave the national specialists on tobacco control the evidence they needed to refute the claims by the tobacco industry that joining the WHO FCTC would harm the economy.

In February 2004, Kyrgyzstan became the first country in the Commonwealth of Independent States to sign the WHO FCTC, ratifying it two later.

The ratification process was adversely affected by the unstable political situation before and after the revolution, the unfavourable political context as a result of lobbying by the tobacco industry, and delays in implementation of the research due to lack of financing.

The Law on Health Protection of the Population of the Kyrgyz Republic from the Hazardous Effects of Tobacco was adopted by Parliament in June 2006. The Ministry of Health used the evidence from the research findings to persuade the President to sign the Law.[25]

In August 2006, the research results were presented at a press conference to demonstrate that the tobacco industry's arguments against the Law had been inaccurate. At the conference, leading university professors, led by the Vice-Minister of Health and national medical organizations, requested the President to sign the Law.

[21] Official statistics of the State Fiscal Inspection for 1995–2005.
[22] Data from the National Statistical Committee, 2000–2004.
[23] Official statistics of the State Fiscal Inspection for 2001–2005.
[24] Data from the Ministry of Ecology and Emergency Situation (Extreme Situation) 2000–2005.
[25] Letter of Minister of Health No. 01-1/1-8087 dated 31 July 2006.

Lessons and conclusions

The experience from Kyrgyzstan suggests that research on tobacco prevalence and the economic aspects of tobacco use can be undertaken and the results used effectively in settings where resources are limited, there are considerable political and regulatory constraints and the tobacco industry is lobbying strongly.

The evidence from the research was used by anti-tobacco advocates as an evidence base and policy instrument in the fight against tobacco, and by the Ministry of Health to:

- promote the ratification of the WHO FCTC;
- encourage the development and adoption of new national tobacco control legislation;
- prove the economic effectiveness of implementing the measures stipulated in the ESTC and in the WHO FCTC.

The research findings will be used as a baseline for further monitoring and evaluation of tobacco control policies.

The design and implementation of an informed national anti-tobacco strategy should not only be based on international research but should also incorporate local research to increase the sensitivity and acceptability of the evidence which can be used to lobby policy-makers successfully.

8. Coalition of nongovernmental organizations against tobacco: the case of Latvia

Collaboration among health professionals, policy-makers and civil society groups is an important element of effective public policy advocacy on tobacco control issues. Although in practice this is difficult to achieve, the Latvian experience provides a successful example of such collaboration which has led to the establishment of a national platform of public health nongovernmental organizations aiming to exert effective influence on efforts to control tobacco.

This case study analyses and describes the creation and development of a coalition of civil society organizations against tobacco and its positive impact on the anti-tobacco campaign.

Situation prior to the initiative

Latvia has one of the highest prevalence rates of smoking in Europe: 47.3% of men and 17.8% of women smoke daily, in addition to 5.8% of the population who are occasional smokers.[26] These numbers have not changed significantly over the last decade. Although attempts to introduce tobacco control measures met with popular resistance until recently, a number of state officials and nongovernmental organizations have begun to collaborate so as to intensify efforts to counter tobacco use. Initially, this collaboration was not well coordinated and there was no common national strategy.

[26] Pudule I et al. *Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums, 2004* [Health behaviour among Latvian adult population, 2004]. Helsinki, National Public Health Institute, 2005 (http://www.vvva.gov.lv/eng_new/publikacijas.php, accessed 28 November 2006).

Launch, development and implementation

The initiative to form a nationwide coalition for tobacco control began in 2003 with a series of regional seminars attended by a wide range of stakeholders including politicians, municipal officials, educators, medical professionals, social workers, psychologists, journalists and health promotion specialists. The main objectives of this initiative were: (i) to raise awareness of key local stakeholders about developments in international and national legislation on tobacco control and to share information on best practices, and (ii) to explore the potential for developing a Latvian Coalition on Smoking Prevention.

These seminars created a momentum for further action and in 2004 a National Conference on Tobacco Control was organized in Riga under the leadership of the Centre for Health Promotion, the Ministry of Health and the Association of Public Health. The Conference aimed to enhance information-sharing regarding multisectoral experience of tobacco control issues among interest groups with a diverse background. A key outcome of the conference was the development of the National Coalition on Tobacco Control – a coalition of 20 organizations from government offices, municipal authorities and nongovernmental organizations – which aimed to promote tobacco control activities at national level and to contribute to global and European tobacco control efforts. The Coalition planned to achieve these aims through a number of activities, in particular to:

- enhance multidisciplinary representation by engaging organizations and individuals in anti-tobacco activities;
- create and implement a system that would inform the public about the consequences of tobacco use on health, the economy and the environment;
- keep the media interested in issues related to tobacco control;
- promote healthy lifestyles and a tobacco-free culture;
- support further restrictions on the access and supply of tobacco products, especially to young people;
- enhance tobacco cessation efforts;
- support and promote the ratification and implementation in Latvia of the WHO FCTC;
- monitor and react to the activities of the tobacco industry, identified as being against society's health interests;
- improve the education of professionals involved in tobacco control;
- support the ban on tobacco advertising while promoting the development of anti-tobacco advertising;
- lobby at policy level against tobacco.

The initiative that led to the establishment of the National Coalition on Tobacco Control has been successful as it has enabled close collaboration between central government, local governments and nongovernmental organizations and facilitated the development of an extensive network for information exchange and support on tobacco-related issues.

Systematic efforts and the use of creative tactics helped to achieve this success. For example, to promote the signing and ratification of the WHO FCTC by the Government, decision-makers and politicians were extensively lobbied, including cooperation with Latvia's ambassador to the United Nations. Members of Parliament, especially the members of the Parliamentary Health

Committee, and WHO representatives were involved in the national intersectoral conference to review the draft of a national action plan on tobacco control.

The creation of an advocacy group consisting of well-known and leading doctors under the leadership of the President of the Latvian Medical Association further strengthened the National Coalition, provided it with additional expertise on tobacco control issues and strengthened the legitimacy of its purpose. This advocacy group and the Coalition prepared a letter which they handed to the Prime Minister at a special meeting in May 2005, urging the government to take action in three areas in particular: (i) the prompt and comprehensive implementation of the WHO FCTC in Latvia, (ii) improvement of legislation on smoke-free work and public places, and (iii) adoption of the national action plan on tobacco control for 2005–2010.

The engagement of the media and policy-makers was a key priority for the advocacy group, which also organized exhibitions and displays in big shopping centres, using antismoking posters based on the collection of the Media Campaign Resource Center of the US Centers for Disease Control and Prevention.

These exhibitions succeeded in achieving good media coverage and attracted the attention of the public and the politicians, including visits by several members of parliament and the Minister of Health, who participated in the opening ceremony of an exhibition. The Coalition also launched a web site offering information with the latest news on tobacco control issues as well as practical advice on how to quit smoking, and developed a monitoring system for collecting regular smoking prevalence data (using standardized methodology of the FINBALT Health monitoring survey).

Enabling context

A number of factors combined to create an environment enabling the development of a national coalition and wider cooperation among various stakeholder groups. For example:

- a national multisectoral coordinating body (commission) on tobacco control was established as early as 1997 and has acted as a platform for wider cooperation between key actors;
- the presence of a large number of medical doctors in parliament (the largest single professional group) who were sensitive to health-related issues favoured the development of strong anti-tobacco action;
- Latvia's accession to the EU in 2004, the influence of EU legislation, participation by nongovernmental organizations in existing European networks on tobacco control, and the technical support provided by WHO all provided a strong impetus for action.

Impact of the policy

Latvia ratified the WHO FCTC in February 2005. The Coalition which substantially contributed to this ratification has now focused its efforts on promoting the implementation of the WHO FCTC.

In 2005, a national action plan for tobacco control was agreed by the Cabinet of Ministers for the period 2006–2010. Promoting the adoption and implementation of the action plan is a key priority for the Coalition.

The national law on tobacco has been amended in alignment with EU Directives 2001/37/EC and 2003/33/EC.

The Law on Excise Tax has been effective since December 2005. By 2010 the tax rate on tobacco products should reach the minimum tax rate prescribed by Directive 92/79/EEC.

Interventions by the Coalition network have led to the successful realization of a number of anti-tobacco projects, including:

- "Smoke-free workplaces policy", carried out in the10 regions;
- "Prevention of children's exposure to tobacco smoke", aimed at preventing children's exposure to environmental tobacco smoke;
- enhanced networking with the international community with active participation achieved through the EU "HELP – For a life without tobacco" campaign, the Smoke-free class competition and the Quit & Win contest for adults;
- other activities, including the establishment of a telephone helpline, health education campaigns, community-based campaigns (including the Quit & Win contest), development of self-help material for stopping smoking, programmes for schoolchildren and provision of counselling by specialists on treatment for substance dependence;
- attainment by the Coalition of full membership of the European Network for Smoking Prevention.

Lessons and conclusions

Public policy advocacy with the cooperation of nongovernmental organizations has strengthened Latvia's capacity to control tobacco. Networking and alliances among nongovernmental organizations, involving various stakeholder groups, formal organizations and informal networks, have provided greater opportunities for success as a result of pooling resources and efforts.

Agreed clear objectives have facilitated communication among the members of the Coalition and helped to achieve effective collaboration with the government.

The development of effective partnerships at all levels, with the commitment and involvement of multiple sectors and stakeholders including the media, policy-makers, health experts and civil society, has been critical to success.

The anti-tobacco coalition was particularly successful in monitoring tobacco control activities, accessing professional lobbying expertise and using this to lobby policy-making institutions in the country, capacity-building for tobacco prevention and cessation activities, and collecting and channelling information on tobacco control to key stakeholders.

Civil organizations have contributed to building bridges between the formal organizations and the informal networks in the anti-tobacco movement.

Coalitions, alliances and networks can be used as part of the strategy to recruit and involve people within a constituency, link multiple constituencies and bridge these diverse constituencies to advance policy discussion on tobacco control and to take effective action.

9. The Millennium Smoking Cessation Campaign "I Can Stop, Too!" in the Netherlands

At the turn of the century, STIVORO,[27] the Dutch Expertise Centre on Tobacco Control which acts as the executive organization of the coalition for tobacco control in the Netherlands, took the lead in launching an intensive media-supported and comprehensive smoking cessation campaign.

STIVORO receives annually €1.4 million from the Government for the development and implementation of public information campaigns to encourage people to stop smoking. Given the unique opportunity provided by the timing, the Millennium Campaign "I Can Stop Too!" was planned to be a large-scale event with a larger-than-usual budget. In 2000 the Dutch anti-cancer Fund (KWF)[28] and STIVORO were also celebrating their 50th and 25th anniversaries, respectively. In 1999, as an anniversary donation, KWF funded STIVORO with an additional €1.4 million which STIVORO decided to spend on the Campaign. This case study summarizes the design, launch and implementation of the Millennium Smoking Cessation Campaign in the Netherlands.

Situation prior to the Campaign

In 1999, smoking prevalence in the group aged 15 years and older was 38% for males and 30% for females, with an estimated 4 million smokers in a population of 16 million. Prevalence had in fact fallen between 1975 and 1994 but it increased in the period 1995–1999 which was of concern to policy-makers and anti-tobacco activists.

Enabling context

Typically, antismoking campaigns are built around events (such as the new year, introduction of statutory smoking bans and increases in the price of tobacco) which encourage the intention to stop smoking. Usually, a large number of smokers attempt to stop smoking around the new year and this, combined with the new millennium, provided a unique window of opportunity to launch the mass media smoking cessation campaign.

Development and implementation of the Campaign

The Millennium Campaign was designed to be implemented in October–December 1999 to coincide with the end of the Millennium. The Campaign "I Can Stop Too!", which aimed to reduce smoking prevalence, had two main objectives:

(i) to encourage smokers to try harder to stop smoking: in the late 1990s, an average of 150 000 people had tried to stop smoking each year[29] and the intervention aimed to double this number; and

(ii) to help people attempting to quit by preventing relapses and increasing the success rate of individual attempts to stop from 7%[30] to 10–15%.

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[27] STIVORO: the founding institutions include the Asthma Foundation, the Heart Association and the Cancer Society, with the Ministry of Health as a partner. The prime objective of the organization is: **"**The promotion of public health through the reduction of the use of tobacco products**"**. STIVORO receives funding from the founding organizations and the Ministry of Health. Projects are also subsidized by the Netherlands Institute of Research and Development and the European Commission.

