Annex 2 SAFE report

Contributes to Deliverable 8.2 Position paper on SAFE

JATC2 JOINT ACTION ON TOBACCO CONTROL

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Table 1: Description of barriers for the expansion of best practices about SAFEs by country

Country	Description of barriers for the expansion of best practices about SAFEs by country
Cyprus	Political interest in expanding the Tobacco law to include them. Also the law as written does not provide any implementation power and as such the law cannot be enforced in any capacity
Czechia	Mainly tobacco industry's marketing of heated tobacco (not EC)
Czechia	Lobbism of tobacco industry, no willingness to tobacco free environment and to implement health recommendation to change the policies. Low health literacy of policy and decisions makers.
Estonia	smokers themselves and distributors of electronic cigarettes
Germany	Heavy lobbying of tobacco and e-cigarette industry are hindering the inclusion of e-cigarettes into existing smokefree legislation. Low interest and committment of politics to change existing smokefree legislation.
Greece	use of movable walls to turn outside areas into indoor areas (especially due to the good Mediterranean weather all year round)
Latvia	Lack of support from politicians, lobby
Lithuania	political will and resources for enforcement
Luxemburg	the organization that represents the restaurants, bars, cafeterias and pubs in Luxembourg has always strongly opposed to smoke free policies and is opposed strongly to the ban in outdoor terraces of bars and restaurants.
Malta	Political will; lack of knowledge by general public of emissions from non-conventional tp
Netherlands	government reluctance to introduce bans in general because a ban must be enforceable
Netherlands	Public support for more restrictions in personal and outdoor public spaces, as the percieved harm for others is low.
Poland	There are two major areas, where the ban can be extended: - private cars with children (no rules; public debate and high support) - ban on balconies in block of flats (public debate, moderate support) Moreover, there is a fine for smoking in public places, but no one respect this rule. Even the police do not respect this law (limited number of fines).
Sweden	According law, there is no smoking ban in private environments such as in your home or other premises for residents that are not temporary. Based on this, it is not prohibited to smoke in flats and appurtenant patios or balconys in apartment buildings. This may cause great inconveniences for the neighbours.
UK	A feeling in the public health community that 'smoking has been solved' and no further measures are required. Also the feeling that measures stigmatise smokers and that we should ensure that such stigmatisation does not take place.

Table 2: Description of barriers for the compliance of best practices about SAFEs by country

Country	Description of barriers for the compliance of best practices about SAFEs by country
Cyprus	Lack of legal framework for enforcing any law aspects
Czechia	Hardly, because there are no global restrictions - just each facility can do it. And if they choose this ban, than it works.
Czechia	Low health literacy of public, low price of the tobacco products, influence of social networking, nicotine addiction, no existence of bonuses and maluses regarding to health insurance for smoke users.
Estonia	smokers themselves and distributors of cigarettes - against the elegisation
Germany	Not enough controls of and not enough personel to control the policies, especially in the hospitality sector.
Lithuania	resources for enforcement, limited quit services, industry activity and corruption
Luxemburg	The main barrier is a political disinterest in enforcing tobacco control laws. And when it is a citizen who reports a breach of the law, answering these complaint calls is at the bottom of local police.
Malta	lack of human resources
Netherlands	First: what exactly do you mean with compliance? E.g. at schools: compliance by students? by staff? by official control agencies? Barriers include: -population support not complete -lack of strong control institution

Poland	It has limited public awareness of the health effects of SHS exposure. There is a relatively high public acceptance of smoking in bus stops/train stops and outdoor (e.g. when walking).
Sweden	Lack of monitoring the adopted legislation.
UK	Lack of budgets for environmental health officers/departments. Very limited enforcement activity now takes place. Shortage of EHOs - limited time and need to focus on other issues. Again, the feeling that 'smoking has been tackled' and other issues are more important.

Table 3: Description of facilitators for the expansion of best practices about SAFEs by country

Country	Description of facilitators for the expansion of best practices about SAFEs
Czechia	Tobacco industry, mainly PM - but this is according to HTP, not EC, please see the big difference between those products
Czechia	To establish smoke free outdoor places, smoke free nature parks, ban on smoking in private cars, better enforceability of ban of smoking, to ensure zero tolerance of superiors towards smokers and their workbreaks (eg. nurses, doctors...)
Estonia	resolute opposition to expansion
Germany	In 2021, one of the federal states (Hesse) included e-cigarettes and heated tobacco products in the federal smokefree legislation. This may serve as an example for the other federal states and might be a starting point to strengthen smokefree legislation.
Greece	outside hospital areas outside hospitality areas (more difficult)
Lithuania	funding quit services funding enforcement transparency requirements and registry for all liaisons with industry transparency of industry financial operations related to NGOs, media and advertising agencies, marketing budgets and similar
Luxemburg	Opportunities for expansion of smoke and aerosol-free environments were included and discussed in the frame of our National Tobacco Control Plan 2014-2018 (https://sante.public.lu/fr/publications/p/plan-national-tabac-2016-2020.html). This resulted in the adoption of concrete measures in our antitobacco law in order to expand smoke and aerosol free environments to open children play areas, open sports arenas when children below 16years are doing sports and in private cars when children below 12 years are on board.
Malta	provide more health information; increase human resources, extend scope of national regulations
Netherlands	First: do you mean by policies only laws? or including agreements. Because: we do have several agreements (e.g. smokefree health care) that could be much stronger when they would be in a law. Now we have the discussion with the ministry: why did you so easily have a no-smoking law in public transportation years ago, but don't you want to make a law on smokefree health care nowadays?
Netherlands	Outdoor public transport stations and recreational parks, as a lot of children use them
Poland	The implementation of the ban on smoking in private cars and private houses (balconies in blocks of flats). Promotion of smoke-free home rules (currently there is no public campaign aimed at this issue).
Sweden	In my opinion, there´s a broad support for smoke- and aerosol-free environments in our country.
UK	We need to focus on where concentrations are greatest and where most people are now exposed to SHS. This involves tackling smoking in the home. Regulations should aim to ensure that children are not exposed to SHS within home evironments.

Table 4: Description of facilitators for the compliance of best practices about SAFEs by country

Country	Description of facilitators for the compliance of best practices about SAFEs
Czechia	Less TI influence, but just concerning HTP, not EC - please see the difference between them
Czechia	To establish smoke free outdoor places, smoke free nature parks, ban on smoking in private cars, better enforceability of ban of smoking, to ensure zero tolerance of superiors towards smokers and their workbreaks (eg. nurses, doctors...), higher price of tobacco products, vending machines - age identification for selling, ban of selling the tobacco products for all people born after the year 2000
Germany	Several federal states did evaluate their smokefree legislation. in the evaluation reports the problem of low control of compliance is mentioned. These reports may be used for improvement of control.
Greece	stronger definition of outside areas - practically as large openings may be covered with shade tents or wind breaks

Hungary	Financial resources to support prevention programs and media campaigns (Tik-Tok videos, instagram, etc.) on smoking and electronic cigarettes prevention especially for the youth.
Lithuania	improved and targeted funding of NGOs for monitoring compliance and enforcement
Luxemburg	Opportunities for improvement of compliance/enforcement of smoke and aerosol-free environments are discussed and facilitated in the frame of our Tobacco Control Plan 2014-2018 (https://sante.public.lu/fr/publications/p/plan-national-tabac-2016-2020.html).
Malta	targeted health promotion towards different age groups and different types of TP
Netherlands	compliance by the public: create more support (e.g. continuing the smokefree generation efforts) enforcement: a more powerful enforcement body.
Poland	More actions are needed to strengthen public awareness about tobacco-related diseases and the link between SHS exposure and diseases. Moreover, more actions are needed to reduce smoking and passive exposure among pregnant.
Sweden	In my opinion, there´s a broad support for smoke- and aerosol-free environments in our country.
UK	Remote sensing and CCTV should be used to identify areas where compliance with existing smoke-free laws is low. This would enable targeting of enforcement resources.

Tables 5: Detail of each best practice on SAFE by country, smoke-free setting and title of the practice
Table 5.1: Austria_SF_nation: Supporting and consulting initiatives addressing the prevention in settings of young people (children and adolescents)

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products)Smoke-free outdoor settings (conventional tobacco products)Voluntary home smoking ban (conventional tobacco products)Indoor aerosol-free regulation for e-cigarettesOutdoor aerosol-free regulation for e-cigarettesIndoor aerosol-free regulation for heated tobacco productsOutdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	Austria
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	The first problem was to get a 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 institutions which bear responsibility for children and adolescents).
F2. What is the overall goal of the practice?	To support youth-concerned institutions (e.g. schools and youth centers) and individuals (e.g. parents) in supporting implementing smokefree environment and better youth protection in their concrete settings
G1. Target settings.	Schools/ public-education institutions/ educational venues except universities (indoor) Universities (indoor)HomeOutdoor areas of school (outdoor)
2- Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	The Austrian Association of Addiction Prevention was one of the motors for a smokefree hospitality and better youth protection by law. In 2014 the association published a position paper and intensively started advocating better tobacco control. During the 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 our working society. Institutions wanted to implement the new laws but didn´t know how. They needed support.

