World Health Organization

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Tobacco-free generations

Protecting children from tobacco in the WHO European Region

Abstract

Several Member States in the WHO European Region are moving towards becoming tobacco-free: a smoking prevalence of 5% or less. Emphasis, in particular, is on protecting younger generations from smoking initiation and other tobacco-related harm. Protecting children from tobacco in the Region is essential, not only because smoking initiation is a key component of an important public health crisis, but also because Member States are responsible for supporting various children's rights. This report highlights ongoing and emerging tobacco-related issues that affect children in the Region and examines the regulatory frameworks, commitments and other tools that Member States should use to protect children from tobacco. This also includes more novel approaches that could – and should – be used to pave the way towards a tobacco-free European Region.

Keywords

Tobacco
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Children's rights
Human rights
Tobacco industry
Tobacco-free generations
Child and adolescent health

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Acronyms

ASSIST	A Stop Smoking in Schools Trial
CRC	(United Nations) Convention on the Rights of the Child
ENDS	electronic nicotine-delivery systems
ICESCR	International Covenant on Economic, Social and Cultural Rights
REFRESH	reducing families' exposure to second-hand smoke in the home (project)
UDHR	Universal Declaration of Human Rights
WHO FCTC	WHO Framework Convention on Tobacco Control

Introduction

Ongoing issues in the WHO European Region

Tobacco smoking represents an important public health issue in the European Region. The Region comprises 53 Member States and almost 900 million people. Of these, 28% smoke, which corresponds to roughly 252 million people *(1)*: half of these people will die prematurely from smoking *(2)*. Due to the high smoking prevalence in the Region, the mortality burden attributable to tobacco use is, in turn, also high at 16% *(1)*. Such deaths are typically from chronic diseases that have serious impacts on the length and quality of life: cardiovascular diseases, chronic bronchitis, emphysema, asthma and various cancers, such as lung cancer. Smoking is also associated with other health conditions, such as diabetes, rheumatoid arthritis and cataracts, and affects fertility, fitness and virtually every organ and system in the body *(3)*.

The Region comprises 53 Member States and almost 900 million people.

Twenty-eight per cent are smokers, which corresponds to roughly 252 million people.

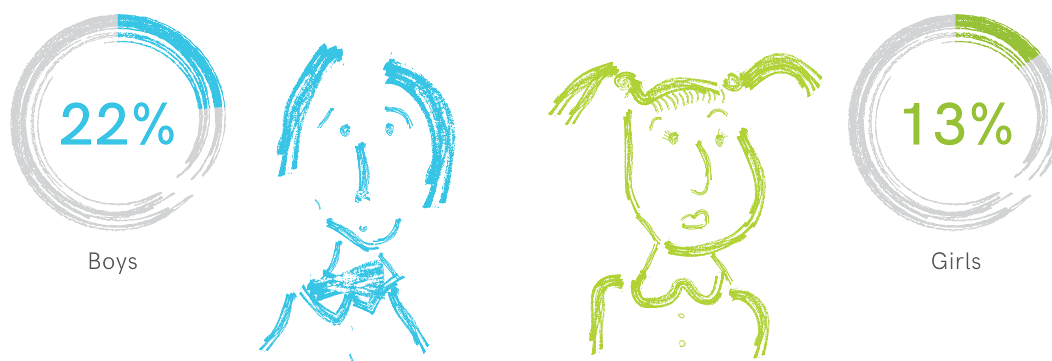
Half of these people will die prematurely from smoking.

On average, smokers lose 20 years of productive life as a direct consequence of smoking *(4)*. This significant loss in productivity, along with the substantial health-related costs incurred by tobacco-related diseases, means that smoking also carries a significant socioeconomic burden *(5)*, which is not offset by potential economic gains such as reduced pension claims *(6)*.

Smoking also directly affects the health of others via the harmful effects of second-hand smoke. Second-hand smoke exposure kills over 600 000 non-smokers globally per year *(2)*, many (31%) of whom are children. These deaths are typically from chronic diseases such as asthma or

respiratory infection *(7)*. Children, who are particularly sensitive to the effects of second-hand smoke exposure, are also put at increased risk of developing middle ear infections, acute respiratory illness, sudden infant death syndrome and behavioural disorders; later in life, they may develop heart disease and lung or other types of cancers *(8)*. Exposure to tobacco in utero increases the risk of complications such as miscarriage, stillbirth, low birth weight, childhood cancer and congenital abnormalities, such as cleft lip *(9)*. Babies exposed to second-hand smoke during pregnancy may be born with nicotine dependence *(10)* and are more predisposed to other neural and behavioural conditions, such as substance abuse, in later life *(11)*. Children exposed to second-hand smoke in the home are also more likely to initiate smoking in the future *(12)*. Despite this, most children under the age of 15 years in the European Region (53.7%) are still exposed to second-hand smoke inside the home, and the vast majority (73.7%) to second-hand smoke outside the home *(13)*.

