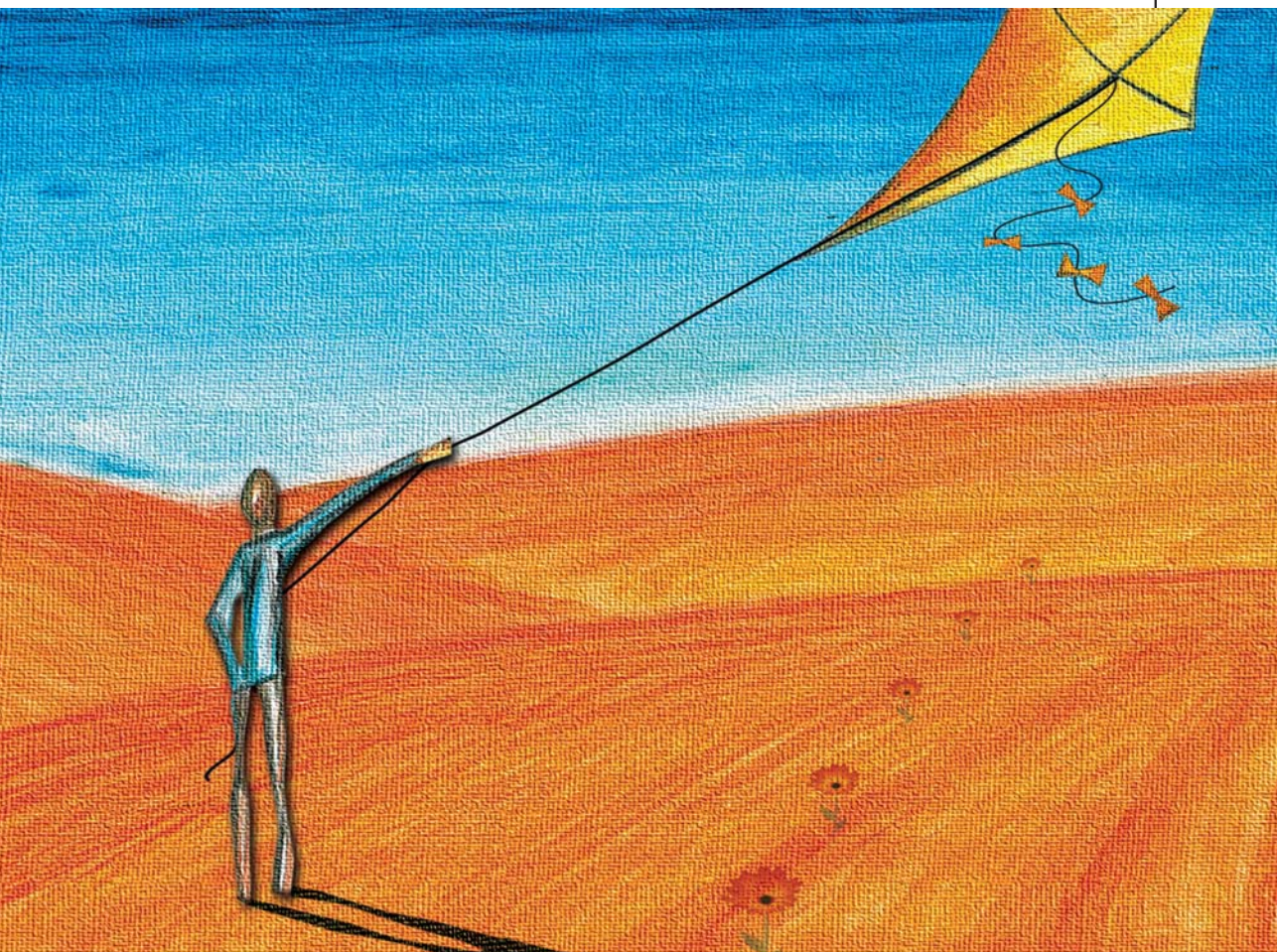
HELSE- OG OMSORGSDEPARTEMENTET

The Norwegian Ministry of Health and Care Services

Strategic plan - Abbreviated version

Norway's National Strategy for Tobacco Control 2006-2010



NORWAY'S NATIONAL STRATEGY FOR TOBACCO CONTROL 2006-2010

Abbreviated version

Foreword

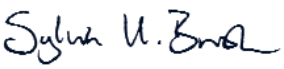
It is positive that only a minority of the population smokes daily. In the longer term, however, our vision should be a smoke-free society. The Government is therefore presenting a new National Strategy for Tobacco Control for the coming five-year period.

The vision up to the year 2010 is as follows:
The number of smokers has dropped significantly and constitutes less than 20 per cent of the population. In particular, there are fewer young smokers. Smoking cessation methods are developed that will suit more people than the current ones. Measures are introduced targeting groups that are not reached well enough today. Social inequalities in smoking prevalence are significantly reduced. Tobacco control is included in the training of everyone who works with children and young people and in all sectors of the health service. Health personnel are more focused on tobacco control and smoking cessation. Smoking is less visible in society. Adults take their function as role models for young people seriously. No pregnant women or their partners smoke during pregnancy or later, as parents of small children. It is legitimate to say no to smoking, while those who smoke without harming others are respected.

In Norway we are now in what could be called the final phase of the tobacco epidemic, which is typified by a significant decline in smoking. Another characteristic of this phase is that the social inequalities in smoking continue and may even increase. Social inequalities are particularly evident in the younger age groups, and there are significant differences depending on the level of education. There are also clear social patterns regarding smoking cessation. In this final phase of the tobacco epidemic, it is therefore important to help eliminate the inequalities in smoking behaviour that are related to social background.

The greatest remaining challenges include offering people professional help to quit smoking near their home, primarily by providing programmes through the health service, which includes regular GPs, health clinics and the school health service, and in connection with maternity care. In addition to this, educational programmes in schools must be reinforced, school playgrounds must become smoke-free, the ban on selling tobacco products to young people must be enforced, increased use of smokeless tobacco must be prevented, and the WHO Framework Convention on Tobacco Control must be followed up.