[28] KWF: Kankerbestrijding/Koningin Wilhelmina Fonds (Queen Wilhelmina anti-cancer fund).

[29] NIPO survey estimates showed that 150 000–200 000 smokers tried to stop at new year 1998/1999. (TNS NIPO is the leading Dutch Institute for Public Opinion and Market Research.)

In addition to these two main objectives, the Campaign also aimed to

- reinforce a positive attitude towards stopping smoking;
- improve STIVORO's effectiveness and specific knowledge about how people stopped smoking;
- create a social stimulus to stop smoking.

The Communication Studies Department of Nijmegen University was engaged by STIVORO to assess the level of achievement against these objectives.

The Campaign targeted smokers aged 20–50 years in the lower socioeconomic groups. It was designed to make appropriate use of the media with a broad range of themes and programmes aimed at the widest possible audience, particularly the social groups targeted. It consisted of three phases:

- a preparatory period when smokers were encouraged to participate in the Campaign, with an emphasis on messages in the media explaining the importance of good preparation if attempts to stop smoking were to succeed;
- the turn of the Millennium on 1 January 2000 as the moment to stop smoking;
- a follow-up period of one month in which those who stopped smoking received support to limit relapses.

Use of the media to increase the number of attempts to stop smoking

The first objective of the Campaign, doubling the number of attempts to stop smoking, was tackled through a collaborative effort with the advertising agency BvH and the communications consultancy DNA to use the media to generate excitement around stopping smoking. An entertaining show on television was thought to be the most suitable way of reaching the target groups, especially as the television stations were eager to broadcast an entertaining show at prime time which would reach a wide audience. A show was devised centred on a game aiming to set a new world record of the largest number of smokers trying to stop smoking. A positive climate and social pressure and stimulation to stop smoking would be created by mobilizing a large number of smokers and reaching a broad audience. "Take part in the record attempt" was the message highlighted in the Campaign communications.

The commercial television stations SBS6 and RTL4 (popular with lower-income groups) were initially approached, and RTL4 agreed to transmit eight episodes of the Campaign show "I Can Stop Too!" in prime time.

From early November 1999, smokers were invited to take part in the record attempt through:

- posters in public places;
- 1.2 million leaflets distributed in periodicals and via newsagents;
- promotional messages on national television to increase publicity and generate excitement;

[30] An attempt to stop without a campaign results in 7% successful stoppers after one year (Baillie A et al. Quitting smoking: estimation by meta-analysis of the rate of unaided smoking cessation. *Australian Journal of Public Health*, 1995, 19:129–131).

- eight "I Can Stop Too!" television shows, with an announcement by the Minister of Health at the end of the last show the total number of people who had stopped smoking;
- free publicity in various media.

Improving the success rate of attempts to stop

The media were also used to help smokers succeed in their attempts to stop through television programmes providing information on stopping smoking, augmented by a series of articles in the regional papers. A web site[31] was also launched with details of courses, information on stopping smoking and order forms for communications material.

All smokers who wanted to try to stop were offered free a support package, containing information on methods (including those used by STIVORO) to improve the success of the attempt and telephone counselling. A television-based course, regional courses for stopping smoking, smoking cessation assistance by health care professionals and nicotine replacement therapies available in pharmacies were also made available at a small cost.

Impact of the Campaign

The Communication Studies Department of Nijmegen University estimated that more than 600 000 people attempted to stop smoking around 1 January 2000, and around 12% of them managed to abstain for more than one year. Exposure to the Millennium Campaign had a positive effect on behavioural determinants for quitting smoking, increased the number of attempts to stop smoking in the short term and reinforced the social stimulus to quit. In the longer term, as a result of the Campaign, many smokers placed gave a higher priority to stopping smoking.

The Campaign was successful in reaching its target groups. Television, and especially the show, proved an excellent way to reach the lower socioeconomic groups. Through the shows "Koffietijd!" (Coffee time) and "RTL-Live", as well as the stop-smoking television courses, the Campaign was particularly effective in reaching women.

The "I Can Stop Too!" Campaign also achieved a high level of free publicity: reports on stopping smoking tripled in the written press while related programmes on television and radio increased fifteen times compared to the preceding year. Free publicity increased population coverage by 150%.

The Campaign was particularly successful in:

- reaching lower socioeconomic groups, especially women;
- achieving broad coverage – 85% of the smoking population or 3.6 million people;
- catalysing access to a variety of means to quit smoking (Table 1);
- encouraging 670 000 smokers to attempt to stop on or around the turn of the Millennium – over twice the number set as an objective;
- enabling 12% of those stopping to abstain for over one year (73 500 people);
- positively affecting short- and long-term behavioural change against smoking;

[31] Nieuwsbank BV. Utrecht, *Recordpoging stoppen met roken,* 2000 (www.dat-kan-ik-ook.nl, accessed 30 November 2006).

- improving people's knowledge of available stop-smoking aids and recognition of the benefits of not smoking, as well as reinforcing a social stimulus to stop smoking for good;
- increasing the demand for nicotine replacement therapies by 50%.

Table 1. Utilization levels for smoking cessation services

Service	Use by smokers (No.)
Television course	526 000
Telephone line	94 830
Internet visits and Web-enabled assistance	46 254
Cessation booklet	523 285
Quit kits	62 471
Tailored advice	24 877
Telephone counselling	1 595
Television course	4 879
Group sessions	1 000

Lessons and conclusions

Exposure to a multifaceted, media-led smoking cessation campaign in the Netherlands greatly increased the number of people attempting to stop smoking and enhanced both short- and long-term abstinence from smoking.

Critical to the success of the initiative were the sophisticated public relations strategy combined with careful selection of the turn of the Millennium as a unique window of opportunity to launch the Campaign.

The comprehensiveness of the Campaign, featuring multiple messages and using various media vehicles to raise awareness, improve knowledge of available cessation programmes, provide access to specific information and resources for smoking cessation and to "de-normalize" smoking made it particularly successful in creating synergies with existing tobacco control programmes.

Effective use of the media enabled the Campaign to reach the vast majority of smokers, particularly people from lower income groups and women, and to meet and even surpass its objectives.

10. The Norwegian experience with smoke-free policies

This case study provides an analysis of an intervention strategy for tobacco control which focused on effective enforcement and compliance with the law to support smoke-free bars and restaurants in Norway. It draws upon documents and preliminary findings from an evaluation of the Government's tobacco control programme commissioned by the Directorate for Health and Social Affairs. The National Institute for Drug and Alcohol Research (SIRUS)[32] and the Research Centre for Health Promotion (HEMIL)[33] were jointly commissioned to undertake the evaluation.

[32] National Institute for Alcohol and Drug Research (SIRUS) (http://www.sirus.no, accessed 23 August 2006).
[33] Research Centre for Health Promotion (HEMIL), University of Bergen (http://www.uib.no/psyfa/hemil, accessed 23 August 2006).

Situation prior to the policy

Norway has been one of the most restrictive countries in Europe regarding tobacco control. Despite increasingly strong measures to control smoking until 2002, around 30% of men and 29% of women still continued to smoke regularly and the number of smokers remained constant for 10 years in the period preceding the new law.[34]

Tobacco advertising has been prohibited since1975. The retail sale price of cigarettes is the highest in Europe due to a tax of 76%.[35] Smoking is forbidden in enclosed public places such as on public transport, in airports and museums.

Launch, development and implementation of the policy

Norway was the second country after Ireland to introduce a total ban on smoking in public places, following heavy pressure from the restaurant workers' union, which reported that its members had a higher incidence of lung cancer than other workers as a result of passive smoking. According to the Ministry of Health, some 300–500 people die from passive smoking each year.

The aim of the law was to ensure that people working in restaurants and bars could carry out their jobs in a smoke-free environment. An information campaign to inform the population of the total ban was implemented through posters, the mainstream media and education in primary schools and nurseries. The campaign also aimed to teach young children about the dangers of second-hand smoke and encouraged them to ask their parents to stop smoking or to smoke outside.

Those who initially resisted the new law argued that a total ban would infringe individual rights in public places and that the policy would economically harm the hospitality industry. Others argued that because of the sub-zero temperatures experienced in Norway for several months of the year, it would be difficult for smokers to limit their smoking to outside places.

However, despite opposition, implementation has been highly successful and the ban has been strictly enforced by employers, employees and customers. The law stipulates that the owners of restaurants and bars are responsible for ensuring compliance with the law and infringements are punishable with fines.[36] Monitoring of compliance with the ban is the legal responsibility of local town councils and the Labour Inspection Authority, which inspects work premises for safety and health.

The municipalities and the Labour Inspection Authority have cooperated extensively to ensure that the law is not breached and the ban is observed. Between May 2004 and May 2005, the Authority inspected 915 bars and restaurants to review enforcement. Some 290 were the subject of orders to make changes to the premises or to enforce the law. There are no statistics regarding the number and the amount of fines issued, as Norwegian legislation does not mandate the amount of the fine that should be issued in cases of breach of the law. Inspection authorities are empowered to assess the level of fines to be issued in each case, depending on the extent of infringement.

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[34] Statistics attributed to Professor Tore Sanner, Oslo Cancer Institute, head of the smoke-free coalition "Tobakksfritt".

[35] Taxes and fees account for 76% of the price of cigarettes. At US$ 9.70 a pack, Norway (together with the United Kingdom) has the most expensive cigarettes in Europe.

[36] Article 6 of the Tobacco Control Act.

Impact of the new legislation

One year after Norway introduced it, the total ban on smoking in public places has been declared a resounding success. According to official figures, the number of smokers declined from 29% in 2002 to 25% in 2005. In this period over 100 000 smokers stopped smoking. Fewer young people are reported to have started to smoke.

Both employers and customers have willingly complied with the law. The Labour Inspection Authority has worked actively to follow up the ban and has reported that compliance has exceeded all expectations.

Surveys of staff working in public places, restaurants and bars has revealed that the total ban on smoking in public places has been easier to enforce and comply with than when separate smoking areas were permitted. A survey of employees working in public places showed that 90% of them complied with the total ban, as compared with 51% when designated smoking areas were permitted.

Public approval of the ban rose after implementation, with customers reporting their appreciation of cleaner air. When the ban on smoking in bars and restaurants entered into force on 1 June 2004, 54% of the population said they were positive towards it. One year later 68% supported the ban and two years later 78% supported it.

Staff working in the hospitality sector have reported fewer health problems, such as respiratory symptoms, dry throats and eyes and nasal irritation. Surveys of those working in the sector have also found that the ban has positively influenced the behaviour of staff who smoked, with many using the ban as an opportunity to stop or reduce their daily cigarette consumption.

Despite the scaremongering by critics of the ban, the economic impact on businesses in the hospitality sector has been minor.[37] In fact, customers have reported no change in the frequency of their visits to bars and restaurants.

On the other hand, since the introduction of the law there has been an increase in the use of snuff.

Lessons and conclusions

The Norwegian experience demonstrates that smoke-free laws can be successfully implemented with strong approval from employers, employees and customers of restaurants and bars. People working in these businesses find it easier to implement a total ban than a partial ban permitting separate smoking areas.

Following implementation of the law introducing the total ban, public opinion in favour of such a ban has risen.

11. Strengthening tobacco control at sub-regional level: public health capacity-building in south-east Europe

This case study provides an analysis of an intervention strategy entitled Public Health Capacity-Building for Strengthening Tobacco Control in South-East Europe (the SEE project). The

[37] A 6% decrease in sales of beer by breweries to pubs has been offset by a 2.8% increase in sales to supermarkets, with little change in the sales turnover index.

strategy focuses on a sub-regional approach to strengthening capacity in support of national tobacco control activities aimed at achieving certain goals, particularly in countries where strong lobbying by the tobacco industry could delay implementation. It draws on historical documents presented to senior policy-makers at intergovernmental consultations and training workshops for the WHO FCTC from 2000 to 2005.[38]

Situation prior to the policy initiative

The countries of south-eastern Europe have recognized that they have significant public health, economic and social problems arising from smoking and the lack of tobacco control. Tobacco consumption has become the largest single risk factor for premature mortality in the region, mainly due to cardiovascular diseases and lung cancer. A significant proportion of the regional population are smokers, with rising trends among women and teenagers. These figures remain significantly higher than in most of the EU countries.[39]

Tobacco control policies have not, in general, been high on the political agenda of the south-eastern European countries and consequently not sustainable as they were not properly implemented. Smuggling has become a major characteristic of the tobacco market. Local production of tobacco and tobacco products, such as in Bulgaria, has a long history and is still a major contributor to the GNP. This complex health, economic, legal and social situation presented a need for strong international cooperation and efforts by all countries in the region to halt the consumption of tobacco products. To make an impact on public health, the WHO FCTC must be supported by capacity-building in a wide range of tobacco control measures. The international community has now taken strategic action (the SEE project) in support of this critical component by developing programmes to strengthen intersectoral cooperation in tobacco control at regional and national levels, thus promoting the ratification and implementation of the WHO FCTC in the region.