Another important problem in the Region is smoking initiation, which is limited almost exclusively to children and young people, as most smokers begin smoking by age 18 *(14)*. In the European Region, child experimentation with cigarettes is common and often starts at a young age. The 2013/2014 Health Behaviour in School-aged Children survey *(15)* reported that 17% of children surveyed in the Region (13% girls, 22% boys) had initiated smoking by age 13. This figure varied between countries: smoking among children aged 13 was most prevalent in Greenland (53% girls, 56% boys) and least prevalent in Iceland (5% girls, 7% boys). Smoking initiation at age 13 was more common among boys in most countries and regions, but was more common among girls in, for instance, Bulgaria, Germany, Hungary, Malta and United Kingdom (England). By age 15, 12% of children surveyed in the Region were reported to be smoking weekly. Typically, current smoking among children aged 15 in most countries and regions ranged from approximately 20% (France, Hungary, Italy) to 10% (the Netherlands, Spain, United Kingdom (Scotland)) *(15)*.



Seventeen per cent of children surveyed in the Region had initiated smoking by age 13.

Smoking initiation among children is an area of concern, as by design, cigarettes are highly addictive. They deliver nicotine to the brain within seconds, and the rapid effects of nicotine are potentiated by adding bronchodilators such as cocoa and liquorice, and freebasing agents such as ammonia *(16)*. Due to the strong addictiveness of tobacco, a large proportion of early experimentations eventually develop into daily, addictive use.

The likelihood of addiction developing depends in part on age. Children under 15 who try smoking have an estimated 50% chance of developing nicotine addiction; the chance is higher if smoking is repeated over a prolonged period *(14)*. Symptoms of nicotine addiction, such as cravings and unsuccessful quit attempts, can appear in children within just days or weeks of first trying a cigarette, long before daily smoking develops *(17)*. Most addictions to tobacco develop before age 21 *(18)*. Estimates suggest that three in four children who smoke in adolescence go on to smoke daily in adulthood, even though most of them express intentions to quit in the near future *(14)*. Adolescents also tend to underestimate the addictiveness of their smoking. Surveys indicate that most of them think they will quit within a year (from when they are surveyed), though in reality only about a third will stop smoking within that time frame *(19)*.

Key message

Most children in the Region are inadequately protected from second-hand smoke exposure, despite their heightened vulnerability to its effects. Smoking initiation is another important problem that is limited almost exclusively to children and young people, a vast proportion of whom will go on to become daily, addicted smokers in adulthood. This in turn results in enormous public health and socioeconomic burdens in the Region.

Why children are more vulnerable to nicotine addiction

Neurobiologically speaking, children are far less resilient to the impacts of addictive drugs such as nicotine. The prefrontal cortex, which is a brain region involved in inhibiting risky behaviours and rationalizing long-term goals, can – when functioning properly – protect an individual from engaging in risky activities such as smoking and from becoming addicted to them *(20)*. However, the prefrontal cortex is still developing through the early 20s *(21)*; the implication is that children and young adults are neurobiologically more vulnerable to smoking initiation and addiction, and the younger the age, the higher the vulnerability. Nicotine use can also impair development of the prefrontal cortex, further undermining its function *(20)*. In other words, a person who initiates smoking before his or her early 20s is not only more likely to develop an addiction, but may also have an impaired ability to exercise control over smoking later in life.

Children are also important targets for tobacco industry marketing. The tobacco industry, aware of the vulnerability of children, has been intentionally targeting children as young as 13 years in its tobacco promotions *(22)*. As early as 1957, the tobacco industry noted that *(23)*:

> hitting the youth can be more efficient even though the cost to reach them is higher, because they are willing to experiment, they have more influence over others in their age group than they will later in life, and they are far more loyal to their starting brand.