<table>
<tr><td>C2. Possible source of information where the practice is described</td><td>There ist no seperate website.</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Supporting und consulting initiatives addressing the prevention in settings of young people (children and adolescents)</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><td></td><td>1-AT-SF-national</td></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>10/01/2014</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>Position paper addressing the ministry of health (content: more rigorous laws concerning smoke-free and aerosol-free environments and youth protection) Lectures and tutorials for the target group (e.g. schools, leisure centers for adolescents) Factsheet “How to make my school smoke-free” for schools Factsheet “How to make my youth center smoke-free” for youth centers.</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>Yes, it has been enforced, but the implementation is still ongoing. Institutions working with children or adolescents can request our factsheets and ask for further personal advice. In the experience of the Austrian Association of Addiction Prevention individual cases (e.g. pupils who consume nicotine products in the outdoor area of schools) are often a “door opener” for the topic in a wider context. It is a request of the Austrian Association of Addiction Prevention to focus on the problem of tobacco and nicotine consumption in general and not on individual cases.</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>Age specific groups
Certain levels in education system</td></tr>
<tr><td colspan="2">4-Ethical aspects</td></tr>
<tr><td>What are the equity and ethical principles underpinning the practice?</td><td>Individual´s rights have been protected.</td></tr>
<tr><td colspan="2">5-Effectiveness, efficiency, evaluation</td></tr>
<tr><td>L1. What are the main outcomes of the practice?</td><td>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 (I don´t know the exact number) Hundreds of parents´ evenings for parents (I don´t know the exact number)</td></tr>
</table>

M1. What indicators are used in the monitoring of the process and outcome of the practice?	number of consultations concerning the implementation of the law in specific settings for young people
N1. Has the practice been formally evaluated?	Yes, the evaluation was carried out internally
N1 bis. If you answered "Yes" or "Not yet"	The Austrian Association of Addiction Prevention is the superordinate organization of the nine Austrian Institutes for Addiction Prevention. Each institute is responsible for its own evaluation. The evaluation consisted of quantitative and qualitative items. The main question is if the measure was practicable and realizable for the specific setting of addiction prevention.
6-Equity	
Q1. What are the equity and ethical principles underpinning the practice?	Individual´s rights have been protected.
7- Potential of scalability, transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9- Empowerment, participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_ImplementationRegional public health authorities_Implementation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	External resources – public
B4. Who has the responsibility of the practice?	Nation
B5. Name of the entity(ies) in national language and English and acronym.	Austrian Association of Addiction Prevention
B6. Please specify also the responsibility of the entity(ies):	www.suchtvorbeugung.net

Table 5.2: Austria_SF_hospitality: Health Impact Assessment: "Smoke free hospitality in Austria"

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes
E1. What is the geographical scope of the practice?	Austria Styria

F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	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.
F2. What is the overall goal of the practice?	To have new data which underline 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 to give the media a reason to repeatedly report about the need for a smoke-free and aerosol-free hospitality
G1. Target settings.	Restaurants and bars (indoor) Hotels (indoor)
2- Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	The involved institutions researched the effect a smokefree hospitality would have in Austria. This Health Impact Assessment provided the basis for arguing the need for a smoke-free and aerosol-free hospitality.
C2. Possible source of information where the practice is described	https://hiap.goeg.at/sites/gfa.goeg.at/files/inline-files/Gesundheitsfolgenabsch%C3%A4tzung_Tabak_Rauchverbot_TNRSG_2018.pdf
B1. Title/Name of the practice.	Health Impact Assessment: "Smoke free hospitality in Austria"
B2. Type of practice.	**2-AT-SF Hospitality** **Type of practice** 1 Information/awareness raising programm 2 **Policy** 3 Action plan 4 **Regulation/ ban** 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know 13 **Other: Research**
B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice has ended
J1. What methods are/ were used in the practice?	Development of a Health Impact Assessment (which is a well described method) Publication of the results Advocating political parties using the results Providing information to the media in order to support them reporting the results
K1. Enforcement of the practice.	There was no overall controlling entity, but every engaged institution reported to their own controlling level.
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population
4-Ethical aspects & 6-Equity	

What are the equity and ethical principles underpinning the practice?	Individual´s rights weren´t affected.
5- Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	1 Health Impact Assessment "Effects of a smoke-free hospitality in Austria" (published 2018) 15 articles in traditional media (not paid) 1 parliamentary question of a political party Many citations in political discussions (not countable)
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Getting a formal Health Impact Assessment finished Having specific data for Austria
N1. Has the practice been formally evaluated?	No
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e., scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	None of the above options
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Development International/European public health authorities_Development National public health_Development Regional public health authorities_Development Local public health authorities_Development Civil_Organizations_Implementation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	Own resources External resources – public
B4. Who has the responsibility of the practice?	Nation Public agency University NGOs
B5. Name of the entity(ies) in national language and English and acronym.	Austrian National Public Health Institute (Gesundheit Österreich GmbH, GÖG) Medical University of Graz Team Health Impact Assessments Styria VIVID - Institute for the Prevention of Addiction
B6. Please specify also the responsibility of the entity(ies):	Responsible for the Health Impact Assessment were the "Team Health Impact Assessment Styria" and VIVID - Institute for the Prevention of Addiction.

Links and additional information
https://hiap.goeg.at/sites/gfa.goeg.at/files/inlinefiles/Gesundheitsfolgenabsch%C3%A4tzung_Tabak_Rauchverbot_TNRSG_2018.pdf

Table 5.3: Austria_SF_cars: Tobacco smoke and aerosol free vehicles with minors present

QUESTIONS	ANSWERS
1. Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Private only
F4. What are the objectives of the practice?	Car smoking ban with minors or pregnant women (conventional tobacco products) Car vaping ban with minors or pregnant women Car heated tobacco product ban with minors or pregnant women

E1. What is the geographical scope of the practice	Austria nationwide
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Children and young people should be protected from the harm of (passive) tobacco use.
F2. What is the overall goal of the practice?	The smoking ban in private cars is a health measure to expand the smoke and aerosol-free environment for people under the age of 18.
G1. Target settings.	Cars
2. Intervention characteristics = Description of the practice	
C1. Please summarize this best practice.	The ban on smoking in private cars is a provision within the federal law. It is aimed at the general population, not only on a specific population group.
C2. Possible source of information where the practice is described	§ 12 para. 4 TNRSG (Tobacco and Non-Smoker Protection Act) https://www.ris.bka.gv.at/Dokument.wxe?Abfrage=Erv&Dokumentnummer=ERV_1995_431
B1. Title/Name of the practice.	Rauchverbot in privaten Fahrzeugen, wenn sich darin eine Person befindet, die das 18. Lebensjahr noch nicht vollendet hat. // Smoking ban in closed private vehicles if there is a person inside who is under the age of 18.
B2. Type of practice.	**3-AT-SF cars** **Type of practice** 1 Information/awareness raising programm 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know
B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	05/01/2018
J1. What methods are/were used in the practice?	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.
K1. Enforcement of the practice.	The ban on smoking in private cars was decided by the Austrian Parliament and has been in force since May 1, 2018. The Minister of Health, in agreement with the Minister of Traffic, is responsible for the implementation of this law.
3. Evidence and/or theory based = Target population	
G2. If any, which is the specific target population?	Age specific groups
4. & 5- Equity & ethical aspects	
Q1. What are the equity and ethical principles underpinning the practice?	The main concern of the present project was the protection of the health of children and young people.
6. Effectiveness, efficiency = Evaluation	

L1. What are the main outcomes of the practice?	There has not yet been conducted an evaluation of this measure.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	An indicator could be the number of administrative cases.
N1. Has the practice been formally evaluated?	Don't know
7. Transferability = Potential of scalability and transferability	
O1. Level of transferability and/ or scalability.	Transferability has not been considered. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.
8. Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9. Participation = Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	National public health_Development National public health_Implementation Regional public health authorities_Development Regional public health authorities_Implementation Other_Org_Development
10. Intersectoral collaboration = Governance and project management	
B4. Who has the responsibility of the practice?	Nation
B5. Name of the entity(ies) in national language and English and acronym.	Bundesminister für Gesundheit im Einvernehmen mit dem für Verkehr zuständigen Minister // Federal Minister of Health in agreement with the Federal Minister of Traffic
B6. Please specify also the responsibility of the entity(ies):	
E2. How was the practice funded?	No funds required

Links and additional information
§ 12 para. 4 TNRSG (Tobacco and Non-Smoker Protection Act) https://www.ris.bka.gv.at/Dokument.wxe?Abfrage=Erv&Dokumentnummer=ERV_1995_431

Table 5.4: Austria_SF_nation: Smoke Free Award

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes
E1. What is the geographical scope of the practice?	Styria
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	The announced implementation of a smokefree hospitality was cancelled. People of health concerned institutions and a considerable section of the population were both frustrated and actively standing up for a smokefree law. Initiatives originated but got little attention by the government. The Smokefree Award gave them a showcase to raise public awareness and showed the wide range of smokefree initiatives. "Smokefree" included "aerosol-free". The Smokefree Award gave them a showcase to raise public awareness and showed the wide range of smokefree initiatives. "Smokefree" included "aerosol-free". The Smokefree Award brought them into the light of public perception and showed the wide range of smokefree initiatives. "Smokefree" included "aerosol-free".