Launch, development and implementation of the policy

The SEE project involves nine countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia (the project leader country), Montenegro, Republic of Moldova, Romania, Serbia and The former Yugoslav Republic of Macedonia. It was developed in 2003/2004 and launched in 2005 as part of the Stability Pact Initiative for Social Cohesion, and will be implemented in phases over the next few years.

Phase one, which lasted from 1 April 2005 to 31 March 2006, focused on generating political support at intersectoral level for the WHO FCTC. A Regional Intergovernmental Consultation was convened in Sofia on 28–29 September 2005 and attended by high-level intersectoral delegations from the eight countries. The conclusions and recommendations from this meeting were reported to the SEE Second Health Ministers Forum in Skopje on 25–26 November 2005, which was also attended by finance ministers. The Regional Consultation was also followed by national intersectoral meetings in the participating countries, thus translating the Sofia commitment into national action towards ratification of the WHO FCTC as early as possible.

Phase two began in March 2006 and focuses on intersectoral capacity-building for tobacco control. A key event was a workshop conducted in Zagreb on 30–31 March 2006. This

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[38] Intergovernmental consultation in Sofia, 28–29 September 2005, and Zagreb, 30–31 March 2006; The South-eastern Europe Health Network (http://www.euro.who.int/stabilitypact/network/20040611_1, accessed 28 November 2006) and WHO Study Group on Tobacco Product Regulation 2004.

[39] *Coordination of FCTC in SEE Countries*, a presentation made by Croatia at the Sofia consultation. Available data show that overall morbidity caused by tobacco in males in south-eastern Europe is 62% higher than the EU average.

introduced a major intercountry training workshop to be convened in Slovenia in October 2006, followed by national intersectoral capacity-building workshops in the participating countries implemented nationally during the second half of 2006 and the beginning of 2007.

Two other phases are planned for the next two to three years to support information campaigns and increase public awareness of and support for tobacco control policies, as well as to strengthen the human and institutional capacity for smoking cessation services in countries.

Enabling context

Tobacco consumption in the south-eastern European countries has been made easier by a variety of factors such as the liberalization of trade, foreign direct investment, global marketing, transnational tobacco advertising, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes. To date, the intervention strategies initiated in Member States have targeted specific areas rather than a comprehensive and systematic approach. The first two phases of the project's tobacco control strategy have been particularly effective because capacity-building was targeted at intergovernmental, sub-regional and intersectoral levels. Within this strategy, several key enabling factors can be identified.

- *The strategic use of training and networking* to build capacity, support and collaboration within constituencies has been shown to be a key component of action plans supporting the implementation of tobacco control strategies and programmes.
- *The identification of synergies among countries and sectors***.** The challenges arising from the differing stages of development and implementation in countries and sectors were addressed by identifying synergies that require dialogue and coordination at intersectoral and intergovernmental levels.
- *Intersectoral consultation and national training workshops targeting the health, economic and legal sectors* built constituencies that were critical to development of legislative frameworks. These constituencies were particularly effective in regard to presenting a counter balance to strong lobbying by the tobacco industry that could have easily delayed or obstructed the implementation of national programmes.
- *The development and strategic use of political forums,* such as the SEE Health Network, were effective means to build support and drive health policy.[40]
- *Resources dedicated to supporting comprehensive project management* improved the effectiveness of implementation strategies. The identification of regional and country project managers, supported by technical advisers and experts, was recommended as a key component for the effective scale-up of national programmes.[41]
- *A developmental and strategically phased approach with interlinking steps promoted capacity-building within and between countries and across sectors* such as the health, economic and legal sectors. For example, the SEE Second Health Ministers Forum followed the initial intergovernmental consultation in Sofia and was attended by health and finance ministers of the eight participating countries. A key objective was achieved when these ministers adopted a statement promoting national policies and international

[40] The SEE Health Network is a political forum set up to coordinate, implement and evaluate commitments of the Dubrovnik Pledge and its regional projects for developing health policy and services. It comprises representatives of ministries of health of its member countries and representatives of intergovernmental organizations.
[41] Programmes and materials for the SEE project were developed with financial support from the government of Norway, and major continuing technical and organizational support is being given by the Regional Office.

collaboration in the countries of south-eastern Europe. Intergovernmental consultations were followed by intersectoral training workshops at intercountry and national levels.

Impact of the policy initiative

Although the WHO FCTC has been in force since February 2005, the south-east European countries are at different stages in the ratification and implementation process. The SEE project has contributed to the major progress made so far towards building the capacity, awareness and collaboration between countries and among sectors that are critical for implementation of tobacco control interventions. This policy has resulted in bringing tobacco control, and particularly the WHO FCTC, higher up the political agenda of the south-east European countries. National action plans are currently being developed. Of greater importance is that a foundation of support and collaboration has been built through raising awareness and capacity-building for the WHO FCTC. The impact of this policy has been demonstrated by the ratification of the WHO FCTC by six of the nine participating countries since 2005.

Lessons and conclusions

A sub-regional approach and networking are effective means of building support for the goals of tobacco control and ratification of the WHO FCTC.

The involvement of other relevant sectors, initiated and led by health ministries, is crucial to strengthen the political climate and capacity for tobacco control.

The ratification and the implementation of the WHO FCTC can be successfully promoted in countries through sub-regional intergovernmental cooperation, supported by WHO.

The ratification of the WHO FCTC in countries creates an immediate demand with expectations and opportunities for capacity-building, cooperation and strengthening of tobacco control at intersectoral level, which are key to the adoption of comprehensive policies in this field.

12. Health Professionals against Tobacco: the Swedish experience

WHO encourages health professionals to be proactive in minimizing the adverse effects on health caused by the addiction to and consumption of tobacco and exposure to tobacco smoke. In particular, the WHO FCTC emphasizes the role of health professional bodies in efforts to incorporate tobacco control into public health agendas and actively contribute to reducing tobacco consumption.

Sweden has a long tradition of fighting against tobacco going back over 40 years. It was the first country in Europe to achieve WHO's goal of reducing the population prevalence of smokers to below 20%. Progress made over the years can be attributed to various factors including, in particular, the accomplishments of nongovernmental organizations of health professionals. This case study describes the role of such organizations and their contribution to the successful anti-tobacco work.

Situation prior to the involvement of health professionals

Sweden was one of the first countries in the world to fund tobacco control efforts. Since the early 1960s a comprehensive programme has been developed, including public information and education activities (1963); publication of scientific reports on the risks of smoking (first published in 1957); explicit commitments by politicians to responsibility in the fight against tobacco (1974);

restrictions (1975) and subsequently a ban (1994) on tobacco advertising and promotion; the regulation and labelling of tobacco products (first warnings introduced in 1977); legislation favouring smoke-free environments, and development of smoking cessation facilities. As a result of this continuous and comprehensive anti-tobacco effort, Sweden now enjoys the lowest prevalence of smokers in Europe.

Health professionals in Sweden have significantly contributed to anti-tobacco activities since the tobacco control efforts began. However, it was only in the last 15 years that this action took a more structured and coordinated form. Prior to this, health professionals' activities were rather fragmented and participation in broad tobacco control efforts was widely acknowledged to be sub-optimal. There were a number of concerns in relation to these activities, in particular:

- greater involvement of health professionals in preventive, advocacy and health-promoting activities was seen as one of the greatest challenges to be accomplished in the area of tobacco prevention efforts;
- training in issues related to tobacco control, an essential precondition for more active involvement of health professionals in the fight against tobacco, was inadequately incorporated into the basic education and training curricula of health professionals;
- coordination of efforts to combat tobacco at regional and national levels was not satisfactory as regards individual activities by health professionals and by their professional associations.

Enabling context and development of the initiative

Various groups of health professionals are ideally positioned to lead tobacco control activities as they are respected by politicians, policy-makers, the public and other health professionals, and through individual and collective action (through their professional associations) they can have a substantial impact on the battle against tobacco. Acknowledgement of this potential and the hitherto sub-optimal participation of this group created an impetus for action.

In 1992, the establishment of the National Institute of Public Health, whose responsibilities included the improvement of coordination of activities against tobacco, helped to catalyse the activities of health professionals and provided them with financial support. In the same year, the establishment of Doctors against Tobacco created the first anti-tobacco front by health professionals. This group focused on promoting health through reducing tobacco use and encouraged the medical profession to focus on tobacco issues. Subsequently, other professional groups espousing the same vision were established, including Dentists and Nurses against Tobacco (1992), Pharmacists against Tobacco (1996) and Psychologists against Tobacco (2000). Teachers against Tobacco joined in 1994. These nongovernmental organizations subsequently formed the umbrella organization, Health Professionals against Tobacco, an informal network which shares information and plans to improve the coordination of activities. Health Professionals against Tobacco aims to promote a tobacco-free culture in Sweden by:

- monitoring and influencing the political processes regarding tobacco control issues;
- increasing the awareness, knowledge and tobacco-free behaviour of members of their professional group;
- creating health education and information materials;
- supporting local tobacco control initiatives;
- engaging in international cooperation.

This network has further expanded with the addition of other nongovernmental organizations such as the Swedish Cancer Society, the Swedish Heart-Lung Foundation, the VISIR (an organization formed in 1974 to promote smoke-free environments) and the National Institute of Public Health.

The success of this collaboration has been greatly facilitated by a number of factors, including:

- the establishment of regional representatives throughout the country to improve communication and coordination of activities, thus encouraging the involvement of professionals in local communities and increasing their engagement and support;
- advocacy aimed at tightening tobacco control legislation to complement other tobacco control efforts (such as tobacco cessation and prevention) and raising the profile and influence of the professional associations in policy-making circles;
- financial autonomy of the organizations achieved through funding provided by the Institute of Public Health, donations and (importantly) by membership fees, which has protected the independence of the organizations in part and provided short-term sustainability.

Impact of the initiative

The efforts of the tobacco control movement have contributed to the adoption of advanced tobacco control legislation which has further helped to reduce tobacco use in the country, so that:

- in 2005 the prevalence of daily smoking was 17% in women and 13% in men, among the lowest in the world;
- in 2005 the rate of daily oral smokeless tobacco use was 4% in women and 22% in men;
- in 2003, among pregnant women, the prevalence of smoking was 10% and the prevalence of oral smokeless tobacco use was 1.4%.

Since 1992, Health Professionals against Tobacco in Sweden have been continuously engaged in multilateral action to advance tobacco control. This has included:

- demonstrations for a comprehensive Tobacco Act;
- advocacy and staging of media events with awards to Saab Automobiles for their decision to produce vehicles without ashtrays and the Swedish Tourist Association for refusing to take sponsorship money from the tobacco industry; attending Swedish Match's annual shareholders' meeting to distribute an alternative company report containing mortality and morbidity statistics which led to two insurance companies immediately selling their shares in the company;
- developing international networks and initiating European conferences.

Between 2003 and 2005, political lobbying and information campaigns were carried out aimed at the media and the public in order to build broad-based support for a review of the tobacco control legislation. There were two objectives: to expand the ban on smoking in all public places to include the hospitality sector, and to encourage ratification by Sweden of the WHO FCTC. These activities were critical to the enactment of the law which came into force in June 2005 banning smoking in all public places. Sweden became a signatory of the WHO FCTC in 2003 and ratified it in 2005.

Lessons and conclusions

Health professionals are important role models as they are regarded by the public as credible sources of health information.

Comprehensive tobacco control programmes should consider a mix of measures, such as legislation and pricing interventions, prevention (through health education and information campaigns that raise awareness of the adverse effects of tobacco on health) and other demand reduction measures that focus on reducing dependence on tobacco and encouraging smokers to stop. Health professionals can play an important role in every facet of these interventions.