At the Ministry's request, the Directorate for Health and Social Affairs drew up proposals for a new strategic plan, which was thereafter distributed for consultation. The Ministry's further work on the strategic plan is based on statements from the consultation round and other inputs. The strategic plan will be normative for future efforts and will be followed up in the Ministry's annual budgets.



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Minister of Health and Care Services

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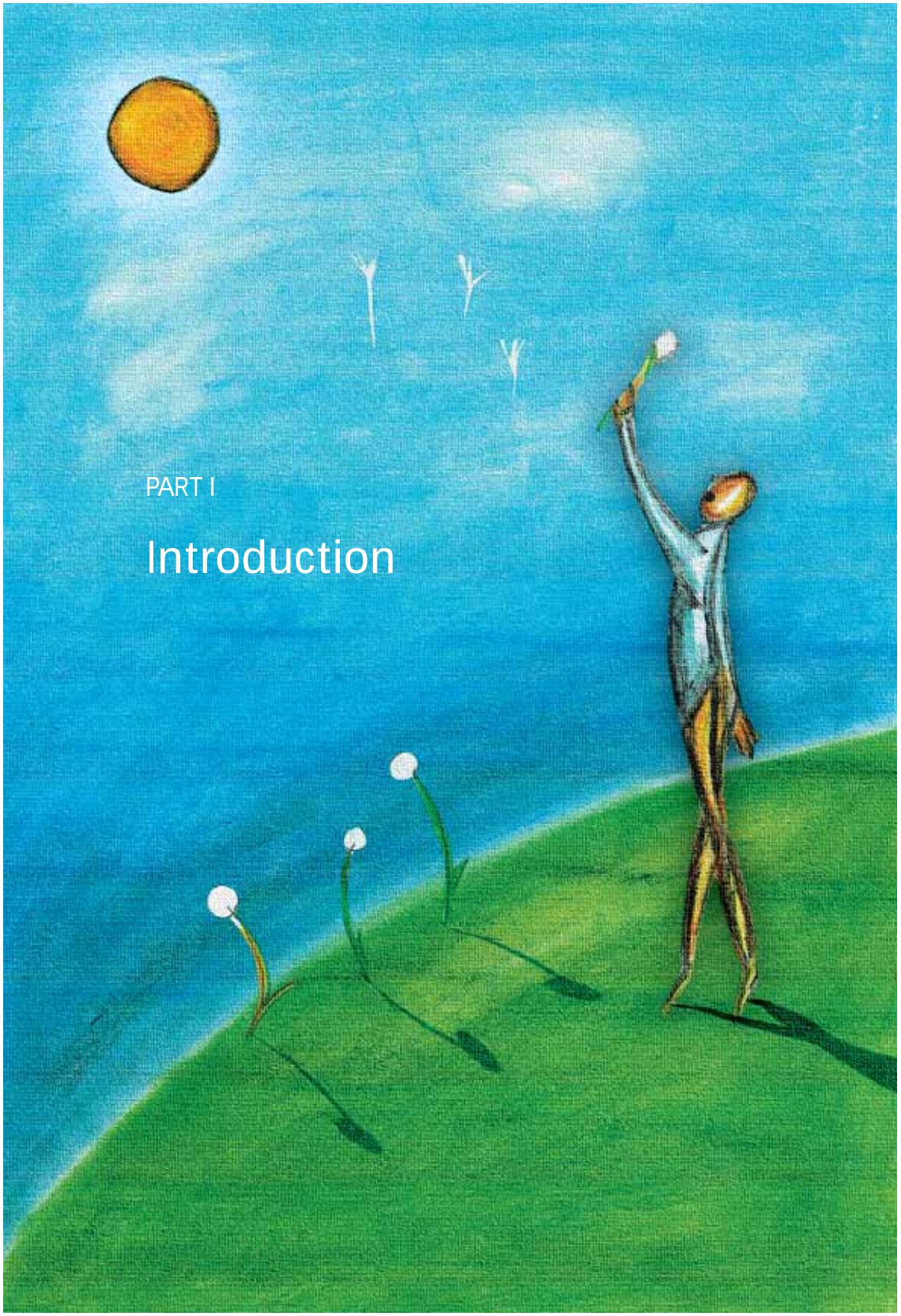


PART I

Introduction

PART I - Introduction

1) The most important priority areas - summary

The main goal of the National Strategy for Tobacco Control 2006-2010 is to promote health in all parts of the population and ensure more years of healthy life by reducing the use of tobacco.

The goal of halving smoking among young people from 2002 to 2007 was launched in the last public health report, Report No. 16 to the Storting (2002-2003): Prescription for a Healthier Norway. Several measures have been implemented to achieve this goal, especially mass media campaigns. In order to achieve the goal, investments must continue to be made in intensive campaigns over a period of several years. Campaigns can also be an important instrument for motivating adults to quit smoking.

In the period 2006-2010, efforts will be concentrated on smoking cessation. Norway is relatively weak in this area compared with other European countries. The health benefits from cessation are well documented, and have proved to be cost-effective compared with many other measures in the health sector. Counselling should be the fundamental element in smoking cessation. In the years ahead it will therefore be vitally important to strengthen the work done by the health service in tobacco control. The health service is also the best arena to reach pregnant women and the parents of small children, who will continue to be a target group in the coming five-year period.

A common denominator for the strategic areas and for the measures that are to be implemented is the importance of reaching people broadly. The local perspective is important, and measures should, to the greatest possible extent, be locally based. In many areas it will be natural to think of public health in a broader perspective than tobacco control alone, and to coordinate measures in several areas of public health. This kind of trans-sectoral perspective is especially important in efforts to reduce social inequalities in health.

The World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC), which entered into force in 2005, provides a new, international arena for tobacco control. Research shows that increasing the price of tobacco products is the most important means of reducing tobacco consumption. This instrument has been widely utilised in Norway, which has imposed high taxes on tobacco products.