<table>
<tr><td>F2. What is the overall goal of the practice?</td><td>The first goal was to turn frustration into force and to continue the efforts for a smokefree and aerosol-free environment. The second goal was to get attention and make the parliament realize, that their decision to overturn legislation for a smoke-free hospitality was wrong.</td></tr>
<tr><td>G1. Target settings.</td><td>Restaurants and bars (indoors) Hotels (indoor)</td></tr>
<tr><td colspan="2">2- Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>In 2018 the Austrian parliament decided to overturn legislation for a smokefree hospitality. A wide range of the population was shocked. VIVID - Institute for the Prevention of Addiction initiated the first Austrian “Smoke Free Award”. In six categories people or respectively initiatives may be awarded for their efforts for a smoke- and aerosol-free environment.</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>www.smoke-free-award.at</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Smoke Free Award</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><td></td><td>4-AT-SF Nation (award)</td></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
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<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice has ended</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>1.) Define application criteria 2.) Choosing an external board of judges, representing a wide range of the population 3.) Call for submissions 4.) Encourage initiatives and actively reach out to people to submit an application 5.) Organizing the event „Smokefree gala “6.) Organizing a keynote speaker 7.) Selection of initiatives for a shortlist (6 categories á 5 candidates) 8.) Gala event with publication of the winners (many guests of honour und successful press responses) Actively reach out to the media and the public relations departments of the candidates’ institutions and support them reporting on the award and generally the topic “smoke-free “</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>Smoke Free Award was implemented. Responsible was VIVID - Insitute for the Prevention of Addiction.</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population</td></tr>
<tr><td colspan="2">4- & 5- Equity and ethical aspects</td></tr>
<tr><td>What are the equity and ethical principles underpinning the practice?</td><td>Individual’s rights of applicants have been protected according to national and European legislation.</td></tr>
<tr><td colspan="2">5-Effectiveness, efficiency, evaluation</td></tr>
</table>

L1. What are the main outcomes of the practice?	30 institutions or rather people were nominated, 6 of them were chosen by a jury to get the first “Smoke Free Award”. Around 100 people joined the Smokefree gala event. 27 articles in the media reported the Smoke Free Award (non-payed).
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Number of applications Media attention to the topic “Smoking ban in hospitality”
N1. Has the practice been formally evaluated?	No
7- Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	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. However, the practice has not been transferred yet.
8-Sustainability	
P1. Sustainability.	unknown
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Implementation Regional public health authorities_Implementation Hospital_staff_Implementation Civil_Organizations_Implementation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	External resources – public
B4. Who has the responsibility of the practice?	NGOs
B5. Name of the entity(ies) in national language and English and acronym.	VIVID - Fachstelle für Suchtprävention VIVID - Institute for the Prevention of Addiction
B6. Please specify also the responsibility of the entity(ies):	VIVID - Institute for the Prevention of Addiction created and implemented the Smoke Free Award 2018. It was a reaction to the government overturning legislation for a nationwide smokefree hospitality.

Additional links and information
www.smoke-free-award.at

Table 5.5: Austria_SF_hospitality: Smoking ban in the hospitality sector

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products)Indoor aerosol-free regulation for e-cigarettesIndoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	Austria Austria nation wide

<table>
<tr><td>F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?</td><td>Extension of health protection of the population by means of advanced non-smoker protection measures.</td></tr>
<tr><td>F2. What is the overall goal of the practice?</td><td>Extension of health protection of the population by means of advanced non-smoker protection measures.</td></tr>
<tr><td>G1. Target settings.</td><td>Restaurants and bars (indoor)Hotels (indoor)</td></tr>
<tr><td colspan="2">2- Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>General smoking ban in indoor hospitality</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>§ 12 para. 1 no. 4 TNRSG (Tobacco and Non-Smoker Protection Act)</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Rauchverbot in der Gastronomie // Smoking ban in the hospitality sector</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><td></td><td>5-AT-SF Hospitality</td></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>11/01/2019</td></tr>
<tr><td>J1. What methods are/ were used in the practice?</td><td>Public consultation, expert panels, research by e.g. indoor hygiene experts and toxicologists, etc.</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>The new rule has been enforced since November 2019.</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population</td></tr>
<tr><td colspan="2">4-Ethical aspects</td></tr>
</table>

What are the equity and ethical principles underpinning the practice?	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.
5-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Increased 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.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	A possible indicator could be the number of administrative cases.
N1. Has the practice been formally evaluated?	No
6-Equity	
Q1. What are the equity and ethical principles underpinning the practice?	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.
7-Transferability, potential of scalability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/ regional/national level and transferability has not been considered in a systematic way.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_DevelopmentNational public health_DevelopmentNational public health_ImplementationNational public health authorities_EvaluationRegional public health authorities_DevelopmentRegional public health authorities_ImplementationResearchers / academics_DevelopmentCivil_Organizations_Development
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	No funds required.
B4. Who has the responsibility of the practice?	Nation
B5. Name of the entity(ies) in national language and English and acronym.	Bundesminister für Gesundheit und die nachgeordneten Behörden // Federal Minister of Health an national/regional health authorities
B6. Please specify also the responsibility of the entity(ies):	Responsible for the enforcement of this legal provision

Table 5.6: Belgium_SF_nation: Generation Smoke Free

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private

F4. What are the objectives of the practice?	Smoke-free outdoor settings (vaping) Note: smoking in car with minors is legally banned in BE To create smoke free environments for all children; such as playgrounds, sport facilities, recreation parks, children's farms, hospital domains, schools and 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.
E1. What is the geographical scope of the practice?	Belgium
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Outdoor smoking bans can be implemented in places where there is a clear presence of children (petting zoos, playgrounds, childcare facilities and sports grounds), with 1) appropriate signage and positive communication and 2) a phased plan to address the issue. When children see others smoking, it creates the impression that smoking is a normal and enjoyable part of life, rather than a deadly addiction. And children copy behaviour. This includes smoking behaviour. But 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). The WHO 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. In order to build support and modify the norm on smoking a voluntary approach can contribute to the achievement of a smoke-free generation. Through the partnerships with municipalities, sport federations/clubs, schools, etc. and the use of the Generatie Rookvrij/Générations sans Tabac signalisation we 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 the label, the partners take ownership of the project and become Generatie Rookvrij/Générations sans Tabac 'ambassadeurs' encouraging other partners to make outdoor children's environments smoke free. See also 'Factsheet Rookvrije Buitenruimten, Nationaal expertisecentrum Tabaksontmoediging, Augustus 2020).
F2. What is the overall goal of the practice?	A smoke free genetation in Belgium in 2037 meaning there will be less than 5% of adult smokers and 0% under 18.
G1. Target settings.	Our target settings until 2024 are, besides the ones mentioned above, outdoor sport facilities, school environments (the outdoor school areas are smoke free by law 24/24 and 7/7 so we envisage the environments around the school area), youth movement, petting zoos. Although this is our focus now, we encourage other outdoor environments to become smoke free and invest/discuss with sectors to make their outdoor areas smoke free (such as for beaches and terraces)
2- Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	Towards a first smoke-free generation in Belgium Children have the right to grow up healthy, including smoke-free. Every week, dozens of children and youngsters start smoking and half of them will die from it. This has to stop! That is why 9 Belgian NGOs active in tobacco control are working together to achieve a first smoke-free generation in Belgium and to ensure that this generation of children will no longer suffer from the consequences of smoking. In 2018, the Alliance for a Smoke-Free Society was established, and they initiated the project Generatie Rookvrij/Générations sans Tabac. In addition to the two funding partners Kom op tegen Kanker and Fondation contre le Cancer, the following organisations have been part of the Alliance since its official launch: the Flemish Institute for Healthy Living, the Flemish Association for Respiratory Care and Tuberculosis Control (VRGT), the Belgian Cardiological League, the Family Association, the Fonds des Affections Respiratoires (FARES), Service d'Etude et de Prévention du Tabagisme (SEPT) and Observatoire de la Santé du Hainaut (OSH). On the one hand, our strategy - through the brand Alliance (B2P) - focuses on better legislation at all policy levels leading to a smoke-free future and better smoking cessation counselling (top-down). At the same time - through the brand Generatie Rookvrij/Générations sans Tabac (B2B/B2C) - we are making environments frequented by children smoke-free (attribution of a label) and supporting smokers to quit smoking (bottom-up). This will create a social movement and increase political support for policy measures.

C2. Possible source of information where the practice is described	https://alliancesocietesanstabac.be/ https://www.generationssanstabac.be/
B1. Title/Name of the practice.	Generatie Rookvrij (BE-NL)/Générations sans Tabac (BE-FR)
B2. Type of practice.	**3-BE-Sfgral** **Type of practice** 1 Information/awareness raising programm 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know
B3. Which is the current phase of the best practice?	Don't know
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	31/05/2018
J1. What methods are/were used in the practice?	For the different organisations/municipalities that decide to make their (outdoor) environment smoke-free an argumentation note, and roadmap have been developed: https://www.generationssanstabac.be/que-puis-je-faire/agir-en-tant-quorganisation - example of sport facilities: https://www.generationssanstabac.be/sites/default/files/2021-10/Plans%20d'actions%202021/Plan%20d'Action%20Sport%202021.pdf. Through a supporting network, the organisations and municipalities are supported to apply for a label. This Generatie Rookvrij/Générations sans Tabac label est une reconnaissance accordée aux organisations, villes et communes qui créent des environnements sans tabac et mettent ainsi tout en œuvre pour protéger les enfants et les jeunes de la dépendance tabagique, d'une part, et pour aider davantage les fumeurs à arrêter, d'autre part. Currently we have about 160 label holders in Belgium that implemented (or are implementing) outdoor smoke free areas. A yearly survey towards municipalities shows the increase of outdoor smoke free environments (see attachment)
J1 bis. If relevant, please upload possible documentation.	Geanonimiseerde resultaten bevraging Vlaamse lokale besturen december 2021.pdf
K1. Enforcement of the practice.	Generatie Rookvrij/Générations sans Tabac is a voluntary approach where organisations/ municipalities obtain for a label. To obtain the label, the conditions of a checklist have to be fulfilled. Once the label is obtained, the organisation looks after the enforcement themselves. Special training can be obtained to train employees of the organisation on how to communicate with smokers on the smoke free area.
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	Vulnerable groups (Pregnant women) General population Socioeconomic position (including educational level)
4-Ethical aspects & **6-Equity**	