The tobacco industry reinforced the representation of smoking as a socially desirable adult behaviour: a rite of passage into adulthood for children that is sustained through nicotine addiction. Tobacco companies knew as early as 1969 *(24)* that:

> a cigarette for the beginner is a symbolic act. I am no longer my mother's child, I'm tough… As the force from the psychological symbolism subsides, the pharmacological effect takes over to sustain the habit.

More publicly, however, tobacco companies claimed that *(25)*:

> We don't want young people to smoke. And we're running ads aimed specifically at young people advising them that we think smoking is strictly for adults … Kids just don't pay attention to cigarette ads, and that's exactly as it should be.

However, evidence indicates that even very young children (aged 3-6 years) respond to tobacco adverts *(26)*. Adverts which highlight that "smoking is strictly for adults" *(25)* actually reinforce the rite-of-passage effect, thereby encouraging children to smoke. The tobacco industry continues to target children in tobacco marketing, both directly and indirectly, through means such as movie placements that normalize smoking, sponsorships of events that children often attend (such as concerts and sports events), or by reinforcing smoker identities through the design of tobacco packaging *(27)*.

Current regulations do not sufficiently protect children from the effects of tobacco marketing. Most countries in the European Region only permit tobacco sales to people aged 18 or above, but smoking initiation usually occurs before that age (even when retailer compliance is good), since many young people can obtain cigarettes from older peers who are legally able to buy tobacco *(18)*. Children in the Region also remain inadequately protected from tobacco industry advertising, promotions and sponsorships, the promotional effects of attractive cigarette packaging, and the impacts of tobacco industry efforts to depict smoking as a normal or desirable social behaviour *(1)*.

Key message

Children are neurobiologically vulnerable to smoking initiation and addiction. Tobacco industry marketing continues to exploit this vulnerability, and children in the Region remain inadequately protected from these effects.

In addition to these important ongoing issues, a number of more recent issues regarding children are of particular concern in the European Region.

Targeting of young females in the Region

The targeting of females through gender-specific messages has occurred in the Region since the 1920s, although the countries involved and the ways in which young women are targeted have changed. Tobacco companies market cigarettes to females as a symbol of glamour, fashion, success and sex appeal, and as a means of staying slim. These marketing messages are conveyed through direct means such as billboard advertising, indirect means such as movie placements, and tobacco packaging. Previously, this occurred primarily in western European countries, but more recently has become a feature in southern and eastern countries in the Region *(28)*. In Austria, Czechia, Italy, Spain and the United Kingdom, smoking is now more common among females than males *(29)*. In countries where smoking prevalence is lower among females, the tobacco industry is reutilizing these gender-specific marketing messages to encourage smoking uptake among young females. The implication is that more gender-sensitive approaches to tobacco control should be employed to more effectively protect young females from smoking uptake and subsequent addiction.

Use of electronic nicotine-delivery systems (ENDS) among children

ENDS are devices that deliver nicotine vapour to the lungs in a similar fashion as cigarettes, through a vapour that is heated via an electronic mechanism. ENDS are relatively new to the market, so their use, design, and marketing remain insufficiently regulated in the Region. Of particular concern is the increased use of ENDS among children and young people, which is encouraged through online marketing. ENDS are marketed in a variety of flavours, shapes and designs that appeal to children, and many ENDS do not resemble cigarettes but everyday items such as pens *(30,31)*.

The use of ENDS is potentially harmful, as some varieties have been found to contain poisonous chemicals such as acrolein and formaldehyde at a similar level to that in cigarettes. No less concerning is their potential to cause and reinforce addictions through nicotine, which can result in the sustained use of ENDS into adulthood or a later switch to cigarette smoking. Experimentation with ENDS among young people has notably increased in recent years, and many of these young people are also using cigarettes. There are also concerns that ENDS will renormalize the act of

smoking, which in turn makes children more vulnerable to initiating the use of ENDS or cigarettes *(30,31)*.

Tobacco-related health inequalities

Another important problem in the Region, particularly in more affluent countries, is the growing gap in tobacco-related health inequalities. Smoking prevalence tends to be higher among people with a low education level or low income, and in minority groups such as Roma *(29)*. This, in turn, puts children in these socially disadvantaged groups at a higher risk of smoking initiation, addiction, and exposure to other tobacco-related harms such as second-hand smoke. The smoking prevalence in some Roma communities, for example, is estimated at 70%, which means that many Roma children are likely to be exposed to second-hand smoke at home *(32)*.

In general, tobacco use – along with other indicators of poor health – is connected to other complex issues such as poverty *(33)*, co-morbid mental illness, substance abuse and child abuse, and social determinants such as education, income, social support systems and social integration *(29)*. To ensure that all children in the Region have equal opportunities to healthy, tobacco-free lifestyles, it is essential to address these social disparities and recognize the interconnections between tobacco use and other important issues.

Key message

A number of important emerging issues need more attention in the Region. They include stronger protection of children from the use and marketing of ENDS and a more gender-sensitive approach. More attention should also be paid to the complex needs of children in socially disadvantaged communities who are more predisposed than others to smoking initiation and other tobacco-related harm.

Tools to protect children from tobacco in the European Region

Human rights treaties

A number of human rights can be used to help protect children from tobacco (summarized in Box 1) *(34–39)*. The WHO Framework Convention on Tobacco Control (WHO FCTC) *(40)*, a key treaty for tobacco control policies in the Region, is based on overarching human rights principles in its emphasis on the right to health (International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12) *(34)* and children's rights (United Nations Convention on the Rights of the Child (CRC)) *(35)*.

BOX 1.

Human rights to protect children from tobacco

1948 Universal Declaration of Human Rights *(36)*

Article 3: everyone has a right to life

Articles 2 and 7: everyone has a right to non-discrimination: "without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status"

Article 25: everyone has a right to social conditions that support good health: "a standard of living adequate for the health and well-being of himself and of his family"

1976 International Covenant on Civil and Political Rights *(37)*

Article 6: everyone has an inherent right to life

1976 International Covenant on Economic, Social, and Cultural Rights *(34)*

Article 12: everyone has a right to "enjoyment of the highest attainable standard of physical and mental health" including "prevention, treatment and control of epidemic, endemic, occupational and other diseases"

BOX 1 (CONTD)

1979 Convention on the Elimination of All Forms of Discrimination against Women *(38)*

Article 12: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care"

1989 Convention on the Rights of the Child *(35,39)*

Article 6: children have a right to live, so "governments should ensure that children survive and develop healthily"

Article 24: children have a right to a "clean and safe environment"

Article 33: children have a right to be protected from "the use of harmful drugs"

Article 36: children have a right to "be protected from any activity that takes advantage of them or could harm their welfare and development"

Children, as anyone else, have a right to life according to Article 3 of the Universal Declaration of Human Rights (UDHR) *(36)* and Article 6 of the International Covenant on Civil and Political Rights *(37)*, and a right to health (ICESCR Article 12) *(34)*. The CRC clearly states that children have a right to life and healthy development (Article 6) *(39)*. This entails that children are protected from second-hand smoke exposure, which impairs their development, and from smoking initiation, which threatens their neurobiological development, life and overall health. Their right to a "clean and safe environment" (CRC Article 24) *(39)* should be used to protect them from second-hand smoke exposure, and the right of children to be protected from "the use of harmful drugs" (CRC Article 33) *(39)* includes protection from initiating the use of harmful and addictive drugs such as tobacco. Otherwise, children are a vulnerable target for the exploitative marketing practices of the tobacco industry. However, children have a right to "be protected from any activity that takes advantage of them or could harm their welfare and development" (CRC Article 36) *(39)*. These rights should be used to protect children from second-hand smoke exposure, tobacco industry marketing and smoking initiation.

Other rights may be engaged to address issues related to health inequalities. Some tobacco promotions are specifically targeted at girls in the Region; Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women *(38)*, which obliges Parties to eliminate all discrimination against women in the field of health care, should be used to support more gender-specific ways of addressing this issue. Children from marginalized or socially disadvantaged communities are more likely to initiate smoking and are more exposed to other tobacco-related harm.

According to UDHR Articles 2 and 7 *(36)*, everyone is entitled to their rights without discrimination based on race, social origin or other status. Everyone is also entitled to social conditions that support good health (UDHR Article 25) *(36)*. Supporting these rights, then, requires Parties to pay more attention to the needs of children in socially disadvantaged groups and recognize the interconnection between tobacco use and other complex societal issues.

Key message

The equal protection of all children from tobacco is not only a means of improving public health and socioeconomic development in the Region, but also an ethical imperative that is reflected in various human rights treaties. Member States who are Parties to these treaties are obliged to protect and promote these rights: in doing so, they need to step up efforts to protect children from tobacco.