The National Strategy for Tobacco Control 2006-2010 deals with eight strategic areas:

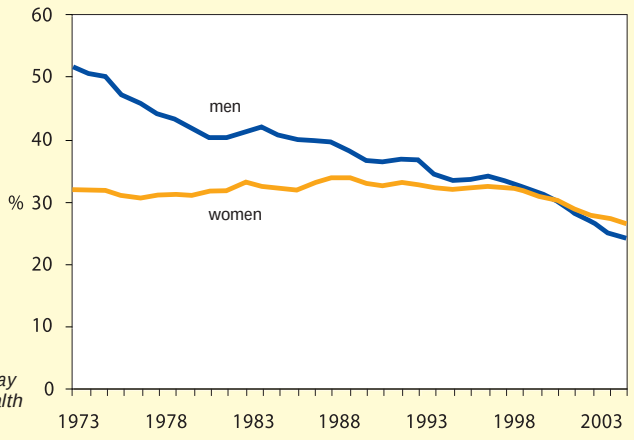
- Tobacco prevention among young people
- Smoking cessation
- Protection from exposure to tobacco smoke
- The use of smokeless tobacco
- Research, monitoring and evaluation
- Information strategies and general communication
- Tobacco control as a part of local public health activities
- Tobacco control in an international perspective

2) Background information

Tobacco use in Norway

In 2005, approximately 25 per cent of the adult Norwegian population (aged 16-74) smoked daily, just about as many men (26 per cent) as women (24 per cent). In addition to this, about 11 per cent smoked occasionally. The largest percentage of daily smokers was found in the 35-54 age-group. In the youngest age-group (16-24), 24 per cent smoked every day.

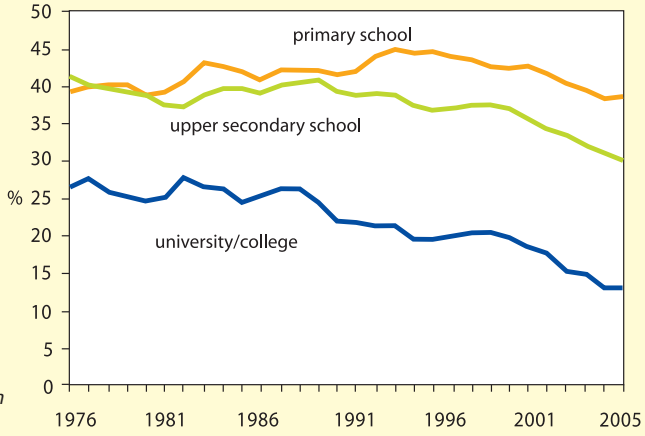
Figure 1: Prevalence of daily smoking, age 16-74



Source: *Statistics Norway* and *Directorate for Health and Social Affairs*

While smoking was equally prevalent in all social strata in the 1960s, people with a low education are now strongly over-represented. Education is one of the factors that appears to have the greatest impact on smoking, and there is a significant difference between the percentages of smokers with a high level and a low level of education. However, the picture is rather different among occasional smokers, where people with a high level of education are over-represented.

Figure 2: Prevalence of daily smoking by education, age 25-74

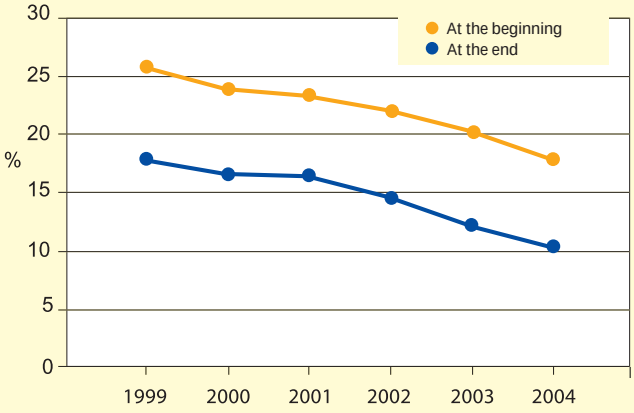


Source: *Statistics Norway* and *Directorate for Health and Social Affairs*

Attitudes to smoking in the home are among the factors that have changed most in recent years. In 2005, 71 per cent of the population stated that they do not permit smoking in their home, compared with 17 per cent in 1993. In 2005, 92 per cent of respondents said that they do not permit smoking in the home when children are present, compared with 53 per cent in 1993.

In 2004, 17.8 per cent of women smoked at the beginning of their pregnancy, compared with 25.7 per cent in 1999. Some women quit during pregnancy, and at the end of pregnancy 10.4 per cent smoked in 2004, compared with 17.9 per cent in 1999. The largest proportion of smokers is found among the youngest mothers.

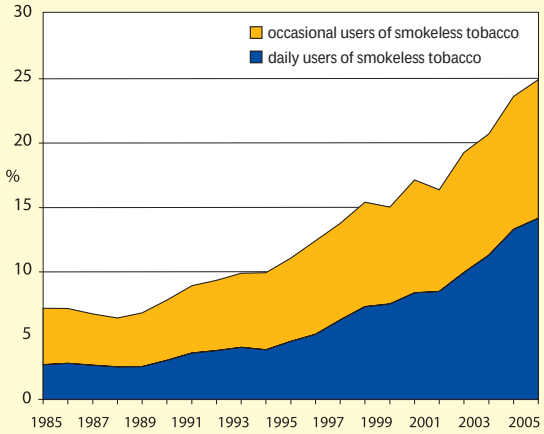
Figure 3: Prevalence of daily smoking among pregnant women at the beginning and end of pregnancy



Source: *Institute of Public Health, Dep. of Medical Birth Registry*

While smoking prevalence is declining, the prevalence of smokeless tobacco use is increasing. Approximately 5 per cent of the population use smokeless tobacco daily. Very few women use smokeless tobacco in Norway, but approximately 9 per cent of men in the 16-74 age-group state that they use it daily, while 8 per cent use it occasionally. The strongest rise is found among younger men; in the 16-44 age-group, the percentage who use smokeless tobacco has tripled since 1985. The use of smokeless tobacco has a different social profile than smoking: the length of education is approximately the same as for the average population.