Q1. What are the equity and ethical principles underpinning the practice?	• 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
5- Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	At the end of December 2021, 139 questionnaires were completed, of which 126 had unique responses. 56% of these cities and municipalities also completed the questionnaire last year, 44% are 'new'. The working group 'smoke-free municipalities' of Generation Smoke Free came together to discuss this and are happy to see that In 2021, despite corona, many municipalities were active in the field of Generation Rookvri
M1. What indicators are used in the monitoring of the process and outcome of the practice?	See survey (previous page). Quantity of label holders (making outdoor areas smoke free) and Charter partners (organisations that subscribe the vision and mission of Generatie Rookvrij/Générations sans Tabac. We have some basic statistics of our website and communication and media actions. If needed, information can be provided.
N1. Has the practice been formally evaluated?	No
7- Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources. A sustainability strategy has been developed.
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Implementation Local public health authorities_Implementation Local public health authorities_Evaluation Hospital_staff_Development Hospital_staff_Implementation Other_Org_Implementation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	Own resources
B4. Who has the responsibility of the practice?	NGos
B5. Name of the entity(ies) in national language and English and acronym.	Belgian Alliance for a Smoke Free Society
B6. Please specify also the responsibility of the entity(ies):	The Alliance developed, initiated and is implementing the project 'Generatie Rookvrij (GRV)/Générations sans Tabac (GsT) https://www.generationssanstabac.be/ in cooperations with many partners (municipalities, sport federations/clubs, schools, hospitals, youth movements, children's zoos). GRV coordinates the project (B2B and B2C)

Links and additional information
https://www.generationsmokefree.be/generation-smoke-free
https://alliancesocietesanstabac.be/

Table 5.7: Belgium_SF_transport: Smoke-free railway platforms

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) Outdoor aerosol-free regulation for e-cigarettes Note: heated tobacco products are not on the Belgian market
E1. What is the geographical scope of the practice?	Belgium
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Exposure to second-hand smoke is harmful for health. On crowded platforms the risk of exposure to second-hand smoke is real. Furthermore, denormalisation of smoking is necessary to prevent youngsters from starting to smoke. Smoke free platforms can attribute to denormalisation of smoking. Last but not least, a majority of rail passengers support smoke-free platforms (68 % according to a customer survey organised by NMBS/SNCB in 2017).
F2. What is the overall goal of the practice?	Protect passengers from second-hand smoke + denormalise smoking behaviour in order to prevent youngsters from starting to smoke.
G1. Target settings.	Railway platforms (outdoor)
2-Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	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, NMBS/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 will 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 ngo's 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.
C2. Possible source of information where the practice is described	https://www.komoptegenkanker.be/blog/eerste-stap-naar-rookvrije-perrons https://press.nmbs.be/proefproject-voor-rookvrije-perrons-in-station-van-mechelen https://press.sncb.be/lancement-dun-projet-pilote-pour-des-quais-non-fumeurs-a-la-gare-de-malines https://www.komoptegenkanker.be/blog/kom-op-tegen-kanker-verwelkomt-wetswijziging-waardoor-alle-belgische-treinperrons-rookvrij-worden https://www.dekamer.be/kvvcr/showpage.cfm?section=flwb&language=nl&cfm=flwbn.cfm?lang=N&dossierID=2082&legislat=55
B1. Title/Name of the practice.	Smoke-free railway platforms

<table>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>7-BE-SF railway</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
<tr><td>13</td><td>Other: behaviour change intervention</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice is at the first stage of implementation but not yet totally developed</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>24/11/2021</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>N./A.</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>In the pilot phase, Generatie Rookvrij (Generation Smoke Free) signalisation is used to inform the passengers. A larger communication campaign will be rolled out in the run-up to the official ban. Railway officials will be in charge for controlling its compliance.</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population</td></tr>
<tr><td colspan="2">4- & 5- Equity and ethical aspects</td></tr>
<tr><td>What are the equity and ethical principles underpinning the practice?</td><td>N.A.</td></tr>
<tr><td colspan="2">6-Effectiveness, efficiency, evaluation</td></tr>
<tr><td>L1. What are the main outcomes of the practice?</td><td>Final result: all railway stations in Belgium will be 100% smoke-free. No lessons learned in this stage of the project.</td></tr>
<tr><td>M1. What indicators are used in the monitoring of the process and outcome of the practice?</td><td>No monitoring is provided, unfortunately.</td></tr>
<tr><td>N1. Has the practice been formally evaluated?</td><td>No</td></tr>
<tr><td colspan="2">7-Potential of scalability and transferability</td></tr>
</table>

O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/ regional/national level and transferability has not been considered in a systematic way.
8-Sustainability	
P1. Sustainability.	Don't know
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Civil_Organizations_Development
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Public agency
B5. Name of the entity(ies) in national language and English and acronym.	NMBS/SNCB, our national railway company
B6. Please specify also the responsibility of the entity(ies):	NMBS/SNCB is responsible for the practice implementation (placing of non-smoking signs, remove ashtrays, ...) the communication towards the train passengers) and the enforcement.
E2. How was the practice funded?	The pilot project was funded by the municipalities where the two railway stations are located (i.e. Mechelen and Charleroi), the rest of the project will be funded by NMBS/SNCB.

Links and additional information
https://www.komoptegenkanker.be/blog/eerste-stap-naar-rookvrije-perrons
https://press.nmbs.be/proefproject-voor-rookvrije-perrons-in-station-van-mechelen
https://press.sncb.be/lancement-dun-projet-pilote-pour-des-quais-non-fumeurs-a-la-gare-de-malines
https://www.komoptegenkanker.be/blog/kom-op-tegen-kanker-verwelkomt-wetswijziging-waardoor-alle-belgische-treinperrons-rookvrij-worden
https://www.dekamer.be/kvvcr/showpage.cfm?section=flwb&language=nl&cfm=flwbn.cfm?lang=N&dossierID=2082&legislat=55

Table 5.8: Belgium_SF_nation: A ban to vape in closed public places

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes Indoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	Belgium
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	E-cigarettes are not free of risks (= health argument). The enforcement of smokefree environments is easier if it is also forbidden to vape (= enforcement argument)
F2. What is the overall goal of the practice?	The first goal is denormalization of smoking and other use of nicotine. The second goal is to raise the motivation for smokers to quit the nicotine addiction and make it easier for ex-smokers to stay smoke free (= relapse prevention).
G1. Target settings.	Restaurants and bars (indoor)
2-Intervention characteristics, description of the practice	

C1. Please summarize this best practice	In Belgium the e-cigarette is considered as a tobacco product. In places with a smoking ban, it is also forbidden to vape. De facto we have vape free restaurants and vape free bars.
C2. Possible source of information where the practice is described	https://www.health.belgium.be/nl/gezondheid/zorg-voor-jezelf/rookproducten-en-e-sigaretten/specifieke-regelgeving-voor-elektronische and https://www.health.belgium.be/nl/gemeenschappelijke-informatie-en-voorschriften-3
B1. Title/Name of the practice.	A ban to vape in closed public places
B2. Type of practice.	

	8-BE-VAPE BAN INDOOR
	Type of practice
1	Information/awareness raising programme
2	Policy
3	Action plan
4	Regulation/ ban
5	Monitoring/surveillance
6	Service delivery approach/method
7	Tool/instrument
8	Guideline
9	Training
10	E-health, mHealth
11	Health in All policies
12	Don't know

B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	22/12/2009
J1. What methods are/were used in the practice?	No specific methods
K1. Enforcement of the practice.	The same entity in charge of controlling smoke free areas is in charge of controlling vape free areas
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population
4- & 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	Respect of art. 5.3. Frame Work Convention Tobacco Control
6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	The main advantage of our 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.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Statistics on compliance
N1. Has the practice been formally evaluated?	Don't know
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.
8-Sustainability	

P1. Sustainability.	The practice has institutional support and stable human resources.
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	National public health_Development National public health_Implementation National public health authorities_Evaluation
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Nation
B5. Name of the entity(ies) in national language and English and acronym.	FOD Volksgezondheid, Federale Overheidsdienst Volksgezondheid (Dutch) SPF Santé, Service Publique Fédéral pour la Santé (French)
B6. Please specify also the responsibility of the entity(ies):	Enforcement Control
E2. How was the practice funded?	No funds required

Links and additional information
https://www.health.belgium.be/nl/gezondheid/zorg-voor-jezelf/rookproducten-en-e-sigaretten/specifieke-regelgeving-voor-elektronische

Table 5.9: Czechia_SF_health care: Tobacco Free Healthcare Services

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Smoke-free outdoor settings (conventional tobacco products) Smoking ban as an anti-Covid-19 measure Indoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for e-cigarettes Vaping ban as an anti-Covid-19 measure Indoor aerosol-free regulation for heated tobacco products Outdoor aerosol-free regulation for heated tobacco products Ban of heated tobacco products use as an anti-Covid-19 measure
E1. What is the geographical scope of the practice?	Czech Republic and Global Network for Tobacco-Free Healthcare Services The National GNTH Network of the Czech Republic All the regions The Czech National Network of Tobacco-Free Hospitals and Healthcare Facilities has 13 members, e.g. Prague, Brno, Pilsen etc.
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	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. They should therefore play a leading role in the prevention and treatment of tobacco addiction.
F2. What is the overall goal of the practice?	Every hospital tries to emphasize the healthy lifestyle of patients and staff. It 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.
G1. Target settings.	Hospitals including outpatient clinics (indoor)Primary health care institutions (indoor) Outdoor areas of hospitals and healthcare institutions (outdoor)
2-Intervention characteristics, description of the practice	