Health professional associations can use a number of strategies to enhance tobacco control, including:

- educating members as to their valuable roles in tobacco control;
- influencing health institutions and educational centres to include tobacco control in their professional training curricula;
- collaborating with the wider scientific community and communicating research evidence on effective tobacco control and cessation strategies to their members and to the general public;
- building partnerships with the community to deliver cessation, prevention and protection messages to the public and encouraging members to participate in public education activities;
- advocating to governments on the effective role of health professionals in tobacco control;
- lobbying governments for continuous funding to sustain a national tobacco control coordinating centre;
- lobbying governments at various levels to provide funding support for smoking cessation services;
- lobbying governments and politicians to support anti-tobacco legislation;
- promoting smoke-free environments and encouraging members not to use tobacco in any form and to set an example as role models.

Through their professional activities and networks, health professionals can help people by giving advice, guidance and answers to questions related to tobacco use and its health effects, and serve as a reference for the media to educate the public and policy-makers.
Autonomy of the professional organizations is a key precondition for their successful intervention in the fight against tobacco and its future sustainability.

For more information, visit www.tobaccoorhealthsweden.org (accessed 22 August 2006) or e-mail professionals@globalink.org.

13. The Tobacco Control Fund in Switzerland

This case study presents the experience from the development and implementation of the Tobacco Control Fund in Switzerland. The initiative was primarily developed to generate additional income for health promotion programmes and research focusing on tobacco-related issues.

In April 2004, a Fund for Tobacco Control (Fonds de Prévention du Tabagisme) was established, financed by an earmarked tax of 2.6 Swiss centimes (SwF 0.026) per pack of cigarettes purchased. The technical peculiarity associated with the creation of this Fund is that the tobacco industry is obliged by law to finance the Fund directly by allocating this sum per packet of cigarettes sold. Thus, the funding is not provided by earmarked money from general tobacco taxation but instead by a more customized earmarked tax on the tobacco companies' revenues generated by their sales.

The situation prior to the creation of the Fund

Tobacco consumption is widespread in Switzerland. Smoking is the leading preventable cause of death. According to the Federal Office of Public Health, each year some 8300 people die from smoking-related illnesses, accounting for approximately one sixth of all deaths. In spite of this worrying epidemiology, however, the price of cigarettes is relatively low. A study carried out in 2000 in 56 cities worldwide and published by WHO showed that in Zurich it takes only 11 minutes of working time to earn the money needed to buy a packet of cigarettes – the lowest time in any of the European cities.

Despite several prevention campaigns and those aimed at smoking cessation, between 1992 and 2002 the number of smokers remained stable at just over 30% of the population aged 15 years and over. In this period, the proportion of smokers in the group aged 15–24 years increased to 37%. In 2000, the number of cigarettes sold to each smoker was more than 20 per day, making Switzerland one of the highest tobacco consumers in Europe.

Despite antismoking campaigns, cigarette consumption among teenagers rose in the 1990s along with other European countries and the United States. A survey published by the Federal Office of Public Health[42] in 2001 found that 31% of young people aged 14–19 years were smokers and 16% of this group smoked daily.

According to the Institute for the Prevention of Alcoholism and Drug Addiction, 9.1% of boys and 7.9% of girls aged 13–14 years smoke at least once a week, with the average age of smoking start-up steadily falling. Between 1992 and 1997, the number of smokers among girls aged 15–19 years doubled. In 2003, the proportion of smokers among women aged 20 years was almost the same as that in men.

In the last decade there have been various attempts to introduce a comprehensive tobacco prevention programme, for example, the Tobacco Prevention Programme led by the Federal Office of Public Health in the period 1996–1999. However, these interventions have enjoyed limited success with tobacco control as they lacked adequate financial resources and suffered from suboptimal cooperation between partners engaged in tobacco prevention. The strength of the tobacco industry has created resistance to the implementation of meaningful tobacco control legislation and policies.

[42] *Alcohol, tobacco, drugs.* Berne, Swiss Federal Office of Public Health (http://www.bag.admin.ch/themen/drogen/index.html? lang=en, accessed 30 November 2006).

Creation, development and implementation of the Fund

The idea of creating a Tobacco Control Fund in Switzerland dates back to 1993, to the so-called "Initiatives Jumelles" (Twin Initiatives). These initiatives called for a change in the Swiss Constitution in order to introduce a comprehensive ban on tobacco and alcohol advertising. The tobacco-related initiative proposed, among other things, the introduction of an earmarked tax to finance tobacco prevention activities. The voters rejected these initiatives, however: an overwhelming 75% voted against them although pre-referendum polls had indicated that a majority favoured advertising bans. The rejection of the initiatives following strong lobbying and media campaigns mounted by the tobacco and alcohol industries in conjunction with the advertising agencies and print media, adversely affected efforts to introduce regulations for tobacco control.

Switzerland has long had a strong pro-tobacco lobby which has prevented the adoption of stringent tobacco control policies, so that the tobacco excise tax percentage is the lowest in western Europe. The laws governing the sale and marketing of tobacco products have been weak in relation to the operations of the tobacco industry.[43] The industry has retained close relationships with officials in the administration and politicians in Parliament and has developed strong alliances with various stakeholder groups such as tobacco-growers in the agricultural cantons and groups from the trade and hospitality sectors. In 1995, to promote local tobacco cultivation, the industry (particularly Phillip Morris) encouraged the creation of a fund whereby SwF 0.026 per pack of 20 cigarettes were allocated to this fund.

Unlike the well-organized and well-funded pro-tobacco lobby, public health advocates were only able to carry out sporadic activities that were limited in scope, necessitating the establishment of an adequately funded institution to support tobacco control and promote tobacco prevention activities.

Public support for tobacco control gained momentum in 2001 when the role of the tobacco industry in undermining health promotion policies was uncovered.[43] A national public media campaign launched in May 2001 kept the issue high on the public agenda and helped to raise awareness and to create a critical mass of people who demanded further action to improve tobacco control. The increasing prevalence of smoking among young people and women was a further catalyst.

In Parliament, the proposal of a lobbyist for nongovernmental organizations that tobacco control in sports settings should be included was crucial in obtaining wider support for the creation of a Tobacco Control Fund, to be financed in the same way as the tobacco growers' fund (i.e. SwF 0.026 per pack of 20 cigarettes sold).

The proposal for a Tobacco Control Fund presented its opponents with a dilemma: either they opposed its creation, which would have also led to the winding up of the fund for the tobacco growers (and thus adversely affecting key allies), or they accepted its creation and financing.

Although there was a favourable environment for the development of a proposal to establish a Tobacco Control Fund, the adoption of the Law was challenging as opposition from and intensive lobbying by the tobacco industry to prevent its enactment led to the emergence of conflicting views in the two Chambers of the Federal Assembly (the Council of States and the National Council). The legislation was eventually adopted by Parliament with a slim majority.

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[43] Lee CY, Glantz SA. *The tobacco industry's successful efforts to control tobacco policy making in Switzerland.* San Francisco, CA, Center for Tobacco Control Research and Education, 2001 (Tobacco Control Policy Making: International, Paper Swiss2001) (http://repositories.cdlib.org/ctcre/tcpmi/Swiss2001, accessed 30 November 2006).

Four factors were critical to achieving a successful result in the Parliamentary vote:

- professional lobbying funded by the tobacco control organizations;
- setting the tax at the same level as the funding for the tobacco growers;
- the creation of strong partnerships of organizations active in the wider public health sector, especially in sport; and
- the inclusion of a proposal to place the surveillance of the Fund under the jurisdiction of the Federal Offices of Public Health and of Sports, thus helping to mobilize support from sports representatives.

Collectively, these efforts built support among parliamentarians for the adoption of the legislation. The Federal Law was passed by Parliament in March 2003 and the Fund started its activities in April 2004 under the surveillance of the Federal Office of Public Health in collaboration with the Federal Office of Sports. The Law also stipulated that the tobacco industry and organizations supported by this industry could not submit projects to the Fund.

The earmarked tax of SwF 0.13 centimes per cigarette sold in Switzerland (SwF 0.026 per pack of 20 cigarettes) is not a general tobacco tax financed by the State but rather by the industry, which contributes the same amount of tax to the fund for the tobacco growers. The expected annual revenues for the Fund are estimated to be SwF18 million.

The Fund, which will use part of its revenues for the implementation of the National Programme on Tobacco Prevention (2001–2007), will use its finances in a number of areas:

- to prevent the initiation of smoking and promote cessation of tobacco use (around 32%);
- to raise awareness and inform the public about tobacco-related issues (around 25%);
- to protect the population from passive smoking (around 8%);
- to develop a network of organizations active in tobacco prevention and create a framework of action to support tobacco prevention (around 5%);
- to promote research on tobacco prevention and control (around 5%);
- administration (max 5% of total costs);
- tobacco prevention in sports (around 25%).

To date, the projects financed by the Fund[44] include:

(i) 7 projects to prevent the initiation of smoking;
(ii) 17 projects to promote the cessation of tobacco consumption;
(iii) 9 projects to protect the population from passive smoking;
(iv) 6 projects to raise awareness and inform the public;
(v) 9 projects to develop a network of active organizations and create a framework for tobacco prevention;
(vi) 13 projects promoting research;
(vii) 5 projects developing prevention programmes focusing on sports and physical activities;
(viii) local comprehensive programmes (includes (i) to (v)).

[44] More information on the projects can found at: http://www.bag.admin.ch/tabak_praevention/00879/index.html?lang=fr, accessed 30 November 2006).

Impact of the policy

Despite the relative popularity of smoking, tobacco control campaigns and activities are gradually gaining momentum with assistance from the Prevention Fund. Recent examples of success include:

- ban on smoking in Federal Railways trains in December 2005;
- introduction of a smoking ban in public places in Ticino Canton (voting in by 79% of the population);
- introduction of national smoking cessation assistance via telephone;
- introduction of new regulations for labelling and marketing of tobacco products, banning descriptions such as “light” and “mild” and limiting the maximum allowed yield for tar to carbon monoxide (10 mg) and nicotine (1 mg); and
- placing of warning labels on cigarette packages in line with the standards required by European Directive 2001/37EC.

Conclusions and lessons learned

Adequate funding for tobacco control measures is necessary if policies are to be successfully introduced. The recently created Tobacco Control Fund provides indicative evidence to reinforce this view.

The creation of the Fund has led to the introduction of an earmarked tax, the revenues from which are used to support the creation of a framework of action to strengthen tobacco prevention activities, to enable anti-tobacco advocates to develop a network of organizations active in tobacco prevention and to promote research on tobacco prevention and control.

The Fund has helped to create a public information capacity about the harm done by tobacco and to harness community involvement in anti-tobacco activities. It has provided recurrent funding for activities aimed at promoting tobacco prevention and has also facilitated the recruitment of specialist and professional expertise.

The tobacco industry operates in a sophisticated and strategic manner, allocating large resources for policy interventions. Over the years, it has developed considerable expertise in intelligence gathering and lobbying activities. To confront this industry effectively, public health advocates had to adopt similar strategies by employing professional lobbyists, public relations experts and public policy specialists. This required financial independence and adequate resources, especially to engage professional lobbyists who, together with the strategic approach adopted by the anti-tobacco advocates to develop multiple partnerships within the wider public health sector (especially with members of Parliament involved in sports lobbying), were critical to the adoption of the Law and the creation of the Fund. The close collaboration between the Federal Office of Public Health and the Federal Office for Sports was also helpful for the successful implementation of the Fund. This collaboration created synergies for optimal management of the Fund and, more importantly, demonstrated that the development of partnerships in the public health domain is instrumental for achieving successful outcomes.

14. Counteracting the illicit trade in tobacco products: the United Kingdom experience

Tobacco smuggling provides a cheap and unregulated supply of cigarettes and hand-rolling tobacco, which undermines the Government's policy of using tax to maintain a high price for tobacco and help reduce smoking, especially among the young. This case study analyses the effectiveness of an intervention policy targeting the smuggling of tobacco products, the "Tackling Tobacco Smuggling" strategy.

Tobacco fraud: the situation prior to the policy initiative

In 2000, more than one cigarette in five smoked in the United Kingdom was smuggled – an increase of 50% on the previous year – and this was predicted to rise to one in three within a few years. Tobacco smuggling was costing over £3 billion a year in lost tax revenue and creating serious law and order problems by funding organized crime.

