World Health Organization

JOINT NATIONAL CAPACITY ASSESSMENT ON THE IMPLEMENTATION OF EFFECTIVE TOBACCO CONTROL POLICIES IN NORWAY

APRIL 2010

INDEX

ABBREVIATIONS

COPD	Chronic obstructive pulmonary disorder
DoH	Directorate of Health
DPH	Division of Public Health
MoH	Ministry of Health and Care Services
NCTC	National Council on Tobacco Control
NGO(s)	Nongovernmental organization(s)
NIPH	Norwegian Institute of Public Health
NRT	Nicotine replacement therapy
QALY	Quality-adjusted life year
SIRUS	Norwegian Institute for Alcohol and Drug Research
WHO	World Health Organization
WHO FCTC	WHO Framework Convention on Tobacco Control

EXECUTIVE SUMMARY

With a 45-year history of tobacco control, Norway has been a leading example for many other countries. Norway was one of the first countries to enact a comprehensive tobacco control act that consequently led to a decline in smoking prevalence. It was also the first to ratify the WHO Framework Convention on Tobacco Control (WHO FCTC). The work on tobacco control over the years has resulted in a continuing decrease in the proportion of adults who smoke. In 2009, the daily smoking prevalence for both men and women reached an all-time low of 21%, very close to the target of 20% set for 2010 by the National Strategy for Tobacco Control for 2006–2010. In addition, smoking prevalence among young people nearly halved between 2002 and 2007.

However, despite progress, tobacco use continues to be a major public health problem in Norway. Smoking causes 6700 totally preventable deaths each year, representing 16% of all deaths in Norway. A significant number of children (estimated over 130 000 in a study from 2004) are still exposed to second-hand tobacco smoke, while young males have dramatically increased their use of *snus*. The higher-prevalence smoking rates in Norway are now found among the less educated population, thereby creating a possible increase in social and health inequalities.

Further progress is both necessary and possible, as evidenced by the fact that similar countries have lower smoking prevalence than Norway. The smoking prevalence in Sweden and the United Kingdom, for instance, is 35% and 22% lower than in Norway, respectively.

In this context, from 26 to 30 April 2010, at the request of the Ministry of Health and Care Services (MoH) of Norway, a group of national, international and WHO health experts held interviews with 60 individuals in Oslo representing 44 institutions involved in tobacco control in Norway in order to assess the country's tobacco control efforts. The assessment team considers the following factors to be **the most significant challenges** to continued progress in tobacco control in Norway:

1. **Tobacco control has lost momentum in recent years. Resources directed to tobacco control are inadequate.**
   Although the Government of Norway has continued to devote attention to the tobacco problem, there are some recognized hindrances to the implementation of tobacco control measures in Norway. The limited human resources and reduction of the budget dedicated to tobacco control since 2007 do not match the good intentions of the health authorities. In addition, the lack of well established mechanisms for cooperation between different national, county and municipal players in tobacco control has prevented the MoH from exerting leadership in this area.

2. **Norway has stopped using mass media campaigns although these are a very effective tool in reducing smoking in all groups, including the lower socioeconomic group.**
   Norway has previously been a leader in mounting effective hard-hitting mass media campaigns. In 2003, following a mass media campaign and the debate on a stronger smoke-free law, smoking prevalence dropped by three percentage points. Despite overwhelming evidence of the effectiveness of the mass media campaigns both in Norway and globally, scant resources are currently dedicated to efforts in this area and there is no communications strategy or plan for future campaigns.

3. **Designated rooms for smoking in workplaces are still allowed, in contradiction to the smoke-free recommendations of the WHO FCTC.**
   Although strict measures to protect the adult population, including workers, from exposure to second-hand tobacco smoke have been introduced in schools, restaurants, bars and other premises, the permission to have designated rooms for smoking in workplaces – as well as an unclear definition of "indoor" places and a lack of monitoring and enforcement strategies – has led to continued exposure to tobacco smoke and to noncompliance with the WHO FCTC Article 8 guidelines.

4. **Children in private spaces remain relatively unprotected from second-hand smoke.**
   While Norway has made progress in protecting workers from exposure to second-hand tobacco smoke, children in private spaces – such as homes and private cars – do not have the same level of protection. The exact extent of the problem is not known, but it probably mostly affects children of families of low socioeconomic status, as smoking prevalence is higher among these groups. In any case, even a small number of exposed children is considered too many.

5. **Cessation services are almost nonexistent, despite this being a high priority in the National Strategy for Tobacco Control for 2006–2010.**
   Smoking cessation has been highly prioritized in national policy documents, but not in budgets or in action. The National Strategy for Tobacco Control for 2006–2010 (smoking cessation section) was shown to be inadequately implemented. While cessation services could be instrumental in helping all smokers, including those with low education, there are no action plans on smoking cessation at national, county or local levels.

To ensure the sustainability of current initiatives and further progress, **five key recommendations** are considered critical in having the best potential for success in the short term. These five recommendations should be considered as priorities:

1. **The Ministry of Health and Care Services should provide stronger national leadership for tobacco control, including significantly more human and financial resources.**
   Norway is legally bound to implement the WHO FCTC provisions and should take more advantage of the treaty's guidelines and future protocols. More staff should be assigned to tobacco control at all levels of the government – national, county and municipal. Furthermore, the trend of decreasing budget allocation to tobacco control should be reversed and adjusted to the current and future national strategies and their targets.

2. **The Ministry of Health and Care Services should renew its dedication to mass media campaigns using best-practice science, as previously employed to test and evaluate communication materials, and to run them at high intensity in the media.**
   Adequate resources should be directed to this critically important area. Running at least two and possibly three major campaigns each year is specifically recommended for there to be a desired effect on reducing the uptake of tobacco use, de-normalizing tobacco use, and prompting quitting over the long term. While there are deep-seated concerns about social inequality in Norway, a broad approach to delivering mass media campaigns, rather than one that attempts to target subgroups, is also recommended.

3. **Ensure universal and equal protection from exposure to second-hand tobacco smoke for all workers and for the public by eliminating designated smoking rooms** (whether with separate ventilation systems or not), by introducing clear and inclusive definitions of terms (e.g. indoor spaces), and by putting in place effective monitoring and enforcement strategies, in line with the WHO FCTC Article 8 guidelines.

4. **Initiate a mass media campaign to educate adults on how to protect children from second-hand tobacco smoke at home.**
   Parents and relatives of children should be informed of the importance of the health problem caused to children by second-hand tobacco smoke. They should be advised never to smoke inside private spaces such as homes even when children are not present. Also they should be advised not to smoke in cars – or even outside – whenever children are present. In addition, Norway should consider legislation, within the limits of social acceptability, to protect children in indoor private spaces.

5. **Smoking cessation needs to be a true priority in the new National Strategy for Tobacco Control 2011–2015 and should be backed by economic resources. As a first step, the current cessation potential of**

the quitline and cessation web site should be maximized in conjunction with the release of pictorial warnings and a mass media campaign.
The cessation strategy should focus on developing a strong national, regional and local infrastructure for the delivery of brief interventions, including recommendation of the national quitline, at every health-care interaction. This should be followed by referral to evidence-based, appropriate and financially suitable smoking cessation services when appropriate.

Other recommendations offered by the team of experts for each of the tobacco control policies assessed follow below.[1] The MoH, in close collaboration with the Directorate of Health, the Parliament and other competent authorities, should:

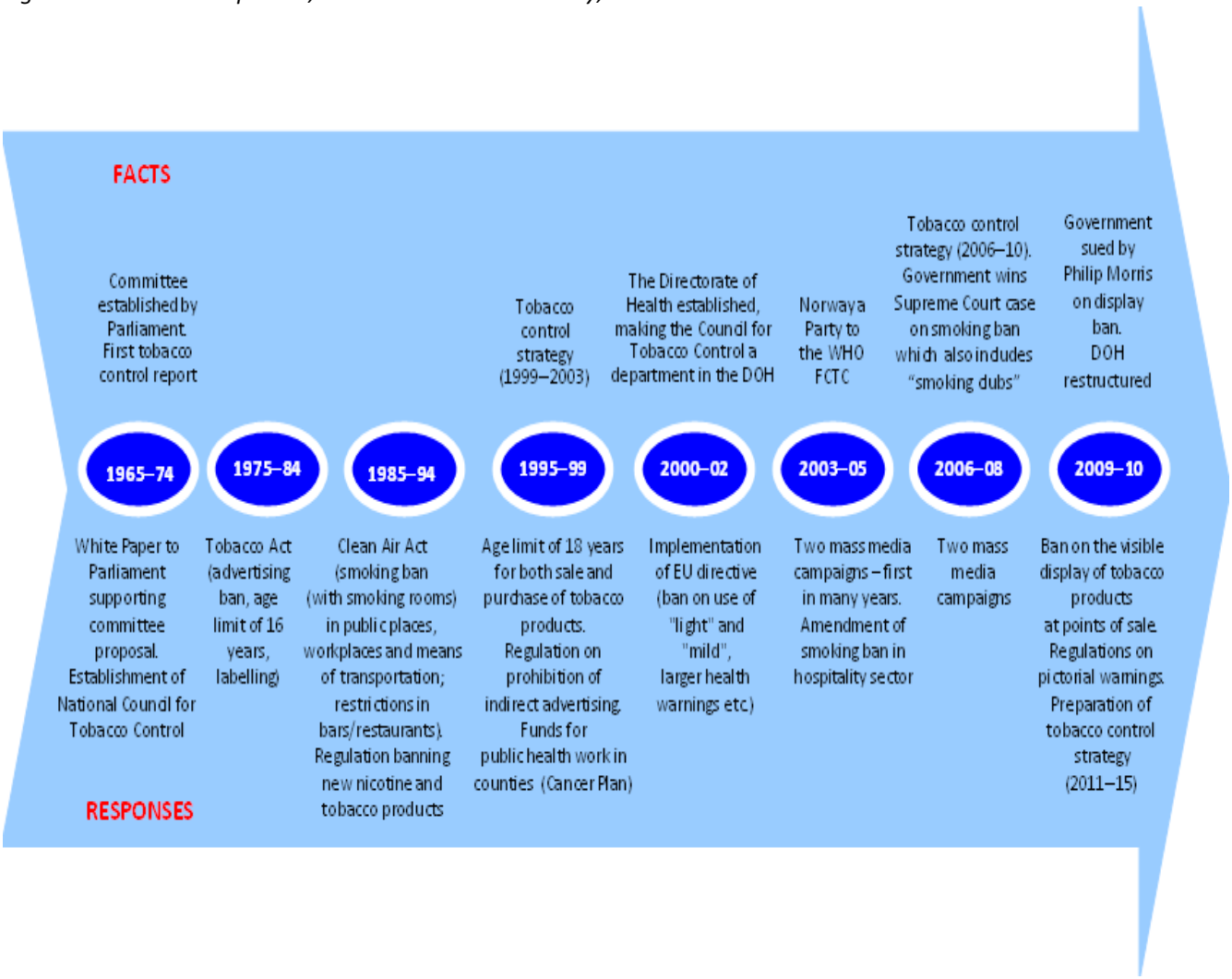
6. Create a licensing system to regulate the sale of tobacco products because sales of tobacco products in general, and sales to minors in particular, are inadequately regulated.
7. Apply the legislation on pictorial health warnings to all tobacco products, including smokeless tobacco.
8. Look for ways to encourage more active participation of civil society in tobacco control work in Norway.
9. Monitor the activities of the tobacco industry that influence the internal market nationally and internationally and implement the WHO FCTC Article 5.3 guidelines.
10. Reduce the difference in tax rates between combustible products and noncombustible products (*snus*).