<table>
<tr><td>C1. Please summarize this best practice.</td><td>“Non-smoking hospital” is the name of an international project whose goal is 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). The gist of Non-smoking hospital is to concentrate on the following: introduction of non-smoking areas, monitoring tobacco use among patients and staff, provision of short intervention as well as the option of intensive treatment for tobacco addiction, training of employees in the provision of these interventions, and organizing health promotion events for staff and the public.</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>https://www.mzcr.cz/nekuracke-nemocnice/; https://www.prolekare.cz/casopisy/casopis-lekaru-ceskych/2017-1/co-znamena-nekuracka-nemocnice-60424; https://www.slzt.cz/nekuracke-nemocnice</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Tobacco Free Healthcare Services</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>9-CZ-SF Health care</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>01/07/2017</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>introduction of non-smoking areas, monitoring tobacco use among patients and staff, provision of short intervention as well as the possibility of intensive treatment of tobacco addiction, training of employees in the provision of these interventions, and organizing health promotion events for staff and the public. https://www.mzcr.cz/nekuracke-nemocnice/</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>Voluntary membership in the project is available for every hospital in the Czech Republic</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population
Health Care Workers</td></tr>
<tr><td colspan="2">4- & 5- Equity and ethical aspects</td></tr>
<tr><td>What are the equity and ethical principles underpinning the practice?</td><td>No underpinning of the practice</td></tr>
<tr><td colspan="2">6-Effectiveness, efficiency, evaluation</td></tr>
<tr><td>L1. What are the main outcomes of the practice?</td><td>It is still ongoing project so the outcomes could not have been reached yet at the moment.</td></tr>
</table>

M1. What indicators are used in the monitoring of the process and outcome of the practice?	STANDARD 1: Leadership and Commitment The healthcare organization has clear and strong leadership that systematically implements the non-smoking policy. STANDARD 2: Communication The healthcare organization has a comprehensive communication strategy to support awareness and implementation of the non-smoking policy and smoking cessation services. STANDARD 3: Education and training. The healthcare organization ensures proper education and training for clinical and other staff. STANDARD 4: Identification, diagnosis and support for smoking cessation. The health organization identifies all tobacco users and provides appropriate care in accordance with international best practices and national standards. STANDARD 5: Non-smoking environment. The healthcare organization has strategies in place to achieve a smoke-free environment. STANDARD 6: A healthy workplace. A healthcare organization has human resource management policies and support systems that protect and promote the health of everyone who works in the organization. STANDARD 7: Involvement in the community. The health organization contributes to and supports tobacco control/prevention within the local community according to the WHO Framework Convention on Tobacco Control and/or national public health strategies. STANDARD 8: Monitoring and evaluation. The healthcare organization monitors and evaluates the implementation of all Global Association standards at regular intervals. GNTH Standards. for the implementation of tobacco control policies in healthcare settings https://www.tobaccofreehealthcare.org/standards/overview
N1. Has the practice been formally evaluated?	Don't know
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	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. However, the practice has not been transferred yet.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources. The practice provides training of staff in order to sustain it
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Implementation International/European public health authorities_Implementation National public health_Implementation National public health authorities_Evaluation Regional public health authorities_Implementation Local public health authorities_Implementation Hospital_staff_Implementation Primary care centre staff_Development Specialized physicians_Implementation General practitioners_Development Pharmacists_Development Nurses_Development Other health care prof_Implementation Informal caregivers_Development Researchers /academics_Development School staff_Development Employers/employees_Development Civil_Organizations_Development Other_Org_Development
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Public agency Government
B5. Name of the entity(ies) in national language and English and acronym.	Ministry of Health of the Czech Republic, Hospitals and Health Care Facilities in the Czech Republic
B6. Please specify also the responsibility of the entity(ies):	Ministry of Health of the Czech Republic

E2. How was the practice funded?	Don't know

Links and additional information
https://www.mzcr.cz/nekuracke-nemocnice
https://www.prolekare.cz/casopisy/casopis-lekaru-ceskych/2017-1/co-znamena-nekuracka-nemocnice-60424
https://www.slzt.cz/nekuracke-nemocnice

Table 5.10: Germany_SF_nation: Law for the protection from second-hand smoke – smoke-free legislation of Hesse

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Smoke-free outdoor settings (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for e-cigarettes Indoor aerosol-free regulation for heated tobacco products Outdoor aerosol-free regulation for heated tobacco products Outdoor smoke-free and aerosol-free regulations applies to children's playgrounds.
E1. What is the geographical scope of the practice?	This legislation only applies to the Federal State of Hesse
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	New products such as e-cigarettes and heated tobacco products (HTPs) are not subject to the existing smokefree legislation. The aerosol produced by e-cigarettes and HTPs is a threat to health and bystanders must be protected from those health hazards. The aerosol contains several potentially hazardous substances and thus the products should not be used in closed rooms while non-smokers are present, and use of those products should be banned in all smokefree places. The use of e-cigarettes and HTPs in smokefree areas may lead to the renormalization of smoking, thus reversing the success of the smokefree legislation, including the paradigm change in society. Including e-cigarettes into smokefree legislation improves the protection of youth, as those products are well appreciated by youth. As by the law for the protection of youth, already minors are not allowed to by and use e-cigarettes and starting in 2024 outdoor advertising for e-cigarettes will be banned.
F2. What is the overall goal of the practice?	The overall goal of the practice is to protect non-smokers and youth from health hazards of aerosol from e-cigarettes and HTPs, as well as to strengthen the denormalization of smoking. Another goal is the protection of youth.
G1. Target settings.	The overall goal of the practice is to protect non-smokers and youth from health hazards of aerosol from e-cigarettes and HTPs, as well as to strengthen the denormalization of smoking. Another goal is the protection of youth.
2- Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	In 2021, as the first of the German federal States, the Federal State of Hesse included e-cigarettes and heated tobacco products into the smokefree legislation of Hesse. Since then, all federal smoking bans also apply to e-cigarettes and heated tobacco products.
C2. Possible source of information where the practice is described	https://www.rv.hessenrecht.hessen.de/bshe/document/jlr-NRauchSchGHEpELS
B1. Title/Name of the practice.	Gesetz zum Schutz vor den Gefahren des Passivrauchens (Hessisches Nichtraucherschutzgesetz - HessNRSG) Law for the protection from secondhand smoke - smokefree legislation of Hesse

<table>
<tr><td>B2. Type of practice. Please select all that apply for this practice.</td><td>
<table>
<tr><td></td><td>10-DK-SF National</td></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>18/11/2021</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>The original smoke-free legislation was applicable up to 2020 and had to be renewed. The usual process for law-making was followed.</td></tr>
<tr><td>J1 bis. If relevant, please upload possible documentation.</td><td>Draft smokefree legislation Hesse 2021.pdf</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>The law came into force on November 18th, 2021, and expires on December 31st, 2028. the responsible persons for enforcement of the law are the heads of the relevant institutions and sectors.</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population.
Age specific groups</td></tr>
<tr><td colspan="2">4-Ethical aspects & 6-Equity</td></tr>
<tr><td>What are the equity and ethical principles underpinning the practice?</td><td>n.a.</td></tr>
<tr><td colspan="2">5- Effectiveness, efficiency, evaluation</td></tr>
<tr><td>L1. What are the main outcomes of the practice?</td><td>E-cigarettes and HTPs may not be used in smokefree areas. As the legislation has been introduced very recently, currently there is no evaluation available.</td></tr>
</table>

M1. What indicators are used in the monitoring of the process and outcome of the practice?	To me it is not known whether and what monitoring is planned by the federal state.
N1. Has the practice been formally evaluated?	No
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/regional/ national level and transferability has not been considered in a systematic way.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	Group of population_Development National public health_Development Regional public health authorities_Development Local public health authorities_Development Other health care prof_Development Researchers/academics_Development Civil_Organizations_Development Other_Org_Development
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	No funds required.
B4. Who has the responsibility of the practice?	Province/Region
B5. Name of the entity(ies) in national language and English and acronym.	Federal State of Hesse
B6. Please specify also the responsibility of the entity(ies):	Parliament of Hesse

Links and additional information
https://www.rv.hessenrecht.hessen.de/bshe/document/jlr-NRauchSchGHEpELS

Table 5.11: Denmark_SF_city: Smoke free outdoor areas_ The city of Aarhus

QUESTIONS	ASNWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private Municipality have come up with a number of proposals for smoke-free outdoor areas. This means areas under the open sky where it is no longer permitted to smoke tobacco, including cigarettes, water pipes and e-cigarettes etc.
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) The objective, by introducing the 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 objective also aims to minimize the amount of people exposed to passive smoking
E1. What is the geographical scope of the practice?	City/municipality of Aarhus
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	The objective, by introducing the 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 objective also aims to minimize the amount of people exposed to passive smoking 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. The Smoking Act only sets a minimum standard. This means that the individual municipalities are welcome to introduce standards that ensure better protection against tobacco smoke. 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
F2. What is the overall goal of the practice?	The objective, by introducing the 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 objective also aims to minimize the amount of people exposed to passive smoking
G1. Target settings.	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
2-Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	The city/municipality of Aarhus has a vision of a smoke free Aarhus. Hence, 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. Prior to this regulation, smoking was already not permitted in the municipality's buildings, and some outdoor areas, e.g. at schools are already smoke-free. It is not permitted for the municipality's employees to smoke during working hours.
	https://www.cancer.dk/forebyg/undga-roeg-og-rygning/indsatser-mod-rygning/roegfri-udearealer/
B1. Title/Name of the practice.	Smoking free outdoor areas - The City of Aarhus, Denmark
B2. Type of practice.	Smoke free legislation
B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice is ongoing

D1 bis. Please provide start date.	01/08/2019 Hearing 9 October 2019. The proposal was in consultation until 6 November 2019, and can be submitted via www.deltag.aarhus.dk. After reviewing the consultation responses, the Magistrate's Department for Health and Care send a combined recommendation to Aarhus City Council, which will be considered in December 2019.
J1. What methods are/were used in the practice?	Involving intersect organisations and within the city alliance there has been given inspiration to how each actor locally can contribute and make a difference for the vision of a smoking free Aarhus. There are many people who take up this shared responsibility. Educational institutions introduce smoke-free school hours, workplaces introduce smoke-free working hours, shops hide tobacco away and everything from dormitories to care homes become smoke-free.
K1. Enforcement of the practice.	In August of 2019 the Councillor sent the city council a resolution proposal that every council committee ought to produce a plan as to how to create smoking free outdoor areas within their own competence of public authority. Every plan was thus combined and sent to an official hearing. The city council proposed the 1st of March 2020 the combined proposal regarding smoking free outdoor areas from the committees together 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.
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population Urban setting
4-& 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	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)
6- Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	The proposal has succeeded in producing multiple smoking 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 smoking free for a period.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	See results
N1. Has the practice been formally evaluated?	Not yet, the intervention is still ongoing, but the evaluation is foreseen
N1 bis. If you answered "Yes" or "Not yet":Please specify the organizations that conducted the evaluation.	The Municipality of Aarhus, Health Promotion
Q1. What are the equity and ethical principles underpinning the practice?	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)
7- Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.

