

GREEN PAPER ON TOBACCO POLICY

Contents

Contents	2
1. Introduction	3
1.1 Legal Grounds	3
1.2 Description of the process for the development of the Green Paper on Alcohol and Tobacco Policy, incl. the parties involved	3
1.3 Description of situation	6
1.4 Goals of tobacco policy	7
1.5 Europe and global tobacco policy	8
2. Overview of the current situation	9
3. Measures to be implemented to reduce the prevalence of smoking and tobacco-related health loss	14
3.1 Measures to ensure smoke-free environment	14
3.2 Measures to reduce the attractiveness of tobacco products	18
3.3 Measures to regulate the marketing of products that offer alternatives to tobacco products	23
3.4 Measures to prevent tobacco consumption, communication work, treatment of tobacco addiction and counselling for giving up smoking	25
3.5 Measures to restrict illicit market and shape taxation policy	30
3.6 Reducing the availability of tobacco products to minors	32
3.7 Monitoring	33
4. Evaluation of impact	34
Annexes	36
Annex 1. Miscellaneous measures for reducing tobacco consumption, discussed at the work group	36
Annex 2. Pictorial warnings (combined warnings)	37
References to studies and documents	41

1. Introduction

1.1 Legal Grounds

The Green Paper relies on the action programme of the Government of the Republic for 2011–2015, section 8, “Efficient combat with infectious diseases that destroy the society, alcoholism, tobacco and drug addiction”, of chapter „Healthy Estonia”. National tobacco policy will be reviewed to reduce tobacco consumption and for imposing stricter penalties for making tobacco available to minors. Activities to be launched to reach this goal shall include the development of a concept for national alcohol and tobacco policy or the "Green Paper on Alcohol and Tobacco Policy". During the planning stage for the implementation of the resolution, it was decided to draw up two different Green Papers, as the legal space surrounding these two substances is different both at Estonian and international level.

1.2 Description of the process for the development of the Green Paper on Alcohol and Tobacco Policy, incl. the parties involved

One of the materials, used as the bases for the development of the concept document, was the evaluation, conducted by the Ministry of Social Affairs in 2010 at the request of the World Health Organisation (WHO) on valid practice and national capacities for reducing tobacco consumption. WHO offered expert assistance for the purposes of development of the concept document by consolidating the most recent international evidence, the best practices of other countries and their experiences, regarding the efficiency and applicability of control measures for tobacco consumption.

Work group, including the members listed below, was established with the order of the Minister of Social Affairs no. 137 of 14 November 2011 to draw up the tobacco policy concept document and devise the positions of Estonia regarding the Directive 2001/37/EC of the European Parliament and of the Council of 5 June 2001 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products:

Head of the work group:

Ivi Normet

Deputy Secretary General for Health Issues of the Ministry of Social Affairs

Members of the work group:

Margus Viigimaa

leader of epidemiology and prevention work group of the Estonian Association of Cardiologists

Marika Merilai

representative of the Estonian Traders Association

Kersti Veidrik

representative of the Estonian Family Doctors Association

Ülle Ani	representative of the Estonian Lung Doctors Association
Urmas Roos	representative of NGO Tubakavaba Eesti (Tobacco Free Estonia)
Karmen Koit	representative of NGO MTÜ Eesti Õpilasesinduste Liit (Estonian Association of Students' Boards)
Mailiis Kaljula	representative of Association of Municipalities of Estonia
Hille Ilves	advisor to the Association of Estonian Cities
Anne Laar	head of Trade Division of Internal Market Department of the Ministry of Economic Affairs and Communications
Heidi Vessel	executive officer of the Customs and Excise Duty Department of the Ministry of Finance
Kadi Ilves	chief expert of the Youth Department of the Ministry of Education and Research
Jenny Jakobson	advisor to Law Enforcement and Criminal Policy Department of the Ministry of the Interior
Pille Luiga	executive specialist of the Co-ordination Division of the Development Bureau of the Law Enforcement Police Department of the Police and Border Guard Board
Hille Reinhold	executive specialist of the Indirect Taxes and Excise Duties Division of the Tax Department of the Tax and Customs Board
Kristina Aidla	head specialist of the Risk Assessment Bureau of the National Health Board
Maris Jesse	Director of the National Institute for Health Development
Katrin Karolin	Head of the Public Health Department of the Ministry of Social Affairs
Aive Telling	chief specialist the Public Health Department of the Ministry of Social Affairs
Meeli Matsalu	head specialist the Public Health Department of the Ministry of Social Affairs
Kersti Berendsen-Koržets	legal advisor to the Legal Department of the Ministry of Social Affairs

The meeting was held in the form of a work group; information was exchanged by electronic means between the meetings. Majority of the measures, approved by the work group, are listed in the policy document. Measures that met with evidence-based and well-argued objections, were not included in the policy document and are listed in the annex to the document.

Apart the official meetings of the members of the work group, there were also meetings with the representatives of tobacco producers and the Estonian Chamber of Trade and Industry. The goal of these meetings was to discuss the immediate economic influence of the implementation of the measures, suggested in the Green Paper, on tobacco producers. Separate meetings were also held with the representatives of a wholesaler of tobacco products and producers of cigarillos concerning restrictions on sale of flavoured tobacco products and with the representative of OÜ Sigarimaja concerning restrictions on sale of hookah tobacco. There were separate meetings with the representatives of the Ministry of Justice to discuss the analysis of punishment practice and smoke-free prisons. Written address was made to the Ministry of

Justice, regarding trade mark right issues, which were raised as the consequence of banning advertising in points of sale and displaying tobacco products in points of sale. Riigi Kinnisvara AS was contacted to get their opinion regarding smoke-free state authorities and the Estonian Hospitals Association regarding smoke-free health care institutions.

1.3 Description of situation

In the middle of the 2000ies, visible progress was made in the development of tobacco control policy in Estonia, relying upon years of experience in developing services that support quitting smoking as an inseparable part of the national health care system. However, the progress made back then has not considerably reduced the prevalence of smoking, except among Estonians with higher education. In general, the prevalence of smoking increased from the beginning until the middle of the 1990ies. This trend changed at the end of the 1990ies and by 2012, the prevalence of smoking had dropped, compared to 1990, by 2 percent, while the prevalence of smoking decreased in Finland and England, respectively by 7% and 10% at the same time. We're most concerned about the fact that the prevalence of smoking among people with lower level of education has grown, compared to the middle of the 1990ies, resulting in bigger social and health-related disparities (1).

In the comparison with the other European Union member states, Estonian school students are among the youngest to try tobacco products (2; 3). Estonia also holds a high position with the number of 13 year old students who smoke at least once per week; we're among the top four with this figure in the European Union. Although the prevalence of smoking did drop, following an abrupt increase, in the late 1990ies (excluding girls), it still remains high. Therefore, tobacco-use related health problems in children and young women show an increase (2).

Among adults, there are 26.02% of regular everyday smokers, 23.98% of former smokers and 8.2% of occasional smokers (4). The percentage of everyday smokers in Estonia (26.0%) is relatively similar to the respective European Union average (25.8%) (1). However, the percentage of smoking-related mortality of the total mortality is somewhat higher than the respective average for the European Union Member States (respectively, 37.6 and 32.9%) (1). We also need to keep on mind that apart mortality, tobacco consumption also affects the incidence of various diseases, which have considerable effect on life quality.

Estonian homes have an inadmissibly smoky environment – tobacco is consumed in approximately every fourth home (4), which makes children vulnerable to tobacco smoke in their very homes. 16% of non-smoking Estonian population has to suffer tobacco smoke in their home environment whereas the respective European Union average is 14% and in Finland and Sweden, accordingly, 2% and 3% (5).

Direct expenses for the state, resulting from smoking, total to the minimum of 65.5 million euros (the analysis was conducted for year 2006). The same year, expenses resulting from smoking totalled to 0.5% of the GDP. This percentage includes direct expenses, which represent the value of treatment services, provided to treat and diagnose diseases related to smoking. The methodology, used for the purposes of the study, was rather conservative and did not include all the accompanying costs, as it did not cover expenses outside the health care sector (e.g. expenses on medicaments). Psycho-social expenditures, for example, pain and suffering, caused for the patient or his or her next of kin, were also not covered (6).

1.4 Goals of tobacco policy

Benchmarks for the achievement of the goals for 2015:

- expected growth of life expectancy in men up to 72.5 and in women up to 82.2 years;
- expected increase of number of years of healthy life (with not restrictions) at the moment of birth in men up to 57.1 and in women up to 62 years.

The following needs to be done to achieve the goals, established in the programme of the Government of the Republic:

- reduce tobacco-related health problems:
 - decrease smoking prevalence;
 - reduce the prevalence of everyday smokers;
 - decrease the population's contact with tobacco smoke;
- prevent the availability of tobacco products to minors.

The aim is to reduce the prevalence of everyday smokers, by 2025, from the level of 2012 or 30% to 18% and the general prevalence of smokers to 24% by 2025.

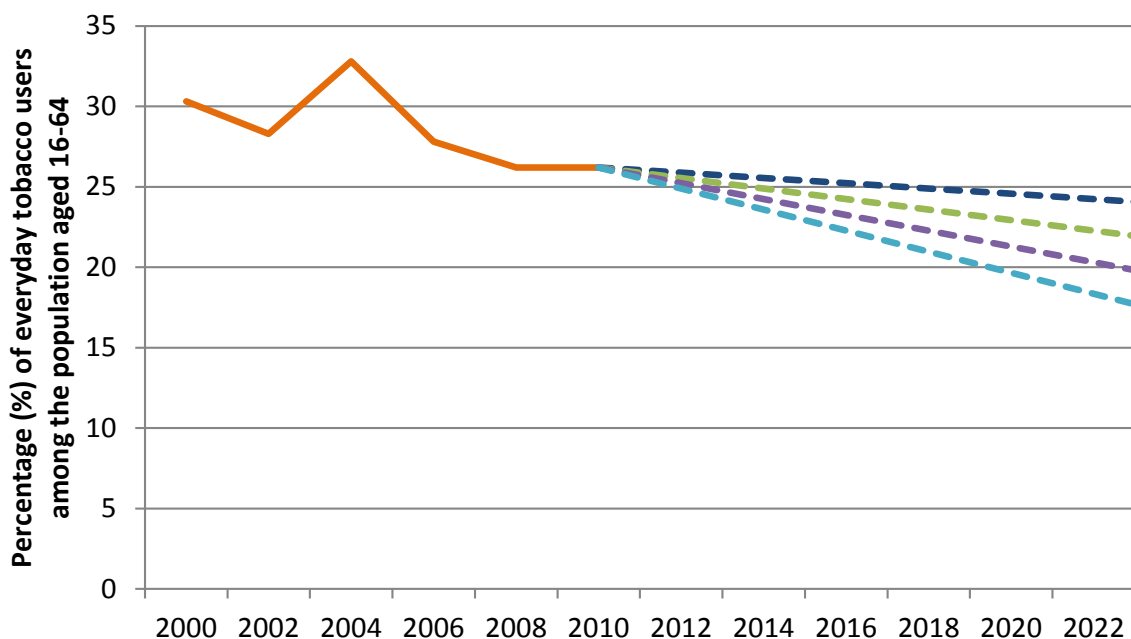


Figure 1. Estimated prevalence of everyday smokers

Relying on international experiences and scientific evidence and considering Estonian context, the work group has suggested the following groups of measures for the achievement of the goals, established in the Green Paper on Tobacco Policy:

- measures to guarantee smoke-free environment;
- measures to reduce the attractiveness of tobacco products;
- measures to regulate the marketing of alternatives to tobacco products;
- measures to prevent tobacco consumption, communication work, treatment of tobacco addiction and counselling for giving up tobacco use;
- measures to restrict the illicit market and shape taxation policy;
- imposing stricter penalties for making tobacco products available to minors;
- monitoring.

1.5 Europe and global tobacco policy

Globally, WHO Framework Convention on Tobacco Control, endorsed by the WHO in 2005, and the guidelines for its implementation are used as the basis for tobacco policy development. Estonia ratified the World Health Organisation (WHO) Framework Convention on Tobacco Control within five months after its entry into force in 2005. The very same year the Riigikogu adopted the Tobacco Act to comply with the requirements, laid down in the Convention and valid requirements of the European directives that discuss tobacco. In Europe, several acts have been adopted to provide the regulative framework for tobacco policies: Directive 2001/37/EC of the European Parliament and of the Council of 5 June 2001 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products, Directive 2003/33/EC of the European Parliament and of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products, Council Directive 2010/12/EU of 16 February 2010 amending Directives 92/79/EEC, 92/80/EEC and 95/59/EC on the structure and rates of excise duty applied on manufactured tobacco and Directive 2008/118/EC and Council Recommendation of 30 November 2009 on Smoke-free Environments (2009/C 296/02). On 19 December 2012, the European Commission made a proposal for the amendment of the Tobacco Products Directive 2001/37/EC, considering the developments that had taken place in research, market and at international level, suggesting that it would be relevant to revoke directive 2001/37/EC and have it replaced with a new directive.

2. Overview of the current situation

Tobacco consumption is one of the main reasons for death in the world that can be prevented (7). Approximately 6 million people per annum die as the consequence of tobacco consumption (8).

People who start smoking as teenagers and smoke for two decades or more will die 20 to 25 earlier than those who have never smoked.

The percentage of everyday smokers in Estonia (26.0%) is relatively similar to the respective European Union average (25.8%). However, the percentage of mortality caused by smoking of the total mortality is somewhat higher than the respective average for the European Union Member States (respectively, 37.6 and 32.9%). More specifically, tobacco-related mortality coefficient per 100,000 inhabitants is 1.5 times higher in Estonia (285.5) than the respective European Union average (194.7) (1).

Apart the fact that smokers die earlier, they also face a greater probability of conceiving several malignant forms of tumour. Tobacco consumption results in higher risk of lung, oesophagus, mouth, throat, kidney, bladder, pancreatic, stomach and cervical cancer. Smokers also face the greater probability of contracting psoriasis, osteoporosis, heart diseases, cataract, emphysema or Buerger's disease. Tobacco smoke facilitates the incurrence of ulcers, premature ageing of skin, hair loss and tooth decay and impairs sperm quality (9).

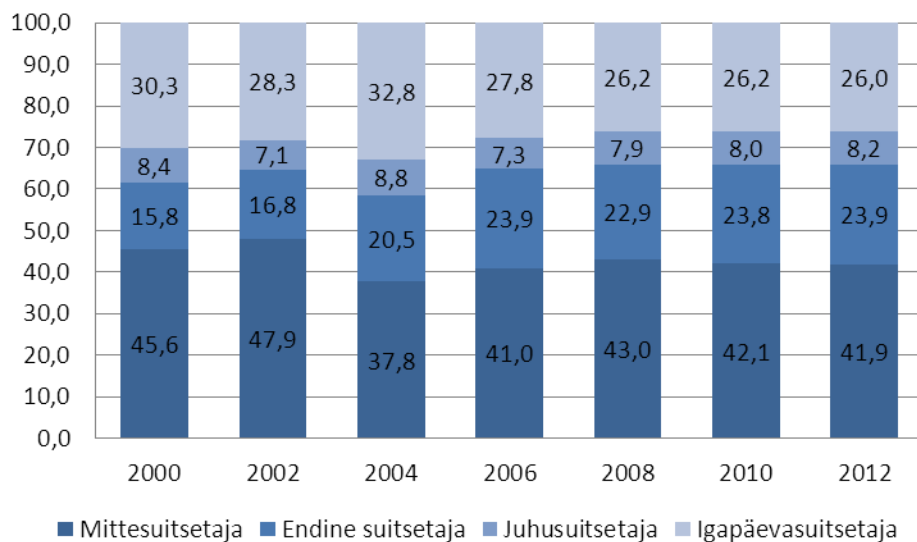
Approximately 8.3% of years of life lost and premature mortality among Estonian population is attributable to tobacco consumption; the main loss results from premature deaths, exceeding the loss of life quality by threefold. According to a study, conducted in 2004, the total smoking-related health loss of Estonian population was 28,235 years of life and this was mostly caused by lung cancer (32%), closely followed by heart ischemia and stroke (10).

Most adult smokers start smoking as youngsters; those who start smoking young face a greater probability of continuing smoking as adults because they are easy prey to nicotine addiction (11).

Apart from smoking-related harm, Estonia stands out, in comparison with other countries, by high smoking prevalence among school students, which is among the highest in the European Union. In Europe, Estonia holds the first place with the fact that school students, aged 11-15, first try smoking at the earliest age, in average, at 11.9 years (2). It is known that apart the aforementioned harm, smoking also has short-term negative influences – impaired lung function, reduced physical performance, increased risk of asthma and coughing (12).

Smoking prevalence grew between the beginning and the middle of the 1990ies. This trend changed at the end of the 1990ies and by 2010, smoking prevalence had dropped, by 2 percent, while smoking prevalence decreased in Finland and England, respectively by 7% and 10% at the same time (1).

Among adults, there are 26.02% of regular everyday smokers, 23.98% of former smokers and 8.2% of occasional smokers (figure 2) (4).



Non-smoker Former smoker Occasional smoker Everyday smoker

Figure 2. Distribution by frequency of smoking

Everyday smoking among men (age group of 16–64 years) shows a 14% decrease, compared to 1994 (1994: 50%, 2012: 36%). Among women, the decrease is less notable for the same period – 3% (1994: 21%, 2012: 18%). As we observe the comparative information for the recent years, we have to admit an increase from 17% in 2008 to 19% in 2010 whereas in 2012, the respective indicator dropped to 18%. In Estonia, the smoking prevalence among women is two times lower than among men (1; 4).

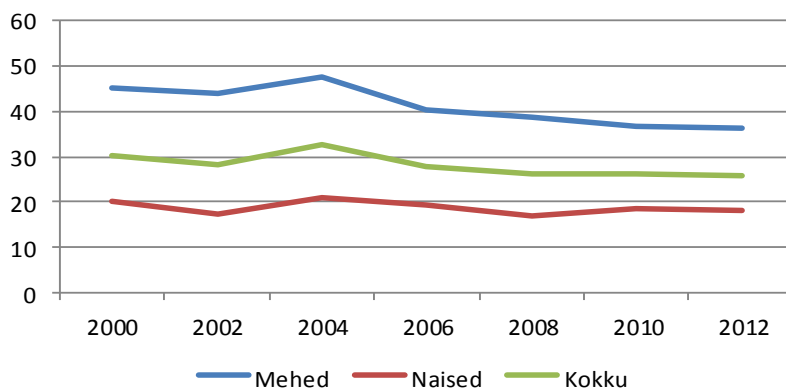
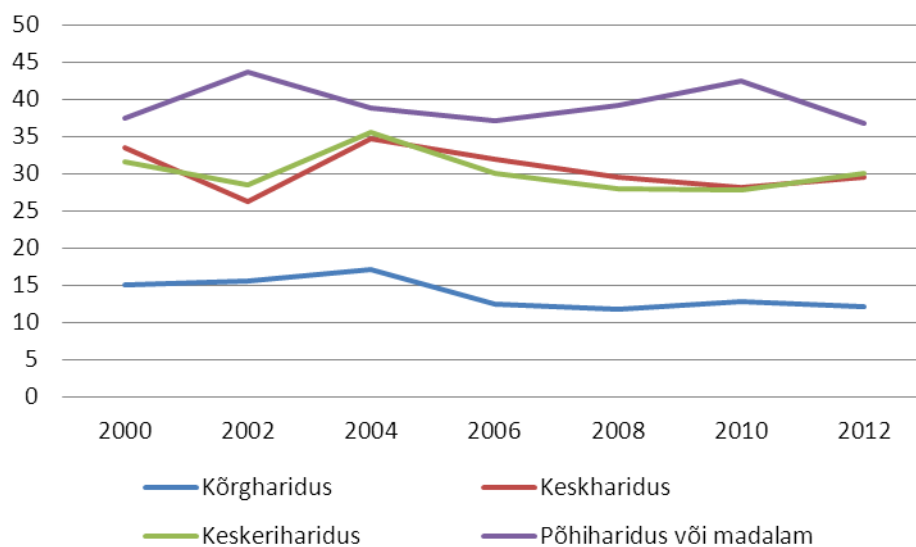


Figure 3. Distribution of everyday smokers by gender (aged 16–64)

Notable differences can be observed in the distribution of everyday smokers by level of education. While 12% of everyday smokers have higher education, the respective percentage among people with basic education is 37%. As we observe the gender aspect, the aforementioned trend is visible both among men and women. The fact that smoking prevalence among less education individuals has increased, compared to the middle of the 1990ies, and decreased among population with higher education, is a reason for concern, as the described situation will result in higher social and health-related disparity. While in 1994 the percentage of smokers among people with higher and basic education was largely the same, respectively 31% and 32%, by 2012, 12% of population with higher education and 37% of people with basic education were smokers. Nevertheless, in 2012 and 2010, a certain decrease in the everyday smoking prevalence was observed; while in 2010 the respective indicator was 42%, it had dropped to 37% by 2012 (4).



Higher education Secondary education Secondary specialised education Basic or lower education

Figure 4. Percentage of everyday smokers among the population by level of education (aged 16–64)

Among school students, aged 13-15 years, the smoking prevalence increased considerably in the late 1990ies and then started to drop again; however, there has been no decrease among girls in middle teens (13). According to a study of 2010, more than half of school students, aged 11–15, have tried smoking (50.4%, 56% of boys, 45% of girls). There are 13.5% of smokers among school students, aged 11-15 – 15.2% of boys and 11.8% of girls. 5.7% of school students, aged 11–15, are everyday smokers – 7.2% of boys and 4.8% of girls. The percentage of both those who have tried smoking and are smokers (incl. everyday smokers) has dropped, both among boys and girls. However, as we observe the age and gender of school students more closely, we will see that among girls the decrease has not been as rapid as among boys and in certain age groups the percentage of smoking among girls has even increased over the recent years (2).

As we compare Estonia to other European Union member states, we see that Estonia holds the first place with the percentage of 15-year-old school students who have tried tobacco by the age of 13 years or before (63% of 15 year old boys and 48% of girls). In other countries the respective indicators are lower both among girls and boys. However, a certain decrease is notable among boys (in 2005, 65%; and in 2010, 63%), but the respective percentage still demonstrates growth among girls (in 2005, 43%; and in 2010, 48%). In average, Estonia school students, aged 11–15 years, are 11.9 years old, in average, when they first smoke (2). On average, boys take up smoking earlier than girls, but the age difference in starting smoking is no longer as large as it used to be (boys at the age of 11.8 years and girls – at the age of 12.1 years). In recent years, general growth of smoking among school students has slowed down (with the exception of girls of certain age group), but a new major problem - the use of hookah – has emerged (14).

Hookah is also popular among school students. 41% of school students, aged 11-15 years, had tried hookah in 2010 (incl. 39% of girls, and 43% of boys). As we compare the information for 2010 with the data for 2005, we see that the prevalence of hookah use has increased (from 35% in 2006 to 41% in 2010) and both among boys and girls (the respective growth among girls 10% and among boys – 3%) (2).

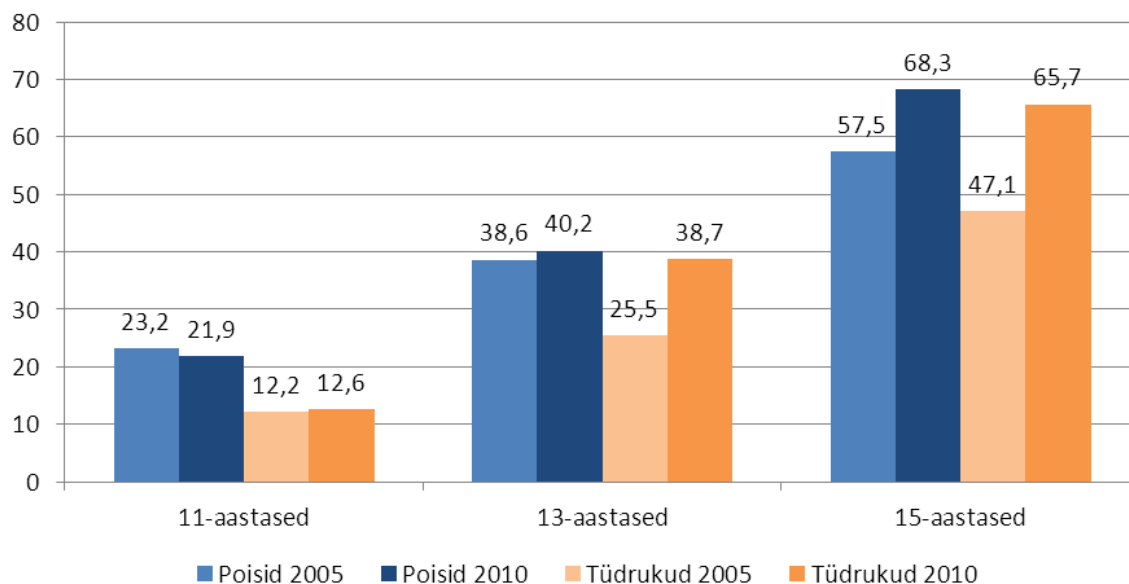


Figure 5. The percentage of young persons who have tried hookah by age and gender

Tobacco products remain readily available for school students. Compared to 2007, there have been no major changes in this respect in 2011. The percentage of school students, who described the availability of tobacco and alcohol products as easy, has somewhat dropped. 70% of school students found that buying cigarettes is quite easy and very easy. Despite the law and control over selling prohibited substances to minor the availability of cigarettes and beverages with low alcohol content had only dropped by 2011 by approximately 5%, whereas the availability of wine and strong alcohol had even increased slightly. More than a half of school students describe cigarettes and alcohol as quite easily available (3).

In Estonia, it would be essential to prevent or postpone the commencement of tobacco products' use and help users to quit. Price and availability of tobacco products have the strongest effect on tobacco consumption among school students. Although the sale of tobacco products to individuals younger than 18 years is prohibited, the law abidance has been insufficient. Social attitude and changes in attitude are also important. The Tobacco Act prohibits smoking on territories of schools and educational establishments.

Alternative products that contain both tobacco and nicotine are becoming increasingly popular and this calls for changes in our legal environment. The popularity of alternative products is largely due to restrictions imposed on regular smoking and the belief that the alternative products are not as harmful for health as conventional cigarettes. Hookah is widely used by young persons; moist snus and e-cigarettes are becoming increasingly popular. According to a public health survey, 8% and 7% of 16-24 years old boys and girls, respectively, use e-cigarettes a couple of times per year. 11% of young persons from age group 16-24 occasionally use moist snus and snuff (4).

Tobacco smokers pose a threat not only for themselves. The risk of getting some diseases, caused by smoking, is not limited to smokers only, but also to non-smokers, exposed to tobacco smoke. The risks are very high for people suffering from asthma, bronchitis and chronic vascular diseases, but also highly sensitive people, prone to allergic reaction. Exposure to tobacco smoke is especially harmful for children. In the European Union, exposure to tobacco smoke in working environment in work places and home atmosphere is, respectively, the cause for death of 79,000 and 7,000 adults. In long-term perspective, exposure to tobacco smoke can increase the risk of lung cancer in a non-smoking partner of a smoker, as much as 30% (3). Incidence of death, related to exposure to tobacco smoke, is 47% among women, 28% among children and 26% among men (15). In average, a non-smoker, staying within the same room with a person who smokes a package of cigarettes per day, a dose equivalent to 7–8 cigarettes. Although exposure to tobacco smoke in workplaces has dropped for men and women to 16% and 10%, respectively, exposure to tobacco smoke remains inadmissibly high in homes – there is a smoker approximately in every fourth home (4). Parents lack knowledge and desire to protect their children from exposure to tobacco smoke. Children are vulnerable to exposure to tobacco smoke in their homes, cars and other places where they stay. Parents should be advised on protecting their children against exposure to tobacco smoke, especially in cases where children suffer from respiratory infections, asthma or ear infections. In Estonia, exposure to tobacco smoke poses a biggest threat for women, above all, young women, and individuals with lower level of education. Since 1998, exposure to tobacco smoke has decreased among men (16).

3. Measures to be implemented to reduce the prevalence of smoking and tobacco-related health loss

3.1 Measures to ensure smoke-free environment

- **Establishing smoke-free protective zones with the minimum scope of 3 metres around the doors of public buildings to protect the population of the country.**
- **Local governments should have the authority to regulate smoking in public places/locations, e.g. public beaches, concert and party venues, open-air events.**
- **Smoke-free state and local government authorities.**
- **Abolishment of areas, dedicated for smoking, in buildings.**
- **Abolishment of special smoking premises from year 20...**
- **Increasing awareness of hazardous influence of tobacco smoke (campaigns, information dissemination materials) to reduce smoking in homes.**
- **The state will ensure training for apartment associations to ensure compliance with restrictions to smoking, laid down by house rules of apartment houses, and hearing and handling of related complaints.**

Tobacco smoke is a seriously detrimental factor for health. There is not level for tobacco smoke content in air that would be safe for health (17). This is the reason why WHO recommends 100% smoke-free environment to people (18).

Although exposure to tobacco smoke (less than one hour per day) in workplaces has dropped for men and women to 16% and 10%, respectively, exposure to tobacco smoke remains inadmissibly high in homes – there is a smoker approximately in every fourth home (4). Parents lack knowledge and desire to protect their children from exposure to tobacco smoke. Children are vulnerable to exposure to tobacco smoke in their homes, cars and other places where they stay. Parents should be advised on protecting their children against exposure to tobacco smoke, especially in cases where children suffer from respiratory infections, asthma or ear infections. The awareness of parents of detrimental effect of tobacco smoke needs to be increased.

Legislation, which is suitably applied – provided that control is exercised over the application of the law – represent a good tool for protecting people from health risks, resulting from exposure to tobacco smoke. Legislation that regulates smoke-free environment will be most efficient when supported by measures like awareness increasing campaigns, support to quitting smoking, health hazard warning on packages of tobacco products and other tools to regulate the use of tobacco products (19). The Tobacco Act, adopted in Estonia in 2005, laid down restrictions and

bans on smoking in public places and the act serves as a good example to demonstrate how norms and standards will shape the attitude of people.

Ventilation systems, separate smoking rooms and partial restrictions are insufficient to protect people from exposure to tobacco smoke (17; 20; 21). Studies have shown that even smoking rooms with exhaust ventilation are not good enough to prevent tobacco smoke from spreading to other rooms (22). It's practically impossible to ensure no air movement between smoking room and adjacent rooms. Studies reveal that even as much as 10% of the air from the smoking room will spread to adjacent rooms (23). A study, carried out in the USA, showed that smoky air, spreading from smoking rooms in airports, which contains small particles, is a threat for people surrounding smoking rooms; there is also a risk for the staff that will be required, occasionally, to enter the smoking room (24). The existing air treatment systems will remove majority of the larger smoke particles, but remain insufficient to remove various gases and finer particles from air. Air conditioning and ventilation systems may even distribute air, filled with tobacco smoke, all over the building (22). Complete abolishment of indoor smoking rooms has been suggested as a measure to ensure high level protection of human health. This is a measure to be considered for implementation in long-term perspective. As an alternative, stricter requirements to ventilation in such rooms have been suggested. In Finland and Sweden, smoking rooms in buildings have not been abolished, but due to technical requirements the establishment of such rooms would be very expensive and people just won't have these rooms any more.

Abolishment of smoking areas in indoor premises has been suggested as the primary and immediately implemented measure. According to the national Health Board, approximately 40 smoking areas remain in various institutions. The following insufficiencies were registered as the outcome of supervision over smoking areas and rooms:

- rooms are not marked with verbal information or symbol to indicate that smoking is allowed;
- rooms are not fitted with information in Estonian language, in reasonable size, in a visible place inside the room: „Suitsetamine kahjustab tervist!“ (*Smoking is detrimental to your health*);
- the rooms don't have negative air pressure;
- exhaust from these rooms is not at least 8.4 litres per second per square metre;
- air exhaust ventilation system is not independent and constant or is not connected to other, constantly operating air exhaust systems by means of a separate duct.

In 2010, the Health Board carried out a study „Compliance with the Tobacco Act at Cultural Establishments, Sports Establishments and Detention Establishments (prisons, houses of detention)“. 16 detention establishments were investigated during the study. There were smoking rooms in 6 establishments, smoking area in 3 establishments and both smoking room and area in one establishment. Eight establishments lacked both smoking room and area. 113 cultural establishments were investigated during the study. There were smoking rooms in 22 establishments, smoking area in 3 establishments and both smoking room and area in one establishment. The smoking room met the requirements in 77% of the establishments. 48 sports establishments were investigated during the study. All the sports establishments involved in the study lacked both smoking room and area. Additionally, the Northern Division inspected 26 care homes; four of them had a smoking room and smoking was prohibited in 20 care homes. On ships, smoking is only allowed in smoking rooms that meet the requirements, laid down in

Article 30, subsection (3) of the Tobacco Act. Smoking is prohibited on all trains. In 2011, 56 care homes were inspected; smoking was prohibited in 26 care homes. The remaining 20 care homes had smoking room and 18 smoking rooms complied with the requirements. 12 care homes had smoking areas; 10 of the smoking areas complied with the established requirements.

In several countries, there are no smoking rooms in public buildings and in work places (18). Total ban on smoking in buildings of public use is established in Ireland, the United Kingdom, Canada, Turkey, Mexico, Uruguay, Australia, New Zealand and the USA.

Most countries have, for the purposes of regulating smoke-free environment, focused on interior spaces as exposure to tobacco smoke is the biggest health hazard indoors, but there are also countries where smoking is also restricted outside buildings. These places are, for example, public beaches, sports fields and stadiums, children's playfields, parks, bus stops and territories of health care institutions. From this year, Australia has banned smoking in playgrounds, sports fields and bus stops. Italy, Poland, the United Kingdom, Australia and the USA have smoke-free beaches. In the USA there are more than 120 smoke-free beaches (25). Cigarette butts are not disturbing for beach visitors only, but add extra expenses to the maintenance of beaches and environmental pollution, which is also hazardous for aqueous environment (26). The movement of smoke-free universities is becoming increasingly popular; according to the estimates there are more than 700 smoke-free universities in the USA (25).

There is sufficient evidence that restrictions on smoking will reduce exposure to tobacco smoke and have positive influence on human health (27). Regulating smoke-free environment by means of laws will influence both behaviour of people and social standards, make smokers quit smoking and serve to reduce positive attitude towards smoking in young persons (28). It was found, as the consequence of 37 studies that were carried out in 1976–2005, that the prevalence of smoking will be diminished, in average, by 3.4 percent points if the principles of smoke-free principles are applied whereas smoke-free policy in work places is directly related to reduced smoking among employees. Positive economic effect of smoke-free environment was also identified (29).

Establishment of smoke-free protective zones with the minimum scope of 3 metres around the doors of buildings of public use to protect the population of the country

Smoking in front of buildings and on balconies of apartment houses is a problem that disturbs the population. A suggestion has been made for solving the problem, involving establishment of smoke-free protective zones with the minimum scope of 3 metres around the doors of buildings of public use to protect the population of the country. The proposal focuses on doors of buildings of public use. The work group has suggested 5 metres as the protective zone around doors; 6-7 metres is the average zone used in the various states of the USA while in Canada the respective zone is 3–5 metres (local governments have the right to impose stricter restrictions) (25). Smoking on balconies and open windows should be regulated by house rules of apartment associations. Appropriate marking of places where smoking is forbidden should be required in case of an area where smoking is prohibited, laid down by law. The Tobacco Act requires some specifications with respect to public transport stops. Today, as provided by Article 29, subsection (10) of the Tobacco Act, smoking is prohibited in public transport shelters, passenger waiting

rooms and passenger terminals. The definition of a public transport shelter needs to be specified, either by law or with separate guidelines. Clear and understandable marking to indicate that smoking is prohibited will be also required.

Smoke-free state and local government authorities

Leading by example and changes in social standards are important for this measure. The state should adopt a leading role for the purposes of changing the attitude. The first stage for the implementation of the measure could involve adoption of a good practice or guidelines and in some years, the provision on smoke-free state authorities could be inserted in the Tobacco Act. Finland, Ireland, the United Kingdom, Canada, USA, Australia, Turkey, Mexico, Uruguay, New Zealand and Bulgaria can be given as an example here. Riigi Kinnisvara AS has no accurate statistical information available on smoke-free state authorities in Estonia.

Health care services and, above all, hospitals have the obligation of leading anti-smoking combat to reduce consumption of tobacco products and detrimental influence of tobacco on health. Not only non-smokers are protected within the framework of this obligation, but active support is also offered to smokers for the purposes of quitting process. This goes for both patients and all the levels of the staff. This is a long-term process and the movement of smoke-free hospitals and health care services plays an important role in moving towards the goal. The Estonian network of smoke-free hospitals and health care services was established in 2005 and belongs, since 2005, to the European Network of Smoke Free Hospitals and Health Care Services (ENSH). The national co-ordinator of Estonian network is Tiiu Härm. The European network has become global today. It's now called the Global Network for Tobacco Free Health Care Services (ENHS) and the Estonian network of tobacco-free health care services is also a part of the network. Members of the network are Tartu University Hospital, East Tallinn Central Hospital, Rapla County Hospital, AS Põlva Haigla (Põlva Hospital) and AS Lõuna-Eesti Haigla (South Estonian Hospital). All these hospitals have reached a silver level in the movement towards tobacco free health care services, which means that 75% of the requirements, established for completely smoke-free establishments, have been met. The final goal is the gold level, which means that both indoor and outdoor premises (territory) of a health care institution will be completely tobacco smoke-free.

Tobacco free prison

Since 2008, increasingly more attention has been paid in Estonian prisons to healthy lifestyle. Amendments, laid down with Article 8² of the regulation of the Minister of Justice no. 72 of 30 November 2000 entered into force, changing indoor premises of prisons a tobacco free zone; tobacco products will be stored in special closed lockers outside prison cells. This means that indoor environment of a prison shall be smoke-free. Considering global tendencies, protection of health of inmates and officials and facilitation of organisation work, the idea of absolutely smoke-free prison environment is worth serious consideration (likewise, use of alcohol is prohibited in prisons).

The goals of a tobacco free prison could be defined as follows, for the purposes of a prison context:

1. contribution to rehabilitation to an inmate (getting rid of an addiction);
2. health protection (improved living environment of inmates and working environment of prison officials);

3. saving on state budget (expenses on health care services and searching the inmates after every walk they take to prevent them from bringing tobacco products into indoor premises).

Internationally, there are some examples of the implementation of tobacco free prisons. For example, in 2011, it was ruled in New Zealand that all prisons will be tobacco free. Prisons of half of the states of the United States of America are also tobacco free. As for Europe, the regulations, applied by different states, vary – in some countries smoking in cells is allowed whereas while others only allow smoking outside the cells. In Europe, there are no countries with completely smoke-free prisons – there are only single prisons where smoking is prohibited (e.g. prisons on Isle of Man or Guernsey).

Having analysed the compliance of the restriction with the Constitution and to manage some of the possible negative effects, resulting from complete prohibition of smoking, on inmates, addicts should be offered counselling and minimum required replacement therapy. Inmates should be also notified well in advance of the upcoming changes and certain benefits should be offered to inmates who decide to give up smoking. Once Estonian prisons become completely smoke-free, smoking of prison officers in the territory of the prisons should be ruled out, considering positive and excellent organisational culture.

When the developers of national tobacco policy decide to support the idea of tobacco free prisons, the Tobacco Act should be amended and prisons enlisted in Article 29 or the list of institutions where smoking shall be prohibited.

3.2 Measures to reduce the attractiveness of tobacco products

- **Use of pictorial warnings for the purposes of marking tobacco products.**
- **Restricting the sale of flavoured tobacco products, for example, menthol, vanilla, strawberry and chocolate flavoured products to protect children and youngsters.**
- **Specified prohibition of tobacco products' sales promotion: prohibiting the distribution of any products, services or presents to consumers.**
- **Regulation of tobacco products' display ban in points of sale.**
- **Drawing up guidelines for the sale of tobacco products for retailers as a concerted effort of the Estonian Traders Association and the Ministry of Social Affairs. Extending the requirement for the submission of ID document upon purchase of tobacco products to purchase up to the age of 30 years, as it is the case with alcohol products.** This would include practical guidelines, good practice for possible activities and notification within companies, avoidance of sales to minors and training of salespersons.

Use of pictorial warnings for the purposes of marking tobacco products

Packaging of tobacco products is a highly influential marketing tool. The use of pictorial warning will increase the awareness of consumers of the detrimental effect of tobacco use, reduce the number of youngsters who take up smoking (30) and motivate smokers to quit (31; 32).

Surveys have demonstrated that pictorial warnings have a much stronger influence than that of text-only warning, primarily among persons with limited literacy and children (33). Consumers will first view visually dominant elements of the packaging. Scary images that provoke strong emotions represent the most efficient method for informing people about the possible health hazards, posed by tobacco use. Pictorial warnings have a strong influence on enhancing the awareness of population of the nature of health hazards that tobacco represents, medium influence on changing the attitude of smokers (quitting smoking) and average influence on changing the behaviour of smokers (less smoking, less smoking at the presence of other people, attempts to quit smoking) (34). It is not possible to directly measure the impact of pictorial warning as changes in prevalence of smoking. Influence has been observed in the decrease number of cigarettes, consumed by smokers, which will increase, on its turn, the probability for quitting smoking. Long-term effect of pictorial warnings on the behaviour of smokers is assumed to be bigger. The United Kingdom carried out impact assessment before the transition to pictorial warnings and as the consequence it was found that the use of pictorial warnings will reduce smoking prevalence by 0.5% (35).

According to Eurobarometer study, conducted in 2012, 73% of Estonian population supports the use of pictorial warnings in packaging of tobacco products (36).

Pictorial warnings are currently used in ten of the European Union Member States – Belgium, Romania, the United Kingdom, Lithuania, France, Malta, Spain, Hungary and Denmark and Ireland (since 2013). Pictorial warnings are also used in Ukraine, since 2012 in the USA and since 2013 also in Russia. In the USA, both sides of the packaging must be marked with pictorial warnings and their size must be 50% of the area of the package. In total, pictorial warnings are used in 57 countries all over the world (37).

The use of pictorial warnings is governed by the 2003/641/EC: Commission Decision of 5 September 2003 on the use of colour photographs or other illustrations as health warnings on tobacco package. Section (5) of the preamble of the Commission decision states that the use of photographs on tobacco packages is a key element of a comprehensive and integrated tobacco control policy. The combined warning (text and pictorial warning) shall cover not less than 40% of the external area of the other most visible surface of the unit packet of tobacco and the area intended for the additional health warning in total. Where Member States require health warnings in the form of colour photographs or other illustrations, tobacco packages for which such photographs are required shall carry a combined warning taken exclusively from the source documents provided by the Commission, without any changes to any of its component. Member States may choose the source documents best adapted to consumers in their countries. Combined warnings were adopted with commission decision no. 1452 of 26 May 2005.

On 19.12.2012, the European Commission published a proposal to repeal the tobacco products directive 2001/37/EC and replace it with a new directive. According to the new draft directive, every consumer and external packaging must be marked with combined health warning – the combination of text warning, specified in Annex 1 to the draft, and coloured photo available from a picture bank, established with an act, delegated by the Commission. Combined warnings must be provided on both sides of packaging and include other visual elements, such as logos with or without smoking cessation phone numbers, e-mail addresses and/or Internet sites designed to inform consumers about the authorities issuing the warning and the programmes available to support those who want to quit smoking.

RAND Europe has considered the effect of the introduction of pictorial warning in the review of impact analysis of the tobacco products directive in 2010. Higher consumption of printing ink has been mentioned in the analysis as a new cost, resulting from the replacement of text warning that required little ink for coloured pictorial warning. The introduction of pictorial warning may increase the price of tobacco products by 1%. Decrease of prevalence, i.e. consumption, will result in lower collection of excise duties. Excise duties imposed on tobacco products should be reviewed periodically to avoid reduced collection of state income. Reduced consumption may also cause employment changes; influence on wholesalers may result in loss of up to 1.5% of jobs and in retail sector, from 1.3% to 2.9% of jobs. The same analysis also mentions that money saved on tobacco products will be probably spent on other goods and services (35).

Restricting the sale of flavoured tobacco products, for example, menthol, vanilla, strawberry and chocolate flavoured products to protect children and youngsters

Those who first start smoking usually choose flavoured tobacco products as the different strong flavours hide the unpleasant taste of tobacco. Surveys carried out in the USA show that young persons are the main consumers of flavoured tobacco products (38). The surveys demonstrated that young persons choose flavoured tobacco products, e.g. flavoured hookah tobacco, instead of conventional cigarettes as the flavoured tobacco products have a better taste and are assumed to be less harmful (39). Documents of tobacco industry have revealed the strategies they have developed to guide young persons to use flavoured tobacco products (40; 41).

At the meeting with representatives of tobacco producers it was found that no flavoured cigarettes, except for menthol cigarettes, are available on the Estonian market. Cigars, cigarillos, pipe tobacco and hookah tobacco are the flavoured products, available from the market. Flavoured cigarette papers (vanilla, strawberry) are also available on the Estonian market and these would also belong to the scope of the restriction. Implementation of this measure should have only very little effect on tobacco producers and whole and retail sellers as the market share of restricted products is very small.

Flavoured cigarettes, except for menthol cigarettes, are banned in the USA since September 2009. Banning of other flavoured tobacco products is also discussed (42). Menthol is one of the most common additives, used in tobacco industry. It has been added to tobacco products since 1920ies to reduce the coarseness of smoke. Menthol will numb throat and make smoke milder by concealing the coarseness of cigarette smoke and make smoking easier. Studies have shown that smoking cigarettes with menthol is rather common among young persons and these

cigarettes are often their first brand (43; 44; 45; 46). Young persons who start by smoking cigarettes with menthol will quite probably continue regular smoking and become everyday smokers with higher probability than young smokers who don't use cigarettes with menthol (44; 47). Young persons are drawn to cigarettes with menthol as menthol will make cigarettes with low tar content more acceptable (48), young persons also feel that cigarettes with menthol present less risk for them than cigarettes that don't contain menthol (46). When compared to grown-ups, young persons are more open to trying cigarettes with different flavours (49).

Smokers who smoke cigarettes with menthol are at a higher risk of nicotine addiction, when compared to cigarettes that are free from menthol (44; 46; 47; 50; 51). The feeling, experienced when smoking cigarettes with menthol, may serve to fix smoking habits, thanks to the pleasant flavour, aroma and cooling effect. Smokers of cigarettes with menthol also inhale more smoke, due to the cooling effect of menthol (43; 44).

The Health Board of Brazil (ANVISA) adopted a resolution on 13.03.2012 to allow only 8 additives of tobacco products instead the current 600; producers were given 18 months as a transition period. As for the EU, France has imposed restrictions on the use of sweeteners and vanillin.

According to Eurobarometer study, which was conducted in 2012, 62% of Estonian population supports the banning of additives that improve the flavour of tobacco products; the support has increased 7%, compared to 2009 (36). On 19.12.2012, the European Commission published a proposal to repeal the tobacco products directive 2001/37/EC and replace it with a new directive. According to the new draft directive, marketing of cigarettes and smoking tobacco with distinguishing flavours will be banned.

Specified prohibition of tobacco products' sales promotion: prohibiting the distribution of any products, services or presents to consumers

Valid Tobacco Act prohibits any public activities that are aimed at increasing sales. This provision needs some specification, as there have been occasions when it has been found that direct contact with people is not a public activity and the idea of distributing presents is not to increase sales, but to express gratitude for making a purchase. The final goal of all and any presents, distributed to consumers, serve the purpose of enhancing sale of tobacco products. Such an amendment will also simplify supervision over the compliance with sales promotion prohibition.

Regulation of tobacco products' display ban in points of sale

The proposal includes restriction of visibility of tobacco products in points of sale by prohibiting, first of all, marking the point of sales of tobacco products with brands, used on tobacco products (repealing Article 26, subsection (2), clause 2) of the Tobacco Act) and, in long-term perspective, ban the display of tobacco products in points of sale. Advertising of tobacco products is prohibited in Estonia; the prohibition is specified in Article 17 of the Advertising Act. However, the ban of advertising is not extended to the use of brands and trade marks of tobacco products that don't express or depict, using an image, tobacco products or consumption thereof. The

evaluation report of tobacco sector evaluation, conducted in 2010 by the WHO, states the need to remove advertisements of tobacco products and supplies from points of sale. Advertising of tobacco products is prohibited, according to the Advertising Act, but there are still problems with so called presentation of product information in points of sale. According to the measure, undertakings shall reserve the right to use a trade mark to extinguish their products; the goal is to restrict visibility of tobacco products in points of sale. Restrictions on the use of tobacco trade marks were first imposed in Finland in 2011. According to the Finnish Tobacco Act, the display ban of tobacco products and their trademarks for the purposes of retail of tobacco products, tobacco replacement products, tobacco imitation products and smoking supplies will be prohibited. The restriction shall not apply to points of sale with a separate entry that specialise in selling tobacco products and smoking supplies, provided that the sold tobacco products or their trade marks are not visible outside the point of sale (52).

Eye-catching displays of tobacco products in points of sales have become increasingly important marketing tools for tobacco producers, above all, in countries where the advertising of tobacco products is forbidden. Another option is to enhance the visibility of products is to extend product families by new product varieties and different packaging, taking more space in displays and attracting the attention of buyers. Compared to 1998, brand variations of tobacco products have diversified, in the United Kingdom, by more than 50% (53). As a consequence, some countries have banned the display of tobacco products in points of sale. Ireland was the first European Union member state in the European Union that adopted the measure in 2009. In the United Kingdom (England), the display of tobacco products has been banned in large stores since April 2012 and the restriction shall become applicable in small stores from April 2015. For the purposes of the United Kingdom, large store means a store with a useful floor area exceeding 280 square metres. Useful floor area is a part of a store that is used to offer services to customers, involving sales of products and display of goods. Estonia could use the practice for banning the display in points of sale as it is done in the United Kingdom – the restriction would be first applicable to larger and then to small stores. The restriction wouldn't be applicable to specialised stores or departments that offer tobacco products or alcohol and wholesalers of tobacco products.

Advertising in points of sales of tobacco products will help to normalise tobacco use, above all, for children. Displays in points of sales also create a supporting environment for impulse purchases, which are a great risk for young persons and persons who want to quit smoking. A study, carried out in Australia, showed that 25.2% of smokers made the purchase at an impulse, at the sight of cigarette packages; 28% who had tried to quit smoking over the last 12 months and 33.9% who had recently given up smoking felt the desire to purchase cigarettes after seeing cigarettes in points of sales (54). All-inclusive ban on advertising of tobacco products would really result in reduced tobacco use while in-part limitations will have no substantial effect (10).

References reveal sufficient evidence to prove that advertising in points of sales and tobacco products' display ban may influence purchase decisions and have effect on young persons. Tobacco products' display ban in points of sale would have the strongest positive effect (35). In Ireland, immediate influence on the attitude of young persons to smoking was noted after the tobacco products' display ban took effect in points of sale (55).

According to the Ministry of Justice, such a prohibition would not be in conflict with the right of a proprietor of a trade mark to use its trade mark. According to Article 3 of the Trade Marks Act (TMA), a trade mark is a sign used to distinguish the goods or services of a person from other similar types of goods or services of other persons. The TMA does not provide that proprietor of trade mark would have the right to demand the use of their trade marks on advertising boards in points of sales/cash desks where the respective goods are sold. Article 14, subsection (2), clause 5) of the TMA provides that proprietor of a trade mark has the right to prohibit third parties from using in the trade mark on advertising materials, but the respective right is laid down by law as a so-called negative right, that the proprietor of a trade mark can use against persons who violate his rights. The proprietor of a trade mark can use its trade marks at its own discretion (e.g. to advertise his products), but this will not give him the right to demand for the advertisement to be displayed in specific places (points of sale). Advertising Act lays down the provisions to the methods and scope for the proprietor of a trade mark for using trade marks of tobacco for advertising purposes and some of the provisions are also specified in the Tobacco Act. The respective issues are covered by Article 17 of the Advertising Act. Article 17, subsection (2) of the Advertising Act gives the list of cases where the trade mark of tobacco products can be used to advertise these products.

Economic impact of prohibiting advertising in points of sale. In practice, there will be no impact on tobacco industry, resulting from the implementation of the measure. The impact of reduced consumption on employment may be around -1.7% in wholesale trade and from 0.2% to 0.1% in retail. Decrease of prevalence, i.e. consumption, will result in lower collection of excise duties (by -0.12%) (35). Excise duties, imposed on tobacco products, should be reviewed periodically to avoid reduced collection of state income.

Rimi Eesti AS has exercised the display ban of tobacco products in their stores since May 2012. This is not a project-based and time limited effort, but a permanent change in the values of the company. In 2012, Rimi Eesti AS relocated, in its stores, majority of the cigarettes to information desk where they can only be purchased by asking the sales clerk. At the same time, 10 of the most common cigarette types remained available at cash desks, at request to cash desk clerk (the cigarette displays at cash desks were turned face inside and customers can no longer take the cigarettes themselves). Analysis, conducted by Rimi Eesti AS, has shown that the sale of cigarettes has dropped by 10% in Rimi hypermarkets. The change may also be somewhat influenced by price increase of cigarettes, resulting for increased excise duty, imposed on cigarettes, certain change of assortment or change of customer types by stores.

3.3 Measures to regulate the marketing of products that offer alternatives to tobacco products

- **Increasing awareness of harmful effect of hookah and moist snus, the main target group being parents and young persons.**
- **Prohibition of sales of smoke-free tobacco products.**

- **Equalising all the smoked products that do not contain tobacco to tobacco products.** Cigarettes that do not contain tobacco, but different mixes of herbs, have been placed into market in various European countries.
- **Imposing age restriction on purchase of smoking supplies.** Smoking supplies are hookahs, pipes, cigarette papers, cigarette casings and the equipment for filling such devices, and e-cigarettes etc.
- **Prohibiting the sale of alternative products that are similar to tobacco products to minors and prohibiting advertising of products that are similar to tobacco products.**

Alternative products containing both tobacco and nicotine are becoming increasingly popular and this calls for changes in legislation. Popularity of alternative products is largely due to belief that these are not as detrimental for health as conventional cigarettes. Hookah has become common among youngsters and minors; moist snus and e-cigarettes are becoming popular fast.

When smoking hookah, health problems arise as the quantities of carbon dioxide and nicotine human body gets are much larger than those available from conventional cigarettes; hookah also supports smoking habits in minors becoming a social standard. There is no research based evidence to prove that hookah would be a healthier alternative to conventional smoking (56). The promise of cleaning of the smoke by directing it through water is deceptive; in fact, depending on the drag of hookah, the quantity of carbon oxide, inhaled by hookah user, may be thirty times and that of the various carcinogenic chemicals four times higher than the quantities inhaled when conventional cigarette is smoked (57). The use of hookah is, for the purposes of Article 7 of the Tobacco Act, smoking or using the smoking tobacco for intended purposes, regardless of the circumstances, whether and what device is used for that purpose. All the requirements and restrictions, imposed on smoking and handling of tobacco products, also apply to the use of hookah and hookah tobacco. Hookah itself is not a tobacco product and therefore not governed by the Tobacco Act. Wide-based information dissemination among the population will be required to teach about detrimental effects of hookah, as today the main problem we face is ignorance about the harmful health effects of hookah.

At the moment, moist snus can be marketed in Estonia. A proposal has been made to prohibit all the smoke-free tobacco products. Smoke-free tobacco products have been classified as carcinogenic and according to the information available; these contain 28 different carcinogenic substances. WHO recommends countries to prohibit the marketing of smoke-free products (58). Moist snus (*snus* in Swedish), which is becoming increasingly popular among younger persons, is moistened tobacco powder that is placed between upper lip and gum to allow for absorption. There will be no smoke, detrimental to non-smokers, as moist snus is used; however, the process of using moist snus is not harmless for the user of the product. Smoke-free products are also not products, assisting in the process of quitting smoking; instead, tobacco use has a

changed form and simultaneous, combined use of smoke-free tobacco products and conventional cigarettes will support and enhance nicotine addiction (59). Moist snus is forbidden in five EU member states: Latvia, Lithuania, Ireland, Greece and Poland. Marketing of moist snus is prohibited in Estonia by the Tobacco Act; the prohibition derives from the Tobacco Products directive 2001/37/EC. Our legislation complies with the directive. Wide-based information dissemination among the population will be required to teach about detrimental effects of moist snus, as today the main problem we face is ignorance about the harmful health effects of moist snus.

E-cigarette is an electronic device that is fitted with exchangeable capsules or can be filled with liquid; it can be used with both nicotine-free mixtures and mixtures that contain nicotine at different levels. The manufacturer has not intended the device to be used to quit smoking, but to be used in places where smoking is prohibited. There is no scientific research available on long-term health effects of e-cigarettes. WHO technical report no. 955 of 2009 includes an analysis of results of studies, available on e-cigarettes (60). The conclusion of the WHO report emphasises that the safety of e-cigarettes is not proved and expresses suspicion that such an administration of nicotine may result in serious toxicological, physiological and addiction causing effects and all these require more substantial analyses. Apart nicotine, the capsules of e-cigarettes also contain numerous other chemicals; however, the effect of these chemical, considering the form of administration, haven't been studied well enough (61).

There is a proposal to establish restrictions like prohibition on advertising, age limit for the sales of the product and prohibition of use in places where smoking is prohibited on e-cigarettes (including forms that do not contain nicotine). The composition of the liquid, used in the product, also requires certain regulations to ensure the safety of the product. E-cigarettes are imitation products, which are intended to increase interest in smoking in young persons and advertisements of e-cigarettes often use a smoking individual and statement that the product represents a healthy alternative for smoking.

3.4 Measures to prevent tobacco consumption, communication work, treatment of tobacco addiction and counselling for giving up smoking

Counselling services, aimed at quitting tobacco consumption and smoking:

- **Development and better availability of counselling services, aimed at quitting tobacco consumption and smoking. Better advertisement of the services and communication of information among potential patients.**
- **Better linking of counselling services to primary health care services.**
Internet-based organisation of trainings for family doctors will be required to ensure better availability of the services to allow cohesion of work in the sphere of prevention of tobacco use and link it to counselling offices.

- **Improving the system for collecting feedback from patients.**

- **Development of Internet-based counselling services.**

Today, Estonia lacks a proper support system for Internet-based counselling; however, more extensive counselling on Internet will make the counselling services more available for the population.

- **Establishment of a uniform help line for quitting smoking.**

Counselling services, aimed at preventing tobacco consumption and starting smoking:

- **Offering the required preparation for non-health care workers, above all, in peer to peer system for young persons, to influence young persons not to start smoking.**
- **Promotion of counselling work, aimed at prevention of tobacco consumption and starting smoking among school students in educational establishments.**

Counselling services for quitting smoking is an important intervention mechanism for the purposes of reducing tobacco use. Constant development of the services and integrating these with the general health care system to ensure better availability of the services to the target group is highly important.

Network of counselling offices was established in Estonia on the bases of health-promoting hospitals in 2005–2007, using the resources that were made available from the funds of the „National strategy for the prevention of cardiovascular diseases“ (2005–2020). In addition, in establishment of counselling offices to help pregnant women and young persons to give up smoking, was established in 2007 within the “National Cancer Strategy” (2007–2015) took place in 2007. From year 2005, development of the services and co-ordination of the work of counselling offices has become a consistent process. In 2010, service development was started within the framework of a programme supported by the European Cohesion Fund, „Measures to support healthy choices 2010–2011“(62), which will be continued into 2013.

In September 2012, 21 counselling offices were opened on the bases of 19 health care institutions (incl. in the Estonian Defence Forces), where the role of counsellors is held by 52 counsellors who have all passed a special in-service training (15 doctors, 29 nurses, 6 midwives and 2 clinical psychologists). The offices offer counselling services to all smokers and users of other tobacco products, regardless of their age. There are more than 400 health care workers, incl. family doctors and nurses and 27 medical specialists of the Defence Forces, who have passed a 16 hour in-service training on counselling in the sphere of quitting smoking. In addition, more than 100 pharmacists, 49 prison medics etc. have been trained in the sphere of tobacco-related harm and quitting options. County principle has been observed for the purposes of offering training and establishing the offices and the availability of counselling materials in both Estonian and Russian language. Counselling offices have been established in larger hospitals,

youth counselling centres, women's clinics or maternity care units, health centres and other health care institutions to ensure better availability of the services to the target group.

Medical counselling in the sphere of quitting smoking is a health care services, which is offered by health care workers to patients at different levels of health care system on the bases of evidence-based methodologies that includes identification of addiction level of tobacco users, enhancing his or her motivation for quitting, distribution of quitting recommendations and advice, development of quitting and treatment plan for patients and medical treatment of addiction. Quitting smoking is primary to prevent diseases or avoid quick progress of existing pathologies. Those who quit smoking before they are 35 years old have the life expectancy equal to non-smokers.

70% of everyday smokers want to give up their habit but are not ready to do that and need the support of a counsellor.

The list provided above describes the efficacy of different options for quitting smoking. The best results will be achieved in combination with intense counselling at counselling clinics (offices) and involvement of medicinal products; it's remarkable that the expected added value of prescription drugs, prescribed by family doctor, is 1%, but recommendation by counsellor adds 10% of efficacy. The efficacy by 12 months is the following:

- only using one's will power 3%;
- written support materials 4%;
- recommendations from family doctor 5%;
- recommendations from family doctor + medications 6%;
- counselling office/clinic for smokers 10%;
- counselling office/clinic for smokers + medications 20%.

Smokers usually end up at the reception of primary care health care worker or specialist with lung, heart or some other complaints. Therefore, the specialists need to be well trained to help to fight tobacco addiction apart treating the diseases, related to their specialty. Tobacco users, suffering from lung, heart or some other disease should have an opportunity (without prior registration) to obtain information both about the links of his or her disease and tobacco use and options available to quit tobacco use. It would be ideal if tobacco users, either when measuring their blood pressure, checking cholesterol or using to learn asthma medications, would end up with a nurse who has sufficient knowledge of short or intense counselling and will help patients to enhance their motivation and advise them in the case of wish to quit smoking. For that purpose, all the health care workers who express the wish should pass a 16 hour in-service training on counselling in the sphere of quitting smoking to offer intense counselling as an integrated part of various health care services.

To ensure better availability of counselling information, many medical institutions already employ nurses, midwives, psychologists, physiotherapists who have passed an in-service training and can offer counselling without prior registration. If this is the case, they must definitely have the opportunity to consult with a doctor who can prescribe medications to treat nicotine addiction.

The process for quitting smoking lasts for 2 months and longer, where appropriate (in total, 8-10 weeks) and requires consistent co-operation between the patient and the counsellor for the whole year following stopping. Patients will be only treated as non-smokers after one year has passed since the first day of stopping smoking. While only 3–6% of addicts will quit smoking and become non-smokers, permanently, the respective percentage is 20% and above in case of counselling. Consistent counselling will involve at least five counselling sessions (3 counselling sessions during the first two months, 2 counselling sessions during the year after stopping – after 6 and 12 months, respectively).

Conditionally, medical counselling on stopping smoking can be divided into short counselling (testing and giving recommendations) and intense counselling (active planning of the stopping process and starting with the counsellor). Short counselling can be successfully offered within the framework of provision of various health care services and is, therefore, a perfect component of primary health care services. Intense counselling is better suited for a counselling tool, used in counselling offices (63).

Better linking of counselling services to primary health care services

Internet-based organisation of trainings for family doctors will be required to ensure better availability of the services to allow cohesion of work in the sphere of prevention of tobacco use and link it to counselling offices. Counselling on stopping smoking is one part of everyday work of primary health care specialists and can be done, most efficiently, in the form of short counselling. Advice on quitting smoking, offered by family doctor/nurse, midwife or occupational health doctors is the best method to enhance patient's motivation to give up tobacco use.

Medical counselling on stopping smoking is a component of family doctors' and nurses' work, just like nutrition counselling of patients with type II diabetes. Once it's obvious that smoking is a risk factor for the patient, the appropriate counselling will be offered to influence the patient's health behaviour. In the case of stopping recommendation, received from health care workers, the efficiency of quitting, after the passing of one year, is 5–10%, which could become an important factor for the purposes of improved public health in the case of routine recommendations. However, quite often no questions will be asked about tobacco use and quitting is not recommended. One reason why doctors often have doubts about recommending giving up tobacco is the fact that they feel demoralised when seeing that patients have not observed the given recommendations. Nevertheless, they should keep on mind that if the recommendations were not followed by immediate quitting, this could still support the patient's future stopping decision (64). Stopping smoking is the minimum requirement for medical counselling at primary health care level:

- initial counselling, according to the guidelines;
- provision of information about counselling offices; reference to counselling offices, where appropriate.

It is the task of family doctor to inform both smokers and passive smokers of detrimental influence on tobacco on health and offer them practical recommendations for stopping smoking and ensuring tobacco free living environment.

Better advertising of counselling services and information communication among potential patients

Years of experience have shown that after counselling offices are introduced on some TV show, radio broadcast, newspaper or magazine, the number of persons, contacting the offices, will increase.

Improving the system for collecting feedback from patients

Until now, only minimum quantities of information has been collected and analysed. It is important to develop a system for collecting information from the target group to assess the efficiency and development requirements of the services.

Development of Internet-based counselling services

Today, there is no proper support system available in Estonia for Internet-based counselling; however, wide-based counselling via Internet would make the service more available. According to the references, Internet-based counselling on stopping smoking is more efficient, provided that we speak about special Internet-based counselling and not a static website. Internet counselling is an additional tool to support other measures of intervention and research shows that this form of counselling is most attractive for young persons (65).

Establishment of a uniform help line for stopping smoking

Telephone counselling is highly efficient and cost effective intervention method to support stopping smoking. Telephone counselling offers help to individuals who want to stop smoking, yet have limited access to other forms of counselling. The efficacy of telephone counselling or the fact that the service helps to stop smoking is evidenced by multiple references (66; 67). Research shows that this is an efficient methods for stopping smoking and several telephone counselling sessions will be probably most effective (68).

Promotion of counselling work, aimed at prevention of tobacco consumption and starting smoking among school students in educational establishments

Work done to prevent young persons from starting smoking must be consistent and the counselling on stopping tobacco use available to young persons. General education schools have health education programmes that are taught by teachers of personal education. Tobacco issues are discussed, with other drugs, in classes 5, 7 and 8; 4-5 lessons per every level. From autumn 2013, students of class 6 will be involved in the programme. Lectors from outside educational establishments are also often invited to give lectures on tobacco-related harm to students of general education schools/gymnasiums. Interactive events will be organised for different target groups, including teachers and parents, to enhance health awareness. „Suitsuprii klass“ (Smoke Free Class) is a prevention programme for students of classes 4-12, organised by the National Institute for Health Development, which lasts for 6 months and was introduced, following the example of Finland, from 2001. Anti-smoking prevention programmes for school students aim to prevent or postpone smoking or the use of smoke-free tobacco products in general, motivate students to give up tobacco products, support smoke-free lifestyle. In

2012/2013, 688 classes or 82% of all the classes that started completed the six month programme.

3.5 Measures to restrict illicit market and shape taxation policy

- **Public health goals must be kept in mind for the purposes of raising excise duty on tobacco products and the price of tobacco products should increase at the same speed with the consumer price index to avoid improved availability of tobacco products.**
- **Measures adopted by the Tax and Customs Board to fight illicit trade:**
 - **influencing consumers to stop using illicit cigarettes;**
 - **notification of employers, local governments and other institutions, related to the individuals, detained for illicit trade;**
 - **in the case of measures that increase the price of tobacco products, analysis for the demand for additional resources and planning of additional, economically justified measures to restrict illicit market in co-operation with the Police and Border Guard Board;**
 - **imposing stricter control measures over individuals repeatedly caught dealing with illicit trade, application of detention on repeated offenders;**
 - **exercising in-depth control over people involved in illicit trade for the purposes of taxation of unlawful gains;**
 - **application for revocation of permits and licenses, required for entrepreneurship in case of entities dealing with illicit trade;**
 - **apply for prohibition on entry to Schengen area to third country citizens who have been involved in illicit trade;**
 - **acquisition of additional X-ray machines for vehicles and trains to detect illicit trade;**
 - **training of tobacco dogs to detect illicit cigarettes.**
- **Review of legislation:**
 - **establishment of limits for large quantities of tobacco products, prohibited for handling, and severe penalties for handling large quantities of tobacco prohibited for handling;**
 - **giving the Tax and Customs Board the authorities for making purchase for the purpose of monitoring compliance with surveillance requirements;**
 - **facilitation of confiscation of the devices used to commit an offence.**

Illicit trade is harmful for public health, economy and also a threat for domestic security. Illicit market cuts down the opportunities for the implementation of efficient tobacco policy.

The Estonian Institute of Economic Research estimates that in 2012, the percentage of illicit trade of cigarettes was 25–29%. In 2012, the share of illicit trade of cigarettes decreased only a little, compared to 2011. During the year, the quantities of sold illicit cigarettes increased and monetary turnover showed the largest growth. It is estimated that in 2012, the state lost approximately 68.7 million euros in excise duty and value added tax as the consequence of illicit trade (69). The Tax and Customs Board and the Police and Border Guard Board play an important role in preventing the spreading of illicit alcohol. The measures to combat illicit market, specified above, are based on the suggestions from the Tax and Customs Board.

The current definition of a crime needs to be amended for more efficient combat against organized crime to impose more efficient measures against illicit market. There is a penal gap in Article 24 of the Tobacco Act, which provides that handling of a smoke-free tobacco product, other than chewing tobacco, shall be prohibited. However, if tobacco products, prohibited for handling, are handled in large quantities, the person concerned can't be held responsible on the basis of Article 376 of the Penal Code. Therefore, composition of crime should include penalty for handling large quantities of tobacco products, prohibited for handling on the basis of Article 24 of the Tobacco Act, incl. handling of large quantities of moist snus. As the scheme for calculating excise duty totals will not be applicable for tobacco prohibited for handling, the Tobacco Act should specify separately the definition of large quantities of tobacco products, prohibited for handling.

Public health goals should be kept on mind for the purposes of raising excise duty on tobacco products and consider the price of tobacco products, compared to average income. Increase in real prices of tobacco products is an efficient tool to reduce tobacco consumption. Increase of prices of tobacco products and reduced consumption can be expressed as price flexibility of demand – 1% of price increase will be equivalent to respective decrease in consumption. Most price flexibility estimates remain between -0.2 through -0.8. Therefore, if prices of tobacco products grow by 10%, this will result on 2–8% decrease of consumption (70). Young persons are expected to be three times as sensitive to prices of tobacco products; therefore, the influence of price increase will be considerable on tobacco consumption of young persons (71).

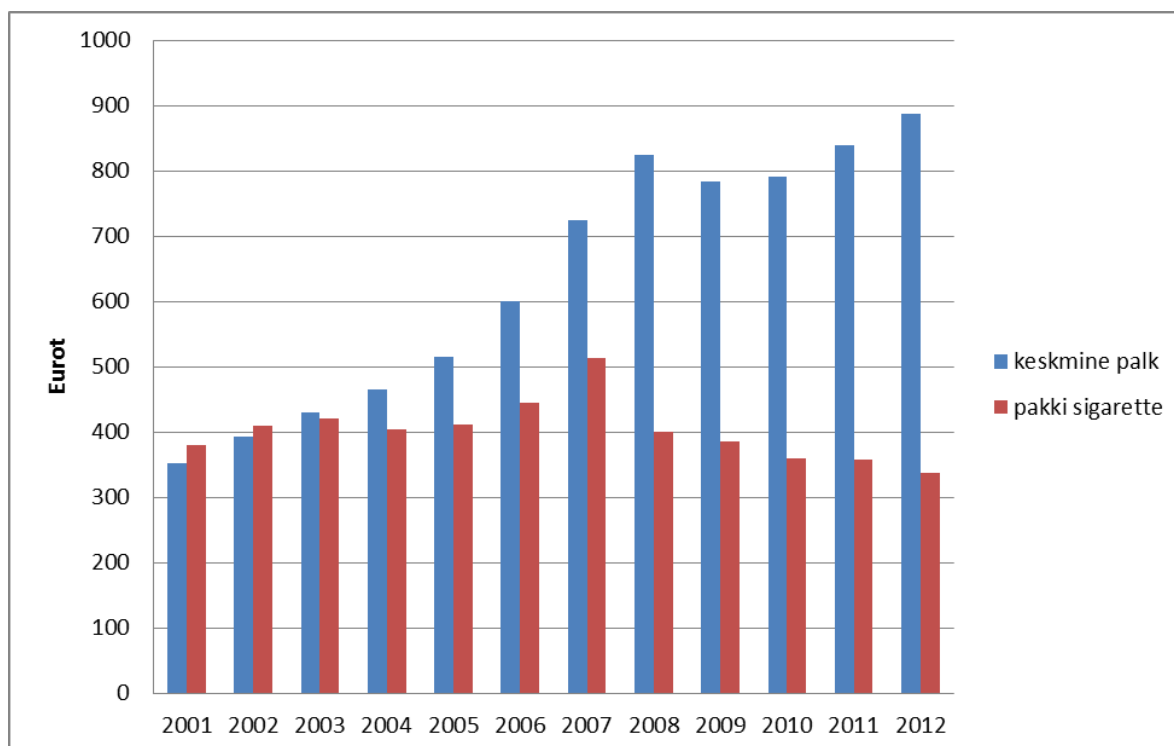


Figure 6. Number of packages of cigarettes available for average wages at weighed average retail price

Difference of tax rates of cigarettes and self-rolled cigarettes should be under consistent observation. As cigarettes become more expensive, we will see that people transfer to cheaper brands and next, tobacco consumers will start to roll their own cigarettes. The same phenomenon can also be observed in Estonia – in 2002, consumption was 8 tons; by 2010 it had increased to 114 tons; since 2011 consumption increase has slowed down.

3.6 Reducing the availability of tobacco products to minors

- **Imposing more efficient supervision over the prohibition to make tobacco products available to minors.**
- **Raising the penalties imposed for the violation of age limit for the purposes of handling tobacco products.**
- **Adding a lecture on detrimental effects of smoking to the regular penalty in the case of consumption, acquisition and holding of tobacco products by minors.**

For the purposes of decreasing the availability of tobacco products to minors, it's highly important to impose more effective supervision over sellers of tobacco products, which will be made more efficient by mutual communication of various supervisory authorities and co-ordinate supervision.

The proposal to introduce stricter regulation to the Tobacco Law is based on the penalty, laid down by Article 44 of the Tobacco Act, which provides that an adult who by inducement, threat or any other act influences a minor in order to cause him or her to commence or increase the consumption of tobacco products or not to give up the consumption of tobacco products shall be punished by a fine of up to 300 fine units. The proposal is to increase the penalty, specified in Article 45, for the violation of the age limit upon the handling of tobacco products, to 300 fine units (currently 200 fine units). A lecture on detrimental effects of smoking should be added to the penalties, laid down with Article 47 and 48 of the Tobacco Act, for consumption, acquisition and holding of tobacco products by a minor; where appropriate, young persons with established tobacco addiction will be referred to counselling on quitting smoking. The programme and materials of the lecture will be developed by the Ministry of the Social Affairs and the National Institute for Health Development.

3.7 Monitoring

- **Starting compilation of a yearbook on tobacco market, use and related losses in Estonia, using a format similar to alcohol yearbook.**

Year book should provide an overview of legal market and consumption and the losses suffered by society as the consequence of use of tobacco products. Separate study needs to be conducted on economic effect of reduced tobacco use to estimate the effect of recent and planned increase of excise duty on tobacco, the level and type of illicit trade and profitability of anti-illicit trade measures. Such year book should be published every other year, not every year, as the information about prevalence of smoking will be made available every other year.

4. Evaluation of impact

Direct expenses for the state, resulting from tobacco consumption, total to the minimum of 65.5 million euros (the analysis was conducted for year 2006). The same year, expenses resulting from tobacco consumption totalled to 0.5% of the GDP. This percentage includes direct expenses, which represent the value of treatment services, provided to treat and diagnose diseases, which are related to tobacco consumption. The methodology, used for the purposes of the study, was rather conservative and did not include all the accompanying costs, as it did not cover expenses outside the health care sector (e.g. expenses on medicinal products). Psycho-social expenditures, for example, pain and suffering, caused for the patient or his or her next of kin, were also not covered (6). Approximately 8.3% of years of life lost and premature mortality among Estonian population is attributable to tobacco consumption; the main loss results from premature deaths, exceeding the loss of life quality by threefold. According to a study, conducted in 2004, the total tobacco-related health loss of Estonian population was 28,235 years of life and this was mostly caused by lung cancer (32%), closely followed by heart ischemia and stroke (10). Economic loss, resulting from early mortality, caused by smoking, is estimated to be around 1.4 billion euros; the calculations were prepared for 2000 (72).

It was found, as the consequence of 37 different studies that were carried out in 1976–2005, that the prevalence of smoking will be diminished, in average, by 3.4 percent points if the principles of tobacco smoke-free principles are applied whereas tobacco smoke-free policy in work places is directly related to reduced smoking among employees. Positive economic effect of tobacco smoke-free environment was also identified as the result of the studies (72).

RAND Europe has considered the effect of the introduction of pictorial warning in the review of impact analysis of the tobacco products directive in 2010. Higher consumption of printing ink has been mentioned in the analysis as a new cost, resulting from the replacement of text warning that required little ink for coloured pictorial warning. The introduction of pictorial warning may increase the price of tobacco products by 1%. Decrease of prevalence, i.e. consumption, will result in lower collection of excise duties. Excise duties, imposed on tobacco products, should be reviewed periodically to avoid reduced collection of state income. Reduced consumption may also cause employment changes; influence on wholesalers may result in loss of up to 1.5% of jobs and in retail sector, from 1.3% to 2.9% of jobs. The same analysis also mentions that money saved on tobacco products will be probably spent on other goods and services (35).

In practice, there will be no impact on tobacco industry, resulting from the implementation of the measure. The impact of reduced consumption on employment may be around -1.7% in wholesale trade and from 0.2% to 0.1% in retail. Decrease of prevalence, i.e. consumption, will result in lower collection of excise duties (by -0.12%) (35).

The economic effect of various measures implemented to reduce tobacco consumption on wholesale sector of tobacco products would be possible employment decrease of approximately 3%. 164 people were employed in tobacco products wholesale in 2011; i.e. this may have

certain effect on approximately 5 jobs. The references offer conflicting information about retail, fluctuating between 0.2% increase in employment and 3% decrease in employment. According to the Estonian Traders Association, retail of tobacco products contributes approximately 3% of total retail (motor vehicles excluded), which is 120 million euros.

Decrease of prevalence, i.e. consumption, will result in lower collection of excise duties. Excise duties, imposed on tobacco products, should be reviewed periodically to avoid reduced collection of state income. Immediate expenses are due from imposing the display ban of tobacco products on traders. According to the Estonian Traders Association, the expected value of a new type of cigarette sales display would be around 800–1,200 euros. According to research company, The Nielsen Company, there are 1,718 stores that trade in tobacco products and there are 3,809 cash desks in these stores. Assuming that average value of a display would be around 1,000 euros, the expenses that accompany the display ban implementation would be around 1.6–3.8 million euros, in average, 930–2,200 euros per point of sale. The example of Ireland supplies information about real expenses absorbed by retailers, which were, in average, about 375 euros per point of sale. Originally, it was estimated that the expenses would be 2,300–6,200 euros per point of sale (73).

Reduced consumption of tobacco products will inevitably have certain effect on tobacco industry and also on retail trade. The resulting economic impact is, however, negligible, considering the economic damages that result from smoking-related diseases and premature mortality.

Annexes

1. Miscellaneous measures for reducing tobacco consumption, discussed at the work group
2. Pictorial warnings

Annex 1. Miscellaneous measures for reducing tobacco consumption, discussed at the work group

- **Allowing the involvement of minors for the making purchase for the purpose of monitoring compliance with surveillance requirements.** The problem of protection available to minors involved was raised at the work group, plus ethical issues.
- **Restricting the number of points of sale of tobacco products according to number of population or area unit. Specialised stores, restrictions to size of stores.** Major expenses for retailers and complicated implementation of the scheme were the main opposing arguments. Such a measure will also result in the hazard of increased illicit trade. Limiting the number of points of sale to reduce the availability of products would result in increased illicit trade.
- **Provisions of law to regulate the display of tobacco products at points of sale: sale of tobacco products only from a separate cash desk/counter.** The measure will not met its purposes as a separate cash desk/counters would result in attractive-looking sales counters which some of Estonian stores already use, immediately next to store entrances. Major expenses for retailers were the main opposing argument.
- **Over the counter medications that support quitting smoking should be sold with cigarettes.** All medications should only remain available via drugstores, i.e. drugstore services. This would help to show the public that the products are medications, intended for specific purpose and this will also help to insure safe and efficient use of the medication. Drugstore services are quite easily available in Estonia.
- **Exemption of tax on fringe benefit made available for counselling services to stop smoking, commissioned by the employer to be offered at work place.**

Annex 2. Pictorial warnings (combined warnings)



Ühendhoiatused

Suitsetamine lühendab eluiga

Eluaegsed suitsetajad
kaotavad oma elust
keskmiselt 14 aastat

Suitsetamine lühendab eluiga



Suitsetamine lühendab eluiga



Suitsetamine lühendab eluiga

Suitsetamine ummistab veresooni ning põhjustab südameinfarkte ja rabandusi

Suitsetajatel on
mittesuitsetajatega
**võrreldes 50% suurem
oht insuldi tekkimiseks**

Suitsetamine ummistab veresooni ning
põhjustab südameinfarkti ja rabandust



Suitsetamine ummistab veresooni ning
põhjustab südameinfarkti ja rabandust



Suitsetamine ummistab veresooni ning
põhjustab südameinfarkti ja rabandust

Suitsetamine tekitab surmavat kopsuvähki



Suitsetamine tekitab kergesti sõltuvust, ära alusta



Suitsetamise lõpetamine vähendab ohtu haigestuda surmavatesse südame- ja kopsuhaigustesse



Suitsetamine võib põhjustada aeglase ja valuliku surma



Suitsetamine toob kaasa naha vananemise



Suitsetamine toob kaasa
naha kiire vananemise



Suitsetamine toob kaasa
naha kiire vananemise

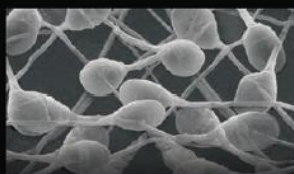


Suitsetamine toob kaasa
naha kiire vananemise

Suitsetamine võib kahjustada spermat ja vähendada viljakust



Suitsetamine võib kahjustada
spermat ja vähendada viljakust

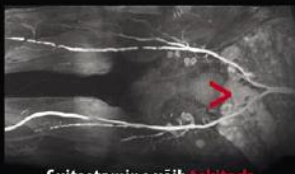


Suitsetamine võib kahjustada
spermat ja vähendada viljakust



Suitsetamine
võib
kahjustada
spermat ja
vähendada
viljakust

Suitsetamine võib tekitada vereringehäireid ja põhjustada impotentsi



Suitsetamine võib tekitada
vereringehäireid ja
põhjustada impotentsust



Suitsetamine võib tekitada
vereringehäireid ja
põhjustada impotentsust



Suitsetamine võib tekitada
vereringehäireid ja
põhjustada impotentsust

Suits sisaldab benseeni, nitrosoamiini, formaldehüüdi ja vesiniktsüaniidhapet



Suits sisaldab benseeni, nitrosoamiini,
formaldehüüdi ja vesiniktsüaniidhapet



Suits sisaldab benseeni, nitrosoamiini,
formaldehüüdi ja vesiniktsüaniidhapet



Suits sisaldab benseeni, nitrosoamiini,
formaldehüüdi ja vesiniktsüaniidhapet

Raseduse ajal suitsetamine kahjustab sinu last



Raseduse ajal **suitsetamine**
kahjustab sinu last



Raseduse ajal **suitsetamine**
kahjustab sinu last



Raseduse ajal
suitsetamine
kahjustab
sinu last

Kaitse lapsi: ära sunni neid hingama tubakasuitsu



Kaitse lapsi: ära sunni neid
hingama tubakasuitsu



Kaitse lapsi: ära sunni neid
hingama tubakasuitsu



Kaitse lapsi:
ära sunni
neid hingama
tubakasuitsu

Arstilt või apteekrilt saad abi suitsetamise lõpetamiseks

**Te suudate seda,
me võime aidata**

Suitsetamisest loobumiseks
saad abi arstilt või apteekrilt

Suitsetamine on tõsine
nikotiinisõltuvus;
ärge kartke abi paluda

Suitsetamisest loobumiseks
saad abi arstilt või apteekrilt



Suitsetamisest
loobumiseks
saad abi
arstilt või
apteekrilt

Otsi abi suitsetamise lõpetamiseks

0803 00 00 00
**Valige vabadus,
me aitame teid**

Otsi abi suitsetamisest loobumiseks



Otsi abi suitsetamisest
loobumiseks: **0803 00 00 00**



Otsi abi suitsetamisest
loobumiseks: **0803 00 00 00**

References to studies and documents

1. World Health Organization. Health for all database, 2012 (information for April).
<http://data.euro.who.int/hfad/>
2. Tervise Arengu Instituut. Kooliõpilaste tervisekäitumise uuring, 2005, 2010. Tervise Arengu Instituut, 2005, 2010.
rahvatervis.ut.ee/bitstream/1/5577/1/Aasvee2012.pdf
www2.tai.ee/uuringud/HBSC_tabeliraamat_tryk.pdf
3. Tervise Arengu Instituut, Tallinna Ülikool. Uimastite tarvitamine koolinoorte seas: 15–16-aastaste õpilaste legaalse ja illegaalse narkootikumide kasutamine Eestis, 2012. Tervise Arengu Instituut, Tallinna Ülikool, 2012
<http://www.tai.ee/en/health-data/research-reports/download/198>
4. Tervise Arengu Instituut. Täiskasvanud elanikkonna tervisekäitumise uuring, 2010, 2012. Tervise Arengu Instituut, 2010, 2012.
rahvatervis.ut.ee/bitstream/1/4047/1/TKU_2010.pdf
https://intra.tai.ee/images/prints/documents/136479842690_TKU_2012.pdf
5. European Commission, Health and Consumer Protection Directorate. Survey on Tobacco: analytical report. European Commission, Brussels, 2009.
ec.europa.eu/public_opinion/flash/fl_253_en.pdf
6. Reinap, M. Olulisemate käitumuslike terviseriskide majanduslik koormus, magistritöö. Tallinna Tehnika ülikool, 2009.
http://www.who.int/fctc/reporting/party_reports/estonia_annex4_economic_burden_of_main_behavioral_health_risks_2009.pdf
7. World Health Organization. Report on the global tobacco epidemic, 2009: implementing smoke-free environments. World Health Organization, Geneva, 2009.
<http://www.who.int/tobacco/mpower/2009/en/>
8. World Health Organization. Global health risks: mortality and burden of disease attributable to selected major risks. World Health Organization, Geneva, 2009.
http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf
9. World Health Organization, koduleht, 2013.
<http://www.who.int/topics/tobacco/en/>
10. Tartu Ülikooli tervishoiu instituut. Haiguskoormuse tõttu kaotatud eluaastad Eestis: seosed riskifaktoritega ja riskide vähendamise kulutõhusus. Tartu Ülikooli tervishoiu instituut, 2004.
http://rahvatervis.ut.ee/bitstream/1/81/1/Sotsiaalministeerium2004_1.pdf

11. Jarvis, M.J. Why people smoke, *British Medical Journal*, 2004, 328, 277–279.
12. U.S. Department of Health and Human Services, Public health services, Centers for Disease Control and prevention, National Center for chronic disease prevention and health promotion, Office on Smoking and Health. Preventing tobacco use among young people: a report of the Surgeon General. U.S. Department of Health and Human Services, Atlanta, 1994.
www.cdc.gov/mmwr/PDF/rr/rr4304.pdf
13. World Health Organization. Joint national capacity assessment of tobacco control policies in Estonia. World Health Organization Regional Office for Europe, Ministry of Social Affairs, Estonia, 2011.
ee.euro.who.int/E95015.pdf
14. Usin, J., Pärna, K., Ringmets, I. Eesti kooliõpilaste suitsetamine 1993/1994–2005/2006: kooliõpilaste tervisekäitumise rahvusvahelise uuringu analüüs. *Eesti Arst*, 2008, 87, 859–866.
15. Öberg, M., Jaakkola, M.S., Woodward, A., Peruga, A., Prüss-Ustün, A. Worldwide burden of disease from exposure to second-hand smoke: a retrospective analysis of data from 192 countries. *The Lancet*, 2011, 377, 139–146.
16. Prättälä, R., Helakorpi, S., Sipilä, N. Sippola, R., Sääksjärvi, K., et al. Social Determinants of Health Behaviours, *Finbalt Health Monitor 1998–2008*, National Institute for Health and Welfare, 2011.
<http://www.thl.fi/thl-client/pdfs/f316c417-cc1d-48e6-a2e2-7389fde28630>
17. U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: a Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
<http://www.surgeongeneral.gov/library/secondhandsmoke/>
18. World Health Organization. Protection from exposure to second-hand tobacco smoke: policy recommendations. World Health Organization, Geneva, 2007.
whqlibdoc.who.int/publications/2007/9789241563413_eng.pdf
19. Euroopa Nõukogu. Nõukogu soovitus, 30. november 2009, suitsuvaba keskkonna kohta (2009/C 296/02). Official Journal of the European Union, 2009.
<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:296:0004:0014:ET:PDF>
20. Wagner, J., Sullivan, D. P., Faulkner, D., Fisk, W. J., Alevantsi, L. E., et al. Environmental Tobacco Smoke Leakage from Smoking Rooms. *Journal of Occupational and Environmental Hygiene*, 2004, 1, 110–118.
21. Pion, M., Givel, M.S. Airport smoking rooms don't work. *Tobacco Control*, 2004, 13, i37–i40.
22. U.S. Centers for Disease Control and Prevention. Ventilation Does Not Effectively Protect Nonsmokers from Secondhand Smoke. U.S. Centers for Disease Control and Prevention, 2011.

http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/ventilation/index.htm

23. Alevantis, L., Wagner, J., Fisk, B., Sullivan, D., Faulkner, D., et al. Designing for smoking rooms. *ASHRAE Journal*, 2003, 6, 26–32.
24. Lee, K., Hahn, E. J., Robertson, H. E., Whitten, L., Jones, L. K., et al. Air Quality in and around airport enclosed smoking rooms. *Nicotine and Tobacco Research*, 2010, 12, 665–668.
25. American Nonsmokers Rights Foundation. Municipalities with Smokefree Beach Laws. American Nonsmokers Rights Foundation, 2012.
<http://www.no-smoke.org/pdf/SmokefreeBeaches.pdf>
26. Slaughter, E., Gersberg, R.M., Watanabe, K., Rudolph, J., Stransky, C., et al. Toxicity of cigarette butts, and their chemical components, to marine and freshwater fish. *Tobacco Control*, 2011, 20, i25–i29.
27. Pell, J.P., Haw, S. The triumph of national smoke-free legislation. *Heart*, 2009, 95, 1377–1379.
28. Bauld, L. Impact of smokefree legislation in England: evidence review. Department of Health, London, 2011.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124961
29. Hopkins, D.P., Razi, S., Leeks, K.D., Kalra, G. P., Chattopadhyay, S. K., et al. Smokefree policies to reduce tobacco use. A systematic review. *American Journal of Preventive Medicine*, 2010, 38, S275–289.
30. White, V., Webster, B., Wakefield, M. Do graphic health warning labels have an impact on adolescents' smoking-related beliefs and behaviours? *Addiction*, 2008, 103, 1562–1571.
31. Hammond, D. Tobacco labelling toolkit: Implementation. In: Hammond, D., editor. *Tobacco Labeling and Packaging Tool-kit: a guide to FCTC article 11*. Waterloo: University of Waterloo, 2008.
32. Hammond, D., Geoffrey, T., Fong, G. T., Borland, R., Cummings, K. M., et al. Text and Graphic Warnings on Cigarette Packages: Findings from the International Tobacco Control Four Country Study. *American Journal of Preventive Medicine*, 2007, 32, 210–217.
33. Hammond, D., Fong, G.T., McNeill, A., Borland, R., Cummings, K. M., et al. Effectiveness of cigarette warning labels in informing smokers about the risks of smoking: findings from the International Tobacco Control (ITC) Four Country Survey. *Tobacco Control*, 2006, 15, iii19–iii25.
34. Sambrook Research International. A review of the science base to support the development of health warnings for tobacco packages. Sambrook Research International, 2009.
ec.europa.eu/health/tobacco/docs/warnings_report_en.pdf
35. Tiessen, J., Hunt, P., Celia, C., Fazekas, M., de Vries, H., et al. Assessing the Impacts of Revising the Tobacco Product Directive. RAND Europe, 2010.
http://ec.europa.eu/health/tobacco/key_documents/index_en.htm

36. TNS Opinion & Social. Special Eurobarometer 385 Attitude of Europeans Towards Tobacco. TNS Opinion & Social, 2012.
http://ec.europa.eu/health/tobacco/eurobarometers/index_en.htm
37. World Health Organization FCTC Implementation Database.
<http://apps.who.int/fctc/reporting/database/>
38. Conwell, L. S., O'Callaghan, M.J., Andersen, M. J., Bor, W., Najman, J. M., et al. Early adolescent smoking and a web of personal and social disadvantage. *Journal of Paediatrics and Child Health*, 2003, 39, 580-605.
39. Primack, B. A., Sidani, J., Agarwal, A. A., Shadel, W. G., Donny, E. C., et al. Prevalence and associations with waterpipe tobacco smoking among US university students. *Ann Behavioral Medicine*, 2008, 36, 81–86.
40. Reynolds, R. J. Inter-office Memorandum, 1974, Bates No. 511244297-4298.
41. Marketing Innovations. Youth Cigarette – New Concepts. Memo to Brown & Williamson, September 1972, Bates No. 170042014.
42. CTFK. Statement from Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association and Legacy Jun 21, 2010.
43. EU project Public Information Tobacco Control (PITOC) (2012).
http://www.rivm.nl/Onderwerpen/Onderwerpen/T/Tabak/PITOC_factsheets_English
44. Tobacco Products Scientific Advisory Committee. Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations. Submitted to FDA: March 23, 2011.
<http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/TobaccoProductsScientificAdvisoryCommittee/UCM269697.pdf>
45. Hersey, J. C., Nonnemaker, J. M., Homsy, G. Menthol Cigarettes Contribute to the Appeal and Addiction Potential of Smoking for Youth. *Nicotine & Tobacco Research*, 2010, 12, S136-S146.
46. Hersey, J. C., Ng, S. W, Nonnemaker, J. M., Mowery, P., Thomas, K. Y., et al. Are menthol cigarettes a starter product for youth? *Nicotine & Tobacco Research*, 2006, 8, 403-413.
47. Nonnemaker, J., Hersey J., Homsy, G., Busey, A., Allen, J., et al. Initiation with menthol cigarettes and youth smoking uptake. *Addiction*, 2013, 108, 171-178.
48. Lee, Y. O, Glantz, S. A. Menthol: Putting the pieces together. *Tobacco Control*, 2011, 20, ii1-ii7.
49. Carpenter, C. M., Wayne, G. F., Pauly, J. L., Koh H. K., Connolly, G., N. New Cigarette Brands With Flavors That Appeal To Youth: Tobacco Marketing Strategies. *Health Affairs*, 2005, 24, 1601-1610.
50. Ahijevych, K., Garrett, B.E. The role of Menthol in Cigarettes as a Reinforcer of Smoking Behaviour. *Nicotine & Tobacco Research*, 2010, 12, 110-116.
51. Ahijevych, K., Garrett, B. E. Menthol pharmacology and its potential impact on cigarette smoking behavior. *Nicotine & Tobacco Research*, 2004, 6, S17-28.

52. FINLEX, koduleht.
<http://www.finlex.fi/fi/laki/ajantasa/1976/19760693>
53. ASH Briefing, Action on Smoking and Health. Tobacco displays at the point of sale. ASH, Briefing, Action on Smoking and Health, London, 2012.
ash.org.uk/files/documents/ASH_701.pdf
54. Wakefield, M, Germain, D., Hendrikesen, L. The effect of retail cigarette pack displays on impulse purchase. *Addiction*, 2008, 103, 322–328.
55. McNeill, A., Lewis, S., Quinn, C., Mulcahy, M., Clancy, L., et al. Evaluation of the removal of point of sale tobacco promotion displays in Ireland. *Tobacco Control*, 2010, 20, 137-143.
56. World Health Organization. TobReg- Advisory note waterpipe tobacco smoking: health effects, research needs and recommended actions by regulators, WHO Study Group on tobacco product regulation, Geneva, 2005.
http://www.who.int/tobacco/global_interaction/tobreg/waterpipe/en/
57. Eissenberg, T., Shihadeh, A. Waterpipe tobacco and cigarette smoking Direct comparison of toxicant exposure. *American Journal of Preventive Medicine*, 2006, 37, 518–523.
58. World Health Organization. Smokeless tobacco control. Report of a WHO Study Group, Geneva, 1988.
http://apps.who.int/iris/bitstream/10665/39026/1/WHO_TRS_773.pdf
59. Report by the Convention Secretariat. Control and prevention of smokeless tobacco products. Fifth session of Conference of the Parties to the WHO Framework Convention on Tobacco Control, Seoul, Republic of Korea, 2012.
apps.who.int/gb/fctc/PDF/cop5/FCTC_COP5_12-en.pdf
60. World Health Organization. Draft Abbreviated Advisory of the WHO Study Group on tobacco product regulation (WHO TobReg) concerning Electronic Nicotine Delivery Systems (ENDS), 2009.
www.elsevierbi.com/~media/.../8/.../90803_who_ecigarette_draft.pdf
61. Thompson, H. Electronic cigarettes: a safe substitute? *New Scientist*, 2009, 11/02/11.
62. Tervise Arengu Instituut. Suitsetamisest loobumise nõustamine Eestis. Tervise Arengu Instituut, 2010.
<http://www.terviseinfo.ee/et/truekised/download/132>
63. Tervise Arengu Instituut. Suitsetamisest loobumise meditsiiniline nõustamine. Metoodiline juhendmaterjal. Tervise Arengu Instituut, 2010.
<http://www.tai.ee/et/valjaanded/trukised-ja-infomaterjalid/download/202>
64. Tervise Arengu Instituut. Suitsetamisest loobumise nõustamine tervishoiu esmatasandil. Metoodiline juhendmaterjal lühinõustamise läbiviimiseks. Tervise Arengu Instituut, 2010.
<http://www.terviseinfo.ee/et/truekised/download/129>

65. Civljak, M., Sheikh, A., Stead, L. F., Car, J. Internet-based interventions for smoking cessation. Cochrane Database of Systematic Reviews, 2013.
66. Fiore, M. C., Jaen, C. R., Baker, T. B., Bailey, W. C., Benowitz, N. L., et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline, U.S. Public Health Service, 2008.
http://www.ahrq.gov/clinic/tobacco/treating_tobacco_use08.pdf
67. Zhu, S., Anderson, C. M., Tedeschi, G. J., Rosbrook, B., Johnson, C. E., et al. Evidence of Real-World Effectiveness of a Telephone Quitline for Smokers. New England Journal of Medicine, 2002, 347,1087–1093.
68. Stead, L. F., Perera, R., Lancaster, T. Telephone counselling for smoking cessation. Cochrane Database of Systematic Reviews, 2006, 3.
69. Eesti Konjunkturiinstituut. Illegaalsete tubakatoodete tarbimine ja kaubandus Eestis 2011 (elanike hinnangute alusel). Eesti Konjunkturiinstituut, Tallinn, 2012.
[http://www.ki.ee/publikatsioonid/valmis/Illegaalsete_tubakatoodete_tarbimine_ja_kaubandus_Eestis_2011_\(elanike_hinnangute_alusel\).pdf](http://www.ki.ee/publikatsioonid/valmis/Illegaalsete_tubakatoodete_tarbimine_ja_kaubandus_Eestis_2011_(elanike_hinnangute_alusel).pdf)
70. World Health Organization. Price and tax policies (in relation to Article 6 of the Convention): technical report by WHO's Tobacco Free Initiative. Report to the fourth session of the COP, Punta del Este, Uruguay, 2010 (document FCTC/COP/4/11): paragraph 4.
<http://www.who.int/fctc/publications/en/>
71. World Health Organization. World Health Organization technical manual on tobacco tax administration. World Health Organization, Geneva, 2010.
whqlibdoc.who.int/publications/2010/9789241563994_eng.pdf
72. Jarvis, A., Vincze, M. P., Falconer, B., Garde, A., Geber, F., et al. A Study on Liability and the Health Costs of Smoking. DG SANCO (2008/C6/046), 2009.
ec.europa.eu/health/tobacco/docs/tobacco_liability_en.pdf.
73. ASH Briefing, Action on Smoking and Health. Industry claims about point of sale display bans – where are they now? ASH Briefing, Action on Smoking and Health, London, 2012.
ash.org.uk/files/documents/ASH_833.pdf