Report of the consultation on best practices for Smoke and Aerosol Free Environments (SAFE) in the EU

Contributes to Deliverable 8.2 Position paper on SAFE

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Abbreviations

CINDI	Countrywide Integrated Noncommunicable Diseases Intervention
DALYs	Disability-adjusted life years
DG-SANTE	Directorate-General for Health and Food Safety
ESDs	Electronic smoking devices
FCTC	Framework Convention on Tobacco Control
GBD	Global Burden of Disease
GDPR	General Data Protection Regulation
GNTFHS	Global Network for Tobacco Free Healthcare Services
HTPs	Heated tobacco products
iPAAC	Innovative partnership for action against cancer
JATC	Joint Action on Tobacco Control
LSST	Lieux De Santé Sans Tabac
NGO	Non-governmental organization
SAFE	Smoke and Aerosol Free Environments
SF	Smoke free
SFE	Smoke Free Environments
SHS	Second-hand smoke
TDT	Transdisciplinary Team Model
TFC	Tobacco Free Campus
WHO	World Health Organization
WP	Work Package

Definitions

The European Commission Best Practice Portal considers three types of actions: awards, good practices and best practices. Awards refers to specific actions to promote a policy through recognition from the community. Good practices is a concept usually used to refer to well established interventions in health, which are already proven to be effective and recommended, and are included in a Guide to be implemented and followed regularly by professionals. Best practices are referred more to actions that have been evaluated under certain criteria and that have to be transferred to other areas.

Good practice

A good practice is not only a practice that is good, but a practice that has been proven to work well and produce good results, and is therefore recommended as a model. It is a successful experience, which has been tested and validated, in the broad sense, and which has been repeated and deserves to be shared so that a greater number of people can adopt it. (Joint action CHRODIS, 2014-2017)

Best practice

A best practice is a relevant policy or intervention implemented in a real-life setting and which has been favourably assessed in terms of adequacy (ethics and evidence) and equity as well as effectiveness and efficiency related to process and outcomes. Other criteria are important for a successful transferability of the practice such as a clear definition of the context, sustainability, intersectorality and participation of stakeholders

Potential Best Practice

A potential best practice within the JATC2 project is an intervention, policy, practice or initiative in Tobacco control implemented at national, regional or local level and not recognized as best practice by an official European body, but which would be susceptible to being so if it fulfilled the criteria of a European Best Practice.

Difference between European best practices and potential best practices

Best practices are those that were evaluated and recognized by European official bodies (such as the European Commission); while potential best practices are those that have not yet been evaluated and recognized by European official bodies. A potential best practice requires an evaluation to become a best practice.

Criteria to evaluate best practices and potential best practices

- **Relevance:** The description of the practice should include information whether it is a priority public health area, a strategy or a response to an identified problem at Local/Regional level, National level or European level, and/or put in place to support the implementation of legislation.

- **Intervention characteristics:** The choice of the target population is clearly described (scope, inclusion and exclusion group, underlying risk factors, etc. A detailed description of the methodology used is provided. SMART (Specific, Measurable, Assignable, Realistic, Time-related) objectives are defined and actions to take to reach them are clearly specified and easily measurable. The indicators to measure the planned objectives are clearly described (process, output and outcome/

impact indicators). The contribution of the target population, carers, health professionals and/or other stakeholders as applicable was appropriately planned, supported and resourced. The practice includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks. Information on the optimization of resources for achieving the objectives. An evaluation process was designed and developed including elements of effectiveness and/or efficiency and/or equity including information affecting the different stakeholders involved. The documentation (guidelines, protocols, etc.) supporting the practice is presented properly, referenced throughout the text and easily available for relevant stakeholders (e.g. health professionals) and the target population.

- **Evidence and theory based:** Scientific excellence or other evidence (e.g. grey literature) was used and analysed in a conscious, explicit and thoughtful manner. The intervention is built on well-founded theory/principles and is evidence based. The relevant concepts are stated and explained.

- **Ethical aspects:** The practice guarantees ethical values. The practice must be respectful of the basic bioethical principles of Autonomy, Nonmaleficence, Beneficence and Justice. The practice includes measures aimed at protecting the rights of individuals, according to national and European legislation. Conflicts of interest (including potential ones) are clearly stated, including measures taken. Relevant information is adequately presented to patients/persons, ensuring conscious and informed decision making.

- **Effectiveness and Efficiency of the intervention:** The practice must work and achieve results that are measurable. The practice has been evaluated from an economic point of view. The practice includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.

- **Equity:** As the reduction of inequities is a major issue in Europe, a practice that includes elements that promote equity, should be ranked higher (for example, if considering a gender perspective).

- **Transferability:** This criterion refers to the practice capacity to being transferred to other settings or scaled up to a broader target population/geographic context. The practice uses instruments that allow for replication (e.g. a manual with a detailed activity description). The description of the practice includes all organizational elements, identifies the limits and the necessary actions that were taken to overcome legal, managerial, financial or skill-related barriers. A communication strategy and a plan to disseminate the results has been developed and implemented. The practice has already been successfully transferred. The practice shows adaptability to difficulties encountered during its implementation.

- **Sustainability:** The practice can be implemented over a long period of time with no (or minor) additional resources, adapting to social, economic and environmental context. The practice has institutional/financial support, an organizational and technological structure and stable human resources. The practice presents a financial report. The practice provides training of staff in terms of knowledge, techniques and approaches in order to sustain it. A sustainability strategy has been developed taking into account a range of contextual factors (e.g. health and social policies, innovation, cultural trends and general economy, epidemiological trends). A contingency plan has been drawn up.

- **Participation:** The structure, organization and content (also evaluation outcomes and monitoring) of the practice was defined and established together with one or more of the following: the target population and families or caregivers and more relevant stakeholders and civil society; Mechanisms facilitating participation of several agents involved in different stages of the intervention as well as their specific role, have been established and well described; Elements are included to promote empowerment of the target population (e.g. strengthen their health literacy, ensuring the right skills, knowledge and behaviour).

- **Intersectoral collaboration:** Ability of the practice to foster collaboration among the different

sectors involved. The practice has been jointly implemented by several sectors. A multidisciplinary approach is supported by the agents involved. A continuum-of-care approach is encouraged through collaboration between social, health and/or other services. The practice sets up coordination arrangements involving all different stakeholders (e.g. professional associations, public institutions, educational establishment, employers).

Executive summary

The consultation on Smoke and Aerosol Free Environments (SAFE) policies was conducted among 110 experts from 30 countries of the EU Member States, Norway, Serbia and the UK between the 21st of June and the 12th of September 2022. The section 1 of the survey explored barriers and opportunities for the expansion, compliance / enforcement of SAFE policies. The section 2 asked about best practices to expand SAFE policies.

The responses of 32 experts drew a total of 37 practices from 19 different countries that were grouped into 10 types of settings as follows: 1- beaches, sports & playgrounds (outdoor), 2- educational (indoor & outdoor), 3- national policies (indoor & outdoor), 4- city (indoor & outdoor), 5- health care & residential (indoor & outdoor), 6- hospitality sector (indoor & outdoor), 7- private cars (indoor), 8- private homes & multiunit housing (indoor & outdoor), 9- public transport (indoor & outdoor) and 10- workplace (indoor & outdoor). (See Annexes of all detailed practices)

A sample of these practices was studied in the “JATC2-WP8 Symposium: Learning from Practices to Improve Smoke and Aerosol-Free Environments (SAFE) in Europe” which was held in Madrid on the 25th of April 2023. The Symposium was an exercise to identify key aspects, including barriers and opportunities for the expansion of best practices on SAFE as also obtained in the consultation to experts.

In this report we compile the findings from the consultation to experts as well as the conclusions drawn from the above-mentioned Symposium:

From the consultation we conclude:

- Smoke-free environment policies have made significant progress in reducing SHS exposure and improving public health. However, challenges persist in adequately addressing the risks posed by second-hand aerosols from e-cigarettes, ensuring enforcement and compliance in various settings, particularly outdoors, addressing disparities, and adapting to emerging smoking products and behaviours.
- Almost all the reported practices, with the exception of “awards”, include monitoring and follow up of its effectiveness and expected outcomes which is crucial for their success.
- The approaches to ensure compliance are diverse depending on the practice and the context (country) going from raising awareness to fining non-compliances. In general, the effectiveness of the practice is better ensured when legislative and enforcement/fining capacities are available.

From the Symposium:

- Main barriers against the expansion of SAFE practices are tobacco industry lobby, reluctance of governments, lack of monitoring and sales regulation, and claims of specific settings against the expansion.
- Main barriers against the enforcement of SAFE practices are lack of comprehensive legislation, lack of human and financial capacity, reluctance of governments, lack of training for authorities and/or public sector, and lack of dedicated funding for tobacco control research and interventions.
- Frequently identified needs for the expansion of SAFE are the need to clarify the importance

of having smoke-free outdoor settings not only smoke-free indoor settings and the need to include electronic cigarettes and heated tobacco products in countries where they are perceived as a harm reduction/modification tool.

- To make a practice successful it needs clarity in its objective. Also, capacity to evaluate the achievement of its objective. It is crucial the identification and involvement of the right stakeholders including the target population, in order to have a well sorted implementation team. It needs, as well, to have legislative support from a clear law, stable human and financial resources, well- designed regular campaigns of awareness, workshops, conferences and adequate tools of dissemination, proper training of the people in charge of implementation, right material to support the practice and empower non- smokers to advocate for rules' compliance.
- To make a practice sustainable it needs to be a successful practice, to have continuity of the teams implementing the practice, to ensure the coalition between civil society and local authorities, and dissemination of results (regular information campaigns specific to the practices).

1. Introduction

Second-hand smoke (SHS) has been described as the combination of smoke emitted from burning tobacco products and the smoke exhaled by individuals (Öberg et al., 2010). The 2019 Global Burden of Disease Study revealed that the exposure to SHS was associated with approximately 1.3 million deaths among non-smokers worldwide and contributed to about 37 million disability-adjusted life years (DALYs), ranking SHS as the 13th leading level 3 risk factor for deaths that year (GBD, 2019).

The evidence on the adverse health effects of SHS alongside strategies such as the WHO Framework Convention on Tobacco Control (WHO FCTC) -adopted in 2003 and later enforced in 2005 – as well as MPOWER measures introduced in 2009, have led to the development and implementation of Smoke-free Environment (SFE) policies worldwide (Carreras et al., 2021; Semple et al., 2022). According to the 2021 WHO report on the Global Tobacco Pandemic, approximately 1.8 billion people reside in countries with comprehensive smoke-free policies (WHO, 2021).

Smoke-free legislations have proven to be effective in reducing SHS exposure (Burkhartd et al., 2023; Strassman et al., 2023). This is particularly true when comprehensive bans are implemented rather than partial ones (Schiavone et al., 2022). Furthermore, such legislations can have positive behavioural changes beyond the ban itself, such as discouraging smoking at home (Mons et al., 2012; Tattan-Birch & Jarvis, 2022).

However, there are challenges and limitations when talking about smoke-free environments policies, such as low compliance with the existing smoke-free laws. Also, the fact that the majority of the existing legislations and regulations related to smoke-free environments often do not regulate non-traditional tobacco products and second-hand aerosols from electronic smoking devices (ESDs) -electronic cigarettes or e-cigarettes-, poses challenges in protecting individuals from the potential health risks associated with second-hand aerosols (Gallus & Fernandez, 2022).

Also, applying smoke-free environment policies can be challenging, especially in certain settings like private homes and vehicles. While public spaces in sectors such as workplaces or hospitality can be regulated more easily, extending these policies to private spaces requires a different approach (Schober et al., 2017).

Moreover, research has shown that smoking is still common even in places where smoke-free policies exist (Smith et al., 2023).

There is a need for policy makers to implement measures that are more effective in regard to reducing the negative impact caused by SHS and SHA (Zhai et al., 2023).

In this report we summarize the results of the consultation on "best" practices to implement Smoke and Aerosol Free Environments conducted to experts from different Member States of the EU and of the consultation with experts at the "Symposium on Smoke and Aerosol Free Environments: Learning from Practices to Improve Smoke and Aerosol-Free Environments (SAFE) in Europe" held in Madrid on the 25th of April 2023.

The European Commission Best Practice Portal considers three types of actions: awards, good practices and best practices. In the following text we refer to the practices indistinctly using the terms "best practice" or just "practice" as such, since most of the reported practices have not yet been evaluated or have not been placed in the Best practices portal of the EU.

The European Joint Action on Tobacco Control 2 -JATC2 was created to strengthen cooperation for tobacco control between Member States and the European Commission. Within this project, several institutions lead activities to achieve this goal.

As part of Work Package 8 (WP8) of JATC2, the Tobacco Control Unit of the Catalan Institute of Oncology (ICO) launched an experts' consultation with the overall goal to gather evidence that will allow Member States to protect their population from exposure to second-hand tobacco smoke and aerosols produced by electronic cigarettes and other novel tobacco products.

2. Methods

The consultation was conducted between June and September 2022 via an online questionnaire exploring, among others, the following criteria: relevance, intervention characteristics, evidence and theory based, ethical aspects, effectiveness and efficiency of the intervention, equity, transferability, sustainability, participation and intersectoral collaboration.

The steps followed in the consultation are: 1- Identification and selection of experts, 2-Designing, programming and testing the online questionnaire, 3- Survey filling out and data collection, 4- Data management and analyses.

2.1. Identification and selection of experts:

A contact list of expert, key informants within fields such as smoke and aerosol free regulation, research, enforcement or NGOs was created.

The experts were identified by using the list of stakeholders organized by countries from WP6 of JATC2, partners of the project in cases where no appropriate contacts were found on those lists and other personal contacts with relevant organizations such as Smokefree Partership (SFP) and the European Conference on Tobacco Control (ENSP). Additionally, internet searches were also conducted for countries where it was particularly challenging to get experts' contacts.

Once the experts were identified, they were contacted via e-mails that explained which kind of key informants we were looking, a request to participate in the consultation and what they should expect from that participation. Availability to answer any questions or to offer further clarifications was always offered.

Particularly, the goal was to identify and select between 3 and 4 national experts per country for a total of 30 European countries (1). The final list of experts had 101 experts from 30 different countries from EU member states, Norway, Serbia and the UK and 60 reserve contacts from 15 countries.

2.2. Designing, programming and testing of the online questionnaire:

The online questionnaire used in the consultation was designed using a previously created core questionnaire that was formulated by Work Package 4 of JATC2 as the main source. The questionnaire consisted of 2 sections and had a total of 60 questions. The section 1 of the survey explored barriers and opportunities for the expansion, compliance / enforcement of SAFE policies. The section 2 asked about best practices to expand SAFE policies and also, about barriers and facilitators for the implementation of each specific best practice.

There were two questions on barriers and facilitators to implement best practices for SAFE and as well as on relevant policies and best practices to achieve smoke and aerosol free environments.

The questions exploring the barriers to implement best practices for SAFE were classified into four categories: (lobbying of the Tobacco and Nicotine Industry (TNI), political barriers, cultural barriers and other barriers such as lack of resources). The question exploring the facilitators to implement best practices for SAFE, were classified into four categories: environmental movement, cultural,

(1) Austria Belgium Bulgaria Croacia Cyprus Czechia Denmark Estonia Finland France Germany Greece Hungary Ireland Italy Latvia Lithuania Luxembourg Malta Norway Poland Portugal Romania Serbia Slovakia Slovenia Spain Sweden The Netherlands UK

communication and social media and other facilitators. Both questions on barriers and facilitators allowed for multiple choice answers and therefore are presented as counts and not as percentages. Both questions had a text field for further explanation.

The questionnaire was programmed using Survey Monkey and was tested by different WP8 partners before the official launch and invitation to experts.

2.3. Survey filling out and data collection:

Each expert key informant was asked to provide information of up to 4 best practices implemented in their countries. Follow-up on data collection was done on a weekly basis.

2.4. Data management and analyses:

Data management and analyses of best practices, barriers and facilitators for its implementation (Section 2):

The summary sheet for each practice organises the information into the following subchapters:

1. Objective, relevance and target setting of the practice; 2. Description of the practice, scope and type of practice; 3. Target population; 4. Equity; 5. Ethical considerations; 6. Evaluation; 7. Transferability; 8. Sustainability; 9. Involvement and participation; and 10. Responsibility, funding and project management.

The subchapters mentioned above were equating the WP4 assessment criteria as follows:

Table 1. Correlation between the structure of reporting practices and assessment criteria

STRUCTURE OF REPORTING PRACTICES	WP4 ASSESSMENT CRITERIA	TYPE OF CRITERIA
1. Objective, relevance and target setting of the practice	Relevance	Exclusion criteria
2. Description of the practice, scope and type of practice	Intervention characteristics	Exclusion
3. Target population	Evidence and/or theory based	Exclusion
4. Equity	Equity	Core
5. Ethical considerations	Ethical aspects	Exclusion
6. Evaluation	Effectiveness, efficiency	Core
7. Transferability	Transferability	Qualifier
8. Sustainability	Sustainability	Qualifier
9. Participation	Participation	Qualifier
10. Responsibility, funding and project management	Intersectoral collaboration	Qualifier

To do the assessment there were three types of criteria: Exclusion criteria (those compulsory to be present), Core criteria (those important for the evaluation) and Qualifier criteria (n)

Each criterion was assessed on a scale from 0 to 5 following the Guidance on Best Practices from WP4, and the iPAAC joint action.

First, quality and completeness of data was analysed; second, data extraction and description was conducted; and lastly, a revision of each practice reported was done followed by a summary sheet and scoring. The scoring process was completed by two reviewers per practice.

Since the objective of this consultation was to identify best practices, the exercise of scoring is important despite the fact that while conducting the exercise there were many missing fields preventing a formal evaluation. Therefore, the following consensus decisions and assumptions were taken to score the reported practices: acceptance that compliance of ethical and equity considerations could be taken for granted for most of the reported practices given their nature; a

higher score was given to those practices that had been formally evaluated, followed by those that had a monitoring process; a higher score was given if the experts indicated that sustainability had been considered or that resources where available in regards to this objective; a higher score was given if transferability had been proven followed by practices that planned on doing so; involvement of the target groups regarding participation and empowerment was also considered for a higher scoring; regarding governance and project management, if the practice offered clear information on the responsible organisation, it was also scored higher; finally, if the target population was consistent with the practice and more specific, the practice was also scored higher.

The final scoring was only considered as part of the criterion used to identify practices to be presented for discussion as learning exercise in the Symposium pre-ECToH conference.

All the reported practices were classified according to the main setting they were applied to, generating a list of 10 types of settings as follows: 1- beaches, sports & playgrounds (outdoor), 2- educational (indoor & outdoor), 3- national/local policies (indoor & outdoor), 4- city (indoor & outdoor), 5- health care & residential (indoor & outdoor), 6- hospitality sector (indoor & outdoor), 7- private cars (indoor), 8- private homes & multiunit housing (indoor & outdoor), 9- public transport (indoor & outdoor) and 10- workplace (indoor & outdoor). (See Annexes of all detailed practices)

The category of national policies was used for practices informed as covering national or local areas with either comprehensive policies or with policies applying to different categories of settings altogether in the nation.

We present the overall description of the type of tobacco product that the practices applied to, the scope, phase, responsibility, focus, funding, transferability, sustainability and involvement of different stakeholders. Finally, the main outcomes of the practices are presented by type of setting and country.

The Symposium was held as a pre-ECToH conference activity on the 25th of April 2023. There were 35 registered participants and among them, 10 panellists were in charge of a proposed small group. This Symposium consisted of three phases: the first one was the presentation of the practices reported at the consultation by type of setting and country as well as the summary of the reported barriers and opportunities for the expansion of SAFE practices; in the second one, 10 groups of 2 to 4 people were organised with the goal of studying 2 reported practices per group. Each group discussed a type of practice according to settings or areas (playgrounds, hospitality sector, workplaces, health care, cars, homes, beaches, cities, national and transport) using as a guide a list of proposed questions. Lastly, in the final phase, the moderator of each group presented to the audience a summary of their group discussion, insights and conclusions. These practices on SAFE were used to enlighten the debate and trigger ideas to answer key questions related to their effectiveness and efficiency, successfulness, sustainability, transferability, enhanced participation and governance, as well as the compliance and enforcement of laws, and the barriers and opportunities for the expansion of SAFE in Europe.

Another information on barriers and facilitators for the implementation of best practices on SAFE collected in Section 2 of the questionnaire, was cross-tabulated with the type of target/setting of the best practice.

Data management and analyses of barriers and opportunities for expansion of SAFE (Section 1):

The free text information on barriers and opportunities for the expansion of SAFE collected in Section 1 of the questionnaire, was grouped into six categories and given the variable name "type of barrier" for its analysis.

3. Results

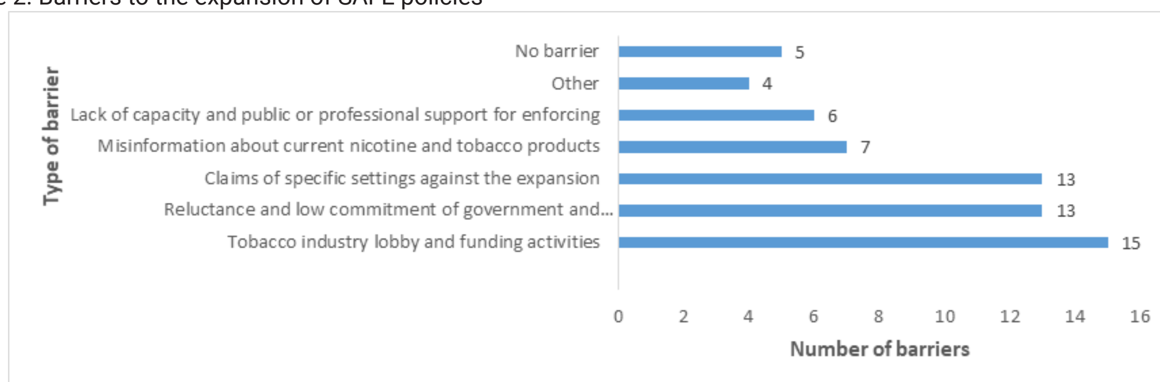
In this chapter we present the summary of information on barriers and opportunities (section 1) and an overview of best practices for SAFE (Section 2 and Annex 1; within this document). A more detailed information on barriers and opportunities and best practices is presented in Supplementary tables (Annex 2; in a different document).

Section 1: Barriers and opportunities for the expansion and enforcement of the reported SAFE practices

Among the 30 countries of EU where some experts on SAFE could be identified (1), there were 63 experts from 29 countries (Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, The Netherlands, UK) that provided information on barriers and opportunities for the expansion and enforcement of SAFE in their country.

Regarding the **barriers for the expansion of SAFE,** there were 63 responses to a free text question that was categorized as follows with the following results: the most frequently mentioned barrier was industry interference, followed equally by government reluctance and claims of specific settings against the expansion. There were also seven respondents mentioning misinformation about current nicotine and tobacco products finally, the lack of capacity to enforce existing laws by the government. Only five responses were mentioning that there was no barrier for expansion of SAFE. (Table 1)

Table 2. Barriers to the expansion of SAFE policies



More specifically, when classifying the barriers for the implementation of best practices into four categories: lobbying of the Tobacco and Nicotine Industry (TNI), political barriers, cultural barriers and other barriers such as lack of resources and tabulating these with **the topic of the practice,** the most frequently informed barriers to implement national/local SAFE practices were cultural ones (43% of the informed barriers for this type of practices), followed by lobbying of the TNI (35.7%). Cultural barriers such as groups of population stating: “Stop bothering smokers” or “smokers have also rights”.