Figure 5: Prevalence of daily and occasional use of smokeless tobacco among men, age 16-44



Source: *Statistics Norway* and *Directorate for Health and Social Affairs*

Health consequences of tobacco use

Approximately 6,400 of Norway's 4.6 million inhabitants die of smoking-related diseases every year (cardio-vascular diseases, respiratory diseases and cancer). It has also been estimated that approximately 350-550 people die from passive smoking. Research into the health consequences from smokeless tobacco use is deficient and partly divergent, but this does not mean that it is possible to confirm that there is no health risk. Preventive measures relating to smokeless tobacco are based on the precautionary principle.

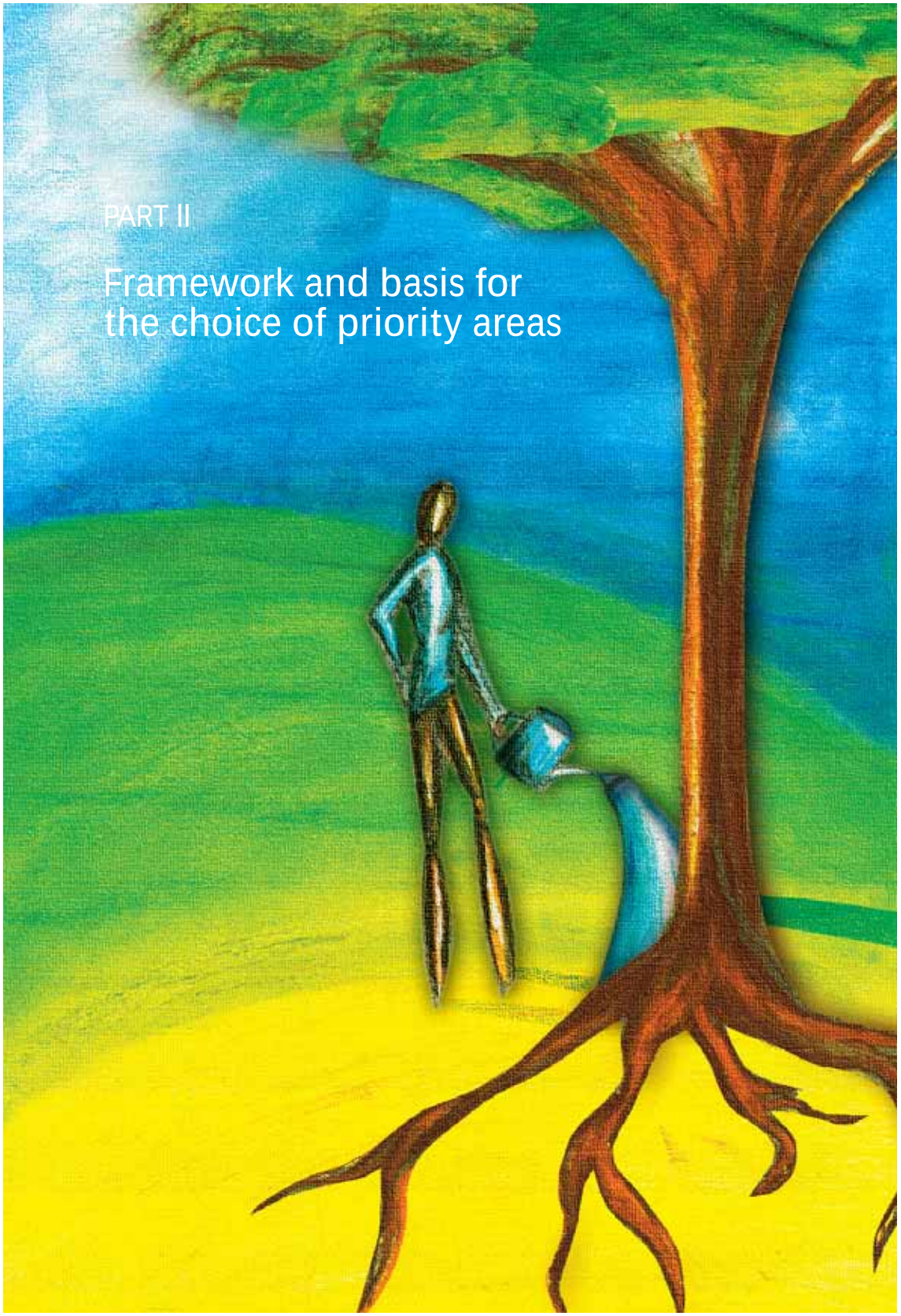
Tobacco use is the single preventable factor that has the greatest influence on people's health conditions. A reduction in the use of tobacco would be a major advance for public health, not only in terms of saved lives but also in terms of improved health and quality of life for a large group of people.

Tobacco control is cost-effective

Of the individual preventable factors, tobacco use is probably the factor that has the most significance for public health. Several international studies point out that tobacco control is cost-effective in comparison with both other preventive measures and measures in the health service. The resources spent on tobacco control are therefore a good investment in public health.

PART II

Framework and basis for the choice of priority areas



PART II - Framework and basis for the choice of priority areas

3) Framework conditions

Legislation

The Act of 9 March 1973 relating to Prevention of the Harmful Effects of Tobacco includes provisions to protect people from passive smoking, a ban on selling tobacco products to persons under the age of 18, a ban on tobacco advertising (both direct and indirect advertising) and provisions concerning the content and labelling of tobacco products. Section 6 of the Act prohibits smoking in public buildings, public transport and in meeting rooms, workplaces and institutions where two or more people are gathered. There are also four important regulations that provide further rules relating to tobacco. The Directorate for Health and Social Affairs is responsible for supervising the ban on advertising and the labelling of tobacco products and is authorised to impose coercive fines if these rules are contravened.