The introduction of the single market in Europe facilitated large increases in international trade and passenger movements and gave EU citizens unrestricted cross-border shopping rights. The high level of tobacco duty in the United Kingdom compared with other EU member states encouraged a rapid growth in legitimate cross-border shopping. However, it also encouraged growth in the illicit market for hand-rolling tobacco from almost nothing in the early 1990s to around half the market in 1995 and nearly 80% in 1999.

Initially, the problem of smuggling was confined to cross-Channel smuggling of hand-rolling tobacco. By 2000, however, cigarette-smuggling had increased rapidly to the point where 70–80% of smuggled cigarettes were transported by freight and "roll-on roll-off" lorries. Organized criminals began to get involved, encouraged by the large arbitrage profits available from the price differentials driven by high United Kingdom tax policy compared to lower rates in the EU and zero rates in Asia.

Launch, development and implementation

In 2000, the Government adopted a radically new approach to tackling tax fraud, to undermine the economics of smuggling by: tackling the supply of tobacco, partly through working with the tobacco manufacturers; disrupting distribution channels through detection and seizure; increasing the risks of smuggling through more intelligent targeting and tougher sanctions; and tackling the demand side by raising public awareness of the dangers and consequences of tobacco smuggling.

The new approach was based on six key components:

- *estimating the size of the problem* – understanding the scale of the problem, which is fundamental to understanding its nature and developing effective solutions, despite the inherent difficulty in measuring illicit activity;
- *analysing the problem* – properly understanding the fraud so that appropriate operational responses are developed and deployed;
- *operational responses* – developing a range of responses to ensure maximum pressure at all levels of the fraud network;
- *establishing outcomes* – designing clear and measurable criteria for success based on impact on the problem;

- *strengthening controls* – underpinning the operational response with an assessment of other changes needed to prevent a tax regime being exploited by fraudsters; and
- *monitoring and delivery* – consistent and regular monitoring of targets through mechanisms such as public service agreements, which are key to ensuring an unwavering focus on delivery of outcomes.

This strategy, implemented in March 2000, represented a move away from a tactical response focused on intermediate levels of success (such as seizures) to an end-to-end strategic approach. This was achieved through a far-reaching package of measures that included unprecedented new investment and, importantly, a clear and ambitious target to reduce the illicit market in cigarettes to 17% by 2005/2006.

Since 2000, the Government has reinforced and refined the tobacco strategy as operational experience of smuggling patterns have required. It has signed memoranda of understanding with the main tobacco manufacturers supplying the domestic market which are designed to restrict the availability of cigarettes manufactured in the United Kingdom to smugglers. These memoranda of understanding have played a crucial role in making it harder for smugglers to source tobacco and now have a proven record of success.

In October 2002, the Government introduced a further package of measures designed to distinguish more clearly between smugglers and genuine shoppers. The package put the onus on HM Revenue & Customs to prove that activity was illegal, and increased guide levels for shoppers from within the EU to allow HM Revenue & Customs officers to concentrate their efforts on those who are more likely to pose a risk of smuggling. At the same time, the Government introduced tougher action for persistent offenders and for those who use violence against the Customs officers.

Impact of the policy and lessons learned

HM Revenue & Customs constantly monitors the illicit market share against targets. The strategy proved to be highly successful, meeting its target two years early, and the Government set a new, more challenging target in 2004 for the strategy to reduce the share of cigarettes smuggled to 13% by 2007/2008.

Since its introduction, the strategy has cut the size of the illicit market in cigarettes from 21% in 2000/2001 to 16% in 2003/2004, a reduction of almost a quarter. Without action through the strategy, the illicit market share was predicted to be 36%, with a revenue loss of around £6 billion.

Inevitably, this success has had consequences. Smugglers have adapted to the new environment, changing the patterns and types of smuggling activity and hence the nature of the domestic market in smuggled cigarettes. At the start of the strategy, the illicit United Kingdom tobacco market was largely made up of genuine domestically manufactured cigarettes bought from outside the EU and smuggled back into the United Kingdom in multimillion cigarette freight consignments.

This has changed and the illicit United Kingdom market is now more complex. In addition to smuggling of genuine domestically manufactured cigarettes, which remains a serious problem, a major new challenge is being posed by significant smuggling of counterfeit cigarettes, while smuggling of hand-rolling tobacco remains persistently high.

The Government is, therefore, building on the resources and controls already in place to tackle tobacco smuggling by introducing a range of new measures to reinforce the strategy, including specific measures to tackle the smuggling of hand-rolling tobacco and counterfeit cigarettes. The new measures are in four main areas:

- *working with tobacco manufacturers* to improve the targeting of counterfeit product and further restrict the supply of both hand-rolling tobacco and genuine cigarettes through existing memoranda of understanding complemented by legislation;
- *enhancing HM Revenue & Customs' operational response*, to strengthen enforcement at all the key points along the supply and distribution chain, with 200 extra staff to focus on hand-rolling tobacco and a 30% increase in the network of foreign liaison officers;
- *using technology* to increase HM Revenue & Customs' ability to detect illicit goods and target resources effectively; and
- *using publicity and communications* to increase awareness of HM Revenue & Customs' enforcement action and to undermine further the appeal of smuggled products to current and potential consumers.

Vital to the success of the reinforced strategy is the new legislation regarding the supply chain, which is based on and backs up the memoranda of understanding. The legislation, which will cover both cigarettes and hand-rolling tobacco, will apply to products smuggled from both EU and non-EU sources. The scheme will impose obligations on manufacturers and levy penalties of up to £5 million for failure to comply with those obligations.

The legislation is designed to complement the memoranda of understanding with the United Kingdom tobacco manufacturers, and ensure that those manufacturers who aid HM Revenue & Customs in their efforts to combat tobacco smuggling are not unfairly disadvantaged. Obligations will therefore be imposed on all tobacco manufacturers, whether or not they have signed a memorandum of understanding with HM Revenue & Customs, to control their supplies to foreign markets and to ensure as far as reasonably practicable that they do not facilitate smuggling.

15. The GYTS in the WHO European Region

This case study describes the design and development of the GYTS, an international collaborative surveillance initiative on tobacco use among young people aged 13–15 years.

The GYTS surveillance system was developed to enhance the capacity of countries to design, implement and evaluate tobacco control and prevention programmes specifically targeting young people. It enables tobacco use to be monitored in targeted segments of the population and, by employing a common methodology across countries, promotes consistency in data collection, which in turn allows intra- and intercountry comparisons.

The GYTS is led by the WHO Tobacco Free Initiative and the US Centers for Disease Control and Prevention, Office on Smoking and Health (CDC/OSH), and includes governments and nongovernmental organizations. It aims to:

- determine the level of tobacco use in the countries surveyed;
- estimate the age at which young people in the target groups start to smoke;
- estimate the likelihood of young people starting to smoke;
- assess the level of exposure of the target groups to tobacco advertising;

- identify attitudes to and beliefs about behavioural norms as regards tobacco use among young people, with the aim of developing targeted prevention programmes;
- assess the extent to which major prevention programmes are reaching school-based populations and how these populations view these programmes.

Situation prior to the policy initiative

Studies in developed countries show that the majority of people begin using tobacco before the age of 18 years.[45,46] It is estimated that 80% of adult tobacco users began smoking as teenagers and by 18 years, 35% of them had become daily smokers. To prevent individuals from smoking, tobacco control efforts need to focus on young people where there is a great potential for success.

Information on tobacco use among young people is not, however, readily available in many countries, especially in the majority of developing countries. The lack of baseline data seriously limits the possibilities for intracountry monitoring and evaluation of tobacco use by young people and impedes intercountry comparisons.

Although many developed countries, predominantly in Europe, have implemented sophisticated youth behaviour surveillance systems which incorporate tobacco use, the use of different survey methods prevents intercountry comparisons. In addition, the majority of countries in the eastern part of the WHO European Region did not have any reliable surveillance and data on smoking prevalence among young people in the late 1990s and at the beginning of the twenty-first century.[47]

Launch, development and implementation

Difficulties in the comparability of surveys in various countries, and their absence in a large number of low-income countries, led WHO and the CDC/OSH[48] to develop the Global Youth Tobacco Survey in consultation with countries in the six WHO regions.

Funding for the development of GYTS, which began in 1999, was provided by the CDC, the Canadian Public Health Association, the US National Cancer Institute, the United Nations Children's Fund (UNICEF), the WHO Tobacco Free Initiative and the United Nations Foundation for International Partnerships (UNFIP).

The survey is school-based and employs a two-stage sample design to produce representative data on smoking among schoolchildren aged 13–15 years. The first stage of the survey consists of a probabilistic selection of schools, followed by the second stage which involves random selection of classes from the schools selected. The survey instrument is in the form of a questionnaire containing a core component that provides essential data for intra- and intercountry

[45] US Department of Health and Human Services. *Preventing tobacco use among young people: a report of the Surgeon General*. Atlanta, GA, US Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health, 1994 (reprinted with corrections, July 1994).
[46] Secretary of State for Health and Secretaries of State for Scotland, Wales and Northern Ireland. *Smoking kills*. A White Paper on tobacco, 30 November 1999. London, HM Stationery Office, 1999.
[47] The Global Youth Tobacco Survey Collaborative Group. Tobacco use among youth: a cross country comparison. *Tobacco Control*, 2002, 11:252–270.
[48] Centers for Disease Control and Prevention, Office on Smoking and Health, Tobacco Information and Prevention Source (TIPS) (http://www.cdc.gov/tobacco/, accessed 28 November 2006).

comparisons. An optional set of questions on specific issues can be added to this core to reflect the needs and priorities of individual countries.

In the WHO European Region the GYTS uses a self-administered questionnaire which includes data on:

- the prevalence of tobacco use
- perceptions and attitudes concerning tobacco use
- information about access to and availability and price of tobacco
- exposure to environmental tobacco smoke
- issues related to tobacco control in school curricula
- media activities in relation to and advertising of tobacco products
- tobacco cessation.

To guarantee a consistent approach, the coordinators of the survey in participating countries were trained in groups to ensure that the protocol and administrative procedures were identical in all countries and designed to protect the privacy of participants by allowing for anonymous and voluntary participation.

A school-based survey enables the target group (13–15-year-olds) to be reached inexpensively, requires only limited field staff and allows completion of the study in a short time.

The GYTS has been implemented in selected countries. Its findings, together with the growing need for data on young people and tobacco, have led WHO and the CDC to develop a multi-agency, international collaborative effort to provide and channel assistance.

Enabling context

A number of factors have together created a context which has enabled the rapid and successful adoption of the GYTS in many countries. First, national experts were actively engaged when the survey was designed, ensuring that it would be responsive to varying local contexts and owned by participating countries. Second, the relative absence of data on tobacco use by young people and the lack of a commonly agreed survey instrument meant that the GYTS, which included a standardized methodology and a validated survey instrument, was welcomed by many countries to enable them to undertake intra- and intercountry comparisons. Third, the GYTS was relatively simple to use and inexpensive to administer, with the data gathered analysed rapidly and returned to participating countries. Fourth, in the European Region the Regional Office aligned the survey with existing experience in many (mostly western) European countries.

A further enabling factor has been the institutionalization of the GYTS in the European Region where it has been carried out through a mutually beneficial partnership between WHO, the CDC and ministries of health in the participating countries. Governments took ownership of the process and contributed human resources. At WHO's request, each ministry of health appointed a national public health institution to be the focal point in the country for the implementation of the project, and within that institution a research coordinator to be in charge, with the coordination of implementation carried out at national level. The research team was drawn from the staff of the coordinating institution or its partners at local level. All research coordinators were trained by CDC and WHO in the GYTS methodology and replicated this training with their teams. Thus, the capacity to implement youth tobacco surveys has been improved at both national and local levels, ensuring a certain level of sustainability of the initiative. The establishment of the GYTS within a specific institution in each country and the creation of a network of adequately trained field staff employed within the structures of the ministry of health has allowed the GYTS to be set up as a

surveillance system rather than a one-time survey. Although the first round was co-financed by the CDC and WHO, the cost of implementation is now being shared at national level for the repeat surveys and the dissemination and policy use of data.

Taking into account the important expertise present in European countries, the Regional Office opened a consultation process with the CDC, national experts responsible for the implementation of national youth tobacco surveys and international experts in the Region responsible for the coordination of other Europe-wide surveys that include a youth tobacco component.