Cultural barriers were also the most frequently mentioned when considering barriers to the implementation in health care and educational facilities. The most frequently mentioned barriers applying to outdoor public places were political (42.9%), followed by cultural (28.6%), lobbying of the TNI and other (14.3%). SAFE practices applying to public transport face equally political barriers and lack of human resources. Workplaces face political and cultural barriers. Finally, according to the experts responses, the barriers to implement SAFE practices in the hospitality sector are equally related with political will and the lobbying of the TNI. (Table 2)

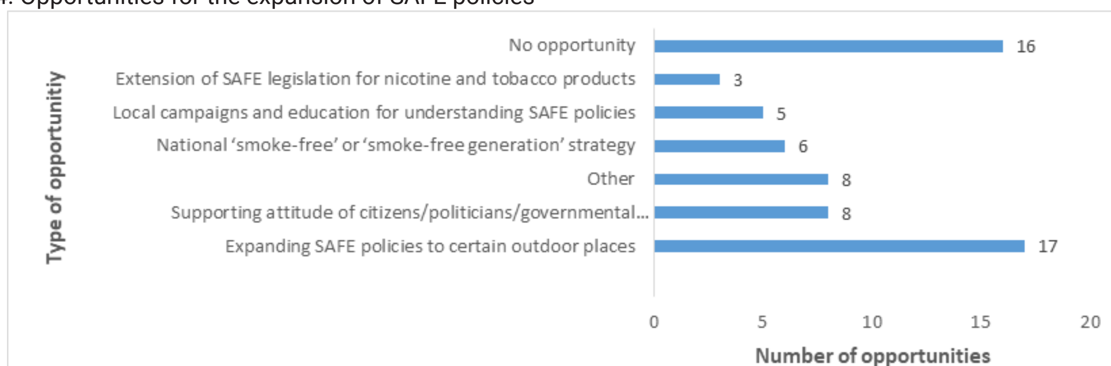
Table 3. Barriers for the implementation of best practices about SAFEs by topics of the best practice

Target of the best practice	Reported practices	Barriers related to the practices (multiple choice)									
	N (%)	Lobbying of the TNI		Political		Cultural		Other*		Total	
		n	%	n	%	n	%	n	%	n	%
National/local legislation	10 (25.0)	5	35.7	2	14.3	6	42.9	1	7.1	14	100
Outdoor public places	7 (16.3)	1	14.3	3	42.9	2	28.6	1	14.3	7	100
Private areas	6 (15.0)	1	25.0	0	0.0	1	25.0	2	50.0	4	100
Health care facilities	4 (10.0)	0	0.0	0	0.0	2	100.0	0	0.0	2	100
Ban on vaping in public indoor	1 (2.5)	1	33.3	1	33.3	0	0.0	1	33.3	3	100
Educational facilities (schools, universities)	3 (7.5)	0	0.0	0	0.0	2	100.0	0	0.0	2	100
Public transports	3 (7.5)	0	0.0	1	50.0	0	0.0	1	50.0	2	100
Workplaces	1 (2.5)	0	0.0	1	50.0	1	50.0	0	0.0	2	100
Hospitality sector	2 (5.0)	2	50.0	2	50.0	0	0.0	0	0.0	4	100
Total	**37 (100.0)**	**10**	25.0	**10**	25.0	**14**	35.0	**6**	15.0	**40**	**100**

Note: *Resources lacking (human, financial), problems with compliance and enforcement, management problem (lack of understanding of the importance of tobacco control), lobbying of users' groups.

Despite the barriers to expansion, there were 47 respondents (74.6%) that identified opportunities for the expansion of SAFE policies (Table 3). More than one-quarter of experts believed that there would be opportunities for expanding SAFE policies to certain outdoor places such as beaches, parks, crowded places, places where children are present, hospitality venues, balconies of private homes, and cars. Improving supporting attitudes towards SAFE policies by citizens, politicians, governmental organizations, and NGOs could also serve as an opportunity. Some experts mentioned as an opportunity ongoing or recently started national 'smoke-free' or 'smoke-free generation' strategies as well as local campaigns and education for the general population to understand SAFE policies. Respondents also indicated a broad range of other opportunities including transparency of industrial financial operations, funding for smoking cessation services or for enforcing SAFE policies, and imposing a significant fine to deter. Although some experts argued the extension of SAFE legislation for nicotine and tobacco products, a few experts were opposed to expand smoke-free policies to these products.

Table 4. Opportunities for the expansion of SAFE policies



Facilitators related to the implementation of the informed practices are summarized in Table 4. For national/local legislation the environmental movements are seen as the main facilitators followed by cultural and other supports of the general population. To promote some changes in outdoor public places, the support of public health authorities, municipalities and NGOs are mentioned to be crucial, followed by communication and social media. The implementation of SAFE practices applying to private areas may be promoted thanks to communication and social media, although some experts

think equally that is not relevant to implement this type of practices. Also, the support of municipalities and NGOs is seen as an important opportunity to expand SAFE practices in educational facilities and the hospitality sector. Environmental, cultural movements and other facilitators are equally seen to help implementing practices in health care facilities. On the other hand, the only facilitator identified by experts to implement SAFE practices at workplaces is cultural development at work. (Table 4)

Table 5. Facilitators for the implementation of best practices about SAFEs by topics of the best practice

Target of the best practice	Reported practices	Facilitators related to the practices (multiple choice)											
	N (%)	Environmental movement		Cultural		Communication, Social media		Other*		Not Relevant		Total	
		n	%	n	%	n	%	n	%	n	%	n	%
National/local legislation	10 (25.0)	4	26.7	3	20	2	13.3	3	20	3	20	15	100
Outdoor public places	7 (16.3)	2	22.2	0	0	3	33.3	4	44.4	0	0	9	100
Private areas	6 (15.0)	1	14.3	1	14.3	2	28.6	1	14.3	2	28.6	7	100
Health care facilities	4 (10.0)	2	25	2	25	1	12.5	2	25	1	12.5	8	100
Ban to vape in public indoor	1 (2.5)	1	25	0	0	1	25	1	25	1	25	4	100
Educational facilities (schools. universities)	3 (7.5)	0	0	1	25	0	0	3	75	0	0	4	100
Public transports	3 (7.5)	0	0	0	0	0	0	1	33.3	2	66.7	3	100
Workplaces	1 (2.5)	0	0	1	100	0	0	0	0	0	0	1	100
Hospitality sector	2 (5.0)	0	0	0	0	1	33,3	2	66.7	0	0	3	100
Total	**37 (100)**	**10**	17.9	**8**	14.3	**11**	19.6	**17**	30.36	**10**	17.9	**56**	**100**

(*) support by health and public health sector, municipalities, NGOs, and other organizations, and support by the general population or employees of workplaces

Finally, barriers and opportunities for the expansion as well as for the compliance with or enforcement of SAFE policies by countries is presented in **supplementary tables (Annex 2).** Additionally, within WP8 a specific reports on Barriers and opportunities for SAFE has been published in CIRCABC.

Section 2: "Best" practices for SAFE: overview

Among the 30 countries of EU where some experts on SAFE could be identified (1), there were 32 experts from 19 countries (Austria, Belgium, Czechia, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Italy, Lithuania, Luxembourg, Malta, Slovenia, Spain, Sweden, The Netherlands and UK) that provided information of at least a best practice for SAFE in their country.

The online questionnaire on best practices was completed by 32 experts out of 110 consulted (response rate 29%). Twelve experts coming from governments, other 12 working in NGOs, 3 experts from the academia, 1 from a public research centre, another one from a public hospital and the remaining three experts did not explain their affiliation.

There were 43 practices reported, three of them were the same practice reported by different experts in the same country, making 41 practices. Other four practices could be qualified as smoking cessation, which gives a total 37 practices on SAFE to be presented in this report.

A summary table of each of these practices is presented in Annex 1. Moreover, a Web based repository of the practices will be shortly made available and functional: https://smokefreebestpractices.eu/

The number of SAFE practices presented by experts included five practices informed by experts of Austria, four practices informed by experts in The Netherlands, three different practices informed by experts from Belgium, Denmark, Slovenia; two practices informed by experts from France, Ireland, Luxembourg, Sweden and UK. Finally, the experts from Czechia, Estonia, Finland, Germany, Hungary, Italy, Lithuania, Malta and Spain provided information on one SAFE practice each. (Table 5 & 6)

Table 6. Number of practices by type of setting and country

Number of practices	Beaches, Sports & playgroung (outdoor)	Educational (indoor & outdoor)	National (indoor & outdoor)	City (indoor & outdoor)	Health care & residential (indoor & outdoor)	sector: Bars & restaurants & hotels (indoor & outdoor)	Private Cars (indoor)	Private homes & multiunit housing (indoor & outdoor)	Public transport (indoor & outdoor)
Austria			2			2	1		
Belgium			2						1
Czechia					1				
Denmark		1		1					
Estonia									1
Finland				1					
France				1	1				
Germany			1						
Hungary			1						
Ireland					1		1		
Italy	1								
Lithuania			1						
Luxembourg	1						1		
Malta			1						
Netherlands	3								1
Slovenia		1					1		
Spain	1								
Sweden			1		1				
UK								2	

Twenty-seven practices apply to both indoor and outdoor settings, 6 practices apply to outdoor settings only and 4 to indoor settings only. The target population of almost all practices was the general population, with some practices applying to private homes, cars or schools or playgrounds, identifying age-specific groups, pregnant women and certain levels of the educational system as target for the practice.

3.1. Type of tobacco or nicotine product objective of the practice

The type of product objective of the practice was mainly conventional tobacco, followed by e-cigarettes and heated tobacco products. There were 20 indoor practices focusing on limiting conventional tobacco along with 15 and 13 of these that were also focused on e-cigs and HTPs, respectively. Twenty-two of the reported outdoor practices focused on banning/limiting consumption/informing against conventional tobacco. At the same time, 18 of these were also focusing on e-cigs and HTPs. There were 7 practices considering cars which objective was conventional tobacco along with 4 of these practices that were also focused on e-cigs and HTPs. Smoke free homes practices were only considering conventional tobacco within their objective.

Other devices that are currently appearing on the market were not explored in the consultation. (Figure 1)

Figure 1. Type of tobacco product objective of the practice by type of setting

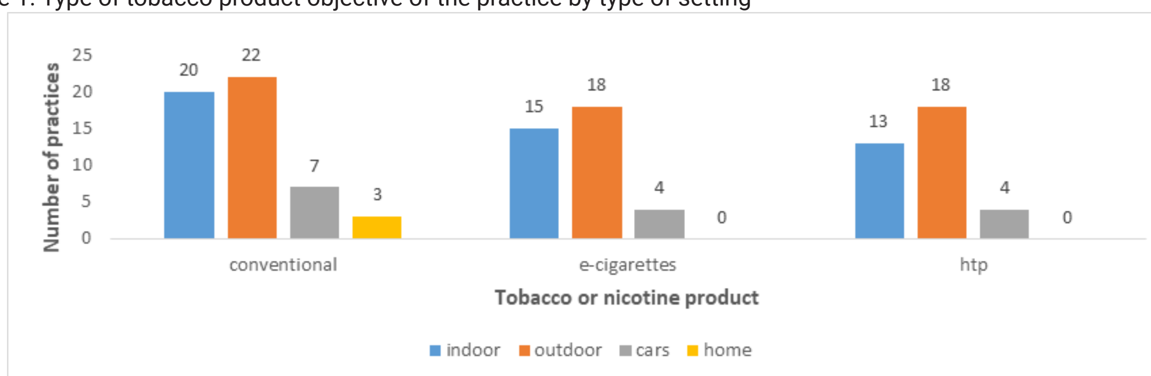


Table 7. List of reported practices (N=37): ID number, country, smoke-free setting and name of the practice

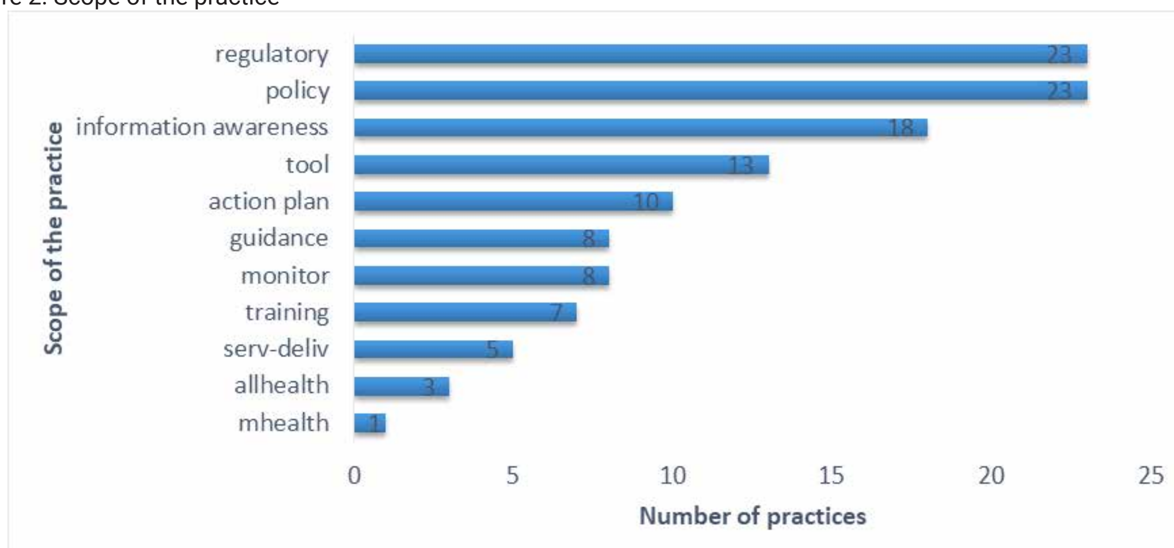
ID	country	Smoke-free setting	Name of the practice
1	AT	sf_national	Supporting and consulting initiatives addressing the prevention in settings of young people (children and adolescents)
2	AT	sf_hospitality	Health Impact Assessment: “Smoke free hospitality in Austria”
3	AT	sf_car	Smoking ban in closed private vehicles if there is a person inside who is under the age of 18.
4	AT	sf_nation	Smoke Free Award.
5	AT	sf_hospitality	Smoking ban in the hospitality sector
6	BE	sf_nation	Generation Smoke Free
7	BE	sf_transports	Smoke-free railway platforms
8	BE	sf_nation	A ban to vape in closed public places
9	CZ	sf_health care	Tobacco free health care services
10	DE	sf_nation	Law for the protection from secondhand smoke – smokefree legislation of Hesse.
11	DK	sf_city	Smoke free outdoor areas_ The city of Aarhus
12	DK	sf_work	Workplaces as settings for implementation of smoke- and aerosol free environments
13	DK	sf_edu	Smoke Free School Hours.
14	EE	sf_transp	Implementation of the smoke-free zone regulation in the public transport shelters and waiting rooms..
15	ES	sf_beach	Smoke-free beaches
16	FI	sf_city	Tobacco-free municipality concept
17	FR	sf_hc	Lieux De Santé Sans Tabac (Smoke-free healthcare Facilities)
18	FR	sf_city	Ville libre sans tabac / Tobacco-free cities
19	HU	sf_nation	Tobacco control in practice- Article 8: Protection from exposure to tobacco smoke - the story of Hungary
20	IE	sf_hc	Health Service ‘National Policy on Tobacco Free Health Services’.
21	IE	sf_car	Ban on smoking in cars when children are present
22	IT	sf_beach	Smoke-free beaches
23	LT	sf_nation	Legal requirement for smoke free environments as part comprehensive Tobacco Control Law
24	LU	sf_car	Smoking ban in cars when children under 12 years are aboard
25	LU	sf_play	General smoking ban in children playground
26	MT	sf_nation	Products and Smoking Devices (Simulating Cigarettes or Tobacco) (Control) Regulations, 2010
27	NL	sf_sport	Smoke-free sports grounds (Rookvrije Sport)
28	NL	sf_transp	Smokefree public transportation in the Netherlands
29	NL	sf_play	Smoke-free petting zoos/city farms and playground associations
30	NL	sf_play	Smoke-free municipal/public playgrounds and sports facilities

31	SE	sf_nation	Smoke-free outdoor settings
32	SE	sf_hc	Non-smoking/smoke-free outdoor environments in the health care sector in Region Östergötland, Sweden
33	SI	sf_car	Tobacco smoke and aerosol free vehicles with minors present
34	SI	sf_work	Comprehensive protection from tobacco smoke and aerosols of related products in all enclosed public places workplaces & open places
35	SI	sf_edu	Smoking ban indoor at school/universities and outddor areas / functional land of schools/universities
36	UK	sf_home	Smoke-free homes (England)
37	UK	sf_home	Take it right outside (Scottland)

3.2. Scope of the practice

Most of the practices have several scopes. The most frequently mentioned scopes are regulatory and policy making (23 out of 37 each, 62%), followed by information awareness (18 out of 37, 49%) and being a tool to expand SAFE (13 out of 37, 35%). Ten practices have the scope of being an action plan (27%), followed by guidelines, monitoring (22%), training (19%), service delivery (14%) and all health (8%). Only one practice has the scope of mobile health. (Figure 2)

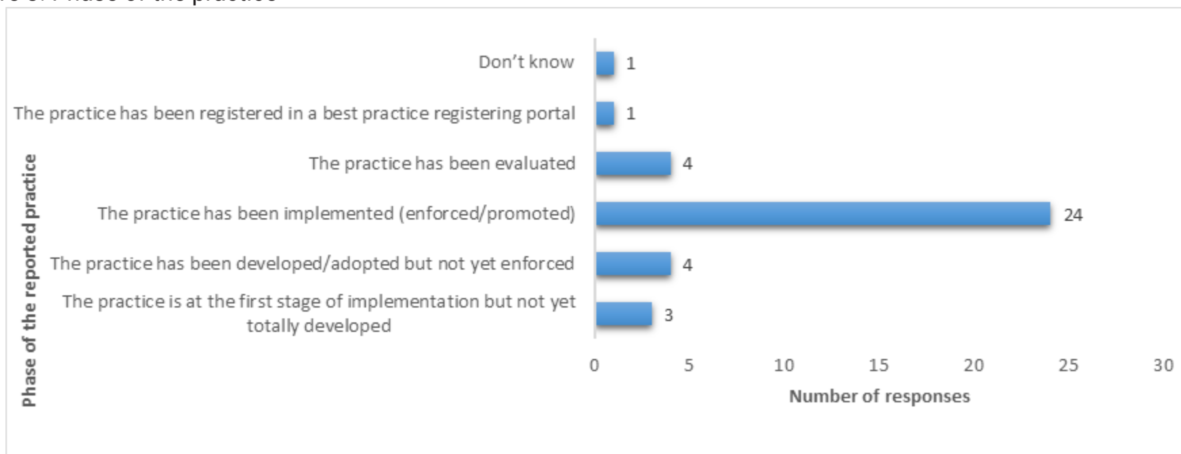
Figure 2. Scope of the practice



3.3. Phase of the practice

There were 4 practices mentioned to have been evaluated, either internally by the same entity implementing the practice or externally, by another entity not involved in implementation of the practice. Most of (24 out of 37) the reported practices have been implemented (enforced and promoted). Four practices have been promoted but not yet enforced and three practices are at the first stage of implementation but not yet totally developed (Figure 3)

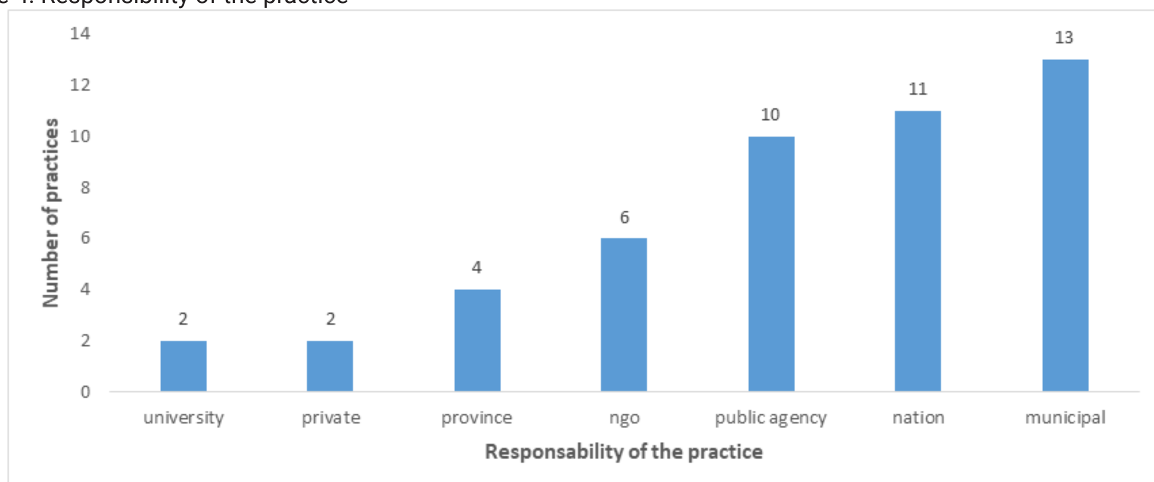
Figure 3. Phase of the practice



3.4. Responsibility of the practice

The responsibility of the practice is held most frequently at municipal level, followed by the national, public agencies and NGOs (Figure 4). In most of the practices the responsibility is shared between municipality and public agency.

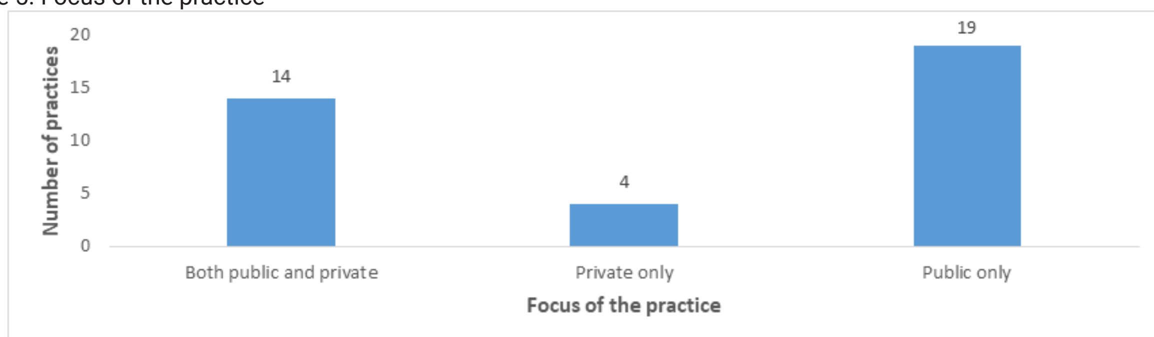
Figure 4. Responsibility of the practice



3.5. Focus (private or public) of the practice

Most of the practices are oriented to public settings, followed by those applying to public and private and four practices are focusing on private settings only. These four practices are the ones on smoke-free cars and smoke-free homes. (Figure 5)

Figure 5. Focus of the practice



3.6. Funding of the practice

Almost half of (17 out of 37) the practices have public funding followed by own resources and no fund needed. The practices applying to private cars are mentioned to not need funds and the only funding of practices applying to beaches and homes is public. Own practice applying to sports club its only funding is through own resources and the remaining settings have complementary sorts of funding. (Table 7)

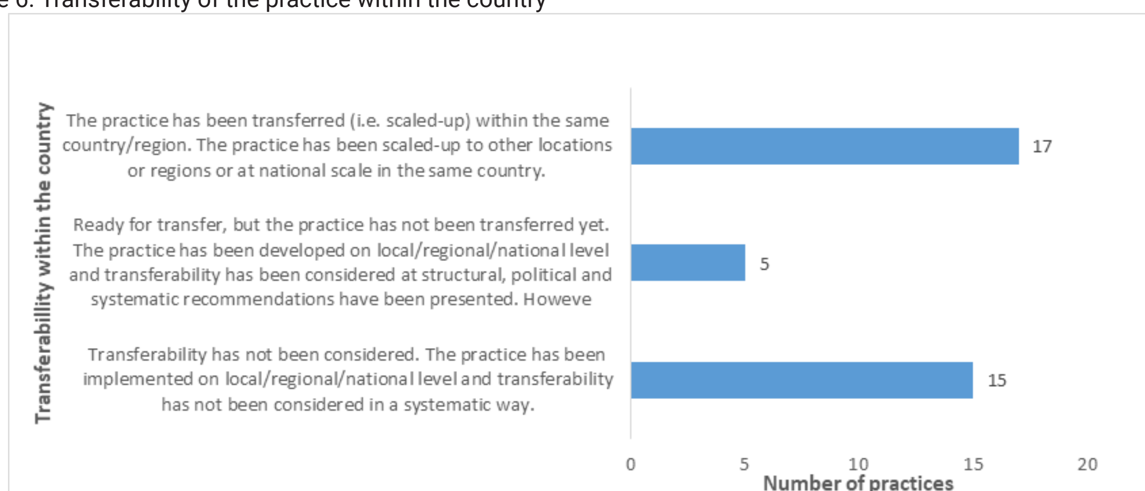
Table 8. Funding of the practice by smoke-free setting

	sf_ beach	sf_car	sf_ city	sf_ edu	sf_hc	sf_ home	sf_ hotel	sf_ nation	sf_ play	sf_ sport	sf_ transp	sf_ work	total
Own resources			1	1	2		1	2	1	1	1	1	11
Public funding	2		2		2	2	1	5	1		1	1	17
no fund		4		1			1	2	1				9
	2	4	3	2	4	2	3	9	3	1	2	2	37

3.7. Transferability of the practice within the country

Most of the practices have been transferred within the country or ready for transfer but for 15 practices, transferability has not been considered. No specific pattern is associated to the type of setting where the practice applies. (Figure 6)

Figure 6. Transferability of the practice within the country



3.8. Sustainability of the practice

There are 20 practices with institutional and human resources support, along with six with training of staff as an important issue to guarantee sustainability. Only four practices mention to have considered sustainability without explaining further which are the measures. The practices where sustainability has not been considered are 2 on beaches and 1 on cars, educational, hospitality sector and transports, respectively. (Table 9)

Table 9. Sustainability of the practice by smoke-free setting

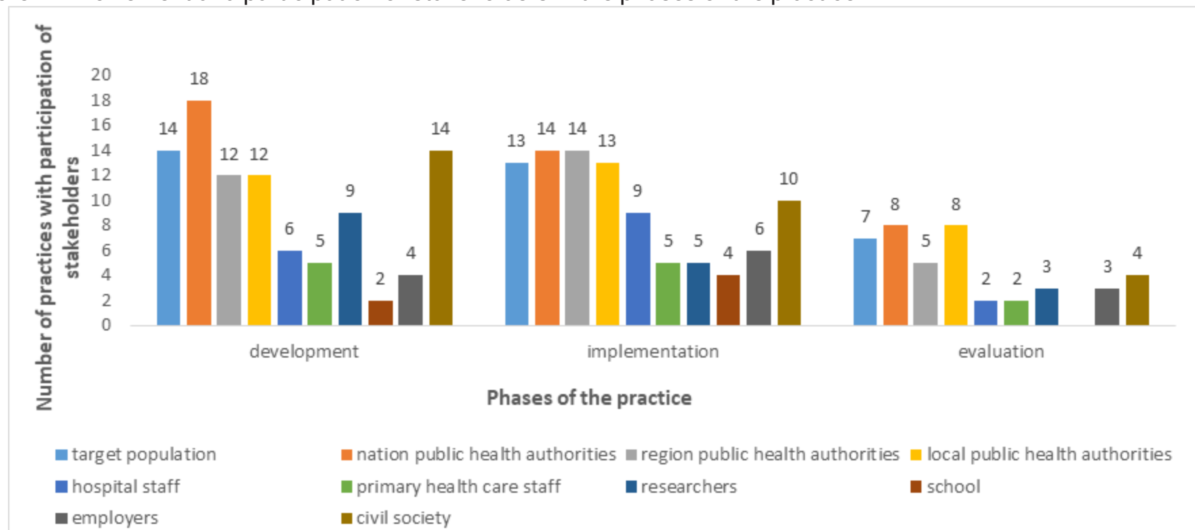
Sustainability	sf_ beach	sf_ car	sf_ city	sf_ edu	sf_hc	sf_ home	sf_ hotel	sf_ nation	sf_ play	sf_ sport	sf_ transp	sf_ work	Total
not considered	2	1		1			1				2		7
institutional support		3	2	1	2	1	1	7	2		1		20
training of staff			1		2	1		1				1	6

sustainability strategy								1	1	1		1	4
Total	2	4	3	2	4	2	2	9	3	1	3	2	37

3.9. Involvement and participation in the development, implementation and evaluation of the practice

The most frequently reported participation was from national public health authorities in the development of 18 practices. The civil society and the target population were involved in the development of 14 and 13 practices, respectively. In the implementation of the practice were mostly involved all public health authorities and the target population. Finally, to evaluate the practice there was a less frequent participation from different stakeholders. (Figure 7)

Figure 7. Involvement and participation of stakeholders in the phases of the practice



3.10. Main outcomes of the practices

The outcomes of the practices were diverse depending on the type of setting and the stage of the practice itself. Since only 4 practices were properly evaluated the reported outcomes of most of the practices were mainly expected but not yet obtained. Most of the information provided is qualitative and/or with indicators of process as follows:

3.10.1. Beaches

- Bibione, Italy, started the smoke-free beach path in 2011 by introducing a smoking ban along the foreshore (i.e. from the first row of beach umbrellas to the water). Tourists were asked to express an opinion on the smoking ban and showed their appreciation of the initiative: out of 2,293 interviewed during the trial, 1,729 were in favour of the ban (1,145 totally in favour and 584 in favour provided smoking areas were set up), while those against were only 564. In recent years Bibione has carried out numerous information and international media awareness campaigns on the risks of passive smoking and the importance of safeguarding the green heritage and habitat of the beach and lagoon from cigarette butts. To get an idea of the impact that smoking on the beach can have, think that in Bibione the ban on smoking along the foreshore made it possible to collect, between 2014 and 2018, as many as 550 thousand cigarette butts that would have ended up in the sea or in the sand. (https://www.ilpopolopordenone.it/Veneto-Orientale/Bibione-addio-alle-sigarette-in-spiaggia)
- In Spain, most of the beaches became smoke free between the year 2018 to 2022, but the policy has been mainly recommendation and raising awareness. There are only four beaches in Catalonia and one in Canary Islands where the policy was endorsed by legislation and the

municipality was empowered to fine non-compliance. Information on outcomes (e.g. number of cigarette butts at the entrance of beaches, number of fines, etc.) is not provided yet. https://nofumadores.org/playas-sin-humos/

3.10.2. Cars

- In Ireland there are less children exposed to tobacco smoke and it also sets the scene that tobacco smoke exposure is harmful (de-normalisation of smoking). https://www.facebook.com/HSElive/videos/459652617568210/
- In Slovenia, the National Institute of Public Health carried out repeated cross sectional studies in order to evaluate the effects of the ban. Minors: Studies were carried out among a convenience sample of on average 16-year old students of high schools all over Slovenia in 2017, 2018 and 2021. The percentage of those exposed to tobacco smoke in any vehicles has statistically significantly decreased between 2017 and 2018 and remained unchanged in 2021. So, the ban had a positive effect on exposure of minors in family vehicles. We also asked about the rules on smoking in family vehicles and the study shows there were no statistically significant changes during this time. 90 % of surveyed students report that in their family vehicles nobody smokes, but around half of the students reports any exposure to tobacco smoke in any vehicle, so obviously other (not family) private vehicles are the major source of exposure. Adults: Repeated cross sectional CINDI surveys "Countrywide Integrated Noncommunicable Diseases Intervention" (CINDI) show that between 2016 and 2020 share of adults, aged 25-74 years, that report that they or another person smokes in their family car, decreased statistically significantly from 7.6 % to 5.6 %. http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO6717

3.10.3. Cities

- In Denmark, the proposal has succeeded in producing multiple smoking free areas where Aarhus municipality has the authority to do so. This applies to among other, but not limited to, playgrounds, bus stops, cultural institutions, outdoor training facilities and multiple social offers by the Children and Young People Committee and the Social Affairs and Employment Committee to children and youth. Meanwhile, in cooperation with the association Strøget in Aarhus (shops and shopping areas), the municipality has started a trial which aims to keep Strøget smoking free for a period. https://www.cancer.dk/forebyg/undga-roeg-og-rygning/indsatser-mod-rygning/roegfri-udearealer/
- In 2021, 99% of municipalities in Finland had made an official decision to become tobacco-free. www.savutonkunta.fi
- In France, the tobacco-free cities initiative shows the involvement of mayors and the interest of other local authorities but it is too early to show results in the population. https://cnct.fr/ville-libre-sans-tabac; https://cnct.fr/wp-content/uploads/2021/10/PLLT-v-NET-21.09.22.pdf

3.10.4. Educational facilities

- In Denmark, an agreement was reached to introduce by law, smoke-free school hours for pupils in all the country's primary schools. Smoke-free school hours mean that no students are allowed to smoke during school hours, regardless of whether they are on the school register or outside the school grounds. The report (in Danish) contains examples of outcomes of the practice: https://www.sdu.dk/da/sif/rapporter/2020/roegfri_skoletid

3.10.5. Health care facilities

- In Ireland, health service staff and the public appreciate the requirement for a tobacco free

health service. There are frequent breaches especially in some of the busy acute sites. Implementation is an ongoing challenge as service managers change and perhaps priorities change. Some negative impacts have included the introduction of smoking shelters where public money has been used to re-erect shelters in contravention of the policy and to move smoking away from visibility at entrances etc. Also some managers do not understand all the aspects of policy implementation (i.e. the main focus being to address and treat tobacco dependence and provide an environment conducive to cessation) therefore dismiss the policy as ineffective if they witness breaches however there could be fantastic training and clinical practice going on in that site. What has helped also is patient satisfaction feedback whereby the public themselves demand better policy implementation and a clean tobacco free health service. Where complaints are received these are forwarded to the hospital or service managers to respond. https://www.tobaccofreehealthcare.org/ https://www.hse.ie/eng/about/who/tobaccocontrol/campus/tobacco-free-campus-toolkit-guidance-document-oct-16.pdf
- Region Östergötland in Sweden is now one of the region with the lowest proportion of daily smokers (6%) and fewer people are smoking in the health care area. https://www.Information+om+rökfria+utomhusmiljöer+på+olika+språk.pdf

3.10.6. Homes

- Smoke free homes in England: Evaluation of the campaign has found: 75% of smokers who saw the campaign said it made them more concerned about smoking, 38% took action, from cutting down, to going outside to smoke, stopping smoking in the same room as a family member, stopping smoking or switching to an electronic cigarette. This last one, (switching to an electronic cigarette) produces aerosols and therefore can not be considered as SAFE practice. https://betterlivesleeds.wordpress.com/2015/04/14/smokefree-homes-take-7-steps-out/
- Take it right outside in Scotland achieved the reduction in self-reported exposure to second-hand smoke in the home as gathered by the annual Scottish Health Survey. The target of reducing the proportion of <16 year olds exposed to SHS at home from 12% to 6% by 2020 was achieved. https://www.nhsinform.scot/campaigns/take-it-right-outside

3.10.7. Hospitality sector

- The Health Impact Assessment "Effects of a smoke-free hospitality in Austria" (published 2018) produces 15 articles in traditional media (not paid). One parliamentary question of a political party. Many citations in political discussions (not countable). https://hiap.goeg.at/sites/gfa.goeg.at/files/inlinefiles/Gesundheitsfolgenabsch%C3%A4tzung_Tabak_Rauchverbot_TNRSG_2018.pdf
- The smoking ban in Austria increased the level of health protection for the general population and in particular for guests and employees as well as a reduction of the smoking prevalence rate. https://www.ris.bka.gv.at/Dokument.wxe?Abfrage=Erv&Dokumentnummer=ERV_1995_431

3.10.8. National (practices applying to more than one type of setting and/or with national geographic coverage)

- One practice reported by Austria produced one position paper, advocating smoke-free and aerosol-free environment (target group: National Ministry of Health) Two factsheets (target groups: 1. schools, 2. youth centers) Hundreds of consultations with expert advice and individual support for institutions working with children or adolescents. Hundreds of parents´ evenings for parents. www.suchtvorbeugung.net
- With the "Smoke Free Award" in Austria, 30 institutions were nominated, 6 of them were chosen

by a jury. Around 100 people joined the Smoke-free gala event. There were 27 articles in the media reported the Smoke Free Award (non-payed). www.smoke-free-award.at

- The initiative Generation Smoke Free in Belgium produced, since May 2018: 160 label holders in 951 sport facilities and 207 playgrounds. https://www.generationsmokefree.be/generation-smoke-free; https://www.komoptegenkanker.be/blog/eerste-stap-naar-rookvrije-perrons
- The main advantage of the Belgian law is that is very simple and very clear to everyone. Same rules for e-cigarettes, heated tobacco products and combustible cigarettes in the smoke free area. https://www.health.belgium.be/nl/gezondheid/zorg-voor-jezelf/rookproducten-en-e-sigaretten/specifieke-regelgeving-voor-elektronische
- In Denmark, e-cigarettes and HTPs may not be used in smoke-free areas. As the legislation has been introduced very recently, there is no evaluation available yet. https://www.rv.hessenrecht.hessen.de/bshe/document/jlr-NRauchSchGHEpELS
- Smoking ban and health at birth: Evidence from Hungary. The smoking ban in hospitality venues in Hungary has improved health at birth, this refers to neonatal and infant health outcomes, including, e.g., preterm birth, low birth weight, live birth infant mortality rate. The effects are larger for newborns of parents with low educational attainment. Newborns at the bottom of the fetal health endowment distribution benefit more. https://www.sciencedirect.com/science/article/pii/S1570677X18300194
- The tobacco control in practice developed in Lithuania obtained a reduction of smoking over time https://e- seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.24500/asr
- In Malta, the prohibition of smoking in public places (and advertising) extended to non-conventional tobacco and related products. https://legislation.mt/eli/ln/2010/22/eng/pdf
- In Sweden, the smoking ban refers to municipalities, playgrounds, sports facilities, outdoor dining areas, areas connected to public transport and entrances to premises to which the public has access. The impression is that the new smoke-free outdoor environments have great acceptance among the population. The smoking ban at entrances is not specified in exact dimensions. Instead, an assessment must be made on a case-by-case basis; the smoking ban must cover such a large area that one should not have to be exposed to smoke when approaching the entrance. This makes it somewhat difficult to apply. The smoking ban in outdoor dining is the smoking ban that has been questioned most loudly and which - at least in the beginning - has been tried to be circumvented in various ways. https://www.folkhalsomyndigheten.se/livsvillkor-levnadsvanor/andts/vad-vi-gor-inom-andts/tobak-och-liknande-produkter/passiv-rokning-2012-2014/

3.10.9. Playgrounds

- In Luxembourg, the general smoking ban in children playground created a general respect and also approbation of this measure among the population (91%) according to a survey realized in 2017 about the general acceptance of the national anti tobacco law of the same year. https://legilux.public.lu/eli/etat/leg/loi/2017/06/13/a560/jo
- In the Netherlands, most of the petting zoos and playground associations are (voluntarily) smoke-free. Compliance can be a challenge, and also the visibility of smoking just outside the petting zoo or playground areas. www.rookvrijegeneratie.nl; www.rookvrijegeneratie.nl/gemeenten; http://kinderboerderijenactief.nl/rookvrij; https://www.nuso.nl/rookvrij; https://www.vereniginglos.nl/

3.10.10. Sports facilities

- Nowadays in the Netherlands, some outdoor sports clubs have voluntarily implemented an outdoor smoke-free policy at their venues (approximately 2,000 outdoor sports clubs with a partly or completely smoke-free policy in the first half of 2022. And 33% of some of the big outdoor sports for children: field hockey, football, tennis, athletics or korfball). These

practices have been described in different scientific articles: Three papers of Garritsen HH et al. (2021) and 2 papers of Smit RA et al.(2022, 2023. www.rookvrijegeneratie.nl/sport

- I&O Research, on behalf of The Health Funds for a Smoke-free Netherlands, have monitored smoke-free policies by the municipalities in the Netherlands in 2021 (questionnaire). Eight out of ten Dutch municipalities play a role in making locations within the municipality smoke-free. Each of the municipalities obtain their own goals, for example ranging from smoke-free petting zoos to smoke-free parks. For public playgrounds specifically, one third (32%) of municipalities report that one or more of the outdoor public playgrounds located in their community are smoke-free. Regarding public sports facilities, such as football pitches, basketball courts and skate parks, in 27% of the Dutch municipalities one or more of the public sports facilities in their community are smoke-free. In this research it was not clear if the municipality was the initiator of the smoke-free public playgrounds and public sports facilities or if they supported initiatives taken by residents of the municipality. In previous research results show that the municipality played an important role as initiator of smoke-free policies at public playgrounds and public sports facilities (I&O Research, 2021).

3.10.11. Transport sector

- All railway stations in Belgium will be 100% smoke-free. No lessons learned in this stage of the project. https://www.komoptegenkanker.be/blog/eerste-stap-naar-rookvrije-perrons
- In Estonia people can wait their transport in a healthier environment. In this regards, the goal has been accomplished. https://www.riigiteataja.ee/en/eli/516042021002/consolide
- In the Netherlands, more than 400 train stations (and their platforms) became total smoke free areas. Millions of passengers are protected against second hand smoke.

3.10.12. Working sector

- In Denmark, the middle managers need clear guidelines for action and training in understanding WHY and HOW - and how to talk with employees. A good approach to avoid conflicts with smokers at workplaces has been to talk about how to handle the urge to smoke during the work hours (to help) instead of talking about smoking cessation. The smoke free strategy can also provide good mental health environments among employees - with healthy breaks and social interaction with colleagues - with a bit of planning. https://www.researchgate.net/publication/351851079_Readiness_for_implementation_of_smoke-free_work_hours_in_private_companies_A_qualitative_study_of_perceptions_among_middle_managers
- In Slovenia, general population is protected from exposure to tobacco smoke and aerosols of related products in all enclosed workplaces and public places. https://www.tobaccocontrollaws.org/legislation/slovenia

4. Discussion

Among the 19 countries where information on SAFE best practices has been obtained, almost all practices have been developed and implemented but very few have run into a proper evaluation process which jeopardizes the capacity to advocate for specific practices more than others. Overall, the practices apply to a broad range of settings, and the national based practices are the most frequently reported. Since the consultation to experts was conducted on a voluntary basis, the results are not expected to be representative of all the practices existing in a country or globally in EU. Nevertheless, the description of each one of these practices is highly valuable to generate ideas and trigger future initiatives by the EU countries.

This report complements to the 2021 Study on smoke-free environments and advertising of tobacco and related products, from Directorate-General for Health and Food Safety (DG SANTE) that explored

SAFE legislation compliance and enforcement in all EU countries that showed most countries have implemented the Council Recommendation (2009 Council Recommendation on smoke-free environments 2009/C 296/02).

Importantly, while all reported smoke-free practices apply to conventional tobacco, half of the reported practices apply also to e-cigs and HTP. Four practices on cars contemplate full banning of these three products. However, the compliance of these practices could not be ascertained. In line with what was reported previously by DG SANTE, where e-cigarettes and HTP seemed to be most common in certain outdoor environments, there were also some practices contemplating banning e-cigs and HTP in outdoor environments.

It is also striking that the most frequent scopes of the reported practices were regulatory, policy making and information awareness, while training, monitoring and action plans were less frequently considered in the practices. This is also in line with the need of regulation to ensure that the practices have enough support to be enforced and to promote its compliance.

The fact that most of the practices are under unique or shared municipal, national or public agency responsibility is probably a good indicator for its sustainability. This is in line with the reported institutional support for 20 of the practices and the public funding reported for 17 of the practices.

5. Conclusions

5.1. From the consultation:

- Smoke-free environment policies have made significant progress in reducing SHS exposure and improving public health. However, challenges persist in adequately addressing the risks posed by second-hand aerosols from e-cigarettes, ensuring enforcement and compliance in various settings, particularly outdoors, addressing disparities, and adapting to emerging smoking products and behaviours.
- Almost all the reported practices, with the exception of "awards", include monitoring and follow up of its effectiveness and expected outcomes which is crucial for their success.
- The approaches to ensure compliance are diverse depending on the practice and the context (country) going from raising awareness to fining non-compliances. In general, the effectiveness of the practice is better ensured when legislative and enforcement/fining capacities are available.

5.2. From the Symposium:

- Main barriers against the expansion of SAFE practices are tobacco industry lobby, reluctance of governments, lack of monitoring and sales regulation, and claims of specific settings against the expansion.
- Main barriers against the enforcement of SAFE practices are lack of comprehensive legislation, lack of human and financial capacity, reluctance of governments, lack of training for authorities and/or public sector, and lack of dedicated funding for tobacco control research and interventions.
- Frequently identified needs for the expansion of SAFE are the need to clarify the importance of having smoke-free outdoor setting not only smoke-free indoor settings and to include electronic cigarettes and heated tobacco products in countries where they are perceived as a harm reduction/harm modification tool.
- To make a practice successful it needs clarity in its objective. Also, capacity to evaluate the achievement of its objective. It is crucial the identification and involvement of the right stakeholders including the target population, in order to have a well sorted implementation team. It needs, as well, to have legislative support from a clear law, stable human and financial resources, well- designed regular campaigns of awareness, workshops, conferences and

adequate tools of dissemination, proper training of the people in charge of implementation, right material to support the practice and empower non- smokers to advocate for rules' compliance.

- To make a practice sustainable it needs to be a successful practice, to have continuity of the teams implementing the practice, to ensure the coalition between civil society and local authorities, dissemination of results (regular information campaigns specific to the practices).

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Annex 1: Abstract of each best practice on SAFE by country, smoke-free setting and title of the practice

1: Austria_SF_nation: Supporting and consulting initiatives addressing the prevention in settings of young people (children and adolescents)

The objectives of the practice are smoke-free indoor and outdoor settings for conventional tobacco products, voluntary home smoking ban for conventional tobacco products and indoor and outdoor aerosol-free regulation for e-cigarettes and for heated tobacco products.

The overall goal is to support youth-concerned institutions (e.g. schools and youth centers) and individuals (e.g. parents) in supporting implementing smoke-free environments and better youth protection in their concrete settings.

The Austrian Association of Addiction Prevention was one of the motors for a smoke-free hospitality and better youth protection by law. In 2014, the association published a position paper and intensively started advocating for better tobacco control. In the last years, smoke-free and aerosol-free environments have been expanded, just like the awareness for a nicotine-free norm. A majority of this development was driven by the law for a smoke-free hospitality and more rigorous legal regulations to protect minors. Not everybody and not every institution was happy with this, as the new regulations were difficult to bring in conformity with the fact that smokers are part of the working society. Institutions wanted to implement the new laws but didn´t know how.

The first problem was to get better tobacco control by law. Finally, after years and in a roundabout way, Austria got it. The second problem was the concretization of the two new national laws: one concerning smoke-free environments (including hospitality and outdoor areas of schools), and other for institutions which bear responsibility for children and adolescents.

The target population for this practice were age specific groups and certain levels in the education system. Individual´s rights have been protected. A group of population and regional public health authorities were involved in the implementation of this practice.

The practice has been implemented (enforced/promoted) and it is practice is ongoing since 10/01/2014 and has been implemented and enforced nationwide, in all regions of Austria.

In terms of evaluations, it's important to bring attention to a position paper advocating for smoke-free and aerosol-free environment (target group: National Ministry of Health), two factsheets (target groups: 1. schools, 2. youth centers), hundreds of consultations with expert advice and individual support for institutions working with children or adolescents. Also, hundreds of parents´ evenings for parents.

The practice has institutional support and stable human resources and has been funded by external resources (public). The practice has been transferred within Austria.

2: Austria_SF_hospitality: Health Impact Assessment: "Smoke free hospitality in Austria"

The objectives of the practice are Smoke-free indoor settings for conventional tobacco products and indoor aerosol-free regulation for e-cigarettes.

The methods used in the practice were: the development of a Health Impact Assessment, publication of the results, advocating political parties using the results and providing information to the media in order to support them reporting the results.

The overall goal of the practice is to have new data which underlines the effect of smoke-free hospitality (data for aerosol-free hospitality were not available); to support campaigns such as "Don´t smoke" with new data; and to give the media a reason to repeatedly report about the need for a smoke-free and aerosol-free hospitality. The practice has been implemented and it has ended.

In 2018 the Austrian parliament overturned legislation for a smoke-free and aerosol-free hospitality. Health professionals and scientist working in different fields of health were shocked and wanted to support the realization of the law. They identified the need for data concerning the specific effects for Austria. As there was no such data available, some of these institutions decided to do the research themselves and deliver the needed data in the form of a Health Impact Assessment.

When implementing the amendment to the Tobacco and Non-Smoker Protection Act TNRSG with further protection of minors, numerous adjustments were necessary in order to avoid a possible health thread and to be able to achieve security for the population. Based on the findings of the present health impact assessment, the greatest Health gain for the Austrian population through the implementation of the originally Closed smoke-free gastronomy combined with an optimized extended protection of minors expected. This would also make a relevant contribution to increasing health equity provided for those socio-economically disadvantaged population groups, which at the same time bears the largest share of the burden of disease on society caused by tobacco use.

The target population was the general population and individual´s rights weren´t affected. In terms of development, groups of population, International/European public health, National public health, Regional public health authorities and Local public health authorities contributed. For implementation, Civil Organizations were involved.

The responsibility of the practice lays on the Nation, a public agency, a University and NGOs. The practice focuses on public settings only and the geographical scope of the practice is Austria. The practice has been transferred (i.e., scaled-up) within the same country/region. Own resources and external resources (public) were used in this practice.

A Health Impact Assessment "Effects of a smoke-free hospitality in Austria" (published 2018), 15 articles in traditional media (not paid) along with parliamentary questions of a political party and many citations in political discussions (not countable) shall be highlighted in terms of evaluation of the practice.

3: Austria_SF_cars: Tobacco smoke and aerosol free vehicles with minors present

The overall goal of the practice is to expand the smoke free regulation and to ban smoking in cars in the presence of minors or pregnant women. This practice covers conventional tobacco products, vaping and heated tobacco products.

The ban on smoking in private cars is a health measure defined by federal law. It is aimed at the general population, not only at a specific population group but the target population are people under the age of 18. It is defined by § 12 para. 4 TNRSG (Tobacco and Non-Smoker Protection Act). It was decided by the Austrian Parliament and in place since May 1st, 2018. The Minister of Health, in agreement with the Minister of Traffic, is responsible for the implementation of this law. The focus of this practice is on private setting, with a car as a target setting and it has been implemented (enforced/promoted) and is ongoing since May 5th, 2018.

National and international experts, e.g., the German Cancer Research Center, came to the conclusion that smoking in vehicles can cause considerable damage. Based on the findings of the experts, the ban was implemented. The justification for the practice relays on the premise that children and young people should be protected from the harm of passive tobacco use.

National and regional public health authorities participated in development and implementation. Other organisations participated in development. The practice has institutional support and stable human resources. The geographical scope of the practice is Austria nationwide and transferability has not been considered in a systematic way.

4: Austria_SF_nation: Smoke Free Award

The objectives of the practice are smoke-free indoor settings for conventional tobacco products and indoor aerosol-free regulation for e-cigarettes

The first goal of the practice was to turn the frustration and displeasure stemming from the cancelation of the legislature into continuous efforts for a smoke-free and aerosol-free environment. The second goal was to draw the attention of the Austrian government and to show the parliament that their decision to overturn the legislation for a smoke-free hospitality was wrong and could potentially have harmful effects on public health.

The practice has been implemented (enforced/promoted) and has ended. The Smoke Free Award was created by VIVID, Institute for the Prevention of Addiction, after the Austrian government overturned the legislation, which included nationwide smoke-free hospitality. In six different categories, people or initiatives may be awarded for their efforts in ensuring a smoke-free and aerosol-free environment, while rewarded at the Smoke Free Gala.

The first step was to define the application criteria. Next, an external board of judges, representing a wide range of the population, was chosen. A call for submissions was issued and initiatives were encouraged to apply. The organizers also actively reached out to people to apply for the program.

While organizing the event Smoke-free gala, a keynote speaker was selected, alongside a selection of initiatives for a short-list (6 categories and 5 candidates). After the Gala event, the winners were published, and the gala had many guests of honor und successful press responses. The organizers reached out to the media representatives and the public relations departments of the candidates' institutions and offered support and help in order for them to report on the award and on the general smoke-free topic.

The announced implementation of a smoke-free hospitality legislature by the Austrian government was cancelled. Thus, health institutions and the public were frustrated and concerned about the current and potential health effects of that decision. They actively began demanding a smoke-free law, which also included aerosol-free regulations. Initiatives originated but received little attention from the government. The Smoke-Free Award, allowed the public and other initiatives to display different smoke-free programs to raise public awareness and to draw the attention to the government. Individual's rights of the applicants were protected according to national and European legislation.

The target population for this practice was the general population. The target group affected by this practice, alongside regional public health authorities, hospital staff and civil organizations, was involved in the implementation of this practice. The practice is funded by external resources (public).

The practice is being enforced in the Austrian region of Styria, and it involves hotels, restaurants, and bars (indoor areas). VIVID, the Austrian Institute for the Prevention of Addiction (NGO) is responsible for this practice, which includes both public and private settings.

The practice has not been formally evaluated. The main outcomes of the practice were the following: 30 institutions (or rather, people) were nominated for the Award and 6 of them were chosen by a jury to receive the first Smoke-Free Award; around 100 people joined the Smoke-Free Gala event; 27 media articles reported the Smoke-Free Award (non-payed).

Indicators used in the monitoring of the practice were the number of applications and the amount of media attention and coverage of the topic "Smoking ban in hospitality".

The practice has been developed on local, regional, and national level. Transferability has been considered and structural, political and systematic recommendations have been presented. However, it has not been transferred yet.

5: Austria_SF_hospitality: Smoking ban in the hospitality sector

The objectives of the practice include smoke-free indoor settings for conventional tobacco products, and indoor aerosol-free regulation for e-cigarettes and for heated tobacco products.

The overall goal is the extension of health protection of the population by means of advanced non-smoker protection measures. The ongoing practice started on 24th of August 2022 and has been implemented (enforced/promoted). The target population for the practice is the general population.

The main objective of this project was to increase the level of health protection among the general population and in particular the guests and employees in the hospitality sector.

A group of population, national public health, regional public health, researchers /academics and civil organizations. contributed in the development of the practice. For the implementation, national public health and regional public health authorities. The evaluation was under national public health authorities.

The intervention focuses on public settings, responsible for the enforcement of this legal provision. It's applied country-wide and the geographical is Austria.

The practice has institutional support and stable human resources. No funds were required. Transferability has not been considered.

6: Belgium_SF_nation: Generation Smoke Free

The objective of the practice is to create smoke free environments for all children such as playgrounds, sport facilities, recreation parks, children's farms, hospital domains and schools. The aim is also to ensure that every child born as of 2019 can grow up smoke free and prevent them from starting to smoke and become addicted to tobacco products or vaping. The geographical scope of the practice is Belgium.

In terms of intervention characteristics, it's important to highlight that the practice is ongoing. It started on the 31st of May of 2018 and has been implemented (enforced/promoted) since then.

The justification behind the practice refers to the fact that when children see others smoking, it creates the impression that smoking is a normal and enjoyable part of life, rather than a deadly addiction. Moreover, children copy behaviour, and this includes smoking behaviour. However, research shows that if smoke-free becomes the norm and there is no smoking in sight, children are less likely to take up a cigarette themselves. It protects them from tobacco addiction. This strategy is underpinned by the World Health Organisation (WHO) which calls denormalization of smoking in the general population, a key strategy to solve the tobacco problem among young people. Legislative banning smoking and vaping everywhere is 1) difficult to enforce 2) contrary to the strategy of creating social support from bottom-up, in cooperation with smokers, through a positive and inclusive message. Therefore, in order to build support and modify the norm on smoking, a voluntary approach can contribute to the achievement of a smoke-free generation.

The target population for this practice is the general population but with special attention on vulnerable groups (pregnant people), and socioeconomic status including educational level.

In terms of equity and ethical considerations, the practice considers human and children's rights framework: 1. Fight against tobacco (right to health, right to grow up smoke-free, right to protection from tobacco addiction) 2. Protection of the environment (right to a healthy environment) - Solidarity: stand up for the most vulnerable groups, smoking is one of the main causes of health inequalities - Cooperation: by joining forces, the Alliance wants to contribute to a smoke-free Belgium and thus realise health benefits for the Belgian population.

Tobacco Free Generations is an initiative of the Alliance for a Tobacco Free Society. The Alliance is

a partnership between Kom op tegen Kanker, the Foundation against Cancer, the Vlaams Instituut Gezond Leven, the Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding, the Belgian Cardiological League, the Gezinsbond, the Respiratory Affections Fund, the Service d Study and Prevention of Smoking. At the same time, a growing number of organizations are supporting Generations Without Tobacco. The working group 'smoke-free municipalities' of Generation Smoke Free came together to discuss this and are happy to see that in 2021, despite Covid-19, many municipalities were active in the field of Generation Rookvri.

Through the partnerships with municipalities, sport federations/clubs, schools, etc. and the use of the Generatie Rookvrij/Générations sans Tabac signalisation they are creating a national network of organisations working on the same ambition. The partners contribute to a healthier, smoke-free environment for children and future generations. Through the acknowledgement of the label, the partners take ownership of the project and become Generatie Rookvrij/Générations sans Tabac 'ambassadors', encouraging other partners to make outdoor children's environments smoke free.

The practice was funded by external public resources and has institutional support and stable human resources. A sustainability strategy has been developed and the practice has been transferred (i.e. scaled-up) within the same country/region.

7: Belgium_SF_transport: Smoke-free railway platforms

The goal of the practice is to protect passengers from second-hand smoke and denormalise smoking behaviour in order to prevent youngsters from starting to smoke. The practice is aimed at creating smoke-free outdoor settings for conventional tobacco products and aerosol-free regulation for e-cigarettes. Heated tobacco products are not available on the Belgian market.

The practice focuses on public only settings, specifically railway platforms (outdoor) and has been ongoing since 24/11/2021. The practice is at the first stage of implementation.

A smoking ban on trains has been in place since 2004. Since 2009, this also applies to the station buildings and all other enclosed places accessible to the public. This also includes covered platforms. However, smoking on outdoor platforms is still allowed according to the legislation.

In 2021, Nationale Maatschappij der Belgische Spoorwegen (NMBS) / Societé Nationale de Chémins de fer Belges, (SNCB) expressed the ambition to make all platforms smoke-free, but this would first require a change in the law. This change in law has been accepted in April 2022 and by 1 January 2023, all Belgian platforms should be smoke-free by law. In the run-up to this legal smoking ban, the NMBS/SNCB launched a pilot project in the stations of Mechelen and Charleroi, in cooperation with various NGOs such as Kom op tegen Kanker. In these two railway stations, under the flag of Generatie Rookvrij (Generation Smoke-Free), all platforms have already been made completely smoke-free.

Exposure to second-hand smoke is harmful for health. On crowded platforms, the risk of exposure to second-hand smoke is real. Furthermore, denormalization of smoking is necessary to prevent youngsters from starting to smoke. Finally, yet importantly, a majority of rail passengers support smoke-free platforms (68 % according to a customer survey organised by NMBS/SNCB in 2017).

The target population for this practice is the general population. Civil society organisations were involved in the development of the practice. No monitoring and formal evaluation have been conducted yet. A public agency, namely NMBS/SNCB, has the responsibility for the practice and its implementation (placing of non-smoking signs, remove ashtrays, etc.), the communication towards train passengers, and the enforcement of the practice. The geographic scope is national (Belgium) and transferability has not been considered in a systematic way.

8: Belgium_SF_nation: A ban to vape in closed public places

The first goal of this practice is the de-normalization of smoking and other use of nicotine. The second goal is to raise the motivation for smokers to quit the tobacco and nicotine use and make it easier for ex-smokers to stay smoke free (relapse prevention).

The practice is aimed at creating smoke-free indoor settings in terms of conventional tobacco products, aerosol-free regulation for e-cigarettes as well as indoor aerosol-free regulation for heated tobacco products.

The practice focuses on public settings, and it has been active since 22/12/2009. It refers to the law which main advantage is that is very simple and very clear to everyone: it prescribes the same rules for e-cigarettes, heated tobacco products and combustible cigarettes in the smoke free area. In Belgium, the e-cigarette is considered as a tobacco product. In places with a smoking ban, it is also forbidden to vape, so restaurants and bars are vape free.

The justification of the practice lays on the fact that e-cigarettes are not free of risks and that the enforcement of smoke free environments is easier if it is also forbidden to vape. In terms of ethical considerations, the art. 5.3. of the Framework Convention on Tobacco Control must be take into consideration.

The target population for the practice is the general population. National public health authorities were involved in the development, implementation and evaluation of the practice. For monitoring and evaluation, the statistic on compliance is used. The governance is at national level. The same entity in charge of controlling vape free areas is the one responsible for controlling smoke free areas. The practice has institutional support and stable human resources.

The geographic scope and responsibility for the practice is national. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.

9: Czechia_SF_health care: Tobacco Free Healthcare Services

Every hospital tries to emphasize a healthy lifestyle for patients and staff. This practice focuses not only on tobacco control, but also on the wider promotion of activities promoting health in general and raising awareness that the normal behaviour is not to smoke.

The specific objectives of the practice include smoke-free indoor and outdoor settings for conventional tobacco products and heated tobacco products, and aerosol-free settings for e-cigarettes as well as a vaping ban as an anti-Covid-19 measure. The practice focuses on both public and private hospitals, including indoor areas in outpatient clinics and primary health care institutions, and outdoor areas of hospitals and healthcare institutions.

"Non-smoking hospital" is the name of an international project whose goal is to achieve a truly smoke-free hospital. Each healthcare facility chooses the sub-goals of this process by itself according to the recommendations of The Global Network for Tobacco Free Healthcare Services (GNTH).

A non-smoking hospital focuses on the following: introduction of non-smoking areas, monitoring tobacco use among patients and staff, provision of a short intervention, as well as the option of intensive treatment for tobacco addiction. Also, training of employees in the provision of these interventions and organizing health promotion events for staff and the public. Voluntary membership in the project is available for every hospital in the Czech Republic.

The reason for the creation of this project is the fact that smoking is the most significant preventable cause of mortality and morbidity in the contemporary world, and hospitals are the natural centre of health care. Therefore, they should play a leading role in the prevention and treatment of tobacco addiction.

The practice has been implemented (enforced/promoted) and is ongoing since 01/07/2017. The target population is the general population with a special focus on health care workers.

In the implementation, the following groups were included: international, European, national and local public health authorities; informal caregivers; and hospital and primary health centres personnel (specialized physicians, nurses, general practitioners and pharmacists). Health care professionals, researchers, academia, civil and other organisations were included in the development of the practice. In the evaluation, regional public health authorities were involved.

The Czech National Network of Tobacco-Free Hospitals and Healthcare Facilities has 13 members, e.g. Prague, Brno, Pilsen etc. The responsibility of the practice and its promotion lays on the Ministry of Health of the Czech Republic, Hospitals and Health Care Facilities in the Czech Republic.

It is still an ongoing project, so the outcomes could not have been reached yet. The hospital itself evaluates the extent to which it meets the project's goals with a self-evaluation questionnaire. The questionnaire in the Czech version can be downloaded from the website of the Ministry of Health of the Czech Republic.

The practice has institutional support and stable human resources. It provides training of staff in order to sustain it. The practice has been developed on local/regional/national level; transferability has been considered and structural, political and systematic recommendations have been presented. However, the practice has not been transferred yet.

10: Germany_SF_nation: Law for the protection from second-hand smoke – smoke-free legislation of Hesse

The objectives of the practice are Smoke-free indoor and outdoor settings for conventional tobacco products and indoor and outdoor aerosol-free regulation for e-cigarettes and for heated tobacco products. When referring to outdoor smoke-free and aerosol-free regulations, the practice applies to children's playgrounds.

The overall goal of the practice is to protect non-smokers, especially the youth, from health hazards of aerosols coming from e-cigarettes and HTPs. The measures also aim to strengthen the de-normalization of smoking, or rather, to send a message that smoking is harmful and is not a necessary component of society.

The practice has been implemented (enforced/promoted) and is currently ongoing. It started on the 18th of November of 2021. The legislature expires on December 31st, 2028.

In 2021 – as the first state out of all German federal States – the Federal State of Hesse included e-cigarettes and heated tobacco products into the smoke-free legislation of Hesse. Since then, all federal smoking bans also apply to e-cigarettes and heated tobacco products. The original smoke-free legislation was applicable up to 2020 and had to be renewed. The usual process for law-making was followed. As the legislation was introduced very recently, no evaluation was carried out so far. There is no information available whether and what monitoring is planned by the federal state. No funds were required for this practice.

New products such as e-cigarettes and heated tobacco products (HTPs) were not subjected to the existing smokefree legislation. The aerosol produced by e-cigarettes and HTPs is a threat to human health, and bystanders must be protected from those damaging effects. The aerosol contains several potentially hazardous substances and thus the products should not be used in closed rooms while non-smokers are present, and the use of those products should be banned in all smokefree places. Potential use of e-cigarettes and HTPs in smokefree areas may contribute to the unwanted renormalization of smoking, thus reversing the success so far achieved by the smokefree legislation, including the paradigm change in society. Including e-cigarettes into smokefree legislation improves the protection of youth, as those products are popular amongst them. Also, the law for the protection

of youth already states that minors are not allowed to buy and use e-cigarettes. Furthermore, starting from 2024 outdoor advertising for e-cigarettes will be banned.

The target population for the practice was the general population with special attention directed towards the youths. The targeted group, alongside national, regional and local health authorities, other healthcare professionals, researchers/academics and civil and other organizations, were included in the development of this practice. No information was provided about the implementation phase. The practice has not been evaluated so far.

The responsibility of the region lays with the province/region of Hesse (Parliament/government of Hesse and the heads of relevant institutions and sectors), and the measures focus only on public settings.

The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.

11: Denmark_SF_city: Smoke free outdoor areas_ The city of Aarhus

The practice is developed to provide protection of tobacco smoke at places that are not regulated by the Smoking Act (Smoke-free Environments Act). The purpose of the Smoking Act (Smoke-free Environments Act) is to ensure protection against tobacco-polluted air indoors at workplaces and in public spaces. However, it only sets a minimum standard. This means that the individual municipalities are welcome to introduce standards that ensure better protection against tobacco smoke.

The overall goal and objective, by introducing smoking free areas, is to prevent kids and the youths from smoking by minimizing the exposure to tobacco and smoking in those areas where they spend a lot of their time. Meanwhile, the practice also aims to minimize the amount of people exposed to passive smoking.

The city council of Aarhus has, as of April 2020, decided that an extended number of the municipality's outdoor areas, including most of the outdoor areas that children and other youths use, must be smoke-free areas. In August of 2019, the Councillor sent the city council a resolution proposal stating that, every council committee ought to produce a plan on to how to create smoking free outdoor areas within their own competence of public authority. Every plan was combined and sent to an official hearing. After the hearing and public consultation process, the Magistrate's Department for Health and Care sent a combined recommendation to Aarhus City Council to adopt this legislation. On the 1st of March 2020, the city council proposed the combined proposal regarding smoking free outdoor areas from all the committees with the hearing material, where, additionally, smoking free bus stops were added by requests of the citizens. In April of 2020, the proposed plans of smoking free outdoor areas were approved by the city council.

Smoke-free playgrounds protect very young children from exposure to tobacco smoke, but also ensure that the playground is not contaminated with cigarette butts. In Aarhus Municipality, the city council has, among other things, decided to introduce a ban on smoking in public playgrounds.

Children's and youth's outdoor areas as well as other playgrounds, parks and areas adjacent to children's and youth's outdoor areas are used by children, young people and their families as well as employees. Thus, the target group is the general population. The local alliance and activities are based on a positive message: "Thank You for not smoking here" (instead of prohibition, mainly because the 98 municipalities are not supported by legislation from the national level).

Local public health authorities and civil organization have been involved in the development and implementation of the practice and will be involved in its evaluation. The councillor of Health and Care, together with the mayor, invited an extended number of local actors - among others, DGI Østjylland (Sport-organizations in the region of eastern Jutland), Salling Group (warehouse), North

side (Music Festival), Scandic Hotels and a range of educational institutions – to be a part of the local alliance for a smoking free Aarhus.

This is a practice implemented at the city/municipality level, by the decision of Aarhus City Council with comprehensive approach to smoke free outdoor areas. It focuses at both private and public settings, namely workplace (indoor), Schools/ public-education institutions/ educational venues except universities (indoor), bus, tramway, trolley-bus stop waiting areas (outdoor), parks (outdoor), stadiums and outdoor arenas (outdoor), outdoor areas of school (outdoor), children's playgrounds (outdoor) and outdoor areas for workplaces.

This is an ongoing intervention and evaluation is foreseen.

The proposal has succeeded in producing multiple smoke-free areas in the areas where Aarhus municipality has the authority to do so. This applies to among other, but not limited to, playgrounds, bus stops, cultural institutions, outdoor training facilities and multiple social offers by the Children and Young People Committee and the Social Affairs and Employment Committee to children and youth. Meanwhile, in cooperation with the association Strøget in Aarhus (shops and shopping areas), the municipality has started a trial which aims to keep Strøget smoke-free for a period.

The practice has institutional support and stable human resources. The responsibility for the outdoor smoking areas spans across the council committee. The council committees have pointed to which areas should compromise the smoking free areas and the responsibility to implement said task rests at the committee. The Health and Care Committee has, in cooperation with the municipality's own printing house (Grafisk Service), developed a collective display for the advertisement of the new proposal and made it easy to order signs and labels. The design is approved by the transverse communication group and health control group of Aarhus municipality.

The practice is funded by the own resources. Intersectional approach was applied in each stage starting from the public hearing to the planned evaluation. The challenge for transferability comes the from absence of national legislation and the fact that extended smoke-free legislations depend on the city council of each of the 98 municipalities. However, several municipalities/cities in Denmark discuss smoke-free outdoor areas and get inspired from other cities.

12: Denmark_SF_work: Workplaces as settings for implementation of smoke- and aerosol free environments

The objectives of the practice are: smoke-free indoor and outdoor settings for conventional tobacco products, indoor and aerosol-free regulation for e-cigarettes and the banning of smoking and tobacco use during worktime - smoke free work hours. The ongoing practice started on 8th of January 2017 and has been implemented (enforced/promoted)

The overall goal is to protect non-smokers from the harmful health effects of passive smoking. Several municipalities and workplaces, both public and private, have implemented the smoking policy - 'Smokefree work hours', where an employee may not smoke at any point during work time. Furthermore, the goal is to provide a supportive environment for people who want to quit smoking by reinforcing social norms which support healthy breaks and improve social interaction with colleagues during the workday instead of promoting smoking-breaks.

The amount of time averages to about 7,5 hours a day despite minor differences in how breaks are placed and paid. The decision of the smoke-free strategy with tobacco use restriction during work hours is made by the top managers in dialoque with the middle managers and employees (the human ressource management collaboration system in Danish municipalities).

Alongside harmful effects of second hand, passive smoking, some of the main arguments for this practice are great health benefits of not smoking, which also results in less sick days, and increased work productivity (because there are no smoke breaks). Also, this practice can create a supportive

enviroment for those who would like to quit or reduce their smoking; there is even potential to reduce social inequality in smoking. Furthermore, such an inviroment will make people less likely to begin smoking in the first place.

The target population for this practice were workers in all ages in public and private workplaces. The employees own free choice - the smokers can still smoke, they are just not allowed to smoke at their workplace anymore (just like not drinking alcohol at work). An ethical training is available and the middle managers must focus on how to support smokers to handle the urge of smoking during workhours

The target group affected by this practice, the public health authoriti¡es, researchers/academics, employers/employees and other organisations were involved in the practice. All of them were involved in the development, implementation and evaluation of the practice. The practice was funded with own resources.

The intervention focuses on both public and private settings and the responsibility of its promotion lays on local municipalies/cities, supported by the Center for Health Promotion, KL, the Local Government in Denmark in collaboration with the Danish Cancer Society and the Danish Health Authority (Health Promotion).

The evaluation of the practice was carried out internally. The middle managers in municipality settings need clear guidelines for action and training in understanding why and how - and how to talk with employees about the practice. The municipalities have made evaluations after implementation of the new smoke-free strategy with good results.

A sustainability strategy has been developed for the practice and it provides training for staff. In terms of transferability, the practice has been scalep up to other locations or regions or at national scale in the same country. The geographical scope applies to Denmark Lemvig Kommune, Ikast-Brande Kommune, Billund Kommune, Kalundborg Kommune, Fredensborg Kommune.

13: Denmark_SF_educational: Smoke Free School Hours

The objective of the practice is to prohibit students from smoking during school time, even if they leave the school premises during breaks. This ban includes all forms of tobacco, all types of nicotine products (except if medically prescribed) and e-cigarettes.

In addition, municipalities have adopted smoke-free work time for their employees, which means that teachers and other staff at primary school are not allowed to smoke during school hours, not even during their breaks or if they leave the school premises.

Therefore, the overall goal is to prevent smoking uptake among children and adolescents, to encourage smoking cessation and to create smoke free environments for children and adolescents. The ongoing practice started on 1st of January 2021 and has been implemented (enforced/ promoted).

The educational facilities are responsible for the enforcement of smoke-free school hours, whereas the municipalities' – as employees /the local management of the school – are responsible for the enforcement of smoke free working hours for teachers and other relevant staff. The municipalities are responsible for the implementation of the measure in primary schools, whereas in high schools and vocational schools, the individual schools are responsible for implementing the measure. No funds were required for the practice.

Smoking is detrimental to our health, and especially to the health of adolescents and children, who are still in development. Besides, since children and adolescents under 18 are not allowed to buy tobacco or to smoke, there is no reason in allowing them to smoke or use tobacco products during school hours. Furthermore, the teachers are role models and should not smoke during their working

time in order to set an example.

Consequently, the target population are students (children, adolescents) and workers in the educational system. It was noted that other organizations were included in the development and implementation of the practice. Target settings were primary schools, high schools, vocational schools, public-education institutions and educational venues except universities.

The practice has never been formally evaluated. The evaluation of the effort indicates that with stricter smoking rules at schools, fewer young people smoke or start smoking. The greatest effect of intervention X:IT could be seen in schools that had implemented all intervention elements as recommended.

Intervention X: IT is a smoking prevention intervention developed by the Norwegian Cancer Society. It is aimed at students from 7th to 9th grade. It includes three areas of action:

1. Smoke-free school time, which implies that neither pupils, teachers nor other staff can smoke during school hours, on school grounds or elsewhere – the purpose is to remove all exposure to smoking in young people's daily life during school hours.
2. Educating about tobacco and smoking in order to equip students with the tools and knowledge to, among other things, resist the pressure to smoke.
3. Parental involvement through smoke-free agreements and talks, where parents are encouraged to talk to their children about smoking and to enter a smoke-free agreement where the child promises to remain smoke-free for one school year at a time.

Intervention X:IT is based on existing scientific literature, which indicates that multi-step interventions are an effective tool in prevention of young people's smoking.

The geographical scope of the practice is Denmark, and the practice has been transferred (i.e., scaled-up) within the same country/region.

14: Estonia_SF_transports: Implementation of the smoke-free zone regulation in the public transport shelters and waiting rooms

The overall goal of the practice is to protect the health of the population. Therefore, this practice is an intervention on general population. The objectives of this practice are smoke-free and aerosol-free outdoor settings for conventional tobacco products, e-cigarettes and heated tobacco products.

The target settings are bus, tramway, trolley bus and stop waiting areas (outdoors). Around the bus or other transport stop, there is a smoke free zone, which is indicated by the lines drawn on the ground. If people smoke in the marked area, they get fined. The focus of this practice is on public settings only.

The practice has been implemented (enforced/promoted) and is still ongoing; it started on 01/06/2021. The enforcement is in practice and in the places where it has been done, it works well. The local municipalities decide if they use this measure.

Country municipal police does the surveillance over the transportation stops smoke-free zones use. This practice helps the law regulations to work better in the real situation and protects peoples' health. In addition, it makes it clearer for people to understand where it is not allowed to smoke.

Regional public health authorities and local public health authorities have been participating in the development, implementation and evaluation of the practice, while a group of population has been participating in its implementation.

In 2014, a Tobacco Politics Green Book was published. Different interested groups, governmental organizations and stakeholders participated in the development of said book. These provided,

besides other recommendations, the measures to establish in front of the doorways of public buildings smoke-free protection zones of at least 3 meters from the door. The same logic has been used for the transportation stops areas. Also, people's concerns were taken into account for implementing these measures. Municipality and city public agency have the responsibility for the practice. The responsible institutions are the police.

The main outcome of the practice is that people can wait their transport in a healthier environment. In this regard, the goal has been accomplished. The monitoring of the practice is based on complaints. Overall, people respect this boundary, and before the measure, there were more complaints about smoking in the transportation stops. The practice has not been formally evaluated. The intervention is still ongoing, but the evaluation is foreseen.

The practice has institutional support and stable human resources; it was funded by public procurement. The geographical scope of the practice is national, and the practice has been scaled-up to other locations or regions or at national scale in the same country.

15: Spain_SF_beaches: Smoke free beaches

The objectives of this practice are smoke-free outdoor settings (conventional tobacco products) and outdoor aerosol-free regulation for e-cigarettes and heated tobacco products. The target population is the general population.

The practice aims to achieve healthier and cleaner beaches, to avoid passive exposure to tobacco smoke, to educate new generations on the premise that "it is normal not to smoke", to avoid environmental pollution of beaches and seas, and reduce the cost of cleaning beaches.

All the Spanish coastal Autonomous Communities, have implemented smoke-free beaches programs. The municipalities of these communities choose whether to adhere to them or not and even some municipalities such as Barcelona promote this program themselves. Once they choose to join them, the beaches in their municipality that have been chosen to be smoke-free (there can be several or all of them) are marked as smoke-free beaches. This is communicated through the media and the office of tourism (this varies depending on the community). These are awareness programs, initiatives of health promotion and environmental protection, because until the spring of 2022, in none of them there has been a municipal regulation that regulates fining for smoking on a smoke-free beach (with the exception of four beaches of Barcelona-Catalonia and one in the Canary Islands). In these four beaches of Catalonia, lighting a cigarette in the beach can face a fine of 450 euros.

The initiative of smoke-free beaches, on top of being a public health measure, is also an environmental measure, since it aims to eliminate one of the most toxic contaminants for the ocean. Cigarette butts pollute up to 50 litres of water with nicotine and tar and they need 10 years to degrade, during which time they are consumed by fish and entered into the food chain.

On some beaches in Spain, smoking is already prohibited. As of now, there are no penalties for non-compliance, but this initiative is increasingly widespread. In summer of 2021, Nofumadores.org counted up to 525 smoke-free beaches in the country, Galicia alone, where the local government has led this initiative brilliantly, there are 187 beaches where smoking is not allowed.

Groups of the target population, national public health authorities, regional public health authorities, local public health authorities, researchers, civil society organisations and stakeholders from other sectors other than the health sector, participated in the development of the practice. In terms of implementation, groups of target population, regional public health authorities and local public health authorities participated. Regional public health authorities, local public health authorities and civil society organisations participated in the evaluation of the practice.

It's important to highlight that, the general public (beach goers) has been empowered by the declaration of those beaches as smoke-free environments and has been key in the success of the

implementation of the measure.

The first smoke-free beaches programs in Spain (2006-2018), were developed and implemented by locally and regionally. In 2018, the NGO Nofumadores.org launched the change.org campaign smoke-free beaches in Spanish and English. Up to May 2022, more than 332.500 signatures have been collected. The NGO has been pushing at a national level for the development of a national law that bans smoking in all Spanish beaches.

Environmental groups sure have had an important role in pushing in this direction. These signatures have been delivered on several occasions to the Ministry of Health, which has agreed, through the Public Health Commission of the Interterritorial Council, to support good practice initiatives such as "smoke-free beaches". The signatures have also been sent to the Ministry of Ecological Transition and to political groups involved in the approval of the "Waste law for contaminated soils for a circular economy". Thanks to that, there was an amendment to the law, passed on April 2022, which allows the City Councils to regulate smoking on the beaches; also, sanctions up to 2,000 euros can be implemented in the Municipal Ordinances.

From 2018 till now all the regional governments in the Spanish coastlines have developed smoke-free beaches campaigns. Within each region (Autonomous Communities), several local governments have decided to implement the program either in some or all their beaches. Regarding the evaluation, it has been done either by regional or local governments in each case. Barcelona and the Canary Islands, intend to use the waste law to fine for smoking in their beaches in summer 2022.

Information regarding the level of comprehension of the practice can be found below:

Andalucía (48)

- Almería (4): Vera, la de Quitapellejos- Palomares y Pozo del Esparto, Cuevas de Almanzora, San Nicolás.
- Fuente Cádiz (24): Conil de la Frontera (La Fontanilla y El Chorrillo), Vejer (El Palmar), Tarifa (Playa Chica, Atlanterra, Valdevaqueros, Lances Sur y Norte y Bolonia), Arcos de la Frontera, Puerto de Santa María, Puerto Real (La Cachucha, La Ministra y El Conchal), Zahara de la Sierra (Playita de Arroyomolinos), La Línea (Santa Bárbara), Sanlúcar de Barrameda (Bonanza, Bajo de Guía, La Calzada-Las Piletas y Jara) y Barbate (Caños de Meca, Zahora, El Carmen y Zahara de los Atunes), Algeciras (playa de La Concha (El Rinconcillo) y Getares).
- Fuente Córdoba: (1) Almodóvar del Río.
- Fuente Granada (2): Granada (Playa Granada), Motril.
- Huelva: (4): Isla Cristina, Punta Umbría, Lepe, Ayamonte.
- Fuente Málaga (13): Mijas (Calahonda-La Luna-Royal Beach, El Bombo y La Cala), Algarrobo, Torrox, Estepona, Vélez-Málaga (Lagos, Mezquitilla, Caleta, Torre del Mar, Almayate, Valle Nizas y Benajarafe.

Asturias (15)

- Villaviciosa (3): Misiego, El Puntal, Miami.
- Soto del Barco (1): Los Quebrantos.
- El Franco (4): Pormenande, Porcía, Castello, Cambaredo.
- Tapia de Casariego (3): playas de la Ribeiría, Santa Gadea, Penarronda.
- Fuente Castropol (1): Peñaronda.
- Castrillòn (3): Munielles, Puertu (Santa María del Mar).

Baleares (12)

- Ibiza (2): Playa urbana de Santa Eulalia del Río, Playa de Talamanca, Cala D'Hort (San José), Cala Sant Vicent (San Juan).

- Mallorca (7): Cala Estancia (Can Pastilla), Cala Anguila (Manacor), Mallorca, Sant Joan (Alcudia), Cala Deià (Deià), Colonia de Sant Pere, (Artà), Cala Millor (Sant Llorenç), Cala des Moro (Sant Antoni de Portmany).
- Menorca (2): Binissafúller (Sant Lluís), Gran Playa (Ciudadela).
- Formentera (1): Playa de Els Pujols.

Canarias (61)

- Las Palmas de Gran Canaria (1): Playa de Las Canteras, Mogán.
- Gran Canaria (19): Las Marañuelas, La Lajilla, Patalavaca, Aguamarina, Medio Almud, Los Frailes, Tiritañas, Veneguera, Amadores, Anfi, Playa de Mogán, Puerto Rico, Taurito, Amadores, El Cura, Puerto de Mogán.
- Galdar, Gran Canaria (22): : Arrastradero, Boca Barranco, Caleta de Abajo, Caletón de los Cangrejos, Dos Roques El Agujero, El Muelle, El Roquete, Furnia, Juncal, La Caleta de Arriba, La Guancha, La Redonda, Lagarto, Martorell, Paso del Salgo, Punta Galdar, Punta del Clavo, Punta del Faro, Risco Partido, Sardina.
- Agüimes, Gran Canaria (8): Vargas, Cabrón, Muelle Viejo, Risco Verde, Soco Negro, El Muelle, La Planita, Playa de Arinaga.
- Arucas, Gran Canaria (11): Charco las Palomas El Peñón, El Puertillo, La Fuente, Las Coloradas, Las Salinas, Los Charcones, Los Enanos, Los Marrajos, Quintanilla y San Andrés.

Cantabria (96)

- Municipio de Val de San Vicente (6): Playa del Pedreru, Playa de las Arenas, Playa de Aramal, Playa de Amió, Playa del Sable, Playa de Berellín.
- Municipio de San Vicente de la Barquera (10): Playa de La Fuente, Playa de Liñera, Playa de la Maza, Playa del Tostadero, Playa del Puntal, Playa del Rosal, Playa de Merón, Playa de Bederna, Playa de Gerra, Playa de Gerruca.
- Municipio de Valdáliga: (2): Playa de Oyambre, Playa de La Rabia.
- Municipio de Comillas (1): Playa de Comillas.
- Municipio de Alfoz de Lloredo (1): Playa de Luaña.
- Municipio de Santillana del Mar (1): Playa de Santa Justa.
- Municipio de Suances (6): Playa de El Sable, Playa de la Tablía, Playa de los Lobos, Playa de la Concha, Playa de La Ribera, Playa de la Riberuca.
- Municipio de Miengo (6 playas): Playa de Cuchía o Marzán, Playa del Huevo frito, Playa de los Caballos o de Umbreda, Playa de Usgo, Playa de Robayera, Playa Currucasa, Playa de Mogro o Usíl, La Playuca.
- Municipio de Piélagos (7): Playa de Valdearenas, Playa de Canallave, Playa de Pedruquíos, Playa de Somocuevas, Playa de Cerrías, Playa de Portío, Playa de la Arnía.
- Municipio de Santa Cruz de Bezana (2): Playa de Covachos, Playa de San Juan de la Canal.
- Municipio de Santander (13): Playa de la Virgen del Mar, Playa de la Maruca, Playa del Bocal, Playa de Mataleñas, Playa de los Molinucos, Playas de El Sardinero Primera y Segunda, Playa de La Concha, Playa del Camello, Playa de los Bikinis, Playa de la Magdalena, Playa de los Peligros.
- Municipio de Camargo (1): Playa de la Punta de Parayas.
- Municipio de Marina de Cudeyo (1): Playa del Rostro.
- Municipio de Ribamontán al Mar (7): Playa de El Puntal, Playa de Somo, Playa de Loredo, Playa de los Tranquilos, Playa de Langre, Playa de Arnillas, Playa de Galizano.
- Municipio de Bareyo (2): Playa de Antuerta, Playa de Cuberris.
- Municipio de Arnuero (4): Playa de la Arena, Playa del Arnadal, Playa del Sable, Playa de Los Barcos.
- Municipio de Noja (2): Playa de Ris, Playa de Tregandín.
- Municipio de Santoña (2): Playa de Berria, Playa de San Martín.

- Municipio de Laredo (3): Playa de Regatón, Playa de La Salvé, Playa de Aila.
- Municipio de Liendo (2): Playa de San Julián, Playa de Sonabia.
- Municipio de Castro Urdiales (6): Playa de Oriñón, Playa de Arenillas, Playa de Ostende, Playa de Brazomar, Playa de Dicido, Playa de El Berrón.

Cataluña (19) :

- Sant Feliu de Guíxols (3): Playa de Sant Feliu, Sant Pol y Canyerets.
- El Masnou (1): Playa de Ocata.
- Lloret de Mar (4): Playa de Sa Boadella, Canyelles, Treumal y Fenals.
- Barcelona (10): Banys del Fòrum, Llevant, Nova Mar Bella, Mar Bella, Bogatell, Nova Icària, Somorrostro, Barceloneta, Sant Miquel, Sant Sebastià.
- Begur (3): Aiguablava, Platja Fonda y Sa Tuna.
- Pineda de Mar (Maresme, Barcelona) (1): Playa de los Pescadores.

Comunidad Valenciana (91 playas)

- Alicante (49):
- Benidorm (1): Cala de Finestrat.
- Denia (1): Playa Marge Roig.
- Elche (6): playa del Carabassí, Playa de L'Altet, Playa Arenakles del Sol, Playa El Pinet, Playa la Marina, Playa del Rebollo.
- El Campello (17): Muchavista , Playa Punta del Riu, Playa Calle del Mar, La Illeta dels Banyets, La Almadraba, Cala del Llop Marí, El Amerador, Cala Nostra, Cala del Puerto/Cala Morro Blanco, Cala d'Enmig, Cala Piteras, Cala del Barranco de Aguas, Playa de la Lloma de Reixes, Cala Monte Lanuza, Cala Baeza, Cala de les Palmeretes, Cala Carritxal.
- Finestrat (1): Playa de la Cala.
- Villajoyosa (13): Playa Carritxal, Playa Xaeco, Playa La Caleta, Playa L'Esparralló, Playa Bol Nou, Playa Paradís, Puntes del Moro, Playa Centro, Playa Varadero, Playa Estudiantes, Playa Tio Roig, Play Torres, Playa Racó Conill
- Alicante (10): Playa de San Juan, Cala de la Palmera, Cala Cantalares, Cala de los Judíos, Playa de la Almadraba, Playa de la Albufereta, Playa de Serragrosa, Playa de El Postiguet, Playa de Agua Amarga, Playa de los Saladares/Urbanova.
- Castellón (22):
- Benicarló (5): Playa Morrongo, Playa Caracola, Playa Norte (Aiguaoliva, Fondalet, Surrach, Mar Xica), Playa Barranquet, Playa Gurugú.
- Castelló de la Plana (1): Playa de El Serradal.
- Benissa (5): Playa la Fustera, Cala Pinets, Cala la Llobella, Cala de l ́Advocat, Cala Baladrar.
- Moncofa (6): Playa Pedra Roja, Playa Grao, Playa Masbo, Playa Belcaire, Playa Beniesma, Playa Estanyol.
- Nules: (1): Playa de les Marines.
- Oropesa (3): Cala Retor, Cala de Oropesa la Vella, playa la Renegá.
- Xilxes / Chilches (2): Playa de Les Cases, Playa Del Cerezo Nules: Playa Les Marines.
- Valencia (19):
- Valéncia (4): Playa Devesa, Playa Garrofera, Playa El Saler, Playa Arbre de Gos.
- Cullera (10): Playa Manery Sant llorenç, Playa Dosel Far, Playa Olivos, Playa Cap Blanc, Playa Racó, Playa Sant Antoni, Playa Escollera, Playa Marenyet, Playa Estany, Playa Brosquil-el Dorado, Playa de Cullera.
- Gandía (2): Playa de l'Auir, Platja Nord.
- Sagunto (3): Playa de Almardá, Playa de Corinto-Malvarrosa, Playa del Puerto de Sagunto.

Galicia (187)

- A Coruña (26 concellos, 70 beaches) Bergondo: O Pedrido esquerdo, O Pedrido Dereita, Gandario Dereita, Gandario esquerda. Boiro: Barraña, Carragueiros, BArraña-Satiño, A. Retorta Cabana de Bergantiños: P. de Rebordelo Cabanas: Praia de Chamoso Camariñas: Arou, Lingunde, O Ariño, O Lago Carnota: Mar de Lira, San Mamede (Boca Do Rio), San Pedro, P Lariño Cedeira: P. da Magdalena, Praia Area Longa Corcubion: Praia de Quenxe, P. de Santa Isabel Dumbría: P. de Ézaro Fene: Almieiras, Maniños Ferrol: A Fragata, P. Esmelle Laxe: Arnado, Traba, Soesto, LAxe-Centro, Laxe-Esquerda Mañón: Esteiro, Bares, Vilela Miño: Praia da Ribeira ou pequena, Perbes Muros: O Cabo (O Castelo), A Rocha, Ventin – O Salto Muxía: P. da Cruz, P. Area Maior Noia: Boa Grande, Boa Pequena Oleiros: P. Santa Cristina dereita, Bastiagueiro Ortigueira: Da Concha, Morouzos Pobra do Caramiñal: Areal Ponteceso: A Ermida, Balarés, Niñóns, Osmo, P. Arnela Porto do Son: A Vila, A Gafa, O Pozo, Arnela, Ornanda, Coira Esquerda, Coira Dereita Rianxo: As Cunchas – Porron, Tanxil, A Torre Ribeira: Rio Azor, O Touro Valdoviño: Prala de Mourillá.
- Lugo (15 conceillos, 32 beaches) Barreiros: Praia de Coto, Arealonga, As Pasadas, Lóngara, Fontela-Valea, Acantilado-Remior, San Bartolo e Altar Begonte: Río Ladra – Praia Fluvial do clube de Begonte Burela: Praia de Sil Castro de Rei: Río Azumara Cervo: O Torno, Cubelas Chantada: PF. Encoro Sangoñedo Cospeito: Río Miño – Xustás Foz: A Rapadoira, Llas, Areoula, Peizas Mondoñedo: Río Tronceda – Coto da Recadeira O Saviñao: Río Miño – Praia de A Cova O Vicedo: P.Xilloi, P. Abrela, P.Caolin, P. Vidreiro Outeiro de Rei: Río Miño – Santa Isabel Ribadeo: P. Esteiro Viveiro: P. Area, P. de Covasdereita, P. de Covas esquerda Xove: Praia de Esteiro.
- Ourense (10 concellos, 12 beaches) A Gudiña: PF. Río Riveira A Veiga: Encoro de Prada – Os franceses Avión: Praia Fluvial de Valderias Bande: PF. de Portoquintela Beariz: PF. de Magros, PF. de Doade Castrelo de Miño: Parque Nautico Castrelo, O Ribeiriño Castro Caldelas: Río Edo – Caldelas O Barco de Valdeorras: PF. Río Sil – O Barco de Vardeorras. Laza: Río Cabras – Regueiro Seco Vilariño de Conso: Río Cenza – O Marcolongo.
- Pontevedra (26 concellos, 73 beaches) A Guarda: Area Grande, O Carreiro, O Muíño, A Lamiña, A Armona. A Lama: Playa fluvial Río Verdugo. Baiona: Barbeira, Frades, Ribeira, Concheira, A Ladeira, Santa Marta. Bueu: Area de Bon, Lapamán, Portomaior, Lagos. Cambados: Praia da Torre, Praia do Facho, Praia Saíñas. Cangas: Melide, Nerga, Barra. Catoira: Río Ulla – Peirao (paseo marítimo). Cerdedo-Cotobade: Playa Fluvial Río Almofrei – Carballedo, Playa Fluvial Río Almofrei – Pozo Negro – Rebordelo, Playa Fluvial Río Almofrei – Xesteira; Calvelo, Playa Fluvial Cabanelas – Viascón. Covelo: Río Tea – P. Maceira. Lalín: Playa Fluvial Pozo de Boi. Marín: Portocelo, Santo do Mar. Mondariz: Río Tea – O Val, Río Tea – Cernadela. Nigrán: Patos. O Grove: Area das Pipas, Area Grande. Poio: Cabeceira, Laño, Xiorto, Area da Barca, Lourido, Raxó, As Sinás. Ponteareas: Playa Río Tea – A Freixa I, Playa Río Tea – A Freixa II, Playa Río Tea – San Roque – Os Remedios. Ponte Caldelas: Playa Fluvial A Calzada. Redondela: Arealonga, Cesantes centro y Cesantes dereita, Playa de Rande. Ribadumia: Playa Río Umia – Cabanelas. Sanxenxo: Playa Panadeira, Playa Silgar, Playa Baltar; Playa Caneliñas, Espiñeira (A Lanzada), Areas Gordas, A Lapa, Foxos, Nosa Señora da Lanzada, Magor. Soutomaior: Playa Matilde, Playa Muxeira. Tomiño: Río Miño – Tomiño – Playa Goián Tui: Río Miño – Playa Fluvial Areeiros, Río Miño – Playa Fluvial Penedo. Vilaboa: O Areeiro, Deilán, Forno do Cal. Vilagarcía de Arousa: Playa Compostela. Vilanova de Arousa: Praia Con da Mina.

Murcia (12)

- Mazarrón (5): Playa de El Rihuete, Playa de Bahía, Playa El Castellar Playa La Reya Playa Nares.
- San Pedro del Pinatar (1): Playa deportiva de Villananitos.
- San Javier (3): Playa deportiva del Pescador (Santiago de la Ribera) Playa el Castillico (Santiago de la Ribera), Playa Mistral (La Manga).
- Los Alcázares (1): Playa de La Concha.
- La Azohía (1): La Chapineta.
- Águilas (1): Cala de las Higuericas.

País Vasco (8)

- Guipuzcoa (2): payas de Itzurun, Santiago (Zumaia).
- Vizcaya (5): playas de Laga, Laida (Ibarrangelu), Isuntza (Lekeitio), Laidatxu, Hondartzape (Mundaka).
- Álava (1): playa interior de Garaio Sur (Burgelu).

16: Finland_SF_city: Tobacco-free municipality concept

The objectives of the practice are: smoke-free indoor and outdoor settings for conventional tobacco products and indoor and outdoor aerosol-free regulation for e-cigarettes and heated tobacco products.

The overall goal of the practice is to help Finnish municipalities and workplaces (both public and private employers) to officially become tobacco-free settings.

The practice started on 1st of January 2012 and is ongoing. It has been implemented (enforced/promoted).

The Finnish nation-wide tobacco-free municipalities project aimed to help municipalities as well as both public and private employers to make the decisions of becoming tobacco-free and assisting them in the implementation of this decision. A set of national criteria for tobacco-free workplaces were developed, with the minimum criteria of tobacco-free work hours. All criteria do not have to be implemented immediately and can instead be implemented over time, but a clear timetable for the introduction of the measures is necessary, with enough time for all parties involved to discuss reasons for the decision and practical implications. Both the management and the employees, as well as occupational health care, are involved in the process even though the ultimate goal is set by management. A communication plan is needed as well as continuous monitoring and evaluation of the process.

The main reason for tobacco-free municipalities are health concerns, or rather, the health benefits of not smoking and smoking cessation and the target population includes all citizens and people in the municipalities of Finland (the general population). The targeted group affected by this practice was involved in the development, implementation, and evaluation of the practice, alongside local public health authorities and employers/employees.

The practice is a nation-wide program (the geographical scope is Finland), and it focuses on both public and private settings (municipalities and workplaces). The municipalities are responsible for the implementation and enforcement at the local level.

The practice has been formally evaluated and the evaluation was carried out internally. The municipalities and workplaces involved in the practice have carried out self-assessments to see if the assigned criteria were met:

The municipality has made an official decision to become tobacco free, and is also a tobacco free workplace with no smoking allowed during working hours and with a no-smoking policy clearly stated in future job adverts; employees that do smoke are encouraged to stop smoking and are also provided with adequate support in order to quit smoking, which is offered during working hours; written instructions about the non-smoking policy were developed and distributed to work units; smoking was prohibited in indoor and outdoor municipality settings which is clearly marked by posters or signs; no new smoking areas will be built, while all remaining smoking areas are located outside and isolated in such a way that the smoke doesn’t drift inside the premises – they were also removed from the proximity of places used and frequented by children and young people; municipality events are smoke-free affairs; tobacco products are not sold in premises operated by the municipality; the municipality has tobacco-free council housing; the occupational health care plan covers support for smoking cessation; and finally, a comprehensive “transdisciplinary team

model". TDT TDT model exists as basis for cessation work.

In addition, many municipalities have carried out a process evaluation and monitor tobacco use. So far, in 2021, 99% of municipalities had made an official decision to become tobacco-free.

The practice has institutional support and stable human resources. The practice provides training of staff in order to sustain it. It was funded by external resources (public). The practice has been scaled-up to other locations or regions or at national scale in Finland.

17: France_SF_health care: Lieux De Santé Sans Tabac (Smoke-free healthcare Facilities)

The overall goal of the practice is to animate the network of regional actors involved in Lieux De Santé Sans Tabac (LSST); facilitate the acquisition of knowledge and know-how of the actors involved; promote the exchange of practices; develop and share evaluation tools including impact evaluation and to support the implementation of the LSST strategy: development of progress indicators and establishments' compliance with the LSST charter.

The objectives of this practice are smoke-free indoor settings (conventional tobacco products and heated tobacco products), smoke-free outdoor settings (conventional tobacco products and heated tobacco products) and promotion of tobacco cessation.

LSST collected political, managing and medical initiatives, organised in a Plan in order to help patients and professionals to quit tobacco, and to enforce a comprehensive smoking ban. The strategy includes: assessing of practices at the Health care facilities, evaluate the number of smokers, examine the consumption practices of practitioners and patient smokers, have a cessation protocol as soon as the patient is admitted and a protocol to relay by the general practitioner as soon the patients quit the hospital. Also, to extend the ban on smoking in outdoor places, periodically review assessment to measure improvements and communicate in a targeted manner with staff, patients and caregivers.

The focus of this practice is on public and private settings, specifically, the target settings are: hospitals including outpatient clinics (indoor), primary health care institutions (indoor), institutions from social sector (indoor), outdoor areas of hospitals and healthcare institutions (outdoor). The practice is at the first stage of implementation but not yet totally developed. The practice is ongoing and started on 30/11/2018.

Different methods and materials are used in this practice:

- Tobacco-free Health care guide
- Booklet Taking care of smokers in healthcare facilities,
- Tobacco-free hospital charter and stickers,
- First steps in smoking cessation booklet
- Signage
- A tobacco-free environment poster
- Publication of the Smoking & Mental Health Guide

The purpose of the guide is to promote the implementation of the LSST strategy in all places welcoming people with psychiatric problems. The guide was published in March 2020. A women's smoker's guide was also developed, had the main objective of reducing smoking-related morbidity and mortality in women. More specifically, objectives are: to disseminate good practices for the prevention and management of smoking in women, to strengthen the knowledge of professionals on the impact of smoking on women at different ages and to improve the identification, and management of female smokers and to promote women's health by reducing the prevalence of smoking.

A first meeting with a multi-professional working group took place in October 2020. The guide was

published in May 2021: Prevention of smoking and support for withdrawal in women. The goal was to promote the exchange of good practices by organizing regional conferences. In 2020 the Réseau de prévention des addictions ARS - Agences régionales de santé (RESPADD) organised, in coordination with the ARS and the regional support missions, two regional LSST conferences on February 4th in Marseille (PACA) and on February 13 in Nantes (Pays de la Loire). In 2021, 4 webinars were organized: April 1st in Normandy, April 16th in Reunion Island, May 31st in Ile-de-France, June st1 in Brittany. These symposiums make it possible to take stock of the LSST strategy in each region, in particular with the presentation of the results of the LSST audit at national and then regional level. A point on the epidemiology of smoking in the region is also proposed. In the afternoon, a time for discussion is devoted to the practices of health professionals and feedback on the various projects/ actions implemented as part of the LSST strategy. Nearly a hundred participants are present at these regional conferences.

Since the decree of November 15th, 2006, which modifies the Evin law and extends the smoking ban (in particular health establishments), second hand smoking should not be a source of questioning. However, to date, very few establishments apply these regulations, mainly through effective and unifying means of awareness and communication aimed at health personnel, patients and relatives, but above all, for lack of specific methodological support and dedicated teams trained within the establishment. These are the main results measured in 2017 by RESPADD with 155 healthcare establishments as part of the Tobacco-Free Health Place Audit, a self-assessment tool allowing each establishment to assess its actions and its margins of progress in establishing a tobacco-free health facility.

Other surveys showed that smoking professionals are less inclined to provide tobacco care to patients who smoke. In addition, the survey on the representations and practices of health professionals involved in oncology conducted by INCa in 2014, shows that only 1 out of 2 medical specialists declares that they systematically question their patients about their tobacco consumption. These obstacles result in a lack of care or unsatisfactory care for patients, generating suffering linked to the lack of nicotine (symptoms of under-dosage), a significant persistence of surgical complications (increased healing time, infections), and a low sense of self-efficacy of health professionals in preventing smoking. All of this data suggests the need to work on this theme and to provide in-depth and ongoing support to health establishments in a "Tobacco-free healthcare facilities" approach. It is necessary to work on this theme and to support it in depth and on a follow-up basis.

To achieve this, it is important to apply this policy with different aspects, taking into account the care of the patient throughout the hospital stay, the mobilization of all the professionals present in the health facilities and the denormalization of tobacco in these public spaces in order to protect the entire population, and in particular, young children, sick people and former smokers.

Therefore, the target population is the general population and vulnerable groups (disability, diseases, pregnant women). National and regional public health authorities, hospital staff, primary care centre staff, and civil organisations participated in the development, implementation and evaluation of the practice. International/European public health authorities, general practitioners, pharmacists and nurses, participated in the implementation, while the group of population was involved in the evaluation. The evaluation is ongoing, by an external partner. The indicators are: number of assessments, number of healthcare facilities participating, number of gold/ silver/ bronze certifications/, and the number of establishments by activity

The responsible institutions are Respadd- réseau de prévention des addictions and ARS - Agences régionales de santé. Respadd is in charge of deploying national strategy, encourage alliances, develop and distribute the national strategy tools. The practice is funded by own resources and by external resources – public.

The geographical scope of the practice is all France and it has been transferred (i.e., scaled-up) within the same country/region. A sustainability strategy has been developed and the practice provides training of staff.

18: France_SF_city: Ville libre sans tabac / Tobacco-free cities

Several cities in the Grand Est region are involved in the “Tobacco-free cities” program, with essential measures common to all the participating cities, as well as additional measures specific for each city and its territory. The measures primarily focus on informing and raising awareness about smoking and its consequences, and also about health benefits and higher quality of life upon stopping smoking; also, it measures focus on establishing new, smoke-free outdoor spaces and promoting smoke-free private spaces. These measures apply equally to all tobacco and nicotine products, including smoked tobacco, electronic cigarettes and heated tobacco products.

The objectives of the practice include smoke-free indoor and outdoor settings for conventional tobacco products, a car smoking ban with minors or pregnant women, also for conventional tobacco products, outdoor aerosol-free regulation in terms of heated tobacco products and finally, other provisions regarding prevention of initiation and cessation.

The overall goal is to develop a community-based approach to tobacco control at the city level, with a focus on improving health and quality of life. To ensure local ownership of the tobacco control package, to develop smoke-free places and to contribute to achieving the goal of tobacco-free generation by 2032.

The practice started on 15th of April and is still ongoing. The “Tobacco-free Cities” program has been developed/adopted but not yet enforced. The responsibility for the practice lays on the cities involved, and they are supported by two civil society organizations - Grand Est Sans Tabac and the Comité National Contre le Tabagisme). The intervention still hasn’t been evaluated since it is still ongoing (mayors of the cities involved are showing interest in participation, alongside other local authorities), but the evaluation will be carried out in the foreseeable future. The practice focuses on public settings only and all the measures are based on scientific evidence.

According to data, the Grand Est region has 1.2 million daily smokers, aged 18 to 75, and is ranked 4th amongst the regions where smoking is the most common. A lot of smokers smoke more than 10 cigarettes a day, more than in the rest of the country, and many of them do not intend to stop smoking. Because of this, the Grand East region has a higher mortality rate (caused by tobacco) than the average rates in the rest of France. The target population is the general population of the cities involved in the practice.

Ethical and equity aspects to be highlighted include that, there is no information regarding potential burdens of this intervention, but it seems that the intervention was implemented equitably, keeping in mind the widespread issue of smoking in the region and with a focus on vulnerable groups (pregnant women). It takes into consideration certain dimensions such as socioeconomic position (including educational level). It is also noted that the independence of this program from the tobacco industry and retailers is ensured and enforced (FCTC article 5.3).

The general population of different cities participated in the development and implementation of the practice. National, regional and local public health authorities alongside civil organizations were included in the development phase. Local and regional public health authorities, various health care professionals (such as hospital and primary care staff, specialized physicians, general practitioners, nurses), informal caregivers, researchers and academics, school staff, employers and employees, and civil organizations, were involved in the implementation phase. Evaluation still hasn’t been carried out.

The practice has institutional support and stable human resources and was funded by external resources (public). It has not been transferred yet, but transferability has been considered, alongside structural, political and systematic recommendations in order to do so.

19: Hungary_SF_nation: Tobacco control in practice- Article 8: Protection from exposure to tobacco smoke - the story of Hungary

The objectives of the practice focus on indoor and outdoor aerosol-free regulation for heated tobacco products.

The country of Hungary has implemented strict tobacco-control measures in recent years. The main goal of these measures is to protect non-smokers from the harmful health effects of second-hand smoking, with a nation-wide smoking ban in all enclosed, indoor public places, and some outdoor public places. This ban is an important contribution to decreasing smoking-related public health issues and smoking-related economic burdens.

Smoking is prohibited in public institutions, in public transport and workplaces, various public areas (such as playgrounds, underpasses, waiting areas), open air spaces of public education institutions, in child welfare and child protection institutions, in the vicinity of health service providers, and also in apartment houses in enclosed rooms of common use.

The practice started on the 1st of January 2012, and is still ongoing. Its target population is the general population.

The Hungarian government recently adopted a stricter legislation regarding the prohibition of smoking, with a total ban on smoking in all enclosed public places. The legislature also includes the introduction of pictures with various health-warnings on the packages of tobacco products. The measure aims at the prevention and reduction of taking up smoking by indicating its harmful effects and emphasizing the responsibility of the smoker towards other people in connection with passive smoking.

Authorized persons are obliged to request anyone violating either the smoking restriction or the restriction on the use of electronic cigarette and electronic device imitating smoking, to immediately cease such infringement. State health care administrative organizations shall monitor compliance with the smoking prohibition, and in case of any infringement, shall impose a healthcare penalty upon the infringer.

Internationally, Hungary is one of the leading countries when it comes to morbidity and mortality associated with smoking and also diseases deriving from smoking, which severely impacts the state budget.

Research has shown that more than 50% of hospitality employees smoke at work, as do 1 in 4 employees in healthcare and education. They mostly smoke in places designated for smoking at their workplace. One in four guests report that, while at hospitality venues, someone will be smoking in their proximity. Only one tenth of employees in health care and education did not work in a smoking environment. Employees themselves claim that smoking disturbs them at the workplace and also state that smoking prohibition should be strengthened in the health care sector. The majority of employees fully supported the new, stricter law.

With these stricter measures, Hungary is coming even closer to the health, political and professional expectations of the EU and WHO, and also substantially decreases the smoking-related public health and economic burdens as well.

The measures of the practice are trying to ensure that smoking is avoided in the presence of vulnerable groups, such as minors, pregnant women, sick people or people with limited mobility. The measures should be applied even in the areas of private life, especially in enclosed areas or inside of cars, thus promoting the implementation and protection of the constitutional rights related to good health and a healthy environment.

Some of the equity and ethical principles underlining the practice are unfavorable general health indicators of the Hungarian population and a desire to provide protection to non-smokers and people who, due to their age or health, require increased protection against the harmful effects of passive

smoking. That is to be achieved through the regulation of tobacco consumption, primarily in public places.

The target group affected by this practice and national, regional and local public health authorities were involved in the development, implementation and evaluation of the practice. Researchers/academics and International/European public health authorities participated in the development phase, alongside civil organizations. Employers/employees helped with the implementation phase, while specialized physicians, researchers/academics and civil organizations were included in the evaluation of the practice.

The intervention focuses on both public and private settings, and the responsibility of its promotion is on the Hungarian government (national public health services and health ministry). The practice has institutional support and stable human resources and has been funded by our own resources.

The evaluation was carried out by an external partner. On one hand, in terms of indicator, the following must be highlighted: number of monitoring sessions of smoking restrictions, number of violations of smoking restrictions, a number of places where violations were mainly detected, number of health care penalties, number of exposures to passive smoking and data on smoking prevalence.

On the other hand, in terms of outcomes, it's important to consider that the smoking ban at hospitality venues in Hungary has improved health at birth. The effects are larger for newborns of parents with low educational attainment – newborns at the bottom of the fetal health endowment distribution benefit more.

The practice is applied countrywide and has been developed on a local/regional/national level. Transferability has been considered; structural, political and systematic recommendations have been presented and the practice is ready for transfer but has not been transferred yet.

19: Hungary_SF_nation: Tobacco control in practice- Article 8: Protection from exposure to tobacco smoke - the story of Hungary

The objectives of the practice focus on indoor and outdoor aerosol-free regulation for all tobacco products, electronic nicotine and non-nicotine delivery systems and herbal products used for smoking.

The country of Hungary has implemented strict tobacco-control measures in recent years. The main goal of these measures is to protect non-smokers from the harmful health effects of second-hand smoking, with a nation-wide smoking ban in all enclosed, indoor public places, and some outdoor public places. This ban is an important contribution to decreasing smoking-related public health issues and smoking-related economic burdens.

Smoking is prohibited in public institutions, in public transport and workplaces, various public areas (such as playgrounds, underpasses, waiting areas), open air spaces of public education institutions, in child welfare and child protection institutions, in the vicinity of health service providers, and also in apartment houses in enclosed rooms of common use.

The practice started on the 1st of January 2012, and is still ongoing. Its target population is the general population.

The Hungarian government recently adopted a stricter legislation regarding the prohibition of smoking, with a total ban on smoking in all enclosed public places. The legislature also includes the introduction of pictures with various health-warnings on the packages of tobacco products. The measure aims at the prevention and reduction of taking up smoking by indicating its harmful effects and emphasizing the responsibility of the smoker towards other people in connection with passive smoking.

Authorized persons are obliged to request anyone violating either the smoking restriction or the restriction on the use of electronic cigarette and electronic device imitating smoking, to immediately cease such infringement. State health care administrative organizations shall monitor compliance with the smoking prohibition, and in case of any infringement, shall impose a healthcare penalty upon the infringer.

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Research has shown that more than 50% of hospitality employees smoke at work, as do 1 in 4 employees in healthcare and education. They mostly smoke in places designated for smoking at their workplace. One in four guests report that, while at hospitality venues, someone will be smoking in their proximity. Only one tenth of employees in health care and education did not work in a smoking environment. Employees themselves claim that smoking disturbs them at the workplace and also state that smoking prohibition should be strengthened in the health care sector. The majority of employees fully supported the new, stricter law.

With these stricter measures, Hungary is coming even closer to the health, political and professional expectations of the EU and WHO, and also substantially decreases the smoking-related public health and economic burdens as well.

The measures of the practice are trying to ensure that smoking is avoided in the presence of vulnerable groups, such as minors, pregnant women, sick people or people with limited mobility. The measures should be applied even in the areas of private life, especially in enclosed areas or inside of cars, thus promoting the implementation and protection of the constitutional rights related to good health and a healthy environment.

Some of the equity and ethical principles underlining the practice are unfavorable general health indicators of the Hungarian population and a desire to provide protection to non-smokers and people who, due to their age or health, require increased protection against the harmful effects of passive smoking. That is to be achieved through the regulation of tobacco consumption, primarily in public places.

The target group affected by this practice and national, regional and local public health authorities were involved in the development, implementation and evaluation of the practice. Researchers/academics and International/European public health authorities participated in the development phase, alongside civil organizations. Employers/employees helped with the implementation phase, while specialized physicians, researchers/academics and civil organizations were included in the evaluation of the practice.

The intervention focuses on both public and private settings, and the responsibility of its promotion is on the Hungarian government (national public health services and health ministry). The practice has institutional support and stable human resources and has been funded by our own resources.

The evaluation was carried out by an external partner. On one hand, in terms of indicator, the following must be highlighted: number of monitoring sessions of smoking restrictions, number of violations of smoking restrictions, a number of places where violations were mainly detected, number of health care penalties, number of exposures to passive smoking and data on smoking prevalence.

On the hand, in terms of outcomes, it’s important to consider that the smoking ban at hospitality venues in Hungary has improved health at birth. The effects are larger for newborns of parents with low educational attainment – newborns at the bottom of the fetal health endowment distribution benefit more.

The practice is applied countrywide and has been developed on a local/regional/national level. Transferability has been considered; structural, political and systematic recommendations have

been presented and the practice is ready for transfer but has not been transferred yet.

20: Ireland_SF_health care: Health Service 'National Policy on Tobacco Free Health Services'

The Health Service Executive (HSE), the leading healthcare provider aims to create a clean and healthier tobacco and e-cigarette free environment for staff, patients / service users and visitors in Irish health services. The policy is helping to change social norms around tobacco use, treating tobacco addiction as a healthcare issue, and promoting smoking cessation by actively advising, encouraging and supporting those who smoke to quit. The policy has two clear aims: to treat tobacco as a healthcare issue and to de-normalise tobacco use in all healthcare services and settings.

The practice focuses on public settings and the policy prohibits smoking and use of e-cigarettes anywhere on the campus including building forecourts, doorways, entrances, walkways, roads and car parks, as well as cars parked on HSE and campus grounds, bicycle sheds and bus shelters.

The practice is ongoing from 01/04/2012. It was the development of a National Health Service policy to implement tobacco free spaces on the grounds of all health care ground (2012) in the absence of a legal framework to enforce such an action. This intervention effects heath service staff, managers, visitors to health services as well as health service users. In addition to the policy to remove smoking on the grounds of health services a further policy on protecting staff from second hand smoke in private domestic settings was developed (2014). Both policies are almost 10 years old and currently under review. A variety of activities and resources to encourage and promote implementation have been put in place in the last 10 years. The tobacco free Ireland programme conducted a series of workshops nationally and with different services (mental health and disability, acute services etc.) to explain what was required to comply answer questions and support managers to implement the policy. Training was provided to Health Promotion staff who also had a role and remit to sit on local working groups and drive policy implementation. A number of conferences and webinars were held to support implementation and a toolkit was drafted as well as generic signage to support sites to communicate the policy to the public. Initially there was a one-day training called brief intervention for smoking cessation which trained staff in assessing tobacco dependence and treating tobacco addiction and this merged in to a more generic training called 'making every contact count'.

There were national service plan Key Performance Indicators (KPIs) for policy implementation and brief intervention training which services were accountable for and this supported implementation. The Irish Health Service has been an active member of a global network called the Global Network for Tobacco Free Health Services and the use of this global set of standards have supported and guided services in policy implementation. Some external organisations (non health service) have also used these standards and principals to implement tobacco free environments e.g. Dutch local authorities. Participation in the Global Network for Tobacco Free Healthcare Services (GNTH) - was instrumental in driving policy implementation and quality improvement. In recent years, significant budget has been set aside to promote tobacco free campus quality improvement through participation in a bursary scheme.

In order to implement national policy objectives contained in the governments 'Healthy Ireland' policy and the governments Tobacco Free Ireland by 2025 policy, the HSE "Tobacco Free Ireland Programme" lead on the development of a National Health Service tobacco free campus policy to protect staff, service users and visitors from the harmful effects of tobacco smoke. The HSE has adopted an official corporate Tobacco Free Campus Policy. A literature review was conducted and a draft policy completed which was shared across the organization inviting feedback.

The target population include: General population, vulnerable groups: people with disability and/or disease and pregnant women.

Any data captured with regard to implementation considers General Data Protection Regulation (GDPR) requirements since this came in to practice in Ireland. There is no patient identifiable data

included in audits etc. Any adverse events more generally in terms of tobacco related incidents are recorded as per normal practice on a national incident management system and staff are required to complete mandatory health and safety training but this is not bespoken to tobacco.

To develop the policy from the outset a steering group was established with representation from HR, primary care, acute care, mental health, disability services, health promotion, tobacco control, health & safety as well as clinical representation (nursing and medical). Once the policy was ratified by the health service board and CEO it was launched with a lead in time of 2 years to implement

Senior managers within their own respective sites are responsible for implementation and compliance on each of their respective sites. There was trade union consultation and a challenge by some staff to the removal of smoking shelters on health care grounds. This was responded to and adjudicated in favour of policy implementation.

The public agency has responsibility of the practice. The HSE implements its own Tobacco free health service policy but is a member of a Global network with representation from Spain, Germany, Austria, Estonia, Finland, France, Georgia, the Netherlands, South Korea, Sweden, Switzerland, Taiwan, Ireland (all regions in the Republic of Ireland).

The practice has been evaluated. In 2016 the tobacco free Ireland programme commissioned an internal national audit of policy implementation. National surveys to assess policy understanding and implementation also took place annually or every second year. Some individual sites completed local evaluations and surveys and or commissioned more formal audits of policy implementation.

In general, health service staff and the public appreciate the requirement for a tobacco free health service. There are frequent breaches especially in some of the busy acute sites. Implementation is an ongoing challenge as service managers change and perhaps priorities change. Some negative impacts have included the introduction of smoking shelters where public money has been used to re-erect shelters in contravention of the policy and to move smoking away from visibility at entrances etc. In addition, some managers do not understand all the aspects of policy implementation (i.e. the main focus being to address and treat tobacco dependence and provide an environment conducive to cessation) therefore dismiss the policy as ineffective if they witness breaches. To address this there is training and clinical practice going on in that site. Patient satisfaction feedback was helpful as the public themselves demand better policy implementation and a clean tobacco free health service. Where complaints are received, these are forwarded to the hospital or service managers to respond.

Policy implementation is/was measured through quarterly KPIs reports, which were reported nationally and published. Further accountability and reporting were required in subsequent years through participation in national surveys coordinated by the tobacco free Ireland programme in response to parliamentary questions that have a legal requirement for a response. The practice has institutional support and stable human resources. The practice provides training of staff in order to sustain it.

National Tobacco Free Ireland Programme has a role and remit to support and drive quality improvements in its implementation, collate data on its implementation. It also coordinates responses to any queries we may receive from government ministers on its implementation, develop tools and supports for it, and develop training for staff. Commission internal audits. All senior level Health Service managers are responsible for implementing the HSE Tobacco Free Campus (TFC) Policy in their own respective services. Individual health service managers responsible for adapting the national TFC policy locally for their respective services and ensuring compliance.

Ready for transfer, but the practice has not been transferred yet. The practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented.

21: Ireland_SF_cars: Ban on smoking in cars when children are present

The overall goal of the practice is to protect children from tobacco smoke exposure. The objective of this practice is to ban smoking for conventional tobacco products with minors or pregnant women in cars.

The practice focuses on public and private settings, but cars are the target setting: the practice states that smoking is not allowed in cars when children are present. It highlights another aspect of awareness in terms of the dangers of passive smoking.

The practice has been developed/adopted. It started on 01/01/2016 and is still ongoing. The action has been enforced by national police, but there is no evidence of any prosecutions.

The justification of the practice lays on the premise that children should be protected from tobacco smoke exposure in the confined spaces of a car. Therefore, the target population for the practice are age specific groups: minors and pregnant women. Equity and ethical principles therefore assume protection of children from tobacco exposure.

The population was involved in the development and the implementation, while the national public health authorities are involved in the development, implementation and evaluation. The responsibility for the practice is at national level with National Police force being responsible for enforcing the ban.

The main outcome of the practice is less children exposed to tobacco smoke. It also sets the scene that tobacco smoke exposure is harmful and contributes to the de-normalisation of smoking. The practice has not been formally evaluated. The geographical scope of the practice is Ireland. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.

22: Italy_SF_beaches: Smoke-free beaches

The aim of the practice is to achieve healthier and cleaner beaches reducing health and cleaning costs. The initiative had a secondary aim linked to health and well-being, which is to safeguard and develop sustainable, healthy tourism, raise public awareness of the damages caused by tobacco to humans and to the environment and contribute to the de-normalization of tobacco consumption. The practice covers conventional tobacco products and heated tobacco products.

The adoption and implementation of the practice is based on voluntary basis as some municipalities may decide that beaches under their jurisdiction (some or all beaches) are 'smoke-free beaches'. Smoking is banned under the beach umbrella and on the seashore but are allowed in specifically identified areas. In Italy, there is no law prohibiting the use of cigarettes/new products in outdoor places.

Therefore, smoking is permitted on the beach unless a specific ordinance is issued by the municipality (COMUNE) responsible for the beach. The first location where this rule was introduced was the Municipality of Bibione (2019), near Venice, and later, it was extended to additional resorts and other municipalities in Italy, such as: Arenzano, Lerici, Sanremo, Savona (region Liguria) Bibione, Chioggia (region Veneto) Cesenatico, Cervia, Ravenna and Rimini (region Emilia Romagna) Pesaro, San Benedetto del Tronto, Sirolo (region Marche) Olbia, Sassari, Stintino, Cabras and the entire Costa Smeralda (region Sardinia) Anzio, Ladispoli, Ponza, Sperlonga, Gaeta, Fiumicino and Torvaianica (region Lazio) Alba Adriatica (region Abruzzo) Manduria and Porto Cesareo (region Puglia) Capaci, Lampedusa, Linosa (region Sicily).

Information on the practice is communicated through the media, the tourist office, and signage on site. Bibione started the smoke-free beach path in 2011 by introducing a smoking ban from the first row of beach umbrellas to the water with exploring opinion on the smoking ban.

The process was set in 10 steps: Step 1. Identify scientific support (research and data) for the

initiative and promotional campaign; Step 2. Identify a champion; Step 3. Engage and involve stakeholders; Step 4. Assess interest in the initiative by the target audience and stakeholders; Step 5. Implement the campaign; Step 6. Dissemination of the initiative prior to campaign launch; Step 7. Enforcement of the smoking ban; Step 8. Assessment of the effect of the campaign; Step 9. Reflecting on evaluation; Step 10. Expand the initiative.

The ban on smoking along the Bibione seashore was enforced under the municipal regulation banning smoking in designated non-smoking areas, it was publicized in brochures and on signs and billboards and had an imposed fine for smoking in these areas ranging from €25 to €500. Local police monitored the non-smoking area on a regular basis. In case of violation, the lifeguards can be contacted in the first instance and, if the smoker continues to disregard the ban, the Municipal Police can be contacted, who will then intervene by sending their officers to the scene. The Municipal Police Officers monitor the beach from 9.30 a.m. to 7.00 p.m.

On 15 June 2022, an important agreement was also signed with the Delta Tagliamento Auxiliary Coast Guard Association, whose volunteers are at the forefront of surveillance and awareness-raising among bathers towards the ban on smoking on the beach, towards the respect for nature and towards the development of greater environmental awareness.

There is now ample scientific evidence showing that smoking on beaches exposes non-smokers to second-hand smoke. Moreover, beaches are often frequented by many children who are generally better protected elsewhere. Last but not least, the environment matters. Cigarette butts cause a lot of damage to the environment because they release thousands of contaminants into the water, and filters, being made of plastic, contribute greatly to micro-plastic pollution and the deterioration of the ecosystem. Smoke pollutes the air and avoids breathing and enjoying the seaside air perfume.

The Bibione initiative was supported by scientific evidence. A study conducted in 2015 by a working group at the National Institute of Tumors in Milan, showed that passive smoking also exists on the beach and is far from negligible: at a distance of about 10 meters and with an average wind speed of 2.7 m/sec, very high peaks of pollution are generated (250 micrograms/m3). These peaks, although they last only a few seconds, are one or two orders of magnitude higher not only than the basal level of the beach but also the level generated by traffic at the roundabout at the entrance to the resort, an area of high vehicular traffic. The average value of Black Carbon (an indicator of the presence of polycyclic aromatic hydrocarbons, many of which are toxic and carcinogenic) from the beginning to the end of the smoke was 7.4 micrograms/m3 compared to 2.1 at the roundabout and 1.8 at the beach basal.

It is precisely for this reason that the 'Breathe the Sea' project has been supported in recent years by the WHO (World Health Organisation), the Ministry of Health, the Veneto Region, ULSS 4 of Eastern Veneto, and the National Cancer Institute.

The smoke-free beaches initiative is based on an awareness-raising campaign intended to be a gentle, non-restrictive nudge to the public. Smokers have been provided with a valid alternative, equipping the 9 km of beach with no less than 41 equipped, delimited, and clearly recognizable wooden islands where they can stop to smoke and properly dispose of their butts inside the ashtrays. The awareness-raising action undertaken with "Bibione respira il mare - Smoke-Free Beach" is well received by both non-smokers and smokers, who are proving increasingly respectful and cooperative.

The target for this practice is the general population. Regional and local public health authorities were involved in development, implementation and evaluation. Other partners were also involved in the development of the practices such as academia and civil society organisations.

Regardless of whether a specific municipal smoke-free beach ordinance is issued or not, it is prohibited to leave cigarette butts of smoking products on the soil, water, and drains of the entire national territory and, therefore, at the seaside too (Article 40 of Law No. 221 of 28 December 2015 - entry into force: 02/02/2016), but unfortunately, this law is not enforced.

In terms of evaluation, initial assessments were carried out when tourists arrived at the umbrella rental offices by means of a questionnaire. Mid-season assessments provided valuable information for making adjustments by means of surveys carried out on a sample of tourists that had received campaign messages and/or an anonymously completed the questionnaire available at hotels, in rented apartments or by umbrellas. To encourage completion of the questionnaire, a reward such as a voucher for a nearby bar was provided. The assessment of the effect of the campaign at the end of the season provided information on what worked, what did not, and what could work better next time. Data also showed that the number of fines issued by the Bibione Municipal Police declined. In previous years about a dozen were recorded per bathing season, to the date of 4th of August 2022, the figure is still zero.

The municipality (COMUNE) is responsible for the beach as it was the case in this practice. Each municipality that decides to ban smoking on the beach can decide autonomously the amount of the fine to be paid in the event of non-compliance. In all cases, the penalties are only administrative and do not involve any risk under criminal law.

The practice has been transferred (i.e., scaled-up) within the same country/region.

23: Lithuania_SF_nation: Legal requirement for smoke free environments as part comprehensive Tobacco Control Law

This practice focuses on smoke-free indoor settings for conventional tobacco products. The overall goal of the practice is to reduce consumption and protect individual and public health. The intervention focuses on both public and private settings.

In the Republic of Lithuania, smoking (using tobacco, tobacco products, products related to tobacco products) is prohibited in all educational and social service institutions that provide social care and/or social care services for children, health care institutions and the territories of these institutions. It is also prohibited in workplaces located in closed rooms (companies, institutions and organizations may have special rooms where smoking is allowed).

The requirements for the installation and operation of smoking rooms (or spaces) are determined by the Government of the Republic of Lithuania or an institution authorized by it for residential premises belonging to common partial ownership rights, other premises with common partial ownership rights and other parts of the building. Also, in all types of public transport (exceptions are long-distance trains, where separate carriages for non-smokers and smokers must be provided), as well as aircraft, (where separate seats for non-smokers and smokers must be provided), in restaurants, cafes, bars, other public catering establishments, clubs, discotheques, internet cafes (internet clubs, etc.), gambling houses (casino), slot machines or bingo parlours, other leisure facilities, premises where sports competitions or other events, and in other premises designed to serve people(exceptions are for specially equipped cigar and (or) pipe clubs); also, in vehicle cabins, (if there are persons under the age of 18 and/or pregnant women in them), in covered areas of public transport stops (pavilions), children's playgrounds and places where public catering services are provided while serving customers in outdoor conditions (at outdoor tables, gazebos, other outdoor facilities),during outdoor sports competitions or other outdoor events, on the balconies, terraces, and finally, in loggias of apartment buildings owned by individual owners, when at least one resident of the house objects to smoking(except for smoking areas).

The practice is ongoing and started on the 1st of January of 1996. It has been implemented and enforced by law.

The justification of this practice included: the protection of health for employees, the right to a smoke free environment, reducing harm from passive smoking and the fact that smoke free legislations are effective.

The target population was the general population. National Public Health was included in the development, implementation and evaluation of the practice. The responsibility lays on the Drug, Tobacco and Alcohol Control Department, as their responsibility is coordinating the development and implementation of all control policies in substance use. This practice used external resources and, in terms of evaluation, it is important to highlight that the practice had an impact on the reduction of smoking over time. The geographical scope of the practice is Lithuania and the practice has been transferred (i.e. scaled-up) within the same country/region.

24: Luxembourg_SF_cars: Smoking ban in cars when children under 12 years are aboard

The overall goal of the practice is to prevent second-hand smoke exposure to children and to preserve their health. The objectives of the practices are a smoking and a vaping ban in cars with minors and/or pregnant women. This applies to conventional tobacco products, e-cigarettes and heated tobacco products.

More specifically, the practice states that smoking and vaping is not permitted in private cars when children under 12 years are aboard. Therefore, the focus of this practice is on private settings, with cars as the target setting. The target population of the practice is the general population with a focus on age specific groups - minors and pregnant women.

The practice is on-going and with a starting date of 06/13/2017. It was debated in the Luxembourg Chamber of Deputies. Luxembourg anti-tobacco law transposing tobacco Directive 2014/40/UE Art 6.3, is the source of information on the practice. The practice is enforced by adoption of this measure into the law.

The justification for the practice is based on protecting children from second-hand smoking and to denormalize the act of smoking. National public health authorities participated in the development, implementation and evaluation. The responsibility for the practice lays on a national level, the institution responsible for it and its promotion being the Ministry of Health of Luxembourg.

The main outcomes of the practice are protection of children against second-hand smoke. In the monitoring of the process and outcome of the practice statistics from the police (number of fines for no respecting of the ban) were used. The practice has not been formally evaluated.

The practice has institutional support and stable human resources. It is a measure that applies to the population of Luxembourg and has been transferred (i.e. scaled-up) within the same country/region

25: Luxembourg_SF_playgrounds: General smoking ban in children playground

The overall goal is to prevent, as much as possible, the young from smoking. Specific objectives are to achieve smoke-free and aerosol-free outdoor settings (for conventional tobacco products, e-cigarettes and heated tobacco products). The smoking ban in playground areas is intended to denormalize the act of smoking and to provide a smoke-free environment for the children. It also intends to raise awareness among adults, especially parents, to not smoke in front of children, as children have a tendency to imitate behaviours.

The practice focuses on public only settings, more specifically on outdoor children's playgrounds. The practice is ongoing with a start date of 06/13/2017. It is based on the political decision and transposing Directive 2014/40/UE in Luxembourg antitobacco law. The police is in charge of the supervision and the control of compliance with this regulation.

The justification of the practice is based on the importance of smoking prevention among children, the denormalization of smoking and protection from second-hand smoking. The target population is the general population with a focus on age specific groups.

National public health authorities were involved in the development, implementation and evaluation of the practice. There is a general respect and also approval of this measure among the population (91%) according to a survey conducted in 2017 in Luxembourg about the general acceptance of the national antitobacco law of 2017.

Indicators are used in the monitoring and, in terms of outcomes of the practice, it's important to measure the existence of statistics about police fines issued for no respecting the measure. However, the practice has not been formally evaluated.

The practice has institutional support and stable human resources. The responsibility and scope of the practice is national (Luxemburg) and is under the Ministry of Health of Luxembourg. Municipalities should ensure the ban is respected. Transferability has not been considered in a systematic way.

26: Malta_SF_nation: Products and Smoking Devices (Simulating Cigarettes or Tobacco) (Control) Regulations

The objectives of the practice are smoke-free indoor settings for conventional tobacco products and indoor aerosol-free regulation for e-cigarettes and heated tobacco products.

The practice started on the 12th of December of 2010 and has been implemented (enforced/ promoted).

The justification for the practice considered to de-normalise smoking, protect the health of the population in terms of second-hand exposure and to extend the scope of banning smoking indoors.

In regulations, unless the context otherwise requires, "the Act" means the Tobacco (Smoking Control) Act. The term "tobacco devices" includes any product bearing the name cigarette or tobacco that is intended as a substitute to a conventional tobacco product or smoking requisite and includes any non-nicotine device. However, it excludes any pharmaceutical nicotine delivery devices. All tobacco devices and any regulations made in terms of advertising and smoking in public places are concerned and have to comply with the provisions of the Act.

The target population was the general population. The practice has institutional support and stable human resources. The outcome of the practice has been the extension of prohibiting smoking in public places (and advertising) to non-conventional tobacco and related products.

27: The Netherlands_SF_sports: Smoke-free sports grounds (Rookvrije Sport)

The overall goal of the practice is to create smoke-free spaces in sports grounds so that children are no longer exposed to smoking and second-hand smoke and its potentially harmful consequences. The practice will contribute to achieving a completely smoke-free generation. It covers conventional tobacco products as well as e-cigarettes and heated tobacco products (aerosol-free regulation). The practice focuses on public or private settings and is ongoing since 01/10/2015. The practice has been registered in a best practice-registering portal.

Nowadays, in the Netherlands, some outdoor sports clubs have voluntarily implemented an outdoor smoke-free policy at their venues (approximately 2.000 outdoor sports clubs in the first half of 2022 and 33% of some of the big outdoor sports for children: field hockey, football, tennis, athletics or korfball). Health Funds for a Smoke-free Netherlands (Dutch Heart Foundation, KWF Dutch Cancer Society, and the Lung Foundation in Netherlands) initiated the 'Smoke-free Generation movement'. They developed a program to motivate and facilitate sports clubs into making sports grounds smoke-free (among other environments), with information and tools like a guideline, smoke-free signs (free of charge for outdoor areas) and communication guidelines and advice.

Young People at a Healthy Weight-Teamfit (Jongeren op Gezond Gewicht (JOGG)-Teamfit) offers

sports clubs the possibility of guidance by sports coaches for implementing smoke-free policies. The 'Nederlands Olympisch Comité*Nederlandse Sport Federatie' (NOC*NSF) and sports federations, set the target for smoke-free sports clubs by 2025. They started a campaign aimed at the boards of sports clubs to become smoke-free (together with Health Funds for a Smoke-free Netherlands/ Smoke-free Generation). The sports federations will make their own sports events smoke-free following the premise "practice what you preach".

The Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten, VNG), launched a guideline for municipalities to achieve smoke-free sports grounds. Regional Public Health Services and municipalities decide if they join the Smoke-free Generation movement/smoke-free sports campaign and thereby encourage and/or support sports clubs to become smoke-free. Some municipalities do this through regulations, for example, by rental agreements of sports fields. Others encourage sports clubs by example through various communication channels or information meetings. The highest level (Eredivisie) and second highest level (First division, Eerste divisie) of professional football in the Netherlands, established smoke-free stadiums. The method used is as follows:

1. Recruitment phase: sports clubs are encouraged by various organizations to introduce a smoke-free sports ground. For example, by sports federations, the Health Funds for a Smoke-free Netherlands, Regional Public Health Services and municipalities.

2. Adoption phase, which is aimed at:

1) The board of the sports club has the confidence to implement a smoke-free policy, i.e. self-efficacy (not only indoor but also outdoor).
2) The board members, volunteers and members of the sports club have a positive attitude towards a smoke-free sports ground.
3) The board actually decides to proceed with the introduction of a smoke-free sports ground.

A positive attitude towards a smoke-free sports ground can be reached (more information is provided in the guideline for smoke-free sports grounds):

- Involving members, volunteers and smokers in the implementation of the smoke-free policy.
- To assess the current situation and opinions about smoking at the sports club (for example, with a survey).
- Discussing the results and proposing a smoke-free policy to the board.
- Determine whether and how the smoke-free policy is presented to members (for example via the General Members' meeting).

3. Implementation phase. In this phase, the smoke-free policy will be introduced. The guidelines for a completely smoke-free sports ground are as follows:

- Indoor areas are completely smoke-free.
- The entire outdoor area is smoke-free: the entrance and all spaces within the fences or other boundaries of the sports club such as the fields, the terrace and the grandstand.
- The smoke-free policy applies to everyone.
- Signs or other indications show that the area is smoke-free.
- The use of e-cigarettes and new tobacco products (such as heated tobacco products) is also not allowed on a smoke-free sports ground. Completely smoke-free policy is the recommendation and the aim. Sports clubs can also achieve it step by step (beginning with partly smoke-free policy) to create support.

The way in which sports clubs implement a smoke-free policy for sports ground, differs. In the guideline of the intervention, the following steps are described under 'implementation':

- Make an action plan.
- Formulate a clear smoke-free policy. Also, to make agreements about how to ensure compliance with the policy.
- Choose a good time for introduction.
- Communicate the new policy in time. Use all existing communication channels to publish the smoke-free policy (such as the website and the newsletter). Include the smoke-free policy in the club rules. Also, inform external parties such as suppliers, sponsors, the municipality and visiting sports clubs.
- Determine what changes are needed on the sports ground and implement them.
- Approach the media for positive attention.

4. Sustainable implementation. For sustainable implementation, it is important that:

- The smoke-free policy is enforced; it is important to approach people who do smoke.
- The board of the sports club evaluates the smoke-free policy and, if necessary, improves it by means of additional steps.
- Support from external organizations remains available.

The smoke-free policy must be actively enforced by the board and volunteers of the sports club. They have to approach people who still smoke and explain the policy.

Outdoor smoke-free policies at sports clubs represent an important new area of tobacco control as many people, including youth, spend a large portion of their free time participating in sports. By creating smoke-free environments, like schoolyards, playgrounds and sports clubs, children are less tempted to smoke and passive smoking is prevented. Smoke-free policies reduce the visibility of smoking, limit the opportunities for smoking and communicate that smoking is socially unacceptable.

The target population for this practice are age specific groups. Different organisations and movements were involved in the development and implementation of the practice such as Smoke-free Generation movement, sport clubs, young people, sports federations, the association of Netherlands Municipalities and regional Public Health Services. Municipality, the city public agency and NGOs have the responsibility for the practice.

The practice been formally evaluated by an external partner. The Health Funds for a Smoke-free Netherlands provide free smoke-free signs for outdoor sports clubs. In this way, the registered sports clubs who implemented smoke-free policy can be identified. In the coming period, the sports federations will also monitor the progress. There are also different scientific articles showing results of evaluation for this practice.

A sustainability strategy has been developed and the practice has been transferred (i.e. scaled-up) within the same country/region.

28: The Netherlands_SF_transports: Smokefree public transportation

The overall goal of the practice is to contribute to the creation of a Smoke-free Netherlands, where children don't start smoking and are protected against second and third-hand smoke. The objectives are smoke and aerosol free outdoor settings (conventional tobacco products, e-cigarettes and heated tobacco products) and to decline the number of tobacco points of sale.

The plan for a smoke-free public transportation started with an integral plan made by the Dutch Railway company (NS) and the company who is responsible for the trains' platforms (ProRail). It consisted of three important parts:

1) Creating a smoke-free environment for everybody (passengers and personnel).

2) Quit selling cigarettes at the train platforms.

3) Offering smoking cessation training for staff

Health Funds for a Smoke-free Netherlands was involved as an advisor in this trajectory.

The general population is the target population of this practice. The focus of this practice is on both public and private settings. More specifically, the target settings are train stations and public transports (indoor), bus, tramway, trolley-bus stop waiting areas (outdoor) and outdoor train platforms. The practice has been implemented (enforced/promoted) and is still ongoing; it started on 10/01/2020.

An integral plan was made in order to reach the objectives. There was no real methodology used. Only a detailed plan and process, including a consultation with relevant partners (i.e., the board and the work council). The handbook "Smoke-free work" of the Health Funds for a Smoke-free Generation was used (in Dutch). The practice is funded by own resources.

The smoke-free stations and train platforms are not part of a formal smoking ban controlled by law. However, they are a total smoke-free zone on the territory of the NS and ProRail companies. Employees of NS remind passengers of the smoke-free policy.

In terms of justification of the practice, the focus was on the problem of second-hand smoke at the railway platforms and the need to de-normalize smoking in order to create a smoke-free generation. Health Funds for a Smoke-free Netherlands puts all of their effort in creating a smoke-free generation. Moreover, as children and adolescents make use of the railway system in the Netherlands, it is important that they travel without exposure to second-hand smoke. Public transportation needs to be safe and clean.

Research shows that whether the exposure to second-hand smoke occurs indoors or outdoors the adverse health effects remain the same. The only difference is that indoors, the concentration of the harmful chemicals, compounds, and particles is kept in and does not go away as quickly as outdoors. Furthermore, smoking at train platforms makes it looks like smoking is normal and something you do when you are waiting for a train to arrive. That is not the desired message to give to children and adolescents.

In terms of ethical considerations, the practice highlights that all passengers are equal. Smokers are not forced to quit smoking; they are just asked to smoke before they enter the train station.

The Municipality, city, province, region, nation, and private institutions have the responsibility for the practice. The responsible institutions are Nederlandse Spoorwegen - Dutch Railways -, NS ProRail - Railoperator -, ProRail Dutch, local and regional governments. The geographical scope of the practice is the Netherlands.

The main outcome of the practice is that more than 400 train stations (and their platforms) in the Netherlands became total smoke-free areas. Millions of passengers are protected against second-hand smoke.

In the monitoring of the process and outcome of the practice, qualitative indicators on what went well/what went wrong and what can be improved, were used. One of the quantitative measures is how often the smoke-free policy is ignored. The practice has not been formally evaluated and transferability has not been considered in a systematic way.

29: The Netherlands_SF_playgrounds: Smoke-free petting zoos/city farms & playground associations

Smoke-free petting zoos and playground associations contribute to a Smoke free Generation.

The objectives of the practice include: to create smoke-free outdoor settings for conventional tobacco products, and aerosol-free regulation for e-cigarettes and for heated tobacco products.

The practice focuses on public settings.

Outdoor smoke-free policies at play areas offer children a healthy and safe environment to play and learn. Health Funds for a Smoke free Netherlands (Dutch Heart Foundation, KWF Dutch Cancer Society, and the Lung Foundation Netherlands) initiated the 'Smoke free Generation movement'. The goal is to achieve a completely smoke free generation.

By creating smoke free environments, like schoolyards, playgrounds and sports clubs, children are less tempted to smoke and passive smoking is prevented. Health Funds for a Smoke free Netherlands are committed to increase support for smoke free environments and activate the general public and relevant organizations. They developed a program to motivate and facilitate play areas to implement a smoke free policy (among other environments). They use information and tools such as a guideline, smoke free signs and communication guidelines.

Petting Zoos Active (KinderboerderijenActief) and The Dutch Union of Playground Organisations (LOS, previously NUSO) joined the Smoke free Generation movement. They also signed The National Prevention Agreement in 2018 and set the target that all petting zoos and playground associations in the Netherlands will become smoke free. With targeted information, they activate petting zoos and playgrounds to implement a smoke free policy and offer guidance and information (and refer to the tools described above).

Regional Public Health Services (GGD's) and municipalities decide if they want to join the Smoke free Generation movement and thereby, they as well encourage and/or support play areas like playgrounds and petting zoos to become smoke free. Nowadays in the Netherlands, because of joint action and collaboration between several organizations, most of the playground associations and petting zoos have voluntarily implemented an outdoor smoke free policy.

Despite smoking is by far the leading preventable cause of mortality and morbidity in the Netherlands, as in many countries, young people still start to smoke. Children who see others smoke are more likely to start smoking when they get older. Therefore, smoke free environments can set the right example for children. At a smoke free petting zoo and playground, children are less tempted to start smoking and passive smoking is also prevented. Smoke-free policies reduce the visibility of smoking, limit the opportunities for smoking and communicate that smoking is socially unacceptable. The target population of the practice are age specific groups.

Different organisation and movements are involved in the initiation of the practice, such as Funds for a Smoke free Netherlands (Dutch Heart Foundation, KWF Dutch Cancer Society, and the Lung Foundation Netherlands) that initiated the 'Smokefree Generation movement'. Pettingzoos Active (KinderboerderijenActief), The Dutch Union of Playground Organisations (LOS, previously NUSO) and some regional Public Health Services (GGD's) and municipalities also joined.

NGOs have the responsibility of the practice: Gezondheidsfondsen voor Rookvrij, Health Funds for a Smoke free Netherlands - KinderboerderijenActief, Pettingzoos Active - LOS (previously NUSO, vSKBN), Dutch Union of Playground Organisations and Association of cooperating city farms in the Netherlands. Additionally, regional Public Health Services (GGD's) and municipalities.

Nowadays, most of the petting zoos and playground associations are (voluntarily) smoke free in the Netherlands. Compliance can be a challenge alongside the visibility of smoking just outside the petting zoo or playground areas. Petting Zoos Active (KinderboerderijenActief) and The Dutch Union of Playground Organisations (LOS, previously NUSO) monitor the progress. A sustainability strategy has been developed

The geographic scope is on a national level (The Netherlands) and the practice has been transferred (i.e. scaled-up) within the same country/region.

30: The Netherlands_SF_sports/playgrounds: Smoke-free municipal/public playgrounds and sports facilities

The overall goal of the practice is to contribute to a smoke-free generation. The National Prevention Agreement states that, the central government, together with over 70 parties, set targets and made agreements to achieve the ambitions that by 2040 fewer people will smoke, be overweight or drink problematically. Within the Agreement, it is set to achieve smoke-free playgrounds by 2025, including the smaller public play areas in municipalities.

The practice is aimed at creating smoke-free outdoor settings for conventional tobacco products and aerosol-free settings for e-cigarettes and heated tobacco products. It is focused on public only settings and is ongoing since 15/10/2015.

Outdoor smoke-free policies at public playgrounds and sports facilities offer children a healthy and safe environment to play. Health Funds for a Smoke-free Netherlands (Dutch Heart Foundation, KWF Dutch Cancer Society, and the Lung Foundation Netherlands) initiated the 'Smoke-free Generation movement'. The goal is to achieve a completely smoke-free generation.

Health Funds for a Smoke-free Netherlands developed information, communication and tools like a guideline to activate and support municipalities to contribute to the goal of a smoke-free generation. Municipalities can decide if they create smoke-free public playgrounds and sports facilities such as football pitches, basketball courts and skate parks in public areas in neighbourhoods. They can implement smoke-free locations through the General Local Ordinance (APV). Mostly, municipalities implement these smoke-free locations in an informal way with public communication for the residents of the municipality and by displaying smoke-free signs. Someone who smokes can be asked to stop smoking, without being fined. At the moment, it is more of a voluntarily policy to create a new social norm. Following this new social norm, indicated by signs, the community itself is motivated to address each other.

Despite smoking is by far the leading preventable cause of mortality and morbidity in the Netherlands, as in many countries, young people still start smoking. Children who see others smoke are more likely to start smoking when they get older. Smoke-free environments can set the right example for children. At smoke-free public playgrounds and sports facilities, children are less tempted to start smoking and passive smoking is prevented. Smoke-free policies reduce the visibility of smoking, limit the opportunities for smoking and communicate that smoking is socially unacceptable. Smoke-free public playgrounds and sports facilities contribute to a smoke-free generation. The target population for the practice are age specific groups.

Regional Public Health Services (GGD's) and The Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten, VNG) encourage and support municipalities to create smoke-free play areas like public playgrounds and sports. Other involved parties include municipalities, Health Funds for a Smoke-free Netherlands (Gezondheidheidsfondsen voor Rookvrij),the Dutch Heart Foundation (Hartstichting), KWF Dutch Cancer Society (KWF) and the Lung Foundation of Netherlands (Longfonds). Also, the Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten, VNG), the Association of Regional Public Health Services and Regional Medical Emergency Preparedness and Planning offices in the Netherlands (GGD GHOR Nederland), and Regional Public Health Services (Gemeentelijke of Gemeenschappelijke Gezondheidsdiensten, GGD's).

The practice been formally evaluated by an external partner. I&O Research, on behalf of The Health Funds for a Smoke-free Netherlands, have monitored smoke-free policies by the municipalities in the Netherlands in 2021 (via questionnaire). Eight out of ten Dutch municipalities play a role in making locations within the municipality smoke-free. Each of the municipalities obtain their own goals, for example ranging from smoke-free petting zoos to smoke-free parks. For public playgrounds specifically, one third (32%) of municipalities report that one or more of the outdoor public playgrounds located in their community are smoke-free.

Regarding public sports facilities, such as football pitches, basketball courts and skate parks, in 27% of the Dutch municipalities one or more of the public sports facilities in their community are smoke-free.

In this research, it was not clear if the municipality was the initiator of the smoke-free public playgrounds and public sports facilities or if they supported initiatives taken by residents of the municipality. In previous research, results show that the municipality played an important role as initiator of smoke-free policies at public playgrounds and public sports facilities. Efficacious elements of municipal tobacco control programs in the Netherlands are being investigated in extensive research by Trimbos Institute.

Municipalities filled in a questionnaire about smoke-free policy in the municipality. Commitment from the municipal administration, available time and resources and active cooperation with partners (in the field of smoke-free) are relevant factors in the process of implementing smoke-free public areas in general as described by I&O Research.

The practice has institutional support and stable human resources. The city has the responsibility of the practice. And municipalities decide if they create smoke-free public playgrounds and sports facilities such as football pitches, basketball courts and skate parks in public areas in neighbourhoods. The geographical scope of the practice is the Netherlands, and the practice has been scaled-up to other locations or regions or at national scale in the same country.

31: Sweden_SF_nation: Smoke free outdoor settings

The overall goal of the practice is to reduce exposure to smoke and de-normalize smoking. This is a legislative practice describing the law proposed by the government. The smoking ban refers to playgrounds, sports facilities, outdoor dining areas, areas connected to public transport and entrances to premises to which the public has access and protection from conventional tobacco products 'smoke, aerosol of e-cigarettes and heated tobacco products. More specifically, it covers outdoor spaces of restaurants, patios/terraces; bus, tramway and trolley-bus stop waiting areas; stadiums and outdoor arenas; hospitals and healthcare institutions; and children's playgrounds. Therefore, the intervention targets general population with a special focus on age specific groups and vulnerable groups (people suffering from diseases).

The practice is justified on the importance of preventing young people to smoke. An important way to achieve that goal is de-normalizing smoking. In other words, making it as invisible as possible. It can be achieved by making various outdoor environments smoke-free.

Making outdoor environments smoke-free is also a way to deal with second-hand smoking, hence promoting everyone´s right to move freely in public space and avoid passive exposure to smoke. The Swedish Public Health Agency (Folkhälsomyndigheten, abbreviated FoHM) and 290 Swedish municipalities are promoters of this best practice.

The national public health authorities, along with a group of population, researchers and civil organizations were involved in the development of the practice. National, regional and local public health authorities, academia and civil organizations were involved its implementation. Finally, national public health authorities were involved in the evaluation.

The intervention is still ongoing, but the evaluation is foreseen and there is still no systematic follow-up of the current smoking bans. The impression is that the new smoke-free outdoor environments have great acceptance among the population. The smoking ban at entrances is not specified in exact dimensions. Instead, an assessment must be made on a case-by-case basis; the smoking ban must cover such a large area that one should not have to be exposed to smoke when approaching the entrance. This makes it somewhat difficult to apply. The smoking ban in outdoor dining is the smoking ban that has been questioned most loudly and which - at least in the beginning - has been

tried to be circumvented in various ways.

The practice has institutional support and stable human resources. The government proposes new laws. Folkhalsomyndigheten (FoHM) is a Swedish state agency that has a national responsibility for public health issues, among other things linked to smoking. The municipalities have supervision over the smoke-free environments. The Public Health Agency provides guidance on how supervision should be carried.

The practice has been implemented on local/regional/national level in Sweden and transferability has not been considered in a systematic way.

32: Sweden_SF_health care: Non-smoking/smoke-free outdoor environments in the health care sector in Region Östergötland

The overall goal of the practice is a total smoke-free outdoor environment in the health care sector in region Östergötland. The objectives of this practice are smoke-free indoor settings (conventional tobacco products and aerosol-free regulation for e-cigarette and heated tobacco products) and smoke-free outdoor settings (conventional tobacco products, aerosol-free regulation for e-cigarettes and heated tobacco products).

This practice is an intervention on general population leading to a policy or about a novel change on organisational/managerial models to create a smokefree environment for those visiting the health care areas, patients, staff and other visitors. The focus of this practice is on public spaces only.

The target settings are schools/ public-education institutions/ educational venues except universities (indoor), universities (indoor), hospitals including outpatient clinics (indoor), outdoor areas of hospitals and healthcare institutions (outdoor), outdoor areas of school (outdoor)

The practice has been implemented (enforced/promoted) and is still ongoing, it started on 01/01/2016. The message focuses on the positive potential of non-smoking healthcare facilities outdoors. The organization takes responsibility for promoting health and disease avoidance. Employees in health care take responsibility and show that non-smoking healthcare environments are important. The patient is motivated to change and is offered a tobacco-subsidy aid. Inpatient patients are offered nicotine medicines. Tools used as enforcement, visual communication, internal and external communication, maps over smoke free area, statistic background, verbal and strategic communication, nudging and tobacco informers patrolling the area.

Tobacco smoking is today the single largest cause of disease and premature death in the western world. It is important to prevent illness and specially to protect children from passive smoking. In 2015 Region Östergötland had the highest proportion (13%) of daily smokers in Sweden.

More people are using tobacco in low socio-economic groups. The message of this practice address everyone. However, in the region, there are so called ”Health communicators” from different nationalities. They can translate the message into the right context.

The general population is the target for this practice. Regional public health authorities, local public health authorities, hospital staff, primary care centre staff, specialized physicians, general practitioners, pharmacists, nurses, informal caregivers, researchers/academics, school staff, employers/employees, civil and other organizations were participated in development and implementation. The practice is funded by the Region Östergötland.

The province/region has the responsibility for the practice. The responsible institutions are all health facilities in region Östergötland. The geographical scope of the practice is regional, and the practice has been implemented in the Region Östergötland.

The main outcome of the practice is that the Region Östergötland is now one of the regions with

the lowest proportion of daily smokers (6%) and fewer people are smoking in the health care area. A sustainability strategy has been developed but transferability has not been considered.

33: Slovenia_SF_cars: Tobacco smoke and aerosol free vehicles with minors present

The overall goal of this practice is to further protect children/minors from exposure to tobacco smoke and aerosols of related products in order protect their health by banning smoking and vaping in cars in the presence of minors or pregnant women. The ban includes conventional tobacco products, electronic cigarettes and heated tobacco products.

The restriction on the Use of Tobacco and Related Products Act (Official Gazette of the Republic of Slovenia, No.9/2017 and 29/2017) includes in its article 39 the measure of banning the use of conventional tobacco products for smoking, heated tobacco products, electronic cigarettes with and without nicotine and herbal products for smoking in all vehicles in the presence of minors (persons under 18 years of age). The practice focuses on both public and private settings.

The ban is supported by a yearly national media campaign and evaluation of effects among adolescents. In Slovenia there is a ban on all private vehicles, not just cars, carrying minors, including public transports and vehicles used for work (this includes conventional tobacco, e-cigarettes, HTPs and herbal products for smoking).

The practice is ongoing, with a start date of 03/17/2017. The development of the measure included: a public consultation as a part of the new Act in 2017, meetings with selected stakeholders (police and municipalities for checking the compliance), an evaluation of the effects of the measure, a media campaign for raising awareness and knowledge led by the Ministry of Health of the Republic of Slovenia on an annual basis with participation of many partners.

Police and Security Officers are responsible for the enforcement and control of compliance of the practice. Checking of the compliance is added to other regular checks in the traffic checks. Police reports on violations are available and show that in 2017 there were 466 violations, in 2018 382, in 2019 402, in 2020 352, in 2021 389 and in 2022 till 3rd of August, 156. Currently there are no data reports on violations from municipalities' Security Officers Services. The Ministry of Health (MoH) is responsible for the relevant law containing this measure and the National Institute of Public Health and other relevant stakeholders (NGOs etc.) are responsible for the promotion of smoke-free environments, including vehicles.

The justification of the practice falls into the extension of smoke-free environments based on the relevant scientific evidence to further protect children/minors from exposure to tobacco smoke and aerosols of related products. Therefore, the target population is the general population with a focus on age specific groups. National public health authorities and civil organisations have been included in the development. Civil and other organizations also were involved in the implementation and evaluations of the practice.

In terms of evaluation, the practice has been formally evaluated by an external partner. Indicators are used in the monitoring of the process. In terms of outcomes, it's important to highlight: the percentage of 16-year old students reporting exposure to tobacco smoke in vehicles, the percentage of adults reporting that they or another person smokes in their family vehicles and, finally, the number of reported violations by the police and municipalities' Security Officers. The National Institute of Public Health carried out repeated cross sectional studies in order to evaluate the effects of the ban.

The practice has institutional support and stable human resources. Transferability has not been considered in a systematic way. The geographical scope of the practice is national (Slovenia).

34: Slovenia_SF_work: Comprehensive protection from tobacco smoke and aerosols of related products in all enclosed public places and workplaces and some open places

The objectives of the practice are: Smoke and aerosol free indoor settings (conventional tobacco products, e-cigarettes and heated tobacco products), car smoking and vaping ban with minors or pregnant women (conventional tobacco products, e-cigarettes and heated tobacco products) and outdoor aerosol-free regulations for heated tobacco products.

The ongoing practice started on the 07th of February of 2019 and has been implemented. It was enforced by the Health inspectorate.

In summer 2019, the Ministry of Health and the Health Inspectorate informed all primary schools, secondary schools and universities of the legal smoking ban in the schools and on their functional land (outdoor: greens, playgrounds, school sports stadiums, etc.). In the letter, it was also announced the inspectorate›s oversight. The first part of inspectorate oversight was carried out in autumn / winter 2019/2020. Because of COVID 19, all the activities stopped. The oversight will continue in autumn / winter 2022/2023.

The Health Inspectorate detected an increase number of reports on infringements, especially when children are not in schools (afternoons and weekends, during the holidays). Also, the extension of the smoke-free environments decision was based on the relevant scientific evidence to the protect general population from exposure to tobacco smoke and aerosols of related products.

The target population was the general population. A part of the population was included in the development and implementation of the practice. National public health was included in the development and implementation and other civil organizations were included as well. The practice has not been formally evaluated. No funds were required.

The intervention focuses on both public and private settings, and the responsibility of its promotion is on the Ministry of Health of Slovenia. The practice is applied country-wide and the geographical scope applies to Slovenia only. It has been scaled-up to other locations or regions or at national scale in the same country.

The outcome of the practice is that the general population is protected from exposure to tobacco smoke and aerosols of related products in all enclosed workplaces and public places.

35: Slovenia_SF_educational: Smoking bans indoor at school/universities and outdoor areas / functional land of schools/universities

The objectives of the practice include smoke-free indoor and outdoor settings for conventional tobacco products and indoor and outdoor aerosol-free regulation for e-cigarettes and heated tobacco products.

The overall goal is to maintain positive messages and examples that schools is providing to children and young people with promoting a healthy lifestyle in a way that provides them non-smoking indoor and outdoor areas. All primary schools, secondary schools and universities -implement the legal smoking ban in the schools and on their functional land (outdoor: greens, playgrounds, school sports stadiums).

The ongoing practice started on 07th of February 2019 and has been implemented (enforced/ promoted) by the practice was enforced by Health inspectorate.

In summer 2019, the Ministry of Health and the Health Inspectorate informed all primary schools, secondary schools and universities of the legal smoking ban in the schools and on their functional land (outdoor: greens, playgrounds, school sports stadiums, etc.). In the letter it was also announced the inspectorate’s oversight. The first part of the inspectorate oversight was carried out in autumn / winter 2019/2020. Because of COVID 19 situation all the activities stopped. The oversight will

continue in autumn / winter 2022/2023.

The Health Inspectorate has detected an increased number of reports of infringements especially when children are not in schools (afternoons and weekends, during the holidays). The target population for this practice takes into consideration the socioeconomic position (including the educational level).

Personal data was not collected fir this practice and the inspector is constantly required to comply with ethical principles and equal treatment according to the powers conferred on the law.

The national public health and school staff participated in the development of the practice. Researchers, academics and also school staff were included in the implementation.

The intervention focuses on public settings only and the responsibility of its promotion lays on the Ministry of Health of Republic of Slovenia and the Health inspectorate of Republic of Slovenia.

COVID 19 situation stopped activities, so we cannot yet talk about achieved improvements. The practice has not been formally evaluated. The practice has institutional support and stable human resources. It was funded with own resources. The geographical scope applies to Slovenia only and transferability has not been considered in a systematic way.

36: UK (England)_SF_homes: Smoke free homes

The overall goal of the practice is to create smoke-free homes and reduce children's exposure to tobacco smoke. The specific objectives of the practice focus on smoke-free indoor settings for conventional tobacco products, voluntary home smoking ban for conventional tobacco products and smoking ban with minors or pregnant women, also for conventional tobacco products. Therefore, the target population was the general population, with a focus on age specific groups. The practice covers private settings only, more specifically cars and homes.

This action encourages smokers to quit or smoke outside hence ensuring children are not regularly exposed to smoke in indoor spaces. It also encourages smokers to take seven steps out of the home to reduce second-hand smoke exposure.

The practice is ongoing and started on 16/04/2015. The action has not been enforced but it has been implemented through a campaign. A group of population was involved in the development, implementation and evaluation of the practice. This practice addresses inequality when it comes to SE status and ethnicity.

The Evaluation of the campaign has found that: 75% of smokers who saw the campaign said it made them more concerned about smoking and 38% took action, from cutting down, to going outside to smoke, stopping smoking in the same room as a family member, stopping smoking, or switching to an electronic cigarette. This last one, (switching to an electronic cigarette) produces aerosols and therefore can not be considered as SAFE practice.

The practice has institutional support, stable human resource and provides training of staff in order to sustain it. The responsibility is on a municipality (local authorities) and city public agency levels. The geographical scope applies to Leeds City Council, Yorkshire, England, and the practice has been transferred within the same country.

37: UK(Scotland)_SF_homes: Take it right outside

This practice was designed to protect children from second-hand smoking and to denormalize the act of smoking.

The goal was to reduce the proportion of children exposed to second-hand smoke (SHS) from 12%

in 2014 to 6% by 2020.

Take it Right Outside (TiRO) was an awareness raising campaign to promote smoke-free homes in Scotland. It was a multimedia campaign that communicated a variety of messages around the harms of second-hand smoke and the benefits of protecting children from its exposure. Therefore, the target setting for this practice are private homes. The practice is ongoing and started on 25/03/2014.

Take it Right Outside can be described as a national mass media initiative that encourages smokers to smoke cigarettes outside their own home to protect children and other family members from SHS. A wide variety of media such as TV, radio, newsprint, billboard, social media and others, was used to communicate key messages. The rationale behind the practice lays on the evidence from the Scottish Health Survey that about 12% of children were exposed to SHS in the home. The Scottish Health Survey is a nationally representative sample that undergoes rigorous equity and ethical oversight at governmental level. TiRO also introduced a national target to reduce this figure by half by 2020. There was no enforcement element to this practice. It was developed to produce a voluntary change in social norms within the framework of smoking in the home. Therefore, the target population was the general population with a focus on age specific groups.

National, regional and local public health authorities as well as other health care professionals, researchers and academics, were involved in the development, implementation and evaluation of the practice. The responsibility of the practice and its promotion is on the Scottish Government.

Hospital staff, primary care centre staff, specialized physicians, general practitioners, pharmacists, nurses and civil organizations, were involved in development and implementation while informal caregivers, school staff and employers/employees were involved in the implementation.

In terms of evaluation, it is important to highlight the reduction in self-reported exposure to second-hand smoke in the home as gathered by the annual Scottish Health Survey. The target of reducing the proportion of <16-year-olds exposed to SHS at home from 12% to 6% by 2020 was achieved. The annual Scottish Health Survey question on children's exposure to SHS at home is used to monitor the practice. TiRO was formally evaluated by the Universities of Aberdeen, Glasgow and Stirling.

The geographical scope applies to Scotland. The practice has been implemented on local/regional/ national level, but transferability has not been considered in a systematic way.