Under the EEA Agreement, Norway is obliged to implement new EU regulations in the areas covered by the Agreement. New EU rules must be adopted by the Norwegian authorities in the form of Acts or regulations in order to become part of Norwegian law.

Organisation and partners

The Ministry of Health and Care Services has the overarching responsibility for preventive activities in the field of tobacco control, while the Directorate for Health and Social Affairs prepares the background material for policy formulation and implements the health policies that are adopted. The Directorate for Health and Social Affairs has a professional advisory board called the National Council on Tobacco Control.

The Directorate for Health and Social Affairs cooperates with national and international players to strengthen tobacco control. At the national level, it cooperates in particular with County Governors, the health service and non-governmental organisations. At the international level, it cooperates mainly with the World Health Organisation (WHO) and various international or non-governmental networks

Documents and agreements governing Norway's tobacco policy

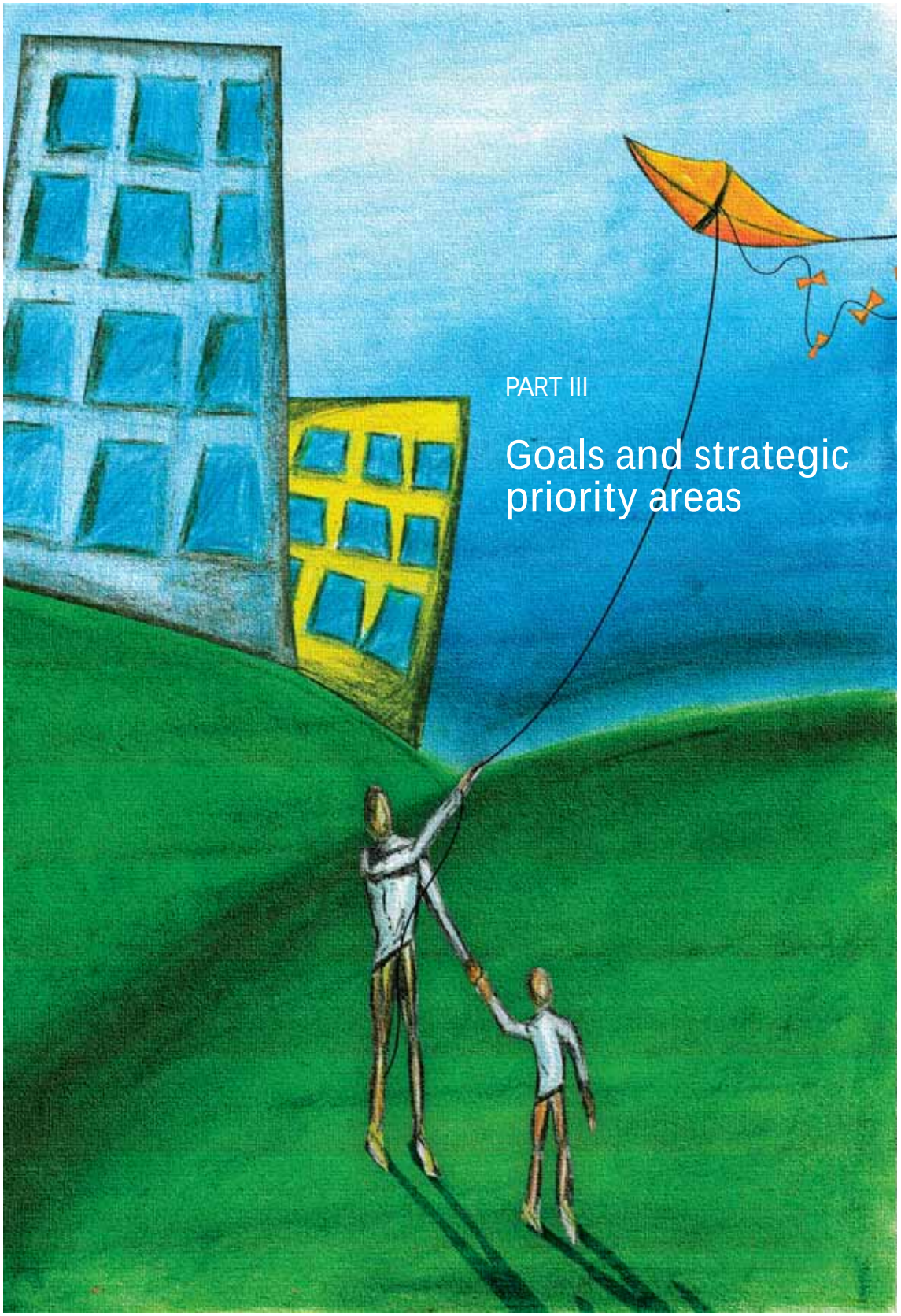
- Report No. 16 to the Storting (2002-2003): Prescription for a Healthier Norway (the Public Health Report)
- WHO Framework Convention on Tobacco Control (FCTC)
- European Strategy for Tobacco Control in the WHO

4) Basis for the choice of measures

Tobacco control in Norway has a long history, and the lessons learned have given us a significant amount of empirical understanding of the possibilities and challenges in this area. One of the factors that is emphasised most often is that while individual measures are important, the greatest impact is achieved by implementing a comprehensive tobacco control policy.

Tobacco control in Norway compared with other European countries

A report from the European Network for Smoking Prevention entitled *Effective Tobacco Control Policies in 28 European Countries* bases its findings on six cost-effective interventions and ranks 28 European countries on the basis of their efforts in these areas. Countries have been ranked according to their total number of points in the areas concerned. Iceland comes top (76 out of 100 points), followed by the UK (72 points), Norway (67 points) and Ireland (62 points). Sweden comes in sixth place, Finland ninth and Denmark sixteenth. Norway does well on the restrictive instruments, such as a ban on tobacco advertising, high taxes, etc., but scores low on cessation (3 out of 10 points) and on the size of the tobacco control budget as a percentage of GDP (6 out of 15 points).In the area of cessation, Norway receives points for having a quitline and for having trained a network of cessation counsellors.



PART III

Goals and strategic priority areas

PART III - Main goals and priority areas

5) Main goals and priority areas

Main goals

The main goal of the National Strategy for Tobacco Control 2006-2010 is to promote health in all parts of the population and ensure more years of healthy life by reducing tobacco consumption.

Social inequalities

While the smoking prevalence in the Norwegian population is declining, the differences in smoking patterns between social groups may nevertheless increase because the largest reduction in daily smoking is seen in the group with the highest level of education. Measures and interventions must be better adapted to reaching the groups where the proportion of smokers is highest.

The work that is in progress on a national strategy to reduce social inequalities in health will set the premises for how ministries will work in this area in the next ten years. The complexity and range of social inequalities in health indicates that measures should be broad-based. Because many of the factors that affect health are found outside the health sector, health considerations must be focused on and better taken into account in other sectors.

The gender perspective

At present, smoking is equally prevalent among men and women. Young women start smoking somewhat earlier than men, but the difference is eliminated by the time they reach the age of 20.

No major gender differences have so far been found as regards factors relating to uptake of and quitting smoking. Some people maintain that women and men have different ways of communicating and that this may, for example, increase the need for specific programmes for men and women, or the need to adapt campaign elements and the choice of channels and broadcasting times. The use of smokeless tobacco is largely a male phenomenon, and related measures should therefore mainly target men.

The multi-cultural perspective

On average, non-western immigrants have less education, a lower income and poorer living standards than the average Norwegian. The higher level of unemployment is one of the reasons for this situation. At the same time, it is important to note that there are significant differences between the various immigrant groups. There are major differences in smoking prevalence in terms of both gender and ethnicity. In

general, women smoke little, while men in certain immigrant groups smoke a great deal. Consequently, it will be impossible to develop a single programme that targets everyone with an ethnic minority background.

Strategic priority areas

The trend in the population's smoking prevalence in recent years shows that Norway is on the right track. It is therefore inappropriate to change course to any great extent, but rather to adjust the course and further develop measures on the basis of the available experience and knowledge. The focus in the next five years will largely be on eight strategic priority areas. There are specific goals for each area, and measures to achieve these goals are described below. Expectations regarding the degree to which the goals will be achieved must be viewed in conjunction with the available budgets.

6) Tobacco prevention among young people

Secondary goals

- Halved daily smoking prevalence among young people (16-24) by 2010, from 24 per cent in 2005
- No sale of tobacco to persons under the age of 18 takes place
- All arenas for children and young people, both within and outside the home, are tobacco-free

Smoking is largely a form of social behaviour that children and young people learn from others. The research community therefore agrees that non-smoking adults are a prerequisite for non-smoking children and young people. Research has shown that many instruments have an impact on young people, including higher prices for tobacco products, restrictions on tobacco promotion, stricter enforcement of the age-limit and preventive programmes in schools.

Measures in schools

- By revising, further developing and marketing the VÆR røykFRI programme (BE smoke-FREE), most pupils in lower secondary schools should have completed this educational programme by the end of the period covered by this strategy, to ensure that as many pupils as possible become aware of the health risks of smoking. The VÆR røykFRI programme should be made easily available in order to be implemented more broadly.
- Efforts will be made to establish measures that reduce the number of smokers in upper secondary schools, with special focus on courses where the smoking prevalence is high.
- Prevention of tobacco and substance abuse is one of the competence targets in the new curriculum. The Directorate for Health and Social Affairs should provide good information in order to increase knowledge relating to tobacco control in the training of teachers and other relevant occupational groups.

Measures to limit tobacco sales

- To reduce the demand for tobacco products, price instruments should be considered on an ongoing basis.
- Proposals should be drawn up for a ban on visible presentation of tobacco products and pictures of tobacco products at retail outlets, for example by placing tobacco products under the counter. Similar legislation has been introduced in Iceland.
- The proposal for an inspection scheme that effectively eliminates illegal sales to persons under the age of 18 should be followed up.

Tobacco-free private and public arenas for young people

- Attention should be drawn to the responsibility and importance of parents as role models. Good information campaigns on the importance of not smoking in the home are important.
- Schools will be urged to ensure that the arenas for school children at all upper secondary schools become smoke-free during the period of the strategy.
- To ensure a smoke-free childhood, also outside the home and school, there should be focus on adults who work in day-care centres, after-school activities and sport. Parents, trainers, leaders of leisure activities and others should not smoke in the vicinity of children and young people, and should take a clear stand against the use of tobacco.
- Smoking in public arenas for children, e.g. areas such as amusement parks, playgrounds and other similar places, should be avoided.

7) Smoking cessation

Secondary goals

- Reduced proportion of daily smokers to less than 20 per cent of the population by 2010 (from 25 per cent in 2005).
- Everyone who wishes to quit smoking has easy access to a good, service, among other things through the health service and workplaces.
- Health personnel have greater focus on and better competence relating to prevention and lifestyle change.
- Tobacco-related diseases and cessation methods are included in relevant training for teachers and social and health workers.

The health benefits of smoking cessation are well documented and helping people quit is cost-effective compared with other measures in the health sector. The methods that have proved effective have used two main approaches: counselling and medical treatment.

Smoking cessation and target groups

- The Quitline 800 400 85 will be further developed as a low-threshold service and health personnel will be better informed about it. It is especially important to

increase the capacity of its proactive service and make it more widely known. Routines for documenting the effects and assuring the quality of services through the quitline will be further developed.

- Steps will be taken to ensure that local services are provided to help people quit smoking, that they are publicly known, and that the primary health service refers people to them. In connection with the follow-up to the "Green Prescription" scheme, cessation counselling should be one of the services. Other arenas for smoking cessation might be workplaces and pharmacies.
- The workplace is an important arena for cessation. In order to improve the working environment, companies are urged to introduce totally smoke-free workplaces and to make working hours smoke-free to the greatest possible extent.
- Cessation courses should be better advertised in order to increase demand. Efforts should also be made to systematically document the effect of such courses. It may be appropriate to work more closely with non-governmental organisations to promote cooperation on and coordination of these courses.
- Appropriate self-help materials will be developed for various target groups.
- Mobile phones and the Internet provide new opportunities for following up individuals trying to quit smoking. The use of this technology makes help available regardless of where people live. These tools may be especially interesting for young, or for people who do not wish to quit with the help of group activities or health personnel.

Training health personnel

- Current education and practice relating to the health hazards of tobacco and smoking cessation should be investigated in relevant courses of study in the social and health sectors.
- Dialogue should be established with relevant educational institutions and vocational organisations in order to initiate and implement tobacco control and cessation methods in relevant courses of study in the social and health sectors.
- Interdisciplinary cooperation within and between various institutions is necessary in order to strengthen prevention in relevant courses of study in the social and health sectors. In this way, it will be possible to achieve a coherent approach to the prevention of lifestyle-related diseases.

The primary health service

- Communication tools will be developed for health personnel, based on motivational interviewing, in order to simplify the initiation and follow-up of patients" cessation attempts . When written material has been produced, efforts should be made to provide training courses.
- Cessation guidelines should be developed for the health personnel in addition to regular GPs. When the guidelines have been prepared, a plan for implementation must be produced.
- The cessation guidelines for the primary health service, prepared by the Directorate for Health and Social Affairs, will be implemented and utilised in conjunction with the rate paid to doctors for cessation services.

The specialist health service

- In order to achieve better confidence in and competence regarding motivational interview techniques, important measures will include preparing guidelines and communication tools for various groups of health personnel for use in hospitals and other health institutions.
- Information material should be prepared for patients and relatives on the tobacco policy of health institutions and cessation aid that is available in the local community.
- To encourage increased focus on prevention, such as individual or group cessation services at hospitals, outpatient clinics, and coping and learning centres, financing schemes for the specialist health service should be reviewed with this in mind.

Medicinal treatment

Studies show that smoking cessation medication significantly increases the success rate. The effect of medicinal treatment is to a large extent dependent on combining the treatment with counselling in order to increase the probability of success. Counselling must therefore be a basic service in measures to help people to stop smoking.

8) Protection from exposure to tobacco smoke

Secondary goals

- No one is involuntarily exposed to tobacco smoke
- Halved percentage of pregnant women who smoke at the end of pregnancy from 10.4 per cent in 2004 by the end of 2010
- Parents do not expose their children to passive smoking in the home, in the car or in other areas

In Norway, legislation has been introduced to protect people from passive smoking at workplaces and on public premises. There is strong focus on smoke-free pregnancy and on smoke-free environments for children.

A smoke-free working environment

- The Directorate for Health and Social Affairs is responsible for the interpretation of and information pursuant to section 6 of the Act relating to Prevention of the Harmful Effects of Tobacco (ban on smoking in public premises and public transport, and in meeting rooms, work premises and institutions where two or more people are gathered) to ensure that the Act is complied with and understood.
- It is difficult to ensure that no-one is unwillingly exposed to tobacco smoke in or near individual offices where people smoke. If smoking in individual offices is to be prohibited, the law must be changed.

Children

- Information campaigns will be carried out that especially target pregnant women, the parents of small children and other adults. Important topics include the potential health hazards for embryos and children from exposure to tobacco smoke. This information should be passed on at meetings with the maternity care services, health clinics and other parts of the health service.
- Preventive measures must particularly target pregnant women under the age of 25, who according to statistics are those who smoke the most.

9) The use of smokeless tobacco

Secondary goals

- The health authorities have sufficient information to be able to provide information and advice to the population on the use of smokeless tobacco
- Halted increase in the use of smokeless tobacco

Smokeless tobacco contains more than 2,500 chemical compounds, including nicotine and carcinogens. Norway bases its efforts to prevent disease on the precautionary principle, and this also applies to the use of smokeless tobacco. Even though the main focus is on smoking, efforts should be made to halt and, in the longer term, reverse the increasing tendency to use smokeless tobacco, especially among men under 45 years of age.

Knowledge and information about smokeless tobacco

- More research into smokeless tobacco should be encouraged. Important topics may include long-term studies of health consequences from early initiation of smokeless tobacco use, cessation methods, and transitional mechanisms between no tobacco use, smoking and smokeless tobacco use.
- The health authorities will disseminate nuanced and updated information on smokeless tobacco through a variety of channels. The focus should be on consumption patterns, trends and health hazards. Furthermore, it is important to promote understanding of the difference between individual risk and risk to the population at large.

Preventing the use of smokeless tobacco

- Smoking cessation experts should also be qualified in cessation of using smokeless tobacco. It will be appropriate to ensure that measures in the primary health service aimed at smoking cessation are also relevant in providing advice about quitting the use of smokeless tobacco.
- Smokeless tobacco and cessation should be a natural element in information activities. This applies in areas such as programmes for schools, printed material and contacts with the media. Information material about smokeless tobacco should

be developed, aimed at both the general public and health personnel. Sports clubs etc., where smokeless tobacco is commonly used, are natural areas of focus.
- To reduce the demand for smokeless tobacco, price mechanisms should be considered on an ongoing basis.
- There should also be focus on parents' responsibility and importance as role models in connection with the use of smokeless tobacco. Parents, trainers, leaders of leisure activities and others should not use tobacco when they are with children and young people, and they should also take a clear stand against the use of tobacco.
- The dental service will be more involved in an effort to reduce the use of smokeless tobacco.

10) Research, monitoring and evaluation

Secondary goals

- Norwegian research on tobacco is intensified and coordinated
- Documentation on the use of tobacco and related measures is collated and made available

Norway lacks sufficient expertise and research funding for tobacco-related topics, and existing research activities can benefit from improved information and coordination. Regular monitoring of the use of tobacco and its consequences for health and evaluations of measures that have been implemented will provide important knowledge that will make it possible to target activities where they will have the greatest effect.

Coordination of research

- Existing research activities, which currently take place at universities, the Cancer Registry of Norway, the Norwegian Institute of Public Health, the Norwegian Institute for Alcohol and Drug Research (SIRUS) and similar institutions should be registered and coordinated to a greater extent.
- A permanent professional forum should be established, with the aim of organising annual conferences on tobacco control, promoting inter-disciplinary projects, assisting research students and publishing data in international publications.

Continuous monitoring

- The continuity of data will be maintained and the monitoring of several risk factors will be coordinated.
- It is desirable to acquire knowledge of the social and cultural factors that make some population groups smoke more than others.

Evaluation

- All measures of a certain importance, scope or investigatory nature should be evaluated. When implementing new measures, evaluation will be integrated as early as possible.

- Evaluation of new measures should include their effect on social inequalities in smoking prevalence.

11) Information strategies and general communication

Secondary goals

- All population groups know that smoking and passive smoking increase the risk of serious diseases and what these diseases are, and realise that they run a high risk of being affected themselves
- All population groups know that it is possible to stop smoking and that there are effective and available products and services to help them
- The population is aware that smoking cessation is of considerable benefit to health and leads to improved quality of life

Mass media campaigns, direct communication, e.g. through health personnel, and strategic media campaigns can be effective means of influencing the knowledge, attitudes and behaviour of young people and adults.

Mass media campaigns

- Since 2003 repeated, intensive mass media campaigns have been an element of the Directorate for Health and Social Affairs' overall strategy for tobacco control. These campaigns are part of the effort to reduce smoking among young people in the period 2003-2007. An evaluation of the campaign in January 2003 showed that campaigns are also an important and necessary element of tobacco control in Norway. Mass media campaigns will therefore be an important component throughout the period of this strategy.

One-on-one communication and the use of printed material/the Internet

- Efforts will be made to ensure that health personnel to a greater extent bring up the subject of smoking with patients. Patients who smoke will be routinely monitored and helped to quit smoking.
- Brochures, differentiated according to target groups and themes, distributed through various channels and adapted to the Internet will make information available to more people.

Information through the media

- The various measures will each have their own media strategy, and in the case of some issues the media strategy will be the main measure. Good preparation and planning will ensure an objective, balanced presentation of each issue. Local media will be a natural element of the media strategies.
- Developments in tobacco control in other countries should be followed closely, both to be used as a basis for Norway's own measures and to disseminate information about developments to the public at large, both through official channels and through the media.

12) Tobacco control as part of local public health activities

Secondary goals

- There is more awareness of and willingness to focus on public health activities
- The public sector cooperates with other sectors on tobacco control
- Local follow-up is an integral part of tobacco control

Many efforts are being made at the local level by different players in municipalities and counties, by non-governmental organisations and by trade unions and vocational organisations. Since the factors that influence health are found in all sectors of society, public health activities must be inter-disciplinary, trans-sectoral, and the object of political support and commitment at all levels.

Raising the awareness of local decision-makers

- Information will to a greater extent be passed on to decision-makers and politicians at all local and regional levels and in all sectors. Important topics include the extent of the health problems caused by tobacco use, the resources that are required to treat tobacco-related diseases, and the cost-effectiveness of tobacco control.
- Local public health activities should be a topic of national conferences on tobacco control.

Inter-disciplinary public health activities and partnerships

- The health authorities will identify areas where it is natural to reinforce national coordination of public health activities. Broad cooperation in connection with public health activities should be encouraged where appropriate (e.g. in areas such as tobacco control, nutrition, physical activity, prevention of substance abuse, mental health, living conditions etc.).
- It is necessary to make active efforts to ensure that tobacco control is an integral and important part of the local and regional partnership for public health. A list of effective local measures will be prepared from which municipal authorities, county authorities and others can choose on the basis of local needs.
- The exchange of experience between local groups and local networks of public health advisers, resource groups and others will be facilitated in order to update professional knowledge and provide encouragement.
- In cases where this is appropriate, efforts will be made to seek cooperation and the exchange of opinion and information with the non-governmental sector, for example through joint projects. The same applies to the trade unions and employer's associations at the local level, and in the public sector, private sector, and non-governmental sector.
- The planning of local follow-up activities will be a routine element in the planning of national campaigns and measures.

13) Tobacco control in an international perspective

Secondary goals

- Norway makes an international contribution through its cooperation with the WHO and through the FCTC
- Information and experience are exchanged between nations and in international forums
- The topic of tobacco control is addressed in connection with Norwegian development cooperation

The WHO FCTC regulates both national conditions and areas that require international solutions. For many years, the WHO has provided expertise and worked to promote international cooperation. About 70 per cent of smokers live in developing countries, and it is here the greatest challenges will lie in future.

Follow-up of activities under the WHO Framework Convention for Tobacco Control

- At FCTC Conferences of the Parties, decisions are made and experiences exchanged. Norway should play an active role in international forums relating to the Framework Convention and the forthcoming negotiations on optional protocols to the Convention.
- Norway will contribute to and follow international efforts to develop more appropriate methods for measuring and testing the toxic effects of tobacco products and other types of product regulation.

Cooperation with other countries and international organisations

- Norway will continue to participate in and support the WHO's efforts to promote tobacco control, both globally and regionally.
- The Nordic countries have a great deal in common, and the establishment of a regular forum for authorities involved in tobacco control should be considered.
- Norway is already a member of organisations such as the European Network for Smoking Prevention (ENSP) and the European Network for Quitlines (ENQ). Norway can be a more active participant in international forums and make Norwegian measures and projects more available.

Tobacco as a theme in Norwegian development cooperation

- Tobacco control will be considered in connection with projects supported by NORAD.

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