WHO Framework Convention on Tobacco Control

Fifty of the 53 Member States in the European Region are Parties to the WHO FCTC, which was adopted in 2003. Measures under the WHO FCTC emphasize the importance of a concerted approach in which tobacco demand and supply are minimized using a variety of measures *(40)*. There is good evidence that these measures protect children from smoking initiation and other tobacco-related harm *(1)*; the proper implementation of the WHO FCTC is essential in protecting children in the Region from tobacco (Box 2).

Only a minority of countries within the Region have properly implemented these measures. As of 2012, just 17% had prohibited smoking in all public places (Article 8), with variable compliance. Only 4% had large, pictorial warning labels on tobacco packaging (Article 11). Few (15%) conducted national anti-tobacco media campaigns across a diverse range of media (Article 12), and only 6% enforced comprehensive bans on direct and indirect forms of tobacco advertising, promotion and sponsorship (Article 13).

The implementation of price and tax measures (Article 6) is better, with good implementation levels observed in 47% of countries within the Region *(1)*, although cross-border price differences and compliance enforcement remain an issue. As of 2017, three European countries (France, Ireland and the United Kingdom) have introduced plain packaging, while a decision to do so with a later entry-into-force date has been taken in several other countries. In general, the WHO FCTC remains a highly promising, yet insufficiently applied, policy tool in the European Region.

Key message

The WHO FCTC is a highly effective, yet underutilized, regulatory framework in the Region. By investing in the health of younger generations, Member States should aim to fully implement all measures that fall within the scope of the WHO FCTC.

BOX 2.

Engaging the WHO FCTC to protect children from tobacco

Article 6

Price and tax measures

Children are less likely to initiate smoking if tobacco prices are high. Tobacco taxation is a powerful and cost-effective way to minimize smoking uptake among children.

Article 8

Protection from exposure to tobacco smoke

Children are more vulnerable to the harmful effects of second-hand smoke. Providing comprehensive protection, particularly in indoor areas, is essential.

Article 9

Regulation of the contents of tobacco products

Some cigarettes contain flavours to appeal to children, making it easier for them to experiment with smoking at an earlier age. Bronchodilators, such as menthol, may also increase the addictive potential of nicotine. Restricting these additives is important, to reduce the likelihood that children will experiment with cigarettes and become addicted to them.

Article 11

Packaging and labelling of tobacco products

Children are influenced by advertising and warning labels on tobacco packaging. Large, pictorial warning labels and plain packaging can prevent smoking initiation among children.

Article 12

Education, communication, training, and public awareness

Children should be made aware of the harms of smoking and of tobacco industry activities targeted at them through effective media campaigns and other evidence-based education programmes.

Article 13

Tobacco advertising, promotion, and sponsorship

Children are a vulnerable target for tobacco industry marketing. All tobacco advertising, promotion and sponsorship, both direct and indirect, should be restricted.

Article 14

Tobacco dependence and cessation

Most addictions develop before age 21 and can develop very quickly in children due to their neurobiological vulnerability. Cessation services, tailored to young people, should be available.

Source: WHO *(1)*.

Health 2020

Member States in the WHO European Region adopted the Health 2020 policy framework in 2012 *(41)*. Box 3 summarizes the underlying principles and priorities of Health 2020.

In the context of tobacco, an approach consistent with Health 2020 should recognize that tobacco-free lifestyles – from the prenatal stage into late adulthood – are essential for social and economic development in the Region. After childhood immunization, tobacco-control interventions are the most cost-effective spending on health *(41)*. An investment in tobacco-free younger generations is especially crucial, as the future of socioeconomic development in the Region depends largely on a healthy, productive younger generation. Promoting tobacco-free younger generations in the Region is also consistent with various human rights and supports the human rights-based approach of Health 2020.

Consistent with the priorities of Health 2020, tobacco-free movements should focus on social determinants – such as race, gender, poverty

BOX 3.

The underlying principles and priorities of Health 2020

- Good health across the life-course is a socioeconomic imperative: it improves quality of life and productivity, and is essential for social and economic development.
- Policies should adopt a human rights-based approach, which particularly emphasizes health as a human right.
- Health equity should be achieved by focusing on social determinants of health and recognizing important interconnections between health and other societal issues. Emphasis should be on creating resilient, cohesive communities and supportive social environments.
- Gender mainstreaming should be integrated into public health, systematically integrating gender considerations into policy planning and implementation.
- Whole-of-government and whole-of-society approaches should be adopted, in recognizing the benefits of joint investments in good health and other initiatives.
- Emphasis should be on collaborative models, partnerships with other sectors, and community involvement. This entails people-centred systems, involving young people in health promotion, and peer-to-peer education.

and other complex societal issues – that predispose children to smoking initiation and other tobacco-related harm. Joint investment should be encouraged between tobacco-free initiatives and programmes that aim to reduce systematic social disadvantage, such that children are given opportunities to thrive on an equal basis. This could involve partnerships with other United Nations agencies, such as the United Nations Children's Fund, or more localized, state-organized social programmes involved in promoting children's welfare, education and rights. In people-centred systems, children should be actively involved in promoting their health, educated on their rights (summarized in Box 1), and encouraged to participate in a culture of health in which a healthy tobacco-free lifestyle – rather than smoking – is considered the norm.

The Ashgabat Declaration

The 2013 Ashgabat Declaration on the Prevention and Control of Noncommunicable Diseases in the Context of Health 2020 focuses on new tobacco-reduction targets to minimize the burdens of noncommunicable diseases in the European Region *(42)*. In December 2014, Member States of the Region – in line with the Ashgabat Declaration – confirmed their commitment to fully implement all measures under the WHO FCTC and to cooperate in reducing global tobacco use by 30% by 2025. In doing so, Member States also agreed to share the ambition of working towards a tobacco-free European Region.

The European child and adolescent health strategy 2015–2020

The European child and adolescent health strategy 2015–2020 *(43)*, which focuses more broadly on improving the health of children in the Region, was adopted in September 2014. An aspect of the strategy is to create a tobacco-free millennial generation in the European Region *(43)*:

> This European generation is the first that can realistically aspire to freedom from tobacco … As countries work towards achieving the global goal of a 30% reduction in tobacco use by 2025, the WHO European Region can look beyond and aspire that all children born in or after 2000 will grow into non-smoking adults and reach middle age on a continent where tobacco is a rarity and where children grow up free of direct or indirect exposure to tobacco smoke.

Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the WHO European Region 2015–2025: making tobacco a thing of the past

In September 2015, ministers of health from the 53 Member States of the WHO European Region signed up to a roadmap of actions for 2015–2025 that will make it possible for coming generations to make tobacco a thing of the past (44).

The roadmap lists the actions with the greatest impact in specific areas. One area involves denormalizing tobacco by:

- enforcing smoke-free legislation, especially in children's environments such as schools and child-care facilities, private homes and cars carrying children;
- enforcing comprehensive bans on all tobacco advertising, promotion and sponsorship and working with the entertainment industry on the portrayal of smoking and placement of tobacco products in the media; and
- increasing public awareness through educational initiatives to prevent young people from starting to smoke, informing them about the risks of children exposed to second-hand smoke, particularly in cars and homes, and training health-care and family-support workers to deliver brief interventions for smoking cessation as a routine part of their work.

Key message

The goal of creating tobacco-free younger generations in the European Region is a necessary and achievable one, which falls within the scope of various policy frameworks and commitments in the Region.

Case studies:

paving the way to a tobacco-free generation

Several countries and regions in the European Region, as well as in other WHO regions, are striving towards official goals to be tobacco-free – a smoking prevalence of 5% or less – by a certain year. Ireland and New Zealand aim to be tobacco-free by 2025 *(45,46)*, United Kingdom (Scotland) by 2034 *(47)* and Finland by 2040 *(48)*. In general, these goals are to be achieved by fully implementing all measures under the WHO FCTC, along with a series of more innovative measures that focus particularly on protecting children from tobacco.

In recognizing their collective responsibility to protect children from tobacco, the importance of investing in a healthier, more productive younger generation, and the need for concerted actions in achieving this goal, these countries are paving the way to a tobacco-free generation.

What follows is a series of short case studies on unique aspects of some of these strategies.

Tobacco denormalization in Ireland

Tobacco denormalization consists of measures taken to imply that smoking is not – and should not be – a normal activity in society. It is an important aspect of many tobacco-free initiatives, including those in Finland, Ireland and United Kingdom (Scotland). Tobacco denormalization, or the normalization of non-smoking, is especially relevant to children since they are highly responsive to the social impact of smoking – the misleading idea that smoking is a normal or socially desirable adult behaviour – and are often targeted as such by the tobacco industry.

Accordingly, tobacco-denormalizing measures target children. The Irish strategy *(45)*, for example, states that:

> This is not an anti-smoker initiative but rather a desire to change our approach towards the use of tobacco across society. Making smoking less attractive to children and young people and increasing its social unacceptability are key elements in the denormalization of tobacco. Denormalization of tobacco at every level of society is one of the key strategies for protecting children.

Box 4 summarizes the specific measures that help to achieve this in Ireland.

BOX 4.

Tobacco denormalizing measures in Ireland

Implementing plain packaging

Children are attracted to fashionable cigarette packs, and the design of the packaging is also used to forge smoker identities in young people and to market cigarettes through brand-stretching. Plain packaging protects children from these marketing tactics.

Protecting children from tobacco industry marketing

This can be achieved by banning all direct and indirect forms of advertising, particularly the sponsorship of events intended for young people (such as concerts).

Restricting the sale and display of tobacco products

The sale of tobacco from vending machines and at events and locations aimed at young people, such as schools, is to be prohibited. This minimizes the exposure of children to tobacco products.

Implementing smoke-free outdoor areas

This is especially important in places children often go, such as school campuses, playgrounds, sports stadiums, parks and beaches. Making the observation of tobacco use more of a rarity for children contributes to the normalization of tobacco-free lifestyles.

Banning smoking in cars

This measure aims primarily to protect children from the harmful effects of second-hand smoke. However, it can also help to raise awareness among parents of the harmful effects of second-hand smoke on their children, which could in turn encourage some parents to quit or smoke outside the home.

Peer-based interventions in the United Kingdom

Social interactions are an important aspect of smoking behaviour. Quitting usually occurs in social clusters, for instance with spouses or friends quitting together *(49)*. Smoking initiation also has strong social aspects: children often initiate smoking together with their peers and tend to select friends based on having similar smoking behaviour *(50)*.

Interventions on preventing smoking uptake tailored to young people and encouraging quitting among children who already smoke should focus on enforcing a positive attitude towards non-smoking among peer groups, and work with influential peers as role models. This idea was used as the basis for a prevention programme in the United Kingdom called A Stop Smoking in Schools Trial (ASSIST) (Box 5).

Addressing tobacco-related health inequities in United Kingdom (Scotland)

In United Kingdom (Scotland), as elsewhere, tobacco-related harm continues to affect the most socioeconomically deprived groups. This complex issue involves factors such as adverse early childhood experiences, poverty, unemployment, lack of education and a lack of support within the social environment. Tackling these factors is not only necessary in achieving a tobacco-free target, but is also considered by the Scottish Government *(47)* to be a collective moral responsibility, particularly to protect children:

> Tackling health inequalities and their underlying causes is part of our collective responsibility to advance the right to life … taking steps to protect us all, particularly children, from risks to life. Such measures are also clearly required to advance the right to the highest attainable standard of health.

This is to be attained by tailoring tobacco-control measures to meet the needs of the most socially disadvantaged groups and addressing the reasons that underlie health inequalities more generally. The focus is on supporting young offenders and on an asset-based approach that encourages community resilience by focusing on the skills, resources and connections that already exist in communities. Socially disadvantaged

BOX 5.

ASSIST

ASSIST works by selecting school students who are popular among their peer groups and training them to act as role models outside the classroom in informal peer-group interactions to encourage their friends not to smoke.

A 2008 pilot of an ASSIST programme among 12–13-year-olds in the United Kingdom indicates that it could significantly reduce smoking prevalence among young people *(51)*. Due to this benefit, the programme is also estimated to be cost-effective *(52)*.

The authors argued that the programme's effectiveness could be enhanced further by repeating it each year with successive year groups, to change the social norms regarding smoking behaviour in the entire school *(51)*. Follow-up studies have also highlighted the importance of paying attention to how influential peers are selected for ASSIST. It was suggested that the selection process should involve the peers themselves. This, in turn, enables young people to develop a stronger sense of involvement in the intervention *(53)*.

people, including children, are thereby encouraged to participate in their health.

Forging partnerships between tobacco-free initiatives and other programmes is another important aspect, particularly those that promote children's health, education, good parenting strategies, and reductions in the use of alcohol and drugs and criminal offences among young people. These programmes are recognized as having important interconnections to tobacco-free initiatives because they provide an opportunity to promote tobacco-free movements, while also contributing to an environment in which such movements can have more influence on children's lifestyle and behaviours *(47)*.

Reducing families' exposure to second-hand smoke in the home (REFRESH) project in United Kingdom (Scotland)

The REFRESH project aims to protect children in United Kingdom (Scotland) from second-hand smoke exposure in the home in a way that is non-coercive and non-stigmatizing to smokers. It works by going into the homes of smoking parents with young children, measuring the air quality in the home and educating the parent on how this could affect the child's health. Personalized advice is then provided on how to improve air quality in the home *(54)*.

Finding an alternative place to smoke (such as a balcony) is difficult in some homes. In some cases, particularly for people living in challenging socioeconomic or environmental conditions, or people with disabilities, smoking outside the home may be unfeasible or unsafe. The advantage of providing tailored advice is to facilitate parents in the process of protecting their children's health. It is also sensitive to the specific conditions of those affected by social disadvantage, and in this way may help to minimize tobacco-related health inequalities. So far, the programme has been reported to have a positive influence on the smoking behaviour of parents in the home *(54)*.

The tobacco-free generation proposal

The legal age for buying tobacco in most Member States in the European Region is 18 years. In places such as Hawaii and New York City (United States of America), this has been raised to 21 years *(55)*, on the basis that most smokers initiate before this age and most addictions to nicotine develop between 18 and 21 years. This approach, then, can help to protect younger generations from smoking initiation and addiction, and increases the age gap between young adults who can legally buy tobacco and children who would otherwise obtain tobacco from them *(18)*.

An alternative approach is to phase out tobacco sales to people born after a specified date, such as 1 January 2000, thereby protecting younger generations from tobacco across the life-course. This approach, termed the tobacco-free generation proposal, has received interest in Singapore, Tasmania (Australia) and the United Kingdom (Box 6).

BOX 6.

Progress with the tobacco-free generation proposal

A group from Singapore published the proposal in 2010, suggesting that minimum-age legislation could be re-written such that tobacco sales are denied to: "a person below the age of 18 years or a citizen born on or after 1 January 2000" *(56)*. The rationale is that this would effectively phase out tobacco use among millennial generations and address the rite-of-passage effect of smoking as it becomes progressively denormalized as an outdated behaviour. The legislation would not affect tourism or foreign employment because it would only apply to citizens *(56)*.

Since then, advocacy movements in Singapore have been working on the promotion of a positive social movement towards a tobacco-free generation, engaging children in the initiative and gaining public support. The focus has also been on human rights-supportive aspects of the proposal *(57)*.

The proposal received support in the Tasmanian Legislative Council in 2012, with a unanimous vote for its implementation *(58)*. In 2014, a private member's bill to review current legislation, the Public Health Amendment (Tobacco-Free Generation) Bill 2014, was presented to the Government of Tasmania *(59)*.

The proposal was presented to the British Medical Association in 2014, where doctors in the United Kingdom voted strongly in favour *(60)*.

Key message

By investing in the health of children, the road to a tobacco-free European Region can be paved through various means. In all cases, the indications are clear that the endpoint – tobacco-free younger generations – is attainable, and that Member States should work together in sharing their strategies and achieving this important goal.

Conclusion

Tobacco smoking is and remains an important issue that affects children in the European Region. Effective policy tools such as the WHO FCTC and human rights treaties remain underutilized; consequently, many children, despite their neurobiological vulnerability to addiction, continue to experiment with cigarettes. A vast majority of children in the Region are also exposed to second-hand smoke and continue to be targeted by tobacco industry marketing. This results in serious health consequences across the life-course, and unacceptable public health and socioeconomic burdens in the Region.

A better investment in children's health, which includes as an essential component their complete protection from tobacco, is therefore key to a healthy, productive population in the European Region. This should include the full implementation of measures under the WHO FCTC, more comprehensive regulations on ENDS, a gender-sensitive approach, and a focus on the social determinants that predispose children from socially disadvantaged groups to tobacco-related harm. These points are reflected in various human rights treaties as being ethically imperative and are also emphasized in the Health 2020 policy framework, the European child and adolescent health strategy, and the Ashgabat Declaration.

Various Member States are already demonstrating that the goal of a tobacco-free European Region is not only crucial, but also attainable. Fully implementing all measures under the WHO FCTC will help to achieve this purpose. In addition, more innovative aspects may include focusing on social determinants and integrating tobacco-free initiatives into other child welfare programmes. Projects such as REFRESH can help to protect children from second-hand smoke exposure in the home. A socially-orientated approach may take the form of peer-based interventions, social movements that normalize non-smoking, or a movement that supports younger generations in staying tobacco-free across the life-course.

In all cases, the message is loud and clear: it is time to step up efforts to protect children in the Region from tobacco and utilize current policy tools in view of a healthy, tobacco-free younger generation.

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