[1] A list with all the recommendations of the assessment is presented in Annex III

I INTRODUCTION

Norway has a 45-year tradition of tobacco control (Fig. 1). The country was one of the first in the world to enact a comprehensive tobacco control act with a consequent decline in smoking prevalence. Cigarettes, hand-rolled and *snus* are the most consumed tobacco products and are imported from other countries. The tobacco industry is represented in Norway by importers and commercial representatives.

Figure 1. Facts and responses, tobacco control in Norway, 1965–2010

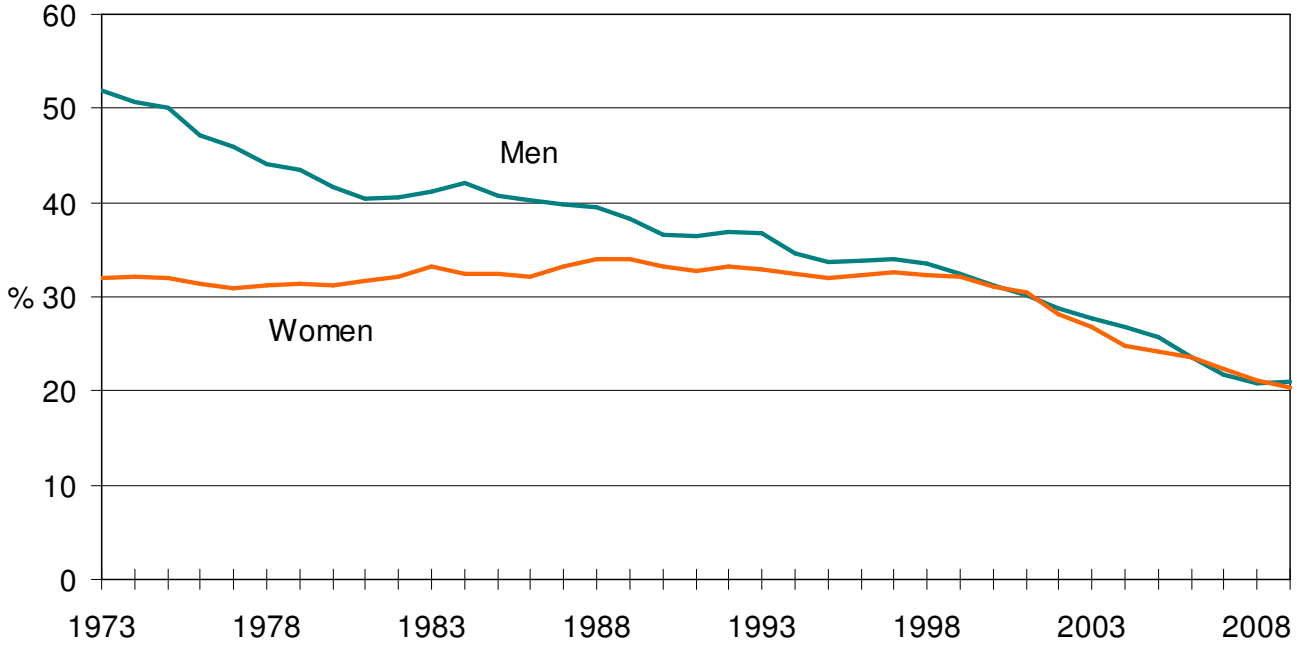


Norway was the first country to sign and ratify the WHO Framework Convention on Tobacco Control (WHO FCTC) on 16 June 2003. The treaty entered into force on 28 February 2005 providing additional leverage to the strengthening of tobacco control in the country.

A recent survey (2009)[2] estimates daily smoking prevalence to be around 21% for both men and women. Trends in smoking among adults show a decline in the population aged 16–74 years between 1973 and 2009 (Fig. 2).

[2] Statistics Norway: http://www.ssb.no/english/subjects/03/01/royk_en/

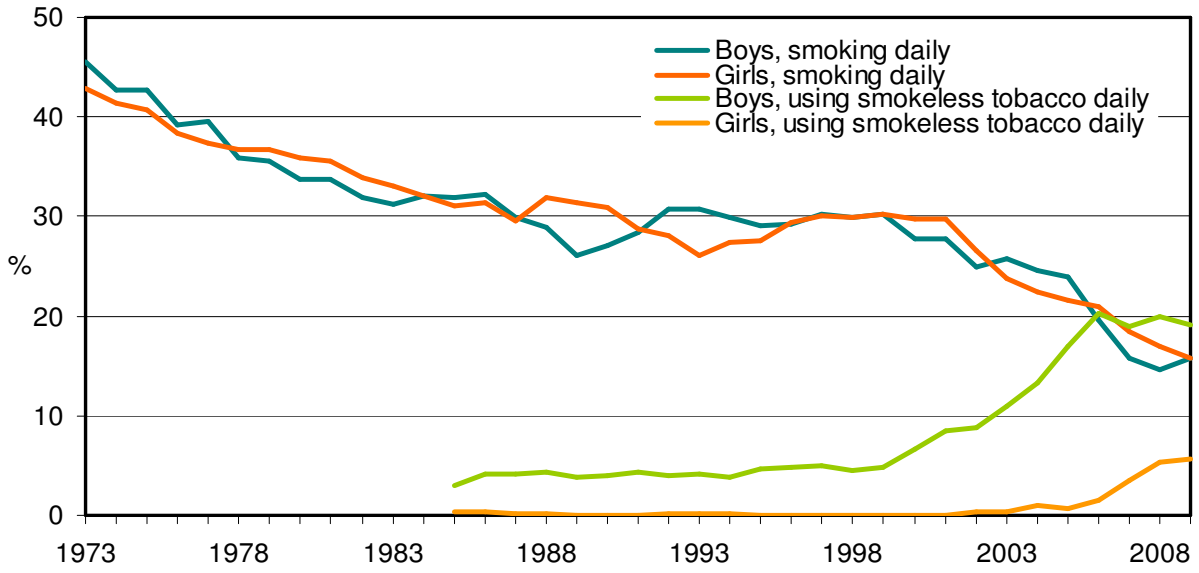
Figure 2. Trends in adult smoking prevalence in Norway, 16-74 years (Statistics Norway/Norwegian Directorate of Health)



While Norway implemented many of the treaty provisions even before the convention came into effect, resulting in the fall of prevalence rates, the government is determined to further strengthen its tobacco control efforts in response to the many challenges to public health posed by tobacco use. Among these are:

1. Smoking prevalence rates among Norway's population are still high compared to those in countries such as Sweden and the United Kingdom where the smoking prevalence is 35% lower and 22% lower respectively. In Norway, tobacco smoking causes 6700 preventable deaths each year.
2. Tobacco use is one of the most important factors in social inequality and health. Significantly higher prevalence rates of smoking can be found among the population with lower educational levels in Norway – a pattern that has evolved since the 1960s.
   Prevalence among subgroups of the population is of particular concern. In pregnant Norwegian women there has been no reported decline in tobacco use in the last five years despite progress in general tobacco control measures. One out of every 10 pregnant women smokes regularly. As regards youth, the smoking prevalence has levelled off at around 17% of the population aged 16–24 years (Fig. 3). There is also an indication that the older Norwegian population is disproportionally affected. Estimates have shown that around 25% of persons aged 45–65 years smoke, and that the reduction of smoking prevalence is decreasing at a much slower pace in this group.
3. Exposure to second-hand tobacco smoke continues to be a public health concern in Norway. Estimates in a study from 2004 have shown that 130 000 children were exposed to second-hand smoke.
4. Despite the negative health effects of *snus*, its use by young males increased dramatically between 1998 and 2010. Currently estimates show that young males use more *snus* than cigarettes (Fig. 3).

Figure 3. Youth and tobacco in Norway: Prevalence of smoking and snus use, 16-24 years (Statistics Norway/Norwegian Directorate of Health)



Assessing the national capacity to reverse the tobacco epidemic in Norway

In this context, at the request of Norway's Ministry of Health and Care Services (MoH), a mission led by WHO conducted a joint assessment of national capacity for implementing tobacco control policies. WHO (headquarters and the WHO Regional Office for Europe) worked together with the Public Health Department in the ministry and with the Directorate of Health (DoH) to organize and conduct the joint capacity assessment.

From 26 to 30 April 2010, a group of 13 national, international and WHO health experts reviewed the status and present development efforts of key tobacco control policies, conducting interviews (face-to-face, and by telephone and videoconference) with key informants in Norway. The group also examined, where appropriate, the underlying capacities for policy implementation, including leadership and commitment to tobacco control, programme management, intersectoral and intrasectoral partnerships and networks, and human and financial resources and infrastructure. Finally, the expert group made recommendations based on the key findings of their analysis to further the development of the following tobacco control policies:

- **M**onitor tobacco use and interventions;
- **P**rotect people from tobacco smoke;
- **O**ffer help to quit tobacco use;
- **W**arn about the dangers of tobacco;
- **E**nforce bans on tobacco advertising, promotion and sponsorship;
- **R**aise taxes on tobacco.[3]

For each policy, the report comprises the following sections:

- Policy status and development. A brief introduction is given on the present status and planned development of the policy in question, based on a thorough review of all documents made available by the MoH prior to the country visit (e.g. Tobacco Control Country Profile, the 2009 WHO report on the global tobacco epidemic, legislation in force, results and conclusions of previous studies and reports) and on interviews.
- Key findings. A summary is provided of the most important aspects discovered by the assessment team after conducting the visits and interviews. Key factors for the success in implementing present policies and developing future ones are considered, namely: political will, programme management and coordination, partnerships and networks for implementation, provision of funds, and human resources.

[3] The implementation of tax policies for tobacco control was examined briefly and only in relation to the different taxation of combustible and non-combustible tobacco products.

- Key recommendations. These are actions required, in the opinion of the assessment team, to improve the design, implementation and enforcement of the policy that was examined.

WHO is grateful to the Government of Norway and the nongovernmental organizations (NGOs) concerned with tobacco control in the country for leading the joint national tobacco control capacity assessment. Many other WHO Member States will follow and will benefit from the lessons learned during this assessment.

MPOWER

FCTC ARTICLE 5.2 (a)[2]

II COORDINATION AND IMPLEMENTATION OF TOBACCO CONTROL INTERVENTIONS

II.1 POLICY STATUS AND DEVELOPMENT

1. Government coordination agencies

In Norway, the Ministry of Health and Care Services (MoH) and the Norwegian Directorate of Health (DoH) – a specialized agency under the MoH – coordinate national tobacco control actions.

The **MoH** undertakes its coordination role in tobacco control through one of its eight departments – the Department of Public Health. The main role of the MoH is to coordinate interministerial responses to country needs and to decide on major tobacco control policies, eventually submitting them to the Parliament or other competent authorities for consideration. The MoH also has the role of ensuring a coordinated Norwegian position in the discussions and negotiations of the WHO FCTC process. Apart from direct support from the director of the department, in the MoH there are two part-time staff working on tobacco control issues. There is a limited budget allocated to tobacco control activities (around NOK 500 000) and this includes the WHO FCTC voluntary contribution.