O2 barriers or challenges	No national legislation. It depends on the city council of each of the 98 municipalities. Several municipalities/cities in Denmark discuss smokefree outdoor areas, and get inspired from other cities, cancer.dk and Local Government Denmark (LGDK)
8- Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	Local public health authorities_Development Civil_Organizations_Development Local public health authorities_Implementation Civil_Organizations_Implementation Local public health authorities_Evaluation Civil_Organizations_Evaluation 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 og eastern Jutland), Salling Group (warehouse), Northside (Music Festival), Scandic Hotels and a range of educational institutions – to be a part of the local alliance for a smoking free Aarhus
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Municipality/City
B5. Name of the entity(ies) in national language and English and acronym.	Aarhus Kommune, City of Aarhus
B6. Please specify also the responsibility of the entity(ies):	the city council of Aarhus
E2. How was the practice funded?	No funds required

Links and additional information
https://www.cancer.dk/forebyg/undga-roeg-og-rygning/indsatser-mod-rygning/roegfri-udearealer/

Table 5.12: Denmark_SF_work: Workplaces as settings for implementation of smoke- and aerosol free environments
Table with all the information from questionnaire

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products)Smoke-free outdoor settings (conventional tobacco products)Indoor aerosol-free regulation for e-cigarettesOutdoor aerosol-free regulation for e-cigarettesBan of smoking and tobacco use during worktime - smoke free work hours
Was the intervention aligned with a policy plan at the local, national, institutional or at international level?	
E1. What is the geographical scope of the practice?	DenmarkLemvig Kommune, Ikast-Brande Kommune, Billund Kommune, Kalundborg Kommune, Fredensborg Kommune
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Smoking restrictions in the workplace are an important component of tobacco control policy because they protect non-smokers from the harmful health effects of passive smoking. Furthermore, smoking restrictions provide a supportive environment for people who want to quit smoking by reinforcing social norms, and even have the potential to reduce social inequality in smoking. Smoke-free workplaces encourage quitting and a reduction in smoking rates. Additionally, individuals working in smoke-free environments are less likely to begin smoking than those who are exposed to smoke. The arguments also pertain to the great health benefits of not smoking, the costs of employee's smoking such as decreased work productivity, and the need for more sick days compared to non-smoking employees. Furthermore, the implementation and enforcement of health policies has been found to protect and promote mental health in the workplace

<table>
<tr><td>F2. What is the overall goal of the practice?</td><td>The overall goal is to protect non-smokers from the harmful health effects of passive smoking. 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</td></tr>
<tr><td>G1. Target settings.</td><td>Workplace (indoor)Workplace inside and outside during work hours</td></tr>
<tr><td colspan="2">2- Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>In recent years, several municipalities and workplaces, both public and private, have implemented an smoking policy - ‘Smokefree work hours’, where an employee may not smoke at any point during work time. 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)</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>Charlotta Pisinger: Readiness for implementation of smokefree work hours: 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</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Workplaces as settings for implementation of smoke- and aerosol free environments</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>12-DK-SF Work</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>08/01/2017</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>Succesful policy requires substantial organizational efforts related to the commitment and support of top managers, middle managers and employees, internal communication about the tobacco use restrictions during work hours, and the organization’s support activities (meetings, involvement in decisionmaking and implementation, information about how to handle the urge to smoke during work hours, activities to make healthy breaks and good mental health environments for employees</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>Please contact Charlotta Pisinger for more information middle managers training on handling the new policy and a joint vision and understanding and how to support/talk with employees about how to handle the urge to smoke</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>Workers in all ages - public and private workplaces</td></tr>
</table>

4-Ethical aspects	
What are the equity and ethical principles underpinning the practice?	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) Note: The ethical training of the middle managers must focus on how to support smokers to handle the urge of smoking during workhours
5-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Municipality experiences: The middle mangers need clear guidelines for action and training in understanding WHY and HOW - and how to talk with employees A good access 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 collegues - with a bit of planning
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Please contact Charlotta Pisinger for more information about the research The municipalities has made evaluation after implementation af the new smoke-free strategy with good results
N1. Has the practice been formally evaluated?	Yes, the evaluation was carried out internally
N1 bis. If you answered "Yes" or "Not yet":	Please contact Charlotta Pisinger for more information
6-Equity	
Q1. What are the equity and ethical principles underpinning the practice?	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) Note: The ethical training of the middle managers must focus on how to support smokers to handle the urge of smoking during workhours
7- Potential of scalability, transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	The practice provides training of staff in order to sustain it's sustainability strategy has been developed
9- Empowerment, participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_DevelopmentGroup of population_ImplementationGroup of population_EvaluationLocal public health authorities_DevelopmentLocal public health authorities_ImplementationLocal public health authorities_EvaluationResearchers / academics_DevelopmentResearchers /academics_ImplementationEmployers/ employees_DevelopmentEmployers/employees_ImplementationEmployers/employees_ EvaluationOther_Org_DevelopmentOther_Org_ImplementationOther_Org_Evaluation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	Own resources
B4. Who has the responsibility of the practice?	Municipality/City
B5. Name of the entity(ies) in national language and English and acronym.	Local municipalities/Cities, supported by Center for Health Promotion, KL, Local Government Denmark In collaboration with The Danish Cancer Society Danish Health Authority - Health Promotion
B6. Please specify also the responsibility of the entity(ies):	Commitment and support of top managers in several municipalities (workplaces)

Links and additional information

Charlotta Pisinger: Readiness for implementation of smokefree work hours: 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

Table 5.13: Denmark_SF_educational: Smoke Free School Hours

<table>
<tr><th>QUESTIONS</th><th>ANSWERS</th></tr>
<tr><td>1- Relevance</td><td>Comprehensiveness of the intervention</td></tr>
<tr><td>F3. Does the best practice focus on public or private settings?</td><td>Public only</td></tr>
<tr><td>F4. What are the objectives of the practice?</td><td>To prevent smoking uptake among children and adolescents, to encourage smoking cessation and to create smoke free environments for children and adolescents</td></tr>
<tr><td>E1. What is the geographical scope of the practice?</td><td>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.</td></tr>
<tr><td>F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?</td><td>Since children and adolescents under 18 are not allowed to buy tobacco there is no justification for letting them smoke or use tobacco products during school hours. Further the teachers are role models and should not smoke in there working time.</td></tr>
<tr><td>F2. What is the overall goal of the practice?</td><td>To prevent smoking uptake among children and adolescents, to encourage smoking cessation and to create smoke free environments for children and adolescents</td></tr>
<tr><td>G1. Target settings.</td><td>Schools/ public-education institutions/ educational venues except universities (indoor)</td></tr>
<tr><td colspan="2">2- Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>Smoke free school hours means that the students are not allowed to smoke during school time, not even if they leave the premises in 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 in the school hours, not even in their breaks or if they leave the premises.</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>General information from the Danish Cancer Society: https://www.cancer.dk/forebyg/undga-roeg-og-rygning/indsatser-mod-rygning/roegfri-skoletid/hvad-er-roegfri-skoletid/
Legislative decree: https://www.retsinformation.dk/eli/lta/2021/1632</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Smoke Free School Hours</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>13-DK-SF School</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>01/01/2021</td></tr>
</table>

J1. What methods are/were used in the practice?	Examples of the methods can be found her- in Danish: https://webshop.cancer.dk/pjecer-og-information/forebyggelse/rygning/2589/katalog-roegfri-skoletid-i-grundskolen?_ga=2.213459602.700692983.1581328421-54404872.1570175278 https://www.cancer.dk/dyn/resources/File/file/9/9149/1613640669/roegfri-skoletid-paa-ungdomsuddannelser.pdf
K1. Enforcement of the practice.	The educational facilities are responsible for the enforcement of smoke free school hours, whereas the municipalities as employers/the local management of the school are responsible for the enforcement of smoke free working hours for teachers and other relevant staff.
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	Workers in all ages - public and private workplaces
4-Ethical aspects & 6-Equity	
What are the equity and ethical principles underpinning the practice?	NA/
5- Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	this report (in Danish) contains examples of outcomes of the practice: https://www.sdu.dk/da/sif/rapporter/2020/roegfri_skoletid
M1. What indicators are used in the monitoring of the process and outcome of the practice?	N/A
N1. Has the practice been formally evaluated?	No
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	Unknown
9 -Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Other_Org_Development Other_Org_Implementation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	No funds required
B4. Who has the responsibility of the practice?	Municipality/City
B5. Name of the entity(ies) in national language and English and acronym.	The government has adopted “Plan against smoking in children and young people” which includes the national measure of smoke-free school hours in primary schools, high schools and vocational school.
B6. Please specify also the responsibility of the entity(ies):	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.