Following these consultations, it was agreed that the operational definition for the GYTS in WHO European countries would be "regular weekly smoking" (young people who had smoked at least once a week during the previous 30 days), complementing the global GYTS definition of "current smoking" (young people who had smoked on at least one day during the previous 30 days). Data for 15-year-old students were used to ensure comparability with the Health Behaviour in School-aged Children survey – a well-developed school-based behavioural survey being carried out in many countries of the Region.

Impact of the initiative

Currently, 26 countries in the WHO European Region use the GYTS. Seven of these (Bulgaria, the Czech Republic, Latvia, Lithuania, Poland, the Russian Federation and Ukraine) implemented the GYTS before 2002 and have reported results. A further nine (Bosnia and Herzegovina, Croatia, Estonia, Georgia, Hungary, Serbia and Montenegro, Slovakia, Slovenia and The former Yugoslav Republic of Macedonia) joined the scheme in 2002 and all of them have already reported their results. Another nine (Albania, Armenia, Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Romania, Tajikistan, Turkey) joined in 2003 while two others (Russian Federation and Ukraine) repeated the survey; of these, eight have prepared country reports. Researchers nominated by the ministries of health in these countries have been trained by the Regional Office. Eight countries plan to repeat the survey in 2006/2007 and others will be encouraged to do so in late 2007/2008, thus creating the basis for a regular, hopefully sustainable, surveillance system for these countries and the Region as a whole. The Regional Office will organize an "exposure and dissemination" workshop for western European countries interested in joining GYTS in the near future. Many countries have already been using GYTS data in the analysis and strengthening of national policies and their impact. The GYTS has provided comparability of smoking prevalence data for young people in a large number of countries and enabled at least half of the participating countries, for the first time, to have reliable national data in this field.

Lessons and conclusions

The GYTS surveillance system has enhanced the capacity of countries to design, implement and evaluate their own tobacco control and prevention programmes. The availability of a relatively easy-to-implement survey with an agreed methodology and validated instrument has allowed rapid uptake and dissemination of this survey in the WHO European Region and the development of a unique database, with robust and reliable data, which can be analysed to provide intra- and intercountry comparisons. Technical, financial and political support from leading institutions has been instrumental in aiding countries to take up and disseminate the findings of the GYTS. The results of these analyses and comparisons can be used to monitor and evaluate the impact of tobacco control initiatives on young people, to inform policy development and for advocacy.

The GYTS has demonstrated that it is possible to create an inexpensive and standardized, worldwide surveillance system for tobacco use by young people, with a methodology that countries can apply easily. These attributes make it a reliable tool, which can be expanded to countries beyond the eastern part of the Region and used to provide a unique resource for monitoring and evaluating global and national tobacco control efforts.

The success of the project in the European Region has undoubtedly been due to the quality of the researchers at national level, coupled with continuous technical support and smooth coordination of its implementation by WHO and the CDC. Partnerships between countries during the implementation process and peer support at sub-regional level have also contributed significantly to the process.

The European experience with advocacy in GYTS has also recently been inspiring some initial efforts in creating internationally standardized approaches for adult smoking prevalence – another major task for the future.

Annex 2

COMPARABLE ESTIMATES OF ADULT DAILY SMOKING PREVALENCE IN THE WHO EUROPEAN REGION

Country	Male prevalence (%)			Female prevalence (%)		
	2002	2005	Relative change	2002	2005	Relative change
Albania	[a]	[a]	[a]	2.6	2.6	0.1
Andorra	35	33	-2.0	24.2	24.7	0.5
Armenia	48.1	48.1	0.0	2.8	2.8	0.0
Austria	40.4	41.3	0.9	36.5	40	3.5
Azerbaijan	[a]	[a]	[a]	0.4	0.4	0.0
Belarus	57.7	57.7	0.0	16.8	16.8	0.0
Bosnia and Herzegovina	48.0	45.7	-2.3	30.6	31.1	0.5
Bulgaria	41.3	41.3	0.0	23.4	23.4	0.0
Croatia	37.2	35.1	-2.1	24.7	25.2	0.5
Czech Republic	30.1	30.0	-0.1	21.5	20.7	-0.8
Denmark	30.2	28.4	-1.8	25.8	24.0	-1.8
Estonia	42.0	42.0	0.0	20.7	20.7	0.0
Finland	25.9	24.9	-1.0	18.2	18.6	0.4
France	31.3	30.6	0.7	23.3	23.6	0.3
Georgia	50.9	50.9	0.0	4.0	4.0	0.0
Germany	32.6	31.7	-0.9	22.7	22.4	-0.3
Hungary	39.3	39.0	-0.3	29.1	29.7	0.6
Iceland	22.8	19.4	-3.4	22.8	19.7	-3.1
Israel	31.5	27.4	-4.1	15.2	15.1	-0.1
Italy	31.6	29.1	-2.5	16.1	15.5	-0.6
Kazakhstan	36.8	36.5	-0.3	6.3	6.5	0.2
Kyrgyzstan	50.9	50.6	-0.3	4.5	4.7	0.2
Latvia	46.6	46.8	0.2	17.4	17.4	0.0
Lithuania	37.2	37.2	0.0	14.0	14.0	0.0
Luxembourg	34.4	33.8	0.6	27.7	28.0	-0.3
Malta	31.1	29.2	-1.9	20.0	20.4	0.4
Netherlands	32.4	31.7	-0.7	27.1	27.6	0.5
Norway	27.4	26.1	-1.3	24.7	23.7	-1.0
Poland	40.2	37.6	-2.5	23.5	23.3	-0.1
Portugal	39.1	37.0	-2.1	–	–	–
Republic of Moldova	49.2	48.9	0.3	4.7	4.8	0.1
Romania	39.3	39.3	0.0	18.4	18.4	0.0
Russian Federation	64.4	64.9	0.5	20.4	21.6	1.2
Serbia and Montenegro (Serbia)	50.8	48.6	-2.2			
Slovakia	35.0	34.8	-0.2	15.1	15.5	0.4
Slovenia	30.2	28.4	-1.8	17.9	18.3	0.4
Spain	35.5	32.7	-2.8	25.5	27.1	1.6
Sweden	16.3	14.4	-1.9	19.4	18.1	-1.3
Switzerland	25.3	23.6	-1.7	18.8	17.7	-0.8
Turkey	45.4	45.1	-0.3	13.6	14.6	1.0
Ukraine	58.1	57.7	-0.4	15.5	18.7	3.2
United Kingdom	28.8	28.8	0.0	27.9	27.9	0.0
Uzbekistan	19.3	19.1	-0.2	0.6	0.6	0.0

[a] See footnote 4 in the main text.

Source: WHO Global InfoBase [online database]. Geneva, World Health Organization, 2006 (http://www.who.int/ncd_surveillance/infobase/web/InfoBaseCommon/, accessed 6 August 2006).

Annex 3

METHODOLOGY FOR ASSESSING TOBACCO SMOKING PREVALENCE

Adult smoking prevalence

The smoking prevalence data published in this report for cross-country comparisons derive from the comparable estimates provided by the WHO Global InfoBase[49] that were available for 41 countries of the WHO European Region and that are based on country-reported data. These data were adjusted for known survey biases, including differences in definitions, regional coverage, age groups sampled and survey years. The estimates presented here are for the definition "current daily smoker" aged 15 years and above, and the years are 2002 and 2005.

Data sources for comparable estimates on tobacco smoking prevalence

Data came from a variety of sources including published peer-reviewed journal articles, government reports and unpublished surveys, and are stored the WHO Global InfoBase and the WHO Regional Office for Europe Tobacco Control database.[50] Data were included if they came from surveys that:

- provided country survey summary data for one or more of four tobacco use definitions: current daily smoker, current smoker, current daily cigarette-smoker, or current cigarette-smoker;
- included randomly selected participants representative of a general population;
- presented prevalence values by age and sex;
- surveyed the adult population aged 15 years and above.

Summary data from 275 sources representing 41 out of 53 countries in the European Region conformed to the inclusion criteria. Where no age- and sex-specific data were available from a country, no estimates were made.

Definition of tobacco use

Cigarette-smoking is by far the most common form of tobacco use in most countries in the European Region.[51] The definitions of "current/daily smokers" and "current/daily cigarette smokers" were, therefore, considered to be the same. The resulting estimates were produced for two definitions of tobacco use, current smoker and daily smoker, only one (daily smoker) being presented here.

Sixty-five surveys from 31 countries captured both current and daily smokers. Using these surveys, the relationship between current smoker and daily smoker was examined running regression models, and the results were applied to the remaining 15 countries reporting only one definition, either current smoker or daily smoker. Regression models were run separately for each sex and each of eastern, northern, southern and western Europe.

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[49] WHO Global InfoBase [online database]. Geneva, World Health Organization, 2006 (http://www.who.int/ncd_surveillance/infobase/web/InfoBaseCommon/, accessed 6 August 2006).

[50] Tobacco control database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (http://data.euro.who.int/tobacco/, accessed 6 August 2006).

[51] Shafey O, Dolwick S, Guindon GE, ed. Tobacco control country profiles, 2nd ed. Geneva, American Cancer Society, World Health Organization, International Union Against Cancer, 2003.

Country-level estimates

A large majority of the 46 countries reporting age- and sex-specific prevalence of tobacco use had nationally representative data. In order to derive a national estimate for countries only reporting sub-national prevalence, the relationship between current/daily smoking in urban versus rural areas was explored using information from 25 surveys from 14 countries and applying regression models.

The resulting prevalence values for daily smoking in rural and urban areas were combined using estimates of percentages of urban and rural populations from the United Nations Population Division.

Association of age and tobacco use

In order to estimate prevalence for standard age ranges (by five-year groups from age 15 years), the association between age and tobacco use was examined for each country and sex using scatter plots of data from the latest nationally representative surveys. The second order or third order function best fitting the country-reported values was applied to derive prevalence values for the standard age ranges for each country.

Estimating for the standard years 2002 and 2005

Twenty-nine countries in the European Region had data from multiple years that could be used to track trends in tobacco use prevalence. For nine of these countries, country-reported data was inconsistent and no trend could be determined. Therefore, no change was estimated from the latest recent survey to the standard reporting years. For the remaining 20 countries that had data from multiple years, regression models were run by country and sex to estimate prevalence values for 2002 and 2005. For the remaining 17 countries with insufficient data to establish a trend, the average subregional trend was applied.

Age standardization

All crude rates were age-standardized to the WHO standard population[52] using the direct method.

Review of estimates by country focal points

After completion of the first round of analysis, the WHO Regional Office for Europe tobacco control national counterparts reviewed the estimates and provided additional recent data, where available. More recent data were provided by 19 countries. Data reported from 16 of these countries met the criteria for inclusion in the analysis. The analysis was re-run using all of the eligible newly provided country-reported data.

Regional and sub-regional estimates

Regional and subregional estimates were obtained for the following groups by pooling across country-level estimates, taking population projections (United Nations Population Division 2004 revision) into account:

[52] Ahmad O et al. Age standardization of rates: a new WHO standard. Geneva, World Health Organization, 2001 (GPE Discussion Paper No. 31).

- the WHO European Region;
- the EU plus Iceland, Norway and Switzerland;
- CIS countries: Azerbaijan, Armenia, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova,[53] Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan;
- SEE countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Republic of Moldova, Romania, Serbia and Montenegro, The former Yugoslav Republic of Macedonia.[54]

Annex 4 presents the data reported by the network of national counterparts for 1999–2001 and 2002–2005. Forty-six countries reported data from 1999 and later, three countries reported data older than 1999 and in three other countries no data were available. Thirty-eight countries provided data from 2002 or later and 38 countries provided data for 1999–2001; 30 countries provided data for both periods. As mentioned above, these are the best available data provided by national counterparts for their respective countries.

Smoking prevalence among young people

Analyses are based on data from the Health Behaviour in School-aged Children Study (HBSC) from 1997/1998 and 2001/2002[55,56] and the Global Youth Tobacco Survey (GYTS) data collected between 2001 and 2004 (GYTS data collected before 2001 were not accepted due to methodological problems).[57] The GYTS data presented in this report are different from the data presented in the GYTS country reports and on the US Centers for Disease Control and Prevention (CDC) web site, because data here represent weekly smoking prevalence in 15-year-olds in order to make the data comparable to the HBSC data. Smoking prevalence rates for boys and girls could be assessed for 41 countries in the WHO European Region: the HBSC provides data for 28 countries and the GYTS adds data for another 13 (mainly eastern European) countries. GYTS data were presented only for countries where the HBSC was not carried out. In 10 countries, no data on the smoking prevalence of young people were available. Data on the smoking rates of different age groups and age of beginning to smoke were obtained from the 2001/2002 HBSC.

Simple averages of the HBSC data were calculated for the periods 1997/1998 and 2001/2002. Population-weighted averages could not be calculated owing to the lack of information on the number of 15-year-olds in the respective countries.

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[53] The Republic of Moldova is included with both the SEE and the CIS countries in order to maintain the integrity of the data relating to the SEE grouping

[54] Serbia and Montenegro became two separate Member States of WHO in September 2006. Throughout this report they are referred to as either one country or two countries according to the dates of the references or data.

[55] Currie C et al., ed. Health and health behaviour among young people: international report. Copenhagen, WHO Regional Office for Europe, 2000 (WHO Policy Series, Health policy for children and adolescents, No. 1) (http://www.hbsc.org/downloads/Int_Report_00.pdf, accessed 23 August 2006).

[56] Currie C et al., ed. Young people's health in context: international report from the HBSC 2001/02 survey. Copenhagen, WHO Regional Office for Europe, 2004 (WHO Policy Series, Health policy for children and adolescents, No. 4). (http://www.euro.who.int/document/e82923_part_1.pdf# search=%22HBSC%201997% 2F1998%22, accessed 23 August 2006).

[57] Global Youth Tobacco Survey. Atlanta, GA, Centers for Disease Control and Prevention, 2006 (http://www.cdc.gov/tobacco/global/gyts/GYTS_factsheets.htm, accessed 6 August 2006).

Annex 4

ADULT SMOKING PREVALENCE IN THE WHO EUROPEAN REGION

Country	Male (%)		Female (%)		Total (%)		Survey year, definition, age group and source
	1999–2001	2002–2005	1999–2001	2002–2005	1999–2001	2002–2005	
Albania	60	46.3	18	3	39	24.6	Data for 2000 Definition: regular and occasional smokers. Age: 15+ years Source: *Evaluation of smoking prevalence among adult population*. Institute of Public Health, 2001. Data for 2002 Source: Herold J, Seither R, Ylli A. *Albania reproductive health survey 2002, preliminary report*. Atlanta GA, Centers for Disease Control, 2003.
Andorra		42		30		36	Data for 2002 Definition: current smokers (including regular and occasional smokers). Age: 16+ years Source: National Health Survey 2002, Ministry of Health and Welfare.
Armenia	67.5	59.6	3.1	2.1	35.3	28.4	Data for 2001 Definition: smoker. Age: 15–54 years. Source: *Armenia Demographic and Health Survey 2000*. Yerevan, National Statistical Service, and Calverton MD, ORC Macro, 2001 (http://www.armstat.am/Publications/1991-2000/demo_2000/demo_2000_800.pdf#search=%22Armenia%20Demographic%20and%20Health%20Survey%202000%22, accessed 21 August 2006). Data for 2005 Definition: smoker. Age: 16–65 years. Source: *General population survey among adults.* National Statistical Service, National Institute of Health, International Centre for Human Development.
Austria		48.1		46.5		47	Data for 1999–2000. Mikrozensus 1999. Smoking habits of the Austrian population. *Statistische Nachrichten*, 1999, 5: 319–326. Data for 2004 Definition: smokers (daily and occasional). Age: 14+ years Source: Uhl A et al. *Österreichweite Repräsentativerhebung zu Substanzgebrauch. Erhebung 2004*. Vienna, Bundesministerium für Gesundheit und Frauen [Ministry of Health and Women's Affairs], 2005 (http://Www.bmgf.gv.at, accessed 23 November 2006).
Azerbaijan							Most recent data from 1997.
Belarus	53.7	56.8	4.8	15.4	26.3	34.3	Data for 1999 Definition: daily smokers. Age: 15+ years. Source: WHO health for all database.[a] Data for 2004 Definition: not available. Age: 16+ years.

Country	Male (%)		Female (%)		Total (%)		Survey year, definition, age group and source
	1999–2001	2002–2005	1999–2001	2002–2005	1999–2001	2002–2005	
Belarus cont'd							Source: *Sociological analysis of actual trends in forming healthy lifestyle of population of Belarus*. Institute for Sociology of the National Academy of Science and Ministry of Health, 2004.
Belgium	36	30	26	25	30	27	Data for 2000 Definition: daily smoking. Age: 18+ years. Source: Survey carried out by the Centre de Recherche et d'Information des Organisations de Consommateurs (CRIOC). Data for 2002 Definition: daily smoking. Age: 18+ years. Source: Survey carried out by the Centre de Recherche et d'Information des Organisations de Consommateurs (CRIOC).
Bosnia and Herzegovina		49.2		29.7		37.6	Data for 2002 Definition: daily smokers. Age: 25–64 years. Source: Laatikainen T et al. *Noncommunicable disease risk factor survey: Federation of Bosnia and Herzegovina, 2002*. Sarajevo Mostar, Ministry of Health of Bosnia and Herzegovina, Public Health Institute of Bosnia and Herzegovina, 2002. Survey conducted by the Institute of Public Health, Federation of Bosnia and Herzegovina, in collaboration with the Ministry of Health of Bosnia and Herzegovina and the National Public Health Institute in Finland.
Bulgaria	43.8		23		32.7		Data for 2001 Definition: daily smokers. Age: 16+ years. Source: Health Interview Survey, National Statistical Institute.
Croatia	34.1	33.8	26.6	21.7	30.3	27.4	Data for 2000 Definition: daily smokers. Age: 18–65 years. Source: *First Croatian Health Project, Sub-project on health promotion, the magnitude and context of problems, Baseline parameters Report*. Zagreb. Data for 2003 Definition: daily smokers. Age: 18+ years. Source: 2003 Croatian Adult Health Survey, Health Systems Project, Ministry of Health, and Canadian Society for International Health, 2004.
Cyprus		38.1		10.5		23.9	Data for 2003 Definition: daily smokers. Age: 15+ years. Source: Ministry of Finance, 2003.
Czech Republic	26.4	29.6	20.4	19.4	23.3	24.34	Data for 2001 Definition: daily smokers. Age: 15+ years. Source: WHO health for all database. [a] Data for 2005 Definition: daily smokers. Age: 15+ years. Source: Sovinova H, Sadilek P, Csémy L. *Czech smoking prevalence survey, 2005*. Prague, Statni Zdravotni Ustav [National Institute of Public Health], 2006 (http://www.szu.cz/dokumenty_soubory/ZPR2A.pdf, accessed 23 November 2006).

Country	Male (%)		Female (%)		Total (%)		Survey year, definition, age group and source
	1999–2001	2002–2005	1999–2001	2002–2005	1999–2001	2002–2005	
Denmark	36.8	28.6	31.9	24.1	34.1	26.3	Data for 2000 Definition: daily smokers. Age: 15+ years. Source: The Danish Council on Smoking and Health. Data for 2005 Definition: daily smokers. Age: 15+ years. Source: *Monitorering af danskernes rygevaner 2004, 2005 [Monitoring smoking habits in the Danish population]*. PLS Ramboell for National Board of Health, The Danish Cancer Society, The Danish Heart Foundation and The Danish Lung Association. Copenhagen, Sundhedsstyrelsen [National Board of Health], 2005 (http://www.sst.dk/#http://www.sst.dk, accessed 23 November 2006).
Estonia	44.1	42	19.9	21	29.4	28	Data for 2000 Definition: daily smokers. Age: 16–64 years. Source: *Health behaviour among the Estonian adult population* (part of the international FinBalt Health Monitor survey – Finland, Estonia, Latvia, Lithuania). Data for 2004 Definition: daily smokers. Age: 16–64 years. Source: Kasmel A, Lipand A, Markina A. *Health Behaviour among Estonian adult population, Spring 2004*. Study from the Estonian Health Promotion Union.
Finland	27	27	20	20	23	23	Data for 2000 Definition: daily or regular smokers and users of smokeless tobacco. Age: 15–64 years (excludes 1% of men who were regular smokeless tobacco users). Source: *Health behaviour among the Finnish adult population*, National Annual Public Health Survey, 2000 Data for 2004 Definition: current smokers. Age: 15–64 years. Source: Helakorpi S et al. *Health behaviour of adult population*. Helsinki, KTL National Public Health Institute, 2005 (http://www.ktl.fi/eteo/avtk, accessed 23 November 2006).
France	33	28.2	21	21.7	27	25	Data for 2000 Definition: daily smokers. Age: 18+ years. Source: *Enquêtes permanentes sur les conditions de vie.* INSEE, 2000. Data for 2005 Definition: current daily user. Age: 12+ years Source: Guilbert P, Gautier A, Wilquin JL. *Baromètre Santé 2005* (premiers résultats). Saint-Denis, INPES, 2006.
Georgia	53.3		6.3		27.8		Data for 2001 Definition: current smokers. Age: 18+ years. Source: Prevalence of smoking in 8 countries of the former Soviet Union: Results from the Living Conditions, Lifestyles and Health Study. *American Journal of Public Health*, 2004, 94(12): 2177–2187.

Country	Male (%)		Female (%)		Total (%)		Survey year, definition, age group and source
	1999–2001	2002–2005	1999–2001	2002–2005	1999–2001	2002–2005	
Germany	38.9	33.2	30.6	22.1	34.8	27.4	Data for 2000 Definition: smoked during the last 30 days. Age: 18–54 years Source: Kraus L, Augustin R. *Repräsentativerhebung zum Gebrauch psychoaktiver Substanzen bei Erwachsenen in Deutschland 2000*. 2001, Vol 47(1). Data for 2003 Definition: current user. Age: 15+ years. Gesundheitswesen. *Mikrozensus 2003 – Fragen zur Gesundheit*, Statistisches Bundesamt, 2003 (http://www.destatis.de/basis/d/gesu/gesutab7.php accessed 9 September 2006).
Greece	46.8		29		37.6		Data for 2000 Definition: current daily smokers. Age: 12–64 years Source: Kokkevi A et al. Sharp increase in illicit drug use in Greece: trends from a general population survey on licit and illicit drug use. *European Addiction Research*, 2000, 6(1):42–49. Kokkevi A et al. Substance use among high school students in Greece: outburst of illicit drug use in a society under change. *Drug and Alcohol Dependence*, 2000 58(1–2):181–188.
Hungary	40.6	36.9	26.3	24.6	33	30.7	Data for 2000 Definition: daily smokers. Age: 18+ years Source: National Centre for Epidemiology, National Health Interview Survey 2000. Data for 2003 Definition: daily smokers. Age: 18+ years Source: Boros J et al. *National Health Interview Survey.* Budapest, Johan Béla National Center for Epidemiology, 2004.
Iceland	24.5	19.3	22.8	19.2	23.6	19.3	Data for 2001 Definition: daily smokers. Age: 15+ years Source: Committee for Tobacco Use Prevention Data for 2004 Definition: daily smokers. Age: 15–89 years Source: Ragnarsdóttir Á, Porsteinsdóttir LM, Porvaldsson M. *Prevalence of smoking in Iceland.* Reykjavík, Institute of Public Health, 2005 (http://www.lydheilsustod.is/rannsoknir/tobak-og-tobaksvarnir/nr/577, accessed 23 November 2006).
Ireland		23.7		24.3		24	Data for 2005 Definition: daily smokers. Age 15+ years Source: *Ireland: current trends in cigarette smoking.* Naas (Ireland), Office of Tobacco Control, 2006 (http://www.otc.ie/research_reports.asp, accessed 21 August 2006).
Israel	30	31.9	24	17.8	27	23.8	Data for 2000 Definition: daily smokers. Age: 15+ years Source: Ministry of Health, Department for Health Education and Promotion, and the Israel Centre for Disease Control. Data for 2003 Definition: daily smokers. Age: 15+ years Source: Ministry of Health, Department for Health Education and Promotion, and the Israel Centre for Disease Control.

Country	Male (%)		Female (%)		Total (%)		Survey year, definition, age group and source
	1999–2001	2002–2005	1999–2001	2002–2005	1999–2001	2002–2005	
Italy	31.6	28.3	17.1	16.2	24.1	22	Data for 2001 Definition: daily smokers. Age: 15+ years Source: *Fumatori in Italia*. Multipurpose survey. Rome, National Institute of Statistics (ISTAT). Data for 2005 Definition: daily smokers. Age: 15+ years Source: *Fumatori in Italia.* Multipurpose survey. National Institute of Statistics (ISTAT) (unpublished document).
Kazakhstan	46.5	40.7	7.6	8.8	23.9	23.1	Data for 2001 Definition: daily smokers. Age: 15+ years. Source: Second National Survey, Almaty, 2002. Data for 2004 Definition: not available. Age: 12+ years Source: Third National Survey on lifestyle and life conditions of population of Kazakhstan, 2004. WHO World Health Survey, Kazakhstan.
Kyrgyzstan	51	41.4	4.5	1.7	25.4	20	Data for 2001 Definition: current smokers. Age: 18+ years Source: Gilmore A et al. Prevalence of smoking in 8 countries of the former Soviet Union: results from the Living Conditions, Lifestyles and Health Study. *American Journal of Public Health*, 2004, 94(12): 2177–2187. Data for 2005 Definition: current smokers. Age: 15+ years Source: National Epidemiological Study of Tobacco Use Prevalence in Kyrgyzstan, 2005.
Latvia	49.1	47.3	13	17.8	29.2	30.1	Data for 1999 Definition: not available. Age: not available Source: FAFO Survey 1999 Data for 2004 Definition: daily smokers. Age: 15–64 years Source: Pudule I et al. *Health behaviour among Latvian adult population*. Helsinki, National Public Health Institute (KTL), 2005 (FINBALT survey).
Lithuania	51.5	39.4	15.8	14.2	32	26.5	Data for 2000 Definition: daily smokers. Age: 20–64 years Source: Grabauskas V et al*. Health Behaviour among Lithuanian Adult Population*. National Public Health Institute, 2000 (B5/2001) Data for 2004 Definition: daily smokers. Age: 20–64 years Source: Kaunas University Study. Grabauskas V et al. *Health behaviour among Lithuanian adult population 2004*. Helsinki, National Public Health Institute (KTL). Helsinki, 2005.
Luxembourg	34	36	26	26	30	31	Data for 2000 Definition: regular daily smokers. Age: 15+ years Source: Fondation luxembourgeoise contre le cancer. Surveys carried out by the ILReS (Institut luxembourgeoise d'études et de recherches sociales) in 1987, 1993, 1998 and 2000.

Country	Male (%)		Female (%)		Total (%)		Survey year, definition, age group and source
	1999–2001	2002–2005	1999–2001	2002–2005	1999–2001	2002–2005	
Luxembourg cont'd							Data for 2003 Definition: daily smokers. Age: 15+ years Source: Margue C. *Le tabagisme au Luxembourg.* Luxembourg, Fondation Luxembourgeoise Contre le Cancer.
Malta		29.9		17.6		23.4	Data for 2002 Definition: daily smokers. Age: 16+ years Source: Asciak RP. *National Health Interview Survey*. Malta, Department of Health Information, 2003.
Monaco							No data available.
Netherlands	38.9	31	30.2	25	34.5	28	Data for 2001 Definition: daily or occasional smokers. Age: 15+ years Source: Jaarverslav Stivoro, 2001 (www.stivoro.nl, accessed 28 November 2006). Data for 2004 Definition: daily smokers. Age: 15+ years. Source: STIVORO, annual national report 2004.
Norway	29.5	27	29.7	24	29.6	26	Data for 2001 Definition: daily smokers. Age: 16–74 years Source: Interview survey, Statistics Norway, 2001. Data for 2004 Definition: daily smokers. Age: 16–74 years Source: Daily smokers in Norway, Statistics Norway, 2004 (http://statbank.ssb.no/statistikkbanken, accessed 23 November 2006).
Poland	42	38	23	25.6	32.5	32	Data for 1999 Definition: daily smokers. Age: 15+ years Source: Nationwide survey on smoking behaviours and attitudes. Data for 2004 Definition: daily smokers (at least one cigarette, pipe, cigar, etc. for longer than 6 months). Age: 15+ years. Source: Nationwide survey on smoking behaviours and attitudes in Poland, 2002–2004. Annual national randomized surveys of adults.
Portugal	30.5		8.9		19.2		Data for 1999 Definition: daily or occasional smokers. Age: 15+ years Source: National Health Survey.
Republic of Moldova	43.3	33.6	3.9	1.8	23.1	15.7	Data for 2001 Definition: daily smokers. Age: 15+ years Source: Gilmore A et al. Prevalence of smoking in 8 countries of the former Soviet Union: results from the Living Conditions, Lifestyles and Health Study. *American Journal of Public Health*, 2004, 94: 2177–2187. Data for 2003 Definition: daily smokers. Age: 15+ years Source: WHO health for all database. [a]
Romania	32.3	40	10.1	19.5	20.8	29.7	Data for 2000 Definition: daily smokers. Age: 15+ years Source: *Health status of population in Romania*. Bucharest, National Institute of Statistics, 2001.

Country	Male (%)		Female (%)		Total (%)		Survey year, definition, age group and source
	1999–2001	2002–2005	1999–2001	2002–2005	1999–2001	2002–2005	
Romania cont'd							Data for 2004 Definition: daily smokers. Age: 15+ years Source: Centre for Health Policies and Studies.
Russian Federation	62.2	61.3	12.6	15.0	34.9	35.8	Data for 2000 Definition: daily smokers. Age: 18+ years Source: *Monitoring Health Conditions in the Russian Federation – The Russian Longitudinal Monitoring Survey 1992–2004.* Data for 2004 Definition: daily smokers. Age: 18+ years Source: *Monitoring Health Conditions in the Russian Federation – The Russian Longitudinal Monitoring Survey 1992–2004.*
San Marino							Most recent data from 1994
Serbia and Montenegro (Serbia)	46		30.9			38	Data for 2000 Definition: daily smokers. Age 20+ Source: Health status, health needs and health care use in Serbia. *Journal of the Institute of Public Health in Serbia*, 2002, 1–2.
Slovakia						28	Data from 2004 Definition: daily smokers. Age: 18+ years Source: Statistical Office of the Slovak Republic, 2004
Slovenia	28		20.1		23.7		Data for 2001 Definition: daily smokers. Age: 15–64 years Source: Zaletel-Kragelj L, Čakš T, Novak-Mlakar D. Kajenje (Smoking). In: Zaletel-Kragelj L, Fras Z, Maučec-Zakotnik J, eds. *Tvegana vedenja, povezana z zdravjem in nekatera zdravstvena stanja pri odraslih prebivalcih Slovenije. Rezultati raziskave Dejavniki tveganja za nenalezljive bolezni pri odraslih porebivalcih Slovenije (z zdravjem povezan vedenjski slog). 2. Tvegana vedenja*. Ljubljana, CINDI Slovenija, 2004, 149–190 (Report of CINDI Health Monitor Survey 2001) (BS-ID: 106677. COBISS-ID: 17878489).
Spain	39.2	34.1	24.6	22.4	31.7	28.1	Data for 2001 Definition: daily smokers. Age: 16+ years Source: *National health survey 2001*. Madrid, Ministry of Health and Consumer Affairs (unpublished) Data for 2003 Definition: daily smokers. Age: 16+ years Source: *National health survey 2003*. Madrid, Ministry of Health and Consumer Affairs (unpublished).
Sweden	17.9	14	19.9	19	18.9	16	Data for 2001 Definition: daily smokers. Age: 16–84 years Source: National Institute of Public Health, Public Health survey 2001. Data for 2004 Definition: daily smokers. Age: 16–84 years. Source: National Institute of Public Health, Public Health survey 2004.
Switzerland	27	24	21	20	24	22	Data for 2001 Definition: daily smokers. Age: 14–65 years. Source: Rümbeli S et al. Tabakmonitoring Schweizerische Umfrage zum Tabakkonsum, November 2005.

Country	Male (%)		Female (%)		Total (%)		Survey year, definition, age group and source
	1999–2001	2002–2005	1999–2001	2002–2005	1999–2001	2002–2005	
Switzerland cont'd							Data for 2005 Definition: daily smokers. Age: 14–65 years. Source: Keller R. *Tabakmonitoring: Entwicklung Rauchprävalenz 2001 bis 2005 [Prevalence of tobacco use from 2001 to 2005]* (www.bag.admin.ch/themes/drogen/00041/00615/00771/index.html, accessed 9 September 2006).
Tajikistan							No data available
The former Yugoslav Republic of Macedonia	40		32		36		Data for 1999 Definition: daily smokers. Age: 15+ years. Source: WHO health for all database.[a]
Turkey		49.4		17.6		31.2	Data for 2003 Definition: daily smokers. Age: 15+ years. Source: WHO health for all database.[a]
Turkmenistan							No data available
Ukraine	58	66.8	14	19.9	34	41.2	Data for 2000 Definition: daily smokers. Age: 15+ years. Source: Alcohol and Drug Information Centre (ADIC – Ukraine) (http://www.adic.org.ua/adic, accessed 23 August 2006). Data for 2005 Definition: daily smokers. Age: 15+ years. Source: Andreeva T. *Tobacco in Ukraine.* Kiev, International Centre for Policy Studies, 2005 (http://www.icps.com.ua/doc/Tobacco_in_Ukraine_ENG.pdf, accessed 23 November 2006).
United Kingdom	29	28	25	24	27	26	Data for 2000 Definition: current smokers. Age: 16+ years Source: *Living in Britain – the 2002 General Household Survey* (covering Great Britain only). London, Office for National Statistics, 2004 (http://www.statistics.gov.uk/pdfdir/lib0304.pdf, accessed 21 August 2006). Data for 2003 Definition: current smokers. Age: 16+ years Source: *Living in Britain: results from the 2003 General Household Survey*. London, Office for National Statistics http://www.statistics.gov.uk/lib2001/index.html, accessed 23 November 2006.
Uzbekistan		24.1		0.9		12.5	Data for 2002 Definition: current cigarette users. Age: male – 15–59 years, female – 15–49 years. Source: Uzbekistan Health Examination Survey 2002, preliminary report, Ministry of Health, State Department of Statistics, Calverton, MD, 2003.

[a] European health for all database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (http://data.euro.who.int/hfadb/, accessed 6 August 2006).

Source: WHO European Network of National Tobacco Control Counterparts. In some cases the source is unpublished or only available in the national language.

Annex 5

WORLD NO TOBACCO DAY AWARD WINNERS, 2002–2006

2002

Janica and Ivica Kostelic, Croatia
Public Health Service Noord-Kennemerland, Netherlands
Professor Raphael Oganov, Russian Federation
Peter and Pavol Hochschorner, Slovakia
Swedish Equestrian Federation, Sweden
Turkish Foundation for Fighting Smoking, Turkey

2003

Commissioner David Byrne, European Commission (special award of the WHO Director-General)
Dr Els Borst-Eilers, Netherlands
Mr Asankhan Jumakmatov, Kyrgyzstan
Mr Konstantin Krasovsky, Ukraine
Dr Andrus Lipand, Estonia
Mr Joško Marušic, Croatia
Comité Nacional de Prevención del Tabaquismo (CNPT), Spain

2004

Mr Micheál Martin TD, Minister for Health and Children, Ireland.
Public and Environmental Health Research Unit, London School of Hygiene and Tropical Medicine, United Kingdom
Dr Göran Boethius, Sweden
Dr Alexander Bazarchyan, Armenia
Dr Olli Simonen, Finland
Tibor Szilagyi, Hungary

2005

Tobacco Control Resource Centre of the British Medical Association, United Kingdom
Professor Bertrand Dautzenberg, Chairperson, Office Français de Prévention du Tabagisme, France
Professor Friedrich Portheine, Germany
Professor Akanov Aikan, First Deputy Minister of Health, Kazakhstan
Dr Tomas Stanikas, Lithuanian Non-smokers Association, Lithuania
Dr Rudolf Zajac, Minister of Health, Slovakia

2006

Elena Salgado Méndez, Minister of Health, Spain
Dr Wim Vleeming, Pharmacologist, Netherlands
The Republican Centre of Hygiene, Epidemiology and Public Health, Belarus
Ms Ingrid Talu, Teachers Against Tobacco, Sweden
European Network of Quitlines