The **DoH** undertakes its coordination role in tobacco control through the Division of Public Health (DPH), one of the six divisions of the DoH. The DoH has major executive roles and collaborates with counties and municipalities. The DoH has recently undergone a major change in its operational structure. As a result, the former Department of Tobacco Control was dissolved and tobacco control activities were distributed between three new departments of the DPH involved in the programme – the Department of Primary Prevention, the Department of Community Public Health and the Department of Healthy Public Policy. Currently, some 15 people work full-time on tobacco control issues in the DoH, including the quitline staff (equivalent of three full-time positions). The budget allocation for tobacco control was reduced from NOK 36.8 million in 2006 to NOK 28.5 million in 2009, a reduction of 23%. The DoH budget includes personnel costs and the Norwegian quitline.

2. Other government structures involved in tobacco control

At the central level, three other government structures are involved in tobacco control – the National Institute of Public Health, the Norwegian Institute for Alcohol and Drug Research, and the Norwegian Labour Inspection Authority.

The **Norwegian Institute of Public Health (NIPH)** undertakes epidemiological, and toxicological and air pollution research and provides information on a regular or ad hoc basis in the area of health statistics and epidemiology, and the ingredients of tobacco products. The NIPH has a very small budget for tobacco control.

The Norwegian Institute for Alcohol and Drug Research (SIRUS) is a research organization that provides qualitative and quantitative social science research related to addictive substances. SIRUS was created to undertake investigation in the area of alcohol and drugs in general and more recently with tobacco. A tobacco control research group is part of the SIRUS structure and it has five fixed-term staff and three PhD students. The costs of tobacco control research are covered by an annual budget of approximately NOK 8 million that includes staff costs. SIRUS is funded by the National Research Council and the MoH.

The National Labour Inspection Authority is responsible for enforcing the smoke-free component of the Tobacco Control Act at workplaces. This activity is undertaken as part of the regular inspection activities so there are neither dedicated persons nor an earmarked budget.

Counties and municipalities

Norway has 19 counties and 430 municipalities. The municipalities have great autonomy in the implementation of primary health care and public health policy. All counties have one public health professional who works as a liaison between the national level and the municipalities and who reports to the council leader and the DoH. The participation of counties and municipalities in tobacco control measures is uneven. Tobacco control is, however, considered a priority in the new decentralization process along with health promotion initiatives (the Coordination Reform).

3. Civil society

Civil society has a limited role in tobacco control in Norway. The main 11 NGOs are organized under an umbrella organization called Tobacco-Free. Tobacco-Free has a board of three members and no staff. Tobacco-Free regularly applies for and receives seed grants from the DoH. While the member organizations collect membership fees, Tobacco-Free itself does not collect membership fees to support itself. The member organizations of the coalition also carry out tobacco control activities of their own.

4. Tobacco control coordination bodies

No formal coordination mechanism was identified between the different players in the MoH, between the MoH and other ministries, and between the government and civil society. Nevertheless, tobacco issues are discussed under other coordination mechanisms within the ministry, and consultations with other players are held on an ad hoc basis.

The MoH has established the National Council on Tobacco Control (NCTC) as an advisory body composed of 10 experts acting in their personal capacities, and the DoH acts as the executive secretariat of the NCTC. Experts are appointed for four years and can be reappointed. The mandate of the NCTC is to propose tobacco control policies for the different levels of the government and give advice on relevant issues. The NCTC meets four times a year to review progress and propose new initiatives.

5. National strategies and plans of action

Norway has prepared a National Strategy for Tobacco Control every five years since 1999. Before 1999 there were various action plans and strategies on tobacco control but they were not as regular as in recent years. A new strategic plan for 2011–2015 is now in the process of being prepared. The national strategies are master plans for tobacco control activities in Norway but their implementation is subject to the availability of funds. Annual workplans involving tobacco control initiatives are prepared in the different government structures and are based on the National Strategy.

6. The presence of the tobacco industry in Norway

British American Tobacco, Phillip Morris, Swedish Match and Imperial Tobacco are the four major transnational tobacco companies in Norway. They are established as importers and distributers of tobacco products. Since 2008 there has been no tobacco manufacture in Norway.

II.2 KEY FINDINGS

II.2.1. Norway has long been a leading example for tobacco control in the international arena

It is recognized that Norway has had an important role in international tobacco control. Norwegian leaders were instrumental in the promotion of the WHO FCTC and the country was the first in the world to sign and ratify the treaty. Furthermore, Norway was one of the pioneers in enacting its first tobacco control act in 1973. Many countries were stimulated in their tobacco control work by Norway's example.

II.2.2. There is a continuous reduction in smoking prevalence in two out of three prevalence targets set by the country

There has been a steady decline in smoking prevalence among both adult males and females and among young people. However, there was no decline in smoking prevalence among pregnant women during the period of the last strategic plan (2006–2010). Also of concern is the use of *snus* among Norwegian youth who are specifically targeted by marketing strategies of the tobacco industry.

II.2.3. The WHO FCTC has not been fully implemented in Norway

The WHO FCTC is an evidence-based treaty to which Norway is legally bound. Under the treaty provisions, Norway is required, for instance, to "take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence" (Article 14) but in practice there is limited compliance with this article. Furthermore, there are guidelines that set best practices in some areas. This is the case for Article 8, providing for "protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places". In this case, Norwegian law allows designated smoking rooms and smoking in single-use offices under certain conditions, which is not in line with the Article 8 guidelines.

II.2.4. Tobacco control in Norway has lost momentum in recent years

It is clear that the Government of Norway continues to devote attention to the tobacco problem. Nevertheless, there are some recognized hindrances to the smooth implementation of tobacco control measures in the country.

The reduction of the budget in recent years, associated with less staff time dedicated to tobacco control, can be considered an indication of reduction in priority. There is also an indication that, when the former DoH Department of Tobacco Control was dissolved, there was no contingency plan for a transition period with a clear redistribution of staff and programmatic functions to ensure continuity and strengthened tobacco control activities. Finally, the National Strategy for Tobacco Control is mainly a health sector document with limited ownership from other sectors of the government and almost no involvement of civil society.

These factors play a role in the sluggish implementation of several important policies contained in the present National Strategy – such as providing support to smoking cessation.

II.2.5. There is a lack of leadership and collaboration in tobacco control which hinders effective implementation of activities

There is good formal and informal collaboration between the MoH Department of Public Health and the team working on tobacco control at the DoH. Nevertheless, there is apparently a vacuum of tobacco control leadership in the DoH. As a consequence, among other things, tobacco control activities are not properly assigned to the three departments in charge of the issue in the recently restructured directorate, thus hampering the coordination of activities with the MoH. Furthermore, apart from the Department of Public Health the two main service departments in MoH (the Department of Municipal Health Care Services and the Department of Specialist Health Care Services) do not participate actively in tobacco control, reducing opportunities in this area.

There is limited cooperation on tobacco control activities within the health sector. In addition, intersectoral collaboration mechanisms for coordination of activities between different government agencies at the national, council and local levels are not yet well established with clear divisions of work.

The NCTC seems to have neither clear direction regarding its expected role in supporting DoH and MoH actions nor feedback from them on whether and how its advice was considered.

The collaboration of the public health sector with civil society is limited. Despite the fact that the NCTC is considered to be a sounding board for obtaining the views of civil society, it has no representatives on it since all its members are invited in their personal capacities.

Further, national intersectoral collaboration for discussing Norway's external positions as a party to the WHO FCTC seems not to be fully operational.

II.2.6. Tobacco control activities at municipal and county level are not yet fully established

Norway's government is currently considering increasing decentralization in the health sector (the Coordination Reform) to address the still limited local activities for stimulating healthy lifestyles, including tobacco control. The principle of the proposed reform is that a minimum set of activities in this area should be delivered by all municipalities. Although some councils and municipalities devote variable degrees of attention to tobacco control, there is generally no regular work in this area except with regard to the municipalities' mandate to enforce the smoking ban. Roles identified as part of the work at municipal level include awareness-raising initiatives and smoking cessation.

II.2.7. Activities of organized civil society have not yet reached their real potential

Tobacco control lacks strategic vision, leadership and a strong stand in Norwegian civil society. Furthermore, a possible role of the government in strengthening NGO's activities, as happens in several countries, has still not been identified. The comparative advantage of the NCTC is not fully used by the health authorities or by civil society.

II.2.8. Mechanisms of monitoring the enforcement of existing tobacco control legislation and reporting to the population are not fully in place

Despite the fact that there are designated authorities in charge of monitoring compliance with existing tobacco control legislation, there are apparently no inspection protocols and defined authorities to undertake monitoring activities. Furthermore, there is no reporting system with regard to the level of compliance for enabling the authorities to support potential policy changes and to provide information to the public.

II.2.9. Tobacco industry marketing tactics and strategies in Norway are barely known

Despite an ongoing legal action contesting tobacco control measures filed against the government by the tobacco industry, there is a wide impression in both governmental and nongovernmental circles that the tobacco industry is inactive and that there is no need to monitor it. However, global experience has shown that, while the industry's work may not be obvious, it is omnipresent, monitoring what health authorities are doing and finding opportunities to influence policy and activities that are to its advantage.

The tobacco market and the tobacco industry's marketing strategies in Norway are not well known and there is no mechanism for monitoring the industry's activities at either national or international level. In this regard, the WHO FCTC Article 5.3 which protects against undue interference from the tobacco industry and the Article 13 guidelines on tobacco advertising, promotion and sponsorship are not being appropriately implemented unless there is monitoring to prevent the activities of the tobacco industry from undermining tobacco control.

II.2.10. Tobacco control research policies are not fully established

Tobacco control research activities in Norway are conducted in response to either the interest of the MoH or the concern of particular researchers. At this point there is no clear strategic plan for tobacco control research and monitoring. Tobacco control research has limited resources that apparently do not match the assessment, monitoring and evaluation needs of the country.

II.2.11. **There is uncritical support of school programmes to prevent initiation among students under the age of 16**

The DoH has administered a school-based tobacco prevention programme that has been documented to have good effects and has been running nationwide since 1997 (and more recently with a revised curriculum). Fifty-six per cent of students in junior high school (age 13–15 years), participate in the programme annually. The programme is conducted in cooperation with the Directorate for Education and Training.

There is uncritical support among politicians and civil society for school programmes aimed at preventing initiation by students under the age of 16 in Norway. This is based on belief in the value of protecting children from tobacco. While this is a very desirable goal, the value and opportunity of such school programmes should be considered in light of the following factors:

- *Effectiveness:* There is evidence that school interventions may be effective in the short term, but evidence of their long-term effects is lacking and therefore the short-tem effects may be only temporary.
- *Cost-effectiveness:* School-based smoking prevention programmes may be cost-effective at a threshold of NOK 180 000–270 000 per quality-adjusted life year (QALY) gained. There are much more cost-effective tobacco control measures that should be considered before investing in school programmes – such as higher taxes on tobacco products and mass media campaigns.
- *Timing of potential effects:* Focusing on preventing initiation of smoking in children will not show visible results in terms of morbidity and mortality reduction for at least five decades.

II.3 RECOMMENDATIONS

II.3.1. Norway is legally bound to implementation of the WHO FCTC provisions and should take more advantage of the treaty's guidelines and future protocols.

Little attention has been paid to the use of the WHO FCTC and its guidelines for the benefit of tobacco control in the country. The WHO FCTC and its guidelines provide a roadmap of cost-effective evidence-based and intersectoral tobacco control measures. Establishing mechanisms to coordinate a multisectoral approach based on the treaty's provisions, guidelines and future protocols with the involvement of the different stakeholders would enhance the current programme and strengthen the leadership of the MoH.

Norway should also revive its leadership role not only as a proactive player – as it was in the treaty negotiations – but also in international tobacco control work in general. As new successes materialize, other countries will look to the continuing leadership of Norway.

II.3.2. There is a need to set new targets for the reduction of the prevalence of tobacco use in the general population and among young people, and to make an increased effort to use gender-sensitive approaches to address specific high-prevalence groups.

Although prevalence has decreased over the years, more can be done to reduce it by setting new targets and strategies. Special attention should be given to high-prevalence groups, including long-term smokers and pregnant women.

II.3.3. Norway should provide more human and financial resources for tobacco control.

It is clear that significantly more human and financial resources should be devoted to tobacco control. More staff should be assigned to tobacco control at all levels of the government – national, county and municipal. Furthermore, the decreasing budget allocation to tobacco control should be reversed and adjusted to the current and future national strategies and their targets.

II.3.4. The Ministry of Health and Care Services should provide stronger national leadership for tobacco control.

The MoH is the main force in promoting tobacco control. However, stronger leadership is needed at the highest possible levels in order to address the intrasectoral issues arising from the WHO FCTC and to advance the implementation of current and future strategies.

The DoH should ensure that tobacco control work continues during the transition period from the former structure to the new one. Tobacco control should also be a true priority in itself, in addition to being part of a comprehensive public health approach.

Moreover, strengthening leadership will improve coordination of the Norwegian position in discussions of the WHO FCTC .

II.3.5. Tobacco control activities should be strengthened at local level.
The Coordination Reform can provide new opportunities to implant tobacco control actions at local level. Both the counties and the municipalities need to have adequate resources to cope with the new expectations and demands. These demands include strengthening the health promotion agenda at local level and introducing coordination mechanisms into existing structures so as to involve responsible officers and all stakeholders in meeting agreed strategic goals defined in an action plan.

Potential roles of the county and municipal levels include awareness-raising along with structuring tobacco cessation services.

II.3.6. The government should look for ways to encourage more active participation of civil society in tobacco control.
Civil society in Norway can play a much more active role in promoting tobacco control activities and can be a strong partner to the government around common goals. This role may include promoting new legislative initiatives and their enforcement, publicly supporting the government against possible industry attacks, and helping build a social critical mass for new policy proposals.

In this regard, the NCTC should have its work expanded to take the leadership in voicing civil society concerns and to collaborate with the government in taking forward the tobacco control agenda.

The government might also consider being more strategic in strengthening partners who are already involved and in promoting the participation of new NGOs in the tobacco control agenda. This could encompass the inclusion of selected civil society partners in the preparation of strategic documents defining the goals and targets for the country. It could also involve the provision of grants and the outsourcing of specific tasks.

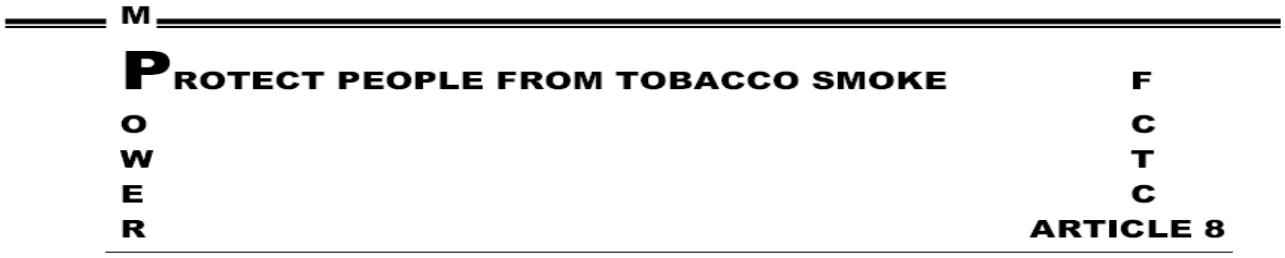
II.3.7. Mechanisms for monitoring the enforcement of existing tobacco control legislation should be included in existing inspection systems.
Enforcement of existing legislation is key in determining its effectiveness. Although there is apparently good compliance with existing legislation, monitoring and evaluation mechanisms should be strengthened where applicable or developed where necessary. Inspection protocols should include the duties of compliance, communication of law enforcement, and provision of information to the public.

II.3.8. The activities of the tobacco industry that influence the internal market should be monitored nationally and internationally.
The tobacco industry – importers, distributors and front groups in Norway and producers and exporters internationally – must not be underestimated. Keeping up to date with the changes in the country's tobacco market, and knowing existing products, brands and the tobacco industry's presence are crucial in anticipating opposition to new tobacco control policies. Understanding the tobacco industry’s marketing strategies nationally and internationally can be an invaluable help in guiding tobacco control policies and protecting the government proactively against attacks. This includes price promotions, new publicity tactics, packaging and product manipulations, and placement strategies to increase profits and reach new customers. Furthermore, studies on the files of tobacco industry documents released as part of the US Master Settlement Agreement can be an important source of information for the country.

In this regard, the mission recommends the establishment of a tobacco industry monitoring system. This can be undertaken either by a research body in the government or by a civil society organization, or by both to ensure complementarity. Such a system would also allow Norway to comply with WHO FCTC Article 5.3 guidelines.

II.3.9. A coherent tobacco control research policy should be established in line with overall tobacco control priorities.

Norway has excellent research structures in place. Nevertheless, there is no strategic research plan that addresses critical needs of the country with priority. A national research policy plan for tobacco control should be established, and financial and human resources should be assured to meet the demands contained in the National Strategy. Research should also consider new frontiers in the upcoming and novel areas in tobacco control, thus guiding the country and providing additional support to the international community. These areas could include issues such as product regulation, plain packaging, and third-hand smoke.



III SMOKE-FREE ENVIRONMENTS

III.1 POLICY STATUS AND DEVELOPMENT

In 1988, an amendment to the Tobacco Control Act ensured smoke-free indoor environments in public areas and means of transportation, as well as in work premises. Designated smoking rooms and smoking in single-use offices are allowed under certain conditions. Restaurants and bars were exempted from the smoking ban until 1 June 2004 when a total ban on smoking in the hospitality sector was introduced. Primary and secondary schools (up to 18 years) have a complete ban on indoor smoking.

The National Strategy for Tobacco Control 2006–2010 states that protection from exposure to tobacco smoke is one of the strategic priority areas.

The owners of or persons managing the facilities are responsible for ensuring compliance, and they may expel a person smoking from the public area or workplace. If the ban is violated the owner/employer may be fined. The municipal councils and the Norwegian Labour Inspection Authority are responsible for enforcement.

III.2 KEY FINDINGS

III.2.1. Smoke-free provisions started to be introduced in Norway at an early stage, but they do not fully comply with WHO FCTC Article 8 guidelines

The designated rooms for smoking permitted by current legislation do not offer universal protection from exposure to second-hand tobacco smoke. A smoke-free hospitals policy exists but the lack of existing enforcement strategies means that the policy is not always adhered to.

Definitions of outdoor and indoor places in the hospitality sector are unclear. Specific enforcement mechanisms – such as signs, availability of information on name and/or telephone number for submitting complaints (free-toll complaint line), removal of ashtrays, and inspection protocols – are not provided in clear, operational detail. It appears that this lack of clarity has led to breaches of the law such as partially "sheltering" restaurant patios or terraces. Also, according to the current definition of "indoor" places, guest areas in the proximity of restaurants and bars continue to be considered as outdoor and thus do not fall under the current smoking ban.

III.2.2. The great majority of the population is aware and supportive of the current smoking ban, having the perception that it provides complete protection

When the complete ban on smoking in bars and restaurants entered into force in 2004, 54% of the population was positive to the ban. Public support has increased since then, and in 2009 approximately 89% supported the ban in

bars and restaurants. Despite this high level of support, the outdoor guest areas established in the proximity of bars and restaurants continue to expose both employees and the public to second-hand tobacco smoke.

Currently, 60% of population supports a complete ban on smoking in indoor workplaces[4]. However, the assessment team observed that there is still ignorance about the danger posed by the smoking rooms to the health of workers.

Concerns have been expressed that children are not sufficiently protected in private places (homes, cars, etc). A study from 2004 estimated that more than 130 000 children in Norway are still exposed to second-hand tobacco smoke. Based on recent data,[5] 73% of the population supports a smoking ban in all indoor places where children are present.

Although data on the number of smoking rooms installed in premises could not be provided to the assessment team, there is a general view that such rooms are rare in both public and private workplaces. A national survey in 2008 showed that 86% of all employees report that they are never exposed to tobacco smoke at the workplace, while another 4% report that they are "almost never" exposed. 1% report to be exposed more than 5 hours a day (while 5% report exposure for 1–5 hours and 4% for less than half an hour). The survey does not distinguish between voluntary and involuntary exposure.

There is widespread interest in banning tobacco use, both indoors and anywhere outdoors, during school hours, as well as in banning smoking, indoors and anywhere outdoors, during paid working hours. The government has encouraged the implementation of such measures at municipal level.

III.2.3. Enforcement authorities seem to rely on an apparent high level of self-enforcement, with an overall perception of excellent compliance with smoke-free provisions, despite the lack of relevant data from regular and systematic monitoring and lack of clear enforcement mechanisms

The Norwegian Labour Inspection Authority conducts inspections of work premises, whereas the municipal councils inspect public premises. In practice, their authority in restaurants and bars overlap to some extent as most are open to the public as well as being workplaces. No data related to formal communication or reciprocal reporting between municipal and labour inspectors could be identified, though there are some examples of joint work.

The smoke-free inspection activities of the National Labour Inspection Authority are part of the daily inspection work. However, "smoke-free places" are not included in the systematic planning for visits, checklists, protocols or the reporting process. Inspection visits and spot-checks tend to take place on an ad hoc basis, or as part of "brief inspection campaigns" around selected premises or grounds (restaurants, workplaces, etc). Due to the lack of specific enforcement guidance and clear duties of compliance inspection, visits remain subject to the subjective perception of inspectors (smell of tobacco smoke, no clear interpretation of indoor/outdoor, etc).

Municipal authorities seem to lack capacity for inspection and enforcement, relying on the same assumption of self-enforcement. Complaints are rare and are addressed through a general call-line of the National Labour Inspection Authority, but it appears that other lines are sporadically used by the public (NGO help-lines and possibly municipalities' phone numbers).

No public institutions have been found to collect and report data regularly on compliance with the law, although some evaluation has been carried out by SIRUS[6] on the compliance in the hospitality sector. Two years after the ban, in 2006, only 2% of restaurant managers had experienced problems with the enforcement of the law.

[4] SIRUS/Synovate 2010
[5] idem
[6] The introduction of smokefree hospitality venues in Norway. Impact on revenues, frequency of patronage, satisfaction and compliance. SIRUS/HEMIL, 2006 (http://www.sirus.no/files/pub/375/SIRUSskrifter0206eng.pdf).

III.2.4. There is no evidence of countrywide efforts to mobilize and involve the community in monitoring and enforcement of the law

Apart from remote initiatives, supported by the government, the assessment team could find no relevant documentation on community involvement in monitoring and enforcement of the law. It appears that members of the community are generally not encouraged to monitor compliance and report violations, although this would broaden the local enforcement agencies' range of enforcement without a major increase in resources. Moreover, local civil society organizations are mostly not perceived as partners or as possible sources of intelligence for the government regarding violations of the law.

III.2.5. Children in private spaces remain relatively unprotected from second-hand smoke

While Norway has made progress in protecting workers from exposure to second-hand tobacco smoke, children in private spaces – such as homes and private cars – do not have the same level of protection. The exact extent of the problem is not known, but it probably mostly affects children of families of low socioeconomic status, as smoking prevalence is higher among these groups. In any case, even a small number of exposed children is considered too many.

III.3 RECOMMENDATIONS

III.3.1. Universal and equal protection should be ensured for all workers and the public from exposure to second-hand tobacco smoke, in line with the WHO FCTC Article 8 guidelines, through the elimination of designated smoking rooms (whether with separate ventilation systems or not) which are currently permitted by the law.

The only way to protect fully the workers and the public from tobacco smoke is to create 100% smoke-free indoor environments with no exceptions. A complete smoking ban in all indoor public places, indoor workplaces, public transport and, as appropriate, in other public places would ensure consistent coverage, efficient enforcement and better understanding among government agencies and the public. The government could consider additional measures to reduce the possibilities of exposure to tobacco smoke by introducing bans on smoking during school/working hours provided that adequate enforcement strategies are put in place.

Due to frequent misinterpretations of the existing definition of indoor/outdoor places in the hospitality sector that were reported as having generated difficulties in law enforcement, the current law should be amended with a clear definition that would be as inclusive as possible.

III.3.2. The Ministry of Health and Care Services, NGOs and other experienced partners, should develop and implement an evidence-based communication strategy for:

- **protecting children from exposure to second-hand tobacco smoke in private places;**
- **raising awareness of the population of the need for amending the current law to protect all citizens from exposure to second-hand tobacco smoke;**
- **mobilizing public support and securing political support for the recommended amendment to the law.**

Key stakeholders targeted by the communication strategy may include, but are not limited to, businesses, restaurants, hospitality associations, employer groups, trade unions, the media, health professionals, the research community and the general public.

III.3.3. Inspection protocols should be reviewed to ensure systematic and coordinated enforcement and monitoring of smoke-free provisions.

The MoH together with the municipal authorities and the Labour Inspection Authority should establish a systematic monitoring and enforcement mechanism based on an overall enforcement plan, both for monitoring compliance and for prosecuting violators.

This mechanism should build on existing enforcement capabilities by including, according to the WHO FCTC Article 8 guidelines: duties of compliance, enforcement strategies, monitoring of compliance, evaluation of impact, a regular mechanism for interagency communication on enforcement, and the systematic provision of information to the public.

III.3.4. Systematic efforts should be taken to mobilize the support of local civil society and the community in order to increase compliance with the law and eventually to reduce smoking prevalence.

The effectiveness of a programme of monitoring and enforcement is enhanced by involving the community in the programme. Engaging the support of the community and encouraging members of the community to monitor compliance and report violations greatly extends the reach of enforcement agencies and reduces the resources needed to achieve compliance. Through their memberships and volunteers, local civil society organizations can be a good source of intelligence for the government regarding violations of the law. Public support and local communities can also be transformed into social monitoring of compliance. Encouraging citizens to make formal complaints will broaden the range of enforcement of the local health surveillance agencies without a drastic increase in resources. Also, civil society organizations such as academic institutions can help carry out monitoring studies to evaluate the success and impact of the law.

III.3.5. Initiate a mass media campaign to educate adults on how to protect children from second-hand tobacco smoke at home.

Parents and relatives of children should be informed of the importance of the health problem caused to children by second-hand tobacco smoke. They should be advised never to smoke inside private spaces such as homes even when children are not present. Also they should be advised not to smoke in cars – or even outside – whenever children are present. In addition, Norway should consider legislation, within the limits of social acceptability, to protect children in indoor private spaces.

IV OFFER HELP TO QUIT TOBACCO USE

IV.1 POLICY STATUS AND DEVELOPMENT

Plans and priorities

The National Strategy for Tobacco Control 2006–2010 includes the following goals for smoking cessation:

- proportion of daily smokers reduced to less than 20% of the population by 2010 (from 25% 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 in prevention and lifestyle change;
- tobacco-related diseases and cessation methods are included in relevant training for teachers and social and health workers.

Health system organization and services

The Norwegian health-care system, including the education of health professionals, is mainly focused on diagnosis and treatment. Smoking cessation is currently not a mandatory service in any part of the health system.

There is a free nationwide quitline which was established in 1996 and run by the DoH. Some 10 000 persons call the quitline annually, half of whom are given smoking cessation counselling.

There is a web-based smoking cessation programme (www.slutta.no). About 10 000 people have enrolled in the programme since 2006.

Reimbursement

General practitioners are refunded when “initiating individual structured smoking cessation as part of treating an illness, following an approved programme” (“takst 102”). The refund is NOK 150 and can be used twice annually for each patient. The refund is given approximately 50 000 times each year, which is modest compared to the number of daily smokers in Norway (800 000). The hospital reimbursement system covers patient training in groups. However, the conditions specifically state that smoking cessation groups are not reimbursed.

Medication

None of the medications that enhance smoking cessation are reimbursed by the social security scheme. Three different medicines are registered on the Norwegian market: nicotine replacement therapy, varenicline (Champix) and bupropion (Zyban). All nicotine replacement products excluding nasal sprays are available over the counter (since 2003). Bupropion (Zyban) and varenicline (Champix) are available on a doctor´s prescription.

Guidelines

The DoH published a national smoking cessation guideline for general practitioners in 2004.

IV.2 KEY FINDINGS

IV.2.1. Although smoking cessation has been described as high priority in national policy documents, adequate planning and funding for putting policy into practice were not identified

There are no action plans on smoking cessation at national, regional or local levels aimed at achieving the smoking cessation goals of the National Tobacco Control Strategy for 2006–2010.

IV.2.2. The smoking cessation services[7] are limited, sporadic and not easily available to all smokers, with a lack of coordination nationally, regionally and locally

There are some smoking cessation services provided by two NGOs (the Cancer Society and the National Health Association), but they are limited to local capacities, are insufficiently evidence-based, and are dependent on personal initiatives. There is limited monitoring and reporting on the extent to which professionals in primary care, hospitals, midwifery and health care for children and young people ask and assess smoking habits and give brief interventions or offer smoking cessation counselling.

The quitline is underused. Quality assessment of the quitline is not systematized. The possibility of referring to the quitline is not well known. Posters and cards about the quitline are distributed both to the public and to professionals, but on an ad hoc basis. The quitline also lacks a branded identity, a tagline and an easy-to-remember number. The Internet-based program www.slutta.no is also underused and not actively marketed.

There is no clear-cut curriculum or standard for the training of counsellors in smoking cessation. Existing training initiatives appear not to be evidence-based. The basic training of health care professionals does not include smoking cessation methods, although it includes information about the risks of smoking. It appears that general practitioners consider that since brief advice for cessation is not reimbursed and it would increase the consultation time, it cannot normally be included in daily practice. General practitioners also admit that because they are not trained for smoking cessation they would prefer to refer the patient to a counselling service. There is no clear understanding among professionals about the difference between a brief intervention and smoking cessation counseling and they cannot identify what intervention they provide.

Information and self-help evidence-based materials – including information for special groups such as ethnic minorities – are not easily available or widespread. There are some materials for pregnant women and families but it is unclear if these are widely used.

IV.2.3. Except for reimbursement for general practitioners "as part of treating an illness, following an approved programme", there are no other reimbursements for treatment of tobacco dependence

The system does not encourage cessation services for all smokers as it reimburses smoking cessation only for patients with a smoking-related disease. Smoking cessation for patients *without* a smoking-related disease is *not* reimbursed. It is explicitly stated in the legislation that subsidizing medication for smoking cessation is *not* allowed. This is based on the Health Insurance Law (Folketrygdloven) and a medicine regulation (Legemiddelforskriften) which prevents the Medicines Agency from assessing applications from the pharmaceutical industry to allow subsidy.

IV.2.4. There are no recent guidelines for policy work with smoking cessation, brief interventions[8] and treatment for tobacco dependence based on scientific evidence and best practice in line with the recommendations of WHO FCTC Article 14

[7] *Smoking cessation service*: This is individual, group or telephone support provided by a counsellor trained in smoking cessation counselling. The programme can be 5–12 sessions and use methods to support smokers to change their behaviour such as cognitive behavioural therapy and motivational interviewing. Medication for smoking cessation is also recommended.

[8] *Brief advice/intervention:* Health care professional will ask about smoking status and recommend cessation and medication (less than 5 minutes).

The guidelines of 2004 for general practitioners were not accompanied by an action plan and have not been implemented. New guidelines for general practitioners are in preparation but no guidelines for other professionals are planned.

IV.2.5. Materials on smoking cessation that need to be made available to the public and health-care professionals are not updated, not systematically distributed and do not accompany the launch of the quitline, web site and awareness-raising campaigns

The quitline telephone number and the web site address are not routinely included in the communication with the public and health-care professionals.

IV.2.6. Alliances between stakeholders (health care professional groups, the Ministry of Health and Care Services, different departments within the Directorate of Health etc.) for raising the smoking cessation agenda as a priority are not functional, and do not aim at supporting and advocating for the implementation of the national smoking cessation plan

IV.3 RECOMMENDATIONS

IV.3.1. Smoking cessation should become a true priority in the new National Strategy for Tobacco Control 2011–2015, with dedicated funds and adequate planning.

The strategy should have a particular focus on developing a strong national, regional and local infrastructure for the delivery of brief interventions at every health care interaction, with recommendation of the quitline.

The strategy should include the development of an overarching national smoking cessation plan with regional and local action plans. Formal consultation with health care professional organizations and their endorsement will be crucial for the successful delivery of this programme. An accountability structure will be important for all aspects of the delivery of the programme. This should be led by the MoH in collaboration with regional and local structures.

IV.3.2. Smoking cessation should be included as an obligatory service into the new laws on Community Health Care and Public Health ("Helse- og omsorgsloven" and "Folkehelseloven").

It is recommended that a system be commissioned by the MoH and developed by the DoH for the delivery, monitoring and evaluation of the smoking cessation programme. This should indicate who will commission it at the regional and local levels and who will deliver which aspects of the programme across Norway, as well as how the contractual agreements will be set up.

The smoking cessation services should be evidence-based, appropriate and financially suitable. Rolling out the accredited smoking cessation programmes in parallel with implementing appropriate accountability, monitoring, evaluation and contractual agreements with providers will contribute to the overall capacity development for smoking cessation in the country.

Appropriate training and accreditation programmes for smoking cessation counsellors should be developed and standardized by the DoH. At the same time, higher educational institutions could integrate smoking cessation and the risks of tobacco into the curriculum for all health care professionals.

IV.3.3. Reimbursement for medication should be investigated by the Ministry of Health and Care Services.

The MoH and DoH should specifically investigate the possibility of changing current blocks in the reimbursement system for general practitioners (reimbursement options for recording tobacco use, giving brief interventions, and smoking cessation).

There is a need for the interpretation of the Law ("Folketrygdloven") and a change of the regulation ("Legemiddelforskriften"). It is recommended to emphasize that nicotine addiction is classified as a disease in the international classification of diseases (ICD-10). Lessons learned from the establishment of the drug addiction

medication systems can be used. There may be a need to investigate whether to allow nicotine replacement therapy (NRT) to be supplied through the reimbursement system by non-medical health care professionals providing cessation services.

IV.3.4. The Ministry of Health and Directorate of Health should lead the preparation of and endorse national consensus guidelines for the treatment of tobacco dependence.

Despite the existence of the guidelines of 2004, the MoH should prepare and endorse national consensus guidelines that promote the role of brief advice in primary health care services. Integrating tobacco cessation into primary health care and other routine medical visits will provide the health-care system with opportunities to remind users that tobacco harms their health and the health of others around them. Repeated advice at every medical visit reinforces the need to stop using tobacco, and advice from health-care practitioners can greatly increase abstinence rates. This intervention is relatively inexpensive because it is part of an existing service that most people use at least occasionally. It can be particularly effective because it is provided by a well-respected health professional with whom tobacco users may have a good relationship.

A suite of guidelines is needed for the systematic implementation of cessation services for different health-care settings (e.g. hospitals, including pre-operative, inpatient and specialty care, pregnancy services, general practice, mental health services, community health care, dentistry and pharmacy). These can include step-by-step guides for implementation of systems in health-care settings and for resources such as referral systems and patient pathways, as well as leaflets and posters. Materials are needed that are targeted at different groups (e.g. ethnic minorities, smokers with high smoking prevalence, pregnant women, patients undergoing an operation, and patients with chronic diseases).

IV.3.5. While implementation of the following recommendations is prepared, a number of immediate steps (short-term actions) should be taken, as follows:

IV.3.5.1 Maximize the current cessation potential of the quitline and web site in conjunction with the release of pictorial warnings and a mass media campaign.

The quitline and web site provision will need to be assessed and updated by the directorate to ensure the delivery of a high quality, evidence-based service which recommends smoking cessation medication. An adequate response will be needed to the possible increase in demand upon the introduction of the new health warnings on cigarette packages that will advertise the quitline number and web site.

Brief advice, quitline and web site should be promoted through health-care professionals and municipal/county health care leaders (e.g. by a relaunch of the quitline and web site).

The DoH should assign responsibility for quality assurance of the smoking cessation services, including the quitline, the web-based programme, the training of counsellors and the delivery of smoking cessation services.

IV.3.5.2. Update information materials on smoking cessation that are available to the public and health-care professionals to ensure that they are evidence-based and applicable to current services.

These materials should be systematically distributed with the launch of the quitline and web site and awareness-raising campaigns. All other forms of advertising and communication with the public and health-care professionals must routinely include the quitline telephone number and the web site address with a short description of services offered. It is also recommended that the quitline should have a branded identity, a tagline and an easy-to-remember number.

IV.3.5.3. Build alliances between health care professional groups, the Ministry of Health and Care Services and different departments within the Directorate of Health to raise the smoking cessation agenda as a priority area.

It will be crucial to engage all stakeholders in supporting and advocating for the implementation of the national smoking cessation plan. The MoH should assess the collaboration with NGOs for cessation work. This existing resource should be reviewed in order to use its potential in line with further national guidance. The NGO cessation services should be evidence-based and accredited, and should have quality assurance checks.

MPOWER

WARN PEOPLE ABOUT THE DANGERS OF TOBACCO

FCTC ARTICLE 11

V WARN PEOPLE ABOUT THE DANGERS OF TOBACCO

V.1 PACKAGING AND LABELLING

V.1.1 POLICY STATUS AND DEVELOPMENT

Norway has had mandated health warnings on tobacco product packaging since 1975. The warnings have been amended several times and since 1995 have been in line with the health warnings mandated by the European Union. Though not part of the European Union, Norway is bound by the Community legislation due to the European Economic Area Agreement. Directive 2001/37/EC concerning the manufacture, sale and presentation of tobacco products has therefore been implemented in national legislation.

Norway has introduced legislation concerning pictorial warnings for smoking tobacco products in line with the European Union directive. This legislation will come into effect on 1 July 2011. The DoH is responsible for the enforcement.

All packages, with the exception of smokeless tobacco packages, shall have two alternative text health warnings covering 30% of the principal large side of the pack: "Smoking kills" or "Smoking seriously harms you and others around you". In addition, a set of 14 combined warnings are used in rotation to cover 40% of the back of the pack. The pictorial warnings are based on the European Commission list. All packages must contain a reference to the quitline number.

V.1.2 KEY FINDINGS

V.1.2.1. Pictorial warnings for cigarettes were pretested but no provisions have been made to apply them to non-combustible products

An evaluation was conducted when the size of text warnings was increased in 2004. It has proved difficult to identify a direct effect of health warnings on behaviour. The study therefore largely refers to the potential effects, and the extent to which the health warnings can be expected to make behaviour modification more likely.[9]

The standardized European Commission pictorial warnings provide an opportunity to choose between several sets of warnings. The choice was based on Internet surveys which gathered information on what emotions the various

[9] http://www.sirus.no/internett/tobakk/publication/205.html

warnings elicited among the Norwegian public. In addition, SIRUS conducted a literature review in order to give advice to the health authorities on what warnings to choose.

V.1.2.2. SIRUS is currently also undertaking research on plain packaging to determine its potential efficacy and impact in Norway

V.1.2.3. There is currently no systematic inspection or monitoring of enforcement

V.1.3 RECOMMENDATIONS

V.1.3.1.The health warnings and their enforcement should be in line with WHO FCTC guidelines.
The size and shape of the health warnings should be consistent with the WHO FCTC Article 11 guidelines, even if the European Community Directive may state otherwise. The new legislation on **pictorial** health warnings should apply to all tobacco products (including smokeless tobacco). The MoH should consider systematic inspections or monitoring of enforcement of pack warnings. The MoH should also consider an evaluation plan for the impact of health warnings and the rotation of messages, even with limited possibilities to change the pictorial warnings, in order, for instance, to compensate for a potential wearing-off effect.

V.1.3.2. Plain packaging should be considered.
Norway should closely follow the development and consider the possibilities of introducing plain packaging.

V.1.3.3. Systematic inspection and monitoring of enforcement should be considered.
Inspectors or enforcement agents should be used for conducting regular spot-checks of tobacco products at importing facilities, as well as at points of sale, to ensure that packaging and labelling comply with the law. Stakeholders should be informed that tobacco products will undergo regular spot-checks at points of sale.

V.2 PUBLIC AWARENESS AND MASS MEDIA CAMPAIGNS

V.2.1 POLICY STATUS AND DEVELOPMENT

Norway's National Strategy for Tobacco Control 2006–2010 states that 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. There is considerable weight of international evidence on the effectiveness of graphic, hard-hitting campaigns in increasing quit rates.

The mass media campaigns are the responsibility of the DoH. The DoH is annually given a budget for tobacco control by the MoH, including for possible mass media campaigns.

Norway has had a comprehensive tobacco control programme since the early 1970s. Some campaigns were carried out during the first decade but the 1980s were quiet, with few campaigns and few resources for tobacco control. In the mid-1990s, however, political interest in tobacco control increased and more resources were made available. In 2002 the Norwegian Minister of Health declared an ambitious goal of reducing youth smoking by 50% within the next five years (from 28% in 2002 to 14% by 2007). The DoH commissioned a scientific review of literature that identified mass media campaigns as one of several effective recommended strategies.[10]

Therefore, since 2003, repeated and intensive mass media campaigns aimed at changing attitudes and behaviour have been an element of the DoH's overall strategy on tobacco control, together with other measures in a comprehensive tobacco control programme (Table 1).

[10] Lund, KE and Rise J (2002) *En gjennomgang av forskningslitteraturen om tiltak for å redusere røyking blant ungdom*.

Table 1. Overview of the mass media campaigns 2003–2007

Year	Intention of the campaign	Budget
2003 (two campaigns)	The aim of the campaign "Every cigarette is doing you damage" was to educate the population on the health risks of smoking. In the second campaign, the focus shifted from the individual smoker to the tobacco industry's deceitful actions, casting the tobacco industry as manipulative and deceptive.	NOK 15 million plus staff costs NOK 9 million plus staff costs (total: NOK 24 million)
2004	Promoted and celebrated the introduction of smoke-free bars and restaurants, with the main message that everyone has the right to a smoke-free workplace.	NOK 12 million plus staff costs
2006	Utilized testimonials of people with chronic obstructive pulmonary disease (COPD) to show the effects of smoking on individuals and the difficulties they face.	NOK 20 million plus staff costs
2007	Existing advertisements from 2003 were reused.	NOK 7 million plus staff costs

From 2002 to 2007, daily smoking prevalence among adolescents aged 16–24 years dropped dramatically from 28% to 16%. From 2007 to 2009 there was no further decline.

V.2.2 KEY FINDINGS

V.2.2.1. There is no current prioritization of mass media campaigns as part of the tobacco control strategy

Despite the overwhelming evidence of the effectiveness of mass media campaigns in global tobacco control, and past experience in Norway of implementing media campaigns with high recall and impact, there are no resources currently dedicated to efforts in this area.

The MoH has not allocated – and the DoH has not expended – adequate funding on mass media campaigns for the past three years. In 2003–2006, stable funding enabled short-term and long-term planning for mass media. Without allocated resources, it is difficult to plan a long-term mass media campaign strategy.

V.2.2.2. There is no communications plan/strategy for the future

There is no communications plan or strategy to sustain information campaigns about the harms of tobacco use or passive smoking.

With the dissolution of the DoH Department of Tobacco Control, the leadership of tobacco control seems less clear at the DoH with respect to communications. This absence of direction was demonstrated by there being no consideration of, or any work on, a strategy or plan for the next mass media campaign or future campaigns.

Mass media campaigns tend to be viewed as necessary chiefly to create debate in the press rather than as social marketing behavioural change interventions that in and of themselves prompt conversation among family and friends as well as quitting. However, research has shown that mass media campaigns can also be effective as a single intervention. Thus, rather than delivering campaigns to specific groups, advertising campaigns that perform well tend to do so among many population subgroups. In other words, a good advertisement works with many. In addition, while earned media attention is always added value to a paid media campaign, and is especially helpful for campaigns that are aimed at policy change, the idea that social marketing campaigns require public debate to be successful is not supported by evidence.

V.2.2.3. There is no communications plan or strategy for advocacy to strengthen legislation or increase funding for tobacco control

While it was widely recognized that funding for tobacco control is a concern, there seemed to be little consideration or planning for how funding might be restored. This planning should include which influential leaders to advocate with and/or how to create alliances that can help put tobacco back onto Norway's main public health agenda.

Several important issues were raised as requiring legislative or regulatory changes yet there did not seem to be a communications strategy or coordinated communication efforts to achieve these changes. Instead, ad hoc earned media stories were pursued on issues such as the importance of tax increases, the need to close loopholes in the smoke-free legislation, and the desire to increase the age limit of those who can buy cigarettes.

V.2.2.4. Dedicated expertise and capacity in social marketing and communications for tobacco control within the Directorate of Health is unclear and insufficient

With a centralized public health office and no distinct programmatic identity for tobacco control since the Department of Tobacco Control was dissolved, it is unclear what the capacity is for leadership specific to strategic communications or social marketing in tobacco control. While there is some in-house expertise, dedicated leadership to tobacco control social marketing through mass media campaigns is needed.

Proactive media communication on tobacco control seems to be episodic although in general there is good media responsiveness by the DoH.

V.2.2.5. Some influential physicians believe Norwegians do not need additional information on the harms caused by smoking

Although there is strong evidence of the effectiveness of continuously running hard-hitting mass media campaigns to warn and remind people of the harms of smoking, several informants said that "Norwegians already know smoking is bad for you" and they were not supportive of additional campaigns in this area.

This perspective is not supported by best practice as prevalence declines have been shown to be possible with frequent messaging over many years. Hard-hitting mass media campaigns over several months a year, and over more than two decades, have enabled significant declines in prevalence in countries such as Australia and New Zealand. Despite their already lower smoking rates, both these countries continue to prioritize the importance of running mass media campaigns because they have been shown to work.

Despite the evidence, some physicians have also expressed concern that graphic mass media campaigns "might be going too far" in shocking people. Some have said, though without citing any evidence, that this shock was particularly hard on persons of low socioeconomic status, despite the fact that it is in this group that prevalence is highest.

It is of concern that a graphic campaign that was planned for 2009 was withdrawn when the Norwegian Medical Association would not endorse it because it was considered too hard-hitting (though without any proof of this).

Health inequality concerns are also being used to argue against running more mass media campaigns. Some have asserted that mass media campaigns mainly increase the knowledge of high and low socioeconomic groups equally and therefore do not narrow the health gap. This rationale for not supporting mass media campaigns is simply not supported by any international evidence.

V.2.2.6. The quitline marketing strategy includes intermittent advertising and media activities

The quitline is marketed at New Year, on World No-Tobacco Day, and through some ad hoc efforts such as radio and newspaper advertisements and earned media activity.

Posters and cards are distributed to, among others, doctors' offices and hospitals, and community health care, but there is no systematic process yet for determining whether they are being made available. A pilot project is underway to get dentists to recommend the quitline and cessation to patients.

A gap in the running of mass media campaigns has meant fewer marketing opportunities for the quitline.

V.2.3 RECOMMENDATIONS

V.2.3.1. The Ministry of Health and Care Services and the Directorate of Health should prioritize mass media campaigns as a proven strategy for prompting people to quit and for supporting tobacco control policies.
A communications strategy and plan should be developed with an adequate budget. The effectiveness of mass media campaigns will depend on their scale and duration. Expenditures have to be high enough to reach smokers sufficiently often and for long enough. The largest impact from mass media in Norway occurred in the period when there were two campaigns with a budget of NOK 24 million.

The scientific review commissioned by the DoH (Lund and Rise, 2002) recommended as best practice a total of NOK 30 per person per year for tobacco control education. This would total NOK 150 million per year. While this budget may not be possible, to be minimally effective it is recommended that a minimum budget of no less than NOK 50 million should be allocated for two to three intensive media campaign bursts per year.

A multiyear plan is optimal in order to be able to plan strategically for campaigns over the long term.

V.2.3.2. Mass media campaigns with strong graphic images are shown to be effective with mass audiences, including subgroups, and targeted campaigns for different socioeconomic groups are not required.
Creative media strategies and good media planning can reach smokers in both low and high socioeconomic groups.

Evidence-based campaigns – strategically planned, message-tested and evaluated – must continue to be used.

Campaigns and materials – including those marketing the quitline – must be uniformly branded to strengthen overall communication on tobacco control.

Intensive media planning with television as the central platform for graphic campaigns should be ensured and should be supported by other forms of traditional media. The potential of social media as an additional tool should be explored.

V.2.3.3. Continually air mass media campaigns with core messaging such as warnings against specific smoking harms, warnings of the health harms of second-hand tobacco smoke, and support for new pack warnings.

V.2.3.4. Use community level and primary care opportunities to target education at specific populations.
Exploit primary health care opportunities for in-office education (wall posters that are linked to mass media campaigns), referrals to quitlines, and materials that doctors, dentists and other health providers can to give patients.

Target information to physicians and other health-care providers who are not always adequately knowledgeable about tobacco and best practice methods for smoking cessation.

Target translated information to pregnant women in immigrant groups that do not speak Norwegian.

VI ENFORCE BANS ON ADVERTISING, PROMOTION AND SPONSORHIP

VI.1 POLICY STATUS AND DEVELOPMENT

The Tobacco Control Act[11] includes a ban on "all forms of advertising of tobacco products" and on the visible display of tobacco products at points of sale. The government may issue regulations concerning exceptions to the provisions of this section.[12] Due to the European Economic Area Agreement, Norway is bound by Directive 2003/33/EC[13] on advertising and sponsorship of tobacco products.

The DoH is responsible for enforcing the advertising ban and the display ban. No display of tobacco products is allowed at the retail points of sale. Philip Morris has challenged the law in the Norwegian courts. The suit is ongoing.

VI.2 KEY FINDINGS

VI.2.1. The existing ban is relatively comprehensive
It does however not fully cover cross-border advertising and the depiction of tobacco in entertainment media products.

VI.2.2. The government is currently preparing its legal strategy to defend itself against the Philip Morris challenge
Tobacco control NGOs have not reacted to this challenge or expressed support for the present legislation which bans the display of tobacco products.

VI.2.3. DoH enforces the ban based only on complaints
There is no proactive monitoring of compliance and no enforcement of the ban on advertising, promotion and sponsorship of tobacco products. Therefore there is no certainty that some forms of advertising, promotion and sponsorship of tobacco products are not being used in Norway.

VI.3 RECOMMENDATIONS

VI.3.1. The Ministry of Health and Care Services should take measures concerning the depiction of tobacco in entertainment media products. The measures should include

- a requirement of certification that “no benefits have been received for any tobacco depictions”;
- prohibition of the use of identifiable tobacco brands or imagery;
- requirement of anti-tobacco advertisements;
- implementation of a rating or classification system that takes tobacco depictions into account, in accordance with WHO FCTC Article 13 guidelines.

[11] Act No. 14 of 9 March 1973 relating to Prevention of the Harmful Effects of Tobacco.
[12] Regulations no. 989 of 15 December 1995 on the prohibition of advertising of tobacco products.
[13] Directive 2003/33/EC on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products.

VI.3.2. A mechanism should be established to monitor new forms of tobacco marketing, promotion and sponsorship.

Effective monitoring, enforcement and sanctions supported and facilitated by strong public education and community awareness programmes regarding all forms of new tobacco marketing will be critical to the implementation of the comprehensive ban on tobacco advertising, promotion and sponsorship.

FCT

ARTICLES 15 & 16

VII. ACCESS TO TOBACCO PRODUCTS

VII.1 POLICY STATUS AND DEVELOPMENT

According to the Tobacco Control Act[14] it is prohibited to sell or to hand over tobacco products to persons under 18 years of age. Tobacco products may be sold to consumers only by persons of 18 years of age or over, or if a person over the age of 18 supervises the selling by a person under 18 years on a daily basis.

In 1989 a regulation banning new nicotine and tobacco products was adopted. Products other than cigarettes, cigars, small cigars, pipe tobacco, roll-your-own, chewing tobacco, and *snus* are illegal on the Norwegian market. Flavoured tobacco products are not banned under this regulation.

VII.2 KEY FINDINGS

VII.2.1. Although by law the police are responsible for prosecuting violations of the age limit, it appears that enforcement efforts are non-existent

VII.2.2. The government formally acknowledges that, while tobacco products cause unparalleled harm to health, their sale is regulated only minimally

Existing evidence indicates that age limits alone have no impact on the consumption of tobacco by minors. Although little research has been conducted on effectively reducing access to tobacco products, particularly by minors, experts consider that any reduction in access to tobacco products must consider a ban on the display of tobacco products (which Norway has) and a system of restricting the retail sale of tobacco products. In recent years the government has discussed an increase in the age limit to 20 years, a ban on packages of cigarettes containing fewer than 20 sticks, and a licensing system for the retail sale of tobacco products.

VII.2.3. Enforcement strategies are limited with regard to *shisha* products

Shisha is not legally imported into the country and sellers claim that *shisha* is not a tobacco product.

VII.3 RECOMMENDATIONS

VII.3.1. The government should expedite consideration of a licensing system for the retail sale of all tobacco products.

- *Features and process:* The licensing system should consider: limiting hours and or days of sale; restricting the location, density and types of outlets; mandatory seller training and licensing; and seller liability, including loss of licence following breaches of licensing conditions. Before a decision is made to establish the licensing system, the following points need to be addressed:

[14] Act No. 14 of 9 March 1973 relating to Prevention of the Harmful Effects of Tobacco.

- study the applicability to tobacco products of the Norwegian model of alcohol licensing;
- develop legal instruments and anticipate and prepare for legal challenges from the tobacco industry and its allies based on national law as well as on international trade and other agreements;
- anticipate the opposition coming from existing retailers and prepare to debate the potential economic impact and effects on the unregistered market of tobacco products.

- *Principle*: This policy is based on a central concern to send an unambiguous public signal that the government regards tobacco as an exceptionally harmful product, deserving of restrictions on retail sale at least comparable to those that apply to prescribed pharmaceuticals in most countries and to alcohol products in Norway.
- *Potential impact on consumption*: Research on licensing measures is limited at this point but it is suggestive of a reduction in sales to adults and minors, as well as a reduction in consumption by minors.
- *Other impact*: In addition to preventing youth access and potentially reducing consumption, the licensing of purveyors of tobacco products is based on a far wider range of concerns including: protecting personal and public health, safety and welfare; controlling provision and limiting availability; monitoring sales; and ensuring quality and accountability.

VII.3.2. The government should expedite the banning of cigarette pack of less of 20 sticks.
The sale of cigarettes individually or in small packets increases the affordability of such products to minors.

VII.3.3. *Shisha* packages should be tested by competent authorities to demonstrate the false claim that they do not contain tobacco.

VII.3.4. The government should ban the permission of flavoured tobacco products on the market.

ANNEX I: LIST OF INSTITUTIONS AND KEY INFORMANTS

NATIONAL CAPACITY ASSESSMENT MEETING PARTICIPANT LIST			
	NAME	**INSTITUTION / ORGANIZATION**	**CITY**
1	Tore Sanner	Tobacco-Free Norway	Oslo
2	Randi Kiil	Norwegian National Health Association	Oslo
3	Ellen Juul Andersen	Norwegian Medical Association	Oslo
4	Erik Normann	Norwegian Directorate of Health, Dept. of Hospital Services	Oslo
5	Bjørn Erikson	Norwegian Confederation of Trade Unions (LO)	Oslo
6	Tore Haug	Norwegian Hospitality Association	Moelv
7	Siri C. Næsheim	Norwegian Directorate of Health, Dept. of Healthy Public Policy	Oslo
8	Bente Thori-Aamot	Ministry of Education	Oslo
9	Hild Stokke	Norwegian Directorate for Education and Training	Oslo
10	Kristin Byrkje	Norwegian Cancer Society	Oslo
11	Anne Sofie Hansen	The Norwegian Heart and Lung Patient Organization	Oslo
12	Britt Inger Skaanes	The Norwegian Asthma and Allergy Association	Oslo
13	Anne Elisabeth Eriksrud	The Norwegian Asthma and Allergy Association	Oslo
14	Ingrid Sandvei Francke	Ministry of Labour, Dept. Working Environment	Oslo
15	Frode Vatne	Labour Inspection Authority Oslo	Oslo
16	Hege Moløkken	Labour Inspection Authority Oslo	Oslo
17	Bjørn-Atle Hansen	Alta municipality	Alta
18	Kenneth Johansen	Alta municipality	Alta
19	Øystein Røssland	Alta lower secondary school	Alta
20	Henriette Øien	Norwegian Directorate of Health, Dept. of Primary Prevention	Oslo
21	Fredrik Hansen	Norwegian Directorate of Health, Dept. of Community Health Services	Oslo
22	Katty Beaven	Bærum hospital	Bærum
23	Else Karin Kogstad	Akershus University Hospital, Centre for Health promotion	Akershus
24	Sigrun Anmarkrud	The Norwegian Association of Midwives	Oslo
25	Trond Egil Hansen	General Practitioners' Association	Oslo
26	Kristin Svanquist	Norwegian Medicines Agency, Dept. of Reimbursement of medicines	Oslo
27	Erik Hviding	Norwegian Directorate of Health, Dept. of Pharmaceutical and Dental Reimbursement	Oslo
28	Per Thomas Thomassen	Ministry of Health and Care Services, Dept. of Public Health	Oslo
29	Jon-Olav Aspås	Ministry of Health and Care Services, Dept. of Public Health	Oslo
30	Maja Lisa Løchen	National Council on Tobacco Control	Tromsø
31	Tharald Hetland	County Medical Officer	Lillehammer
32	Knut-Inge Klepp	Norwegian Directorate of Health, Director of Division of Public	Oslo

		Health	
33	Bjørn-Inge Larsen	Norwegian Directorate of Health, Director General	Oslo
34	Christina Halvorsen	ANB (News Agency)	Oslo
35	Anne Hafstad	Aftenposten (Newspaper)	Oslo
36	Nils Petter Nordskar	Ideer Media AS, Managing director (former: Virtual Garden, Creative Director)	Oslo
37	Øystein Østraat	Ministry of Health, Dept. of Municipal Health Care Services	Oslo
38	Trude Bakke	Norwegian Association for general practice	Oslo
39	Torunn Janbu	Norwegian Medical Association	Oslo
40	Dagfinn Høybråten	Member of Parliament	Oslo
41	Bent Høie	Member of Parliament, Chair of Health Committee	Oslo
42	Steinar Krokstad	HUNT Research Centre, Norwegian University of Science and Technology	Verdal
43	Frode Olav Finsås	Ministry of Finance, Dept. of Tax Policy	Oslo
44	Jostein Rise	Norwegian Institute for Alcohol and Drug Research (SIRUS)	Oslo
45	Karl Erik Lund	Norwegian Institute for Alcohol and Drug Research (SIRUS)	Oslo
46	Roger Ingebrigtsen	Ministry of Health, State Secretary	Oslo
47	Marianne van der Vel	Norwegian Cancer Society	Oslo
48	Hans Geelmuyden	Geelmyuden.Kiese	Oslo
50	Vibeke Olufsen	Sør-Trøndelag University College, Nurse education	Trondheim
51	Kari Huseby	Oslo Police Department (Former: Norwegian Directorate of Health, Director of Dept. of Tobacco Control)	Oslo
52	Trond Markestad	Norwegian Medical Association, Head of Ethical Committee	Oslo
53	Sigrid Skattebo	Norwegian Directorate of Health, National Quitline	Oslo
54	Terje Hagen	Norwegian National Health Association	Oppland
55	Morten Rolstad	The Norwegian Dental Association	Oslo
56	Trine Oksholm	The Norwegian Nurses Organisation, Lung nurses	Oslo
57	Tore Reinholdt	The Norwegian Pharmacy Association	Oslo
58	Intesar Al-Ataby	Health forum for women (NGO working for immigrants)	Oslo
59	Petter Andreas Ringen	Oslo University Hospital Aker, Head of psychosis department	Oslo
60	Gase Handeland	Norwegian Directorate of Health, Dept. of Communications	Oslo

ANNEX II: LIST OF ASSESSMENT TEAM MEMBERS[15]

1. **Dr Vera da Costa e Silva,** Independent consultant on tobacco control, Rio de Janeiro, Brazil
2. **Barbro Holm Ivarsson,** Independent consultant on tobacco control, Stockholm, Sweden
3. **Dr. Svein Henriksen,** General Practitioner, Oslo, Norway
4. **Rita Lindbak,** Senior Adviser, Directorate of Health, Oslo, Norway
5. **Dr Kristina Mauer-Stender,** Technical Officer, Noncommunicable Diseases and Environment, World Health Organization Regional Office for Europe, Copenhagen, Denmark
6. **Sandra Mullin,** Senior Vice President for Communication, World Lung Foundation, New York, USA
7. **Dr Ghazaleh Pashmi,** Assistant Regional Tobacco Policy Manager, Regional Public Health Group London, UK
8. **Dr. Armando Peruga,** TFI Programme Manager, Tobacco Free Initiative, World Health Organization, Switzerland
9. **Dr. Luminita Sanda,** TFI Capacity Building Officer, TFI Programme Manager, Tobacco Free Initiative, World Health Organization, Switzerland
10. **Dr. Hege Wang,** Knowledge Centre for the Health Services, Oslo, Norway
11. **Dr. Karl-Olaf Wathne,** Special Adviser, Ministry of Health and Care Services, Oslo, Norway
12. **Agnethe H. Weisæth,** Adviser, Directorate of Health, Oslo, Norway
13. **Helena Wilson,** Senior Adviser, Ministry of Health and Care Services, Oslo, Norway

[15] in alphabetical order

ANNEX III: LIST OF ALL RECOMMENDATIONS, CHAPTER BY CHAPTER

II. COORDINATION AND IMPLEMENTATION OF TOBACCO CONTROL INTERVENTIONS

II.3.1. Norway is legally bound to implementation of the WHO FCTC provisions and should take more advantage of the treaty's guidelines and future protocols.
II.3.2. There is a need to set new targets for the reduction of the prevalence of tobacco use in the general population and among young people, and to make an increased effort to use gender-sensitive approaches to address specific high-prevalence groups.
II.3.3. Norway should provide more human and financial resources for tobacco control.
II.3.4. The Ministry of Health and Care Services should provide stronger national leadership for tobacco control.
II.3.5. Tobacco control activities should be strengthened at local level.
II.3.6. The government should look for ways to encourage more active participation of civil society in tobacco control.
II.3.7. Mechanisms for monitoring the enforcement of existing tobacco control legislation should be included in existing inspection systems.
II.3.8. The activities of the tobacco industry that influence the internal market should be monitored nationally and internationally.
II.3.9. A coherent tobacco control research policy should be established in line with overall tobacco control priorities.

III. PROTECT PEOPLE FROM TOBACCO SMOKE - SMOKE-FREE ENVIRONMENTS

III.3.1 Universal and equal protection should be ensured for all workers and the public from exposure to second-hand tobacco smoke, in line with the WHO FCTC Article 8 guidelines, through the elimination of designated smoking rooms (whether with separate ventilation systems or not) which are currently permitted by the law.
III.3.2. The Ministry of Health and Care Services, NGOs and other experienced partners, should develop and implement an evidence-based communication strategy for:

- protecting children from exposure to second-hand tobacco smoke in private places;
- raising awareness of the population of the need for amending the current law to protect all citizens from exposure to second-hand tobacco smoke;
- mobilizing public support and securing political support for the recommended amendment to the law.

III.3.3 Inspection protocols should be reviewed to ensure systematic and coordinated enforcement and monitoring of smoke-free provisions.
III.3.4. Systematic efforts should be taken to mobilize the support of local civil society and the community in order to increase compliance with the law and eventually to reduce smoking prevalence.
III.3.5 Initiate a mass media campaign to educate adults on how to protect children from second-hand tobacco smoke at home.

OFFER HELP TO QUIT TOBACCO USE

IV.3.1. Smoking cessation should become a true priority in the new National Strategy for Tobacco Control 2011–2015, with dedicated funds and adequate planning.
IV.3.2. Smoking cessation should be included as an obligatory service into the new laws on Community Health Care and Public Health ("Helse- og omsorgsloven" and "Folkhelseloven").
IV.3.3. Reimbursement for medication should be investigated by the Ministry of Health and Care Services.
IV.3.4. The Ministry of Health and Directorate of Health should lead the preparation of and endorse national consensus guidelines for the treatment of tobacco dependence.
IV.3.5. While implementation of the following recommendations is prepared, a number of immediate steps (short-term actions) should be taken, as follows:

IV.3.5.1 Maximize the current cessation potential of the quitline and web site in conjunction with the release of pictorial warnings and a mass media campaign.

IV.3.5.2. Update information materials on smoking cessation that are available to the public and health-care professionals to ensure that they are evidence-based and applicable to current services.

IV.3.5.3. Build alliances between health care professional groups, the Ministry of Health and Care Services and different departments within the Directorate of Health to raise the smoking cessation agenda as a priority area.

WARN PEOPLE ABOUT THE DANGERS OF TOBACCO

PACKAGING AND LABELLING

V.1.3.1.The health warnings and their enforcement should be in line with WHO FCTC guidelines.

V.1.3.2. Plain packaging should be considered.

V.1.3.3. Systematic inspection and monitoring of enforcement should be considered.

PUBLIC AWARENESS AND MASS-MEDIA CAMPAIGNS

V.2.3.1. The Ministry of Health and Care Services and the Directorate of Health should prioritize mass media campaigns as a proven strategy for prompting people to quit and for supporting tobacco control policies.

V.2.3.2. Mass media campaigns with strong graphic images are shown to be effective with mass audiences, including subgroups, and targeted campaigns for different socioeconomic groups are not required.

V.2.3.3. Continually air mass media campaigns with core messaging such as warnings against specific smoking harms, warnings of the health harms of second-hand tobacco smoke, and support for new pack warnings.

V.2.3.4. Use community level and primary care opportunities to target education at specific populations.

ENFORCE BANS ON ADVERTISING, PROMOTION AND SPONSORHIP

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VI.3.2. A mechanism should be established to monitor new forms of tobacco marketing, promotion and sponsorship.

ACCESS TO TOBACCO PRODUCTS

VII.3.1. The government should expedite consideration of a licensing system for the retail sale of all tobacco products.

VII.3.2. The government should expedite the banning of cigarette pack of less of 20 sticks.

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