Additional links and information

General information from the Danish Cancer Society: https://www.cancer.dk/forebyg/undga-roeg-og-rygning/indsatser-mod-rygning/roegfri-skoletid/hvad-er-roegfri-skoletid

Legislative decree: https://www.retsinformation.dk/eli/lta/2021/1632

this report (in Danish) contains examples of outcomes of the practice: https://www.sdu.dk/da/sif/rapporter/2020/roegfri_skoletid

Table 5.14: Estonia_SF_transports: Implementation of the smoke-free zone regulation in the public transport shelters and waiting rooms

QUESTIONS	ANSWERS
1. Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) Outdoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice	Estonia
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	It helps for the law regulations to work better in the real situation and protects people's health. Also, it makes it clearer for people to understand where it is not allowed to smoke.
F2. What is the overall goal of the practice?	To protect the health of people.
G1. Target settings.	Bus, tramway, trolley-bus stop waiting areas (outdoor)
2. Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	Around the bus stop is the smoke free zone which is indicated by the lines drawn on the ground. If people smoke in the marked area, they get fined.
C2. Possible source of information where the practice is described	Estonian Tobacco Act https://www.riigiteataja.ee/en/eli/516042021002/consolide Article about the practice is use: https://p-tln.geenius.ee/rubriik/uudis/bussipeatustes-ei-tohi-suitsetada-juba-praegugi-aga-nuud-joonistatakse-maha-ka-keelutsoonid/
B1. Title/Name of the practice.	Ühistranspordi ootekojas suitsuvaba tsooni regulatsiooni rakendamine. / Implementation of the smoke-free zone regulation in the public transport shelters and waiting rooms.
B2. Type of practice.	**14-EE-SF Transport** **Type of practice** 1 Information/awareness raising programme 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know
B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	01/06/2021

J1. What methods are/were used in the practice?	In 2014 there was published a Tobacco Politics Green Book. In the development of the book participated different interest groups, governmental organizations and stakeholders. There are given besides other recommendations, the measures to establish in front of the doorways of public buildings smoke-free protection zones at least 3 meters from the door. The same logic has been used for the transportation stops areas. Link to the Tobacco Green Book: https://untobaccocontrol.org/impldb/wp-content/uploads/reports/estonia_annex2_tobacco_green_paper.pdf Also people's concerns were taken into account for implementing these measures. One article from 10.01.2021: https://pealinn.ee/2021/06/10/video-ja-fotod-tallinn-margistab-suitsuvaba-alana-ligi-600-uhissoiduki-peatust/
K1. Enforcement of the practice.	It is in practice and in the places where it has been done, it works well. The local municipalities decide if they use this measure.
3. Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population
4. & 5- Equity and ethical aspects	
Q1. What are the equity and ethical principles underpinning the practice?	If we understand correctly, then in our country Municipal Police does the surveillance over the transportation stops smoke-free zones use.
6. Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	People can wait their transport in a healthier environment. There are more complaints about smoking in the transportation stops. In this regard, the goal has been accomplished.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	The monitoring is based on complaints.
N1. Has the practice been formally evaluated?	Not yet, the intervention is still ongoing, but the evaluation is foreseen
N1 bis. If you answered "Yes" or "Not yet": Please specify the organizations that conducted the evaluation.	There are planned surveys in the general population and analysis of complaints.
7. Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8. Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9. Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	Group of population_Implementation Regional public health authorities_Development Regional public health authorities_Implementation Regional public health authorities_Evaluation Local public health authorities_Development Local public health authorities_Implementation Local public health authorities_Evaluation
10. Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Municipality/CityPublic agency
B5. Name of the entity(ies) in national language and English and acronym.	Munitsipaalpolitsei / Municipal police Politsei / Police
B6. Please specify also the responsibility of the entity(ies):	Surveillance, raising awareness, fining.
E2. How was the practice funded?	The funding was done by public procurement

Links and additional information
https://www.riigiteataja.ee/en/eli/516042021002/consolide
https://p-tln.geenius.ee/rubriik/uudis/bussipeatustes-ei-tohi-suitsetada-juba-praegugi-aga-nuud-joonistatakse-maha-ka-keelutsoonid/
https://untobaccocontrol.org/impldb/wp-content/uploads/reports/estonia_annex2_tobacco_green_paper.pdf
https://pealinn.ee/2021/06/10/video-ja-fotod-tallinn-margistab-suitsuvaba-alana-ligi-600-uhissoiduki-peatust/

Table 5.15: Spain_SF_beaches: Smoke free beaches

QUESTIONS	ANSWERS
1. Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products); Outdoor aerosol-free regulation for e-cigarettes; Outdoor aerosol-free regulation for heated tobacco products; avoid to polute the environment
E1. What is the geographical scope of the practice	All the beaches listed in the narrative report above
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Smoke-free beaches on top of being a public health measure, it's also an environmental measure since would also eliminate one of the most toxic contaminants of the ocean, as cigarette butts pollute up to 50 litres of water with nicotine and tar, taking 10 years to degrade, during which time it is 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 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.
F2. What is the overall goal of the practice?	The overall goal is to achieve healthier and cleaner beaches. Avoid passive exposure to tobacco smoke, educate new generations that "it is normal not to smoke", avoid environmental pollution of our beaches and seas and reduce the cost of cleaning beaches.
G1. Target settings.	Beaches (outdoor)
2. Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	All the Spanish coastal Autonomous Communities, with the exception of Catalonia, have implemented smoke-free beach programs. The municipalities of these communities choose whether to adhere to them or not. 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, communication is made through the media and the office of tourism (this varies from community to community). These are awareness programs, health promotion and environmental protection, because until the spring of 2022, except for one beach in the Canary Islands, in none of them has there been a municipal regulation that regulates fining for smoking on a smoke-free beach.
C2. Possible source of information where the practice is described	Baleares: https://www.caib.es/sites/tabaquisme/es/playas_sin_humo/, Canarias: https://www.laprovincia.es/las-palmas/2022/05/16/playas-gran-canaria-prohibe-fumar-66153757.html, Galicia: https://www.sergas.es/Saude-publica/Praias-sen-fume?idioma=es, Asturias: https://www.astursalud.es/noticias/-/noticias/la-consejeria-de-sanidad-pone-en-marcha-el-programa-playas-sin-humo-para-promover-una-vida-sin-tabaco-e-impulsar-el-respeto-a-las-personas-y-al-medio-, Cantabria: https://www.eldiario.es/cantabria/ultimas-noticias/cantabria-realidad-proyecto-playas-humo-prohibicion-fumar-covid-19_1_6178225.html País Vasco: https://www.euskadi.eus/playas-sin-humo/web01-a3tabaco/es/, Comunidad Valenciana: https://www.sp.san.gva.es/sscc/opciones4.jsp?Opcion=REDPLAYAS&Nivel=2&MenuSup=SANMS&perfil=inst&Idioma=es , Murcia: https://www.murciasalud.es/pagina.php?id=418715&idsec=1377 , Andalucía: https://www.juntadeandalucia.es/organismos/saludyfamilias/areas/salud-vida/adulta/paginas/playas-piscinas-sin-humo.html , Barcelona: https://www.barcelona.cat/es/que-hacer-en-bcn/banos-y-playas#:~:text=Playas%20sin%20humo%20Barcelona%20favorece%20la%20disponibilidad%20de,chiringuitos%20y%20el%20paseo.%20Barcelona%20playa%20a%20playa, https://www.barcelona.cat/es/noticia/todas-las-playas-seran-sin-humo-y-mas-accesibles_1163454

Did the design thoroughly describe the practice in terms of purpose, SMART objectives, methods (i.e., Recruitment, location of intervention, concrete activities, and timeframe (sequence, frequency, and duration))?	
B1. Title/Name of the practice.	Smoke-free beaches
B2. Type of practice. Please select all that apply for this practice.	**15-ES-SF Beaches** **Type of practice** 1 Information/awareness raising programme 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know
B3. Which is the current phase of the best practice?	The practice has been evaluated
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	
J1. What methods are/ were used in the practice?	Communication to the general public through press releases to the media; fences, flags, panels and posters signalling the beaches; distribution of brochures, badges and stickers; promotion on websites of town halls, tourist offices. Implementation, in some cases, through beach police who inform offenders. In most cases, the implementation is achieved thanks to citizen support for the measure and its empowerment. Evaluation through surveys to beach goers. Murcia: https://www.murciasalud.es/pagina.php?id=419489&idsec=1377, Baleares: https://www.caib.es/sites/tabaquisme/es/playas_sin_humo/, Galicia: https://www.sergas.es/Saude-publica/Praias-sen-fume?idioma=es, Andalucía: https://www.juntadeandalucia.es/organismos/saludyfamilias/areas/salud-vida/adulta/paginas/playas-piscinas-sin-humo.html.
J1 bis. If relevant, please upload possible documentation.	
K1. Enforcement of the practice.	The practice has not been enforced in the sense that there haven't been fines for non-compliance anyhow it has worked to a great extent. City halls, and I would say also beach goers, were in charge of the supervision and controlling of its compliance.
3. Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population
4. & 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	don't know
6. Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Less people smoking and less cigarette butts on smoke-free beaches. Bigger awareness about the environmental problem causes by tobacco butts

M1. What indicators are used in the monitoring of the process and outcome of the practice?	It varies from one municipality to another. Not all municipalities.
N1. Has the practice been formally evaluated?	Yes, the evaluation was carried out internally
N1 bis. If you answered "Yes" or "Not yet": Please specify the organizations that conducted the evaluation.	Only Murcia regional Government and Barcelona local government have done/published their evaluation which were carried out through a survey among beach goers. Murcia 2019: https://www.murciasalud.es/recursos/ficheros/465617-Evaluacion_atisfaccion_Playas_sin_humo_2019.ok.pdf,
7. Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e., scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
Is there an analysis of requirements for eventual scaling up such as foreseen barriers and facilitators, available? (i.e. resources, organisational commitment, ...)	
	Just to political will or lack of it. And maybe the lack of policial resources to enforce the compliance and fine for non-compliance.
8. Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
	The practice provides training of staff in order to sustain it
9. Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Groups of the target population - Development ; Groups of the target population - Implementation ; National public health authorities - Development ; Regional public health authorities - Development - Implementation- Evaluation; Local public health authorities - Development-implementation-evaluation; Researchers-development; Civil society organisations- Development-evaluation; Stakeholders from other than the health sector-Development;
	The first smoke-free beaches programs in Spain (20006-2018) where developed and implemented by local and regional programs. In 2018 the NGO Nofumadores.org launched the change.org campaign Smoke-free beaches in Spanish and English. Up to the date (May 2022) more that 332500 signatures have been collected. The NGO has been pushing at a national level for the development of a national law which ban 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 Health Ministry, who has agreed, through the Public Health Commission of the Interterritorial Council, to support good practice initiatives such as "smoke-free beaches". The signatories have also been sent to the Ministry of Ecological Transition and 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, that was kept in the law passed on April 2022, which allows the City Councils to regulate smoking on the beaches, which may be sanctioned in the Municipal Ordinances up to 2,000 euros. From 2018 till now all the regional governments in the Spanish coastlines have developed smoke-free beaches campaigns. Within each region (Comunidad Autónoma) 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. In summer 2022 Barcelona and the Canary Island will use the waste law to fine for smoking in their beaches. Regarding the implementation it has been the general public (beach goers), which have been empowered by the declaration of those beaches as smoke-free environments), have been key in the success of the implementation of the measure.
10. Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	External resources – public

B4. Who has the responsibility of the practice?	Municipality/City; Province/Region
B5. Name of the entity(ies) in national language and English and acronym.	Several regions (Canary Islands, Balear Islands, Galicia, Asturias, Cantabria, Pais Vasco, Comunidad Valenciana, Murcia and Andalucía) and cities of Spain coastline (Barcelona, in Catalonia, which is the only autonomous community which doesn't have a smoke free beaches program. In other autonomous communities are the municipalities who decides if joining the smoke. Free beaches program or not. Some municipalities chose only to picj a bunch of their beaches as smoke-free and other ones decides to pick them all, and some other ones decide only to pick part of some beaches as smoke-free, for example the areas dedicated to sports or playgrounds).
B6. Please specify also the responsibility of the entity(ies):	Municipality. So far, the programs were voluntary and there were no fines for non-compliance. Since the pass of the new waste law in April 2022 some municipalities as Las Palmas de Gran Canaria, Tenerife (Canary Islands) and Barcelona (Catalonia) have announced they'll fine for smoking on beaches next summer of 2022.

Links and additional information

Communication to the general public through press releases to the media; fences, flags, panels and posters signaling the beaches; distribution of brochures, badges and stickers; promotion on websites of town halls, tourist offices. Implementation, in some cases, through beach police who inform offenders. In most cases, the implementation is achieved thanks to citizen support for the measure and its empowerment. Evaluation through surveys to beach goers.
Murcia: https://www.murciasalud.es/pagina.php?id=419489&idsec=1377,
Baleares: https://www.caib.es/sites/tabaquisme/es/playas_sin_humo/,
Galicia: https://www.sergas.es/Saude-publica/Praias-sen-fume?idioma=es,
Andalucía: https://www.juntadeandalucia.es/organismos/saludyfamilias/areas/salud-vida/adulta/paginas/playas-piscinas-sin-humo.html.

Table 5.16: Finland_SF_city: Tobacco-free municipality concept

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Smoke-free outdoor settings (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for e-cigarettes Indoor aerosol-free regulation for heated tobacco products Outdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	Municipalities in Finland
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	- Promote municipalities and workplaces to become tobacco-free - Context: Health in all policies,
F2. What is the overall goal of the practice?	to help municipalities as well as both public and private employers to make official decisions to become tobacco-free
G1. Target settings.	Workplace (indoor) municipalities, public and private employers
2- Intervention characteristics, description of the practice	

<table>
<tr><td>C1. Please summarize this best practice.</td><td>The nation-wide tobacco-free municipalities project (2012-2018) in Finland aimed to help municipalities as well as both public and private employers to make decisions to become tobacco-free AND to assist in the implementation of the decision. There is a set of national criteria for a tobacco-free workplace. The minimum criteria is for the work-time to be tobacco-free. In 2021 99% of municipalities in Finland had made an official decision to become tobacco-free. The decision is the most important first step. All national criteria do not have to be implemented immediately. It is important that there is a clear timetable for introducing the tobacco-free concept and that there is enough time for all parties involved to discuss reasons for the decision and practical implications. Both management and employees as well as occupational health care needs to be involved in the whole 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.</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>www.savutonkunta.fi</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Tobacco-free municipality concept</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>16-FI-SF City</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>01/01/2012</td></tr>
</table>

J1. What methods are/were used in the practice?	Criteria for tobacco-free workplaces include: • The municipality is a tobacco-free workplace- Smoking is not allowed during working hours • Written instructions have been issued to work units about the non-smoking policy • Smoking is prohibited in indoor and outdoor premises owned and operated by the municipality • Indoor and outdoor premises are clearly marked by, for example signs, decals or posters • All smoking areas have been located outdoors in such a way that tobacco smoke does not drift inside premises • No new smoking areas will be built • Smoking areas have been removed from premises and areas dedicated for children and young people • Tobacco products are not sold in premises operated by the municipality • Municipal promotional and other events are non-smoking • Non-smoking policy is mentioned in municipal job adverts • The municipality develops tobacco-free council housing • Employees who smoke are offered support to quit • Support to be made available during working hours • The occupational health care plan covers support for smoking cessation • A comprehensive TDT model exists as basis for cessation work All national criteria do not have to be implemented immediately. It is important that there is a clear timetable for introducing the tobacco-free concept and that there is enough time for all parties involved to discuss reasons for the decision and practical implications. Both management and employees as well as occupational health care needs to be involved in the whole 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.
K1. Enforcement of the practice.	Municipalities are responsible about implementation and enforcement at local level
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	All people in the municipalities in Finland
4-Ethical aspects	
What are the equity and ethical principles underpinning the practice?	No information about this.
5-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	In 2021, 99% of municipalities in Finland had made an official decision to become tobacco-free.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Are the following criteria met: - municipality had made the official decision to become tobacco-free • The municipality is a tobacco-free workplace- Smoking is not allowed during working hours • Written instructions have been issued to work units about the non-smoking policy • Smoking is prohibited in indoor and outdoor premises owned and operated by the municipality • Indoor and outdoor premises are clearly marked by, for example signs, decals or posters • All smoking areas have been located outdoors in such a way that tobacco smoke does not drift inside premises • No new smoking areas will be built • Smoking areas have been removed from premises and areas dedicated for children and young people • Tobacco products are not sold in premises operated by the municipality • Municipal promotional and other events are non-smoking • Non-smoking policy is mentioned in municipal job adverts • The municipality develops tobacco-free council housing • Employees who smoke are offered support to quit • Support to be made available during working hours • The occupational health care plan covers support for smoking cessation • A comprehensive TDT model exists as basis for cessation work
N1. Has the practice been formally evaluated?	Yes, the evaluation was carried out internally
N1 bis. If you answered "Yes" or "Not yet"	The municipalities and workplaces have carried out self-assessment if the criteria were met. In addition, many municipalities have made process evaluation and also have monitor tobacco use etc.
6-Equity	

Q1. What are the equity and ethical principles underpinning the practice?	No information about this.
7-Transferability, potential of scalability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources. The practice provides training of staff in order to sustain it.
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_DevelopmentGroup of population_ImplementationGroup of population_ EvaluationLocal public health authorities_DevelopmentLocal public health authorities_ ImplementationLocal public health authorities_EvaluationEmployers/employees_ DevelopmentEmployers/employees_ImplementationEmployers/employees_Evaluation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	External resources – public
B4. Who has the responsibility of the practice?	Municipality/City
B5. Name of the entity(ies) in national language and English and acronym.	Finnish Heart Association/The Savo regional Heart Association Suomen Sydänliitto/Savon sydänpiiri www.savutonkunta.fi
B6. Please specify also the responsibility of the entity(ies).	The project was coordinated by the Savo regional Heart Association.

Links and additional information
www.savutonkunta.fi

Table 5.17: France_SF_health care: Lieux De Santé Sans Tabac (Smoke-free healthcare Facilities)

QUESTIONS	ANSWERS
1. Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Smoke-free outdoor settings (conventional tobacco products) Indoor aerosol-free regulation for heated tobacco products Outdoor aerosol-free regulation for heated tobacco products Promotion of Tobacco cessation

F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Since the decree of November 15, 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), a low sense of self-efficacy of health professionals in preventing smoking. All of these data suggest 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, 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 his 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.
F2. What is the overall goal of the practice?	- Animate the network of regional actors involved in 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 - Support the implementation of the LSST strategy: development of progress indicators and establishments' compliance with the LSST charter
G1. Target settings.	Hospitals including outpatient clinics (indoor)Primary health care institutions (indoor) Institutions from social sector (indoor)Outdoor areas of hospitals and healthcare institutions (outdoor)
2. Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	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. Strategy includes assessing of practices at the Healthcare facilities; evaluate the number of smokers, examine the consumption practices of practitioners and patients smokers , have a cessation protocol as soon as the patient is admitted and a protocol for relay by general practician as soon the patients quit the hospital, extend the ban on smoking in outdoor places, periodically review assessment to measure improvements, communicate in a targeted manner with staff, patients and caregivers.
C2. Possible source of information where the practice is described	https://www.respadd.org/le-respadd/lieu-de-sante-sans-tabac/
B1. Title/Name of the practice.	Lieux De Santé Sans Tabac (Smoke-free healthcare Facilities)

<table>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>17-FR-SF Health care</th></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice is at the first stage of implementation but not yet totally developed</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>30/11/2018</td></tr>
<tr><td>J1. What methods are/ were used in the practice?</td><td>Tobacco-free Healthcare guide, booklet Taking care of smokers in healthcare facilities, Tobacco-free hospital charter, stickers, First steps in smoking cessation booklet, signage, tobacco-free environment poster. - Publication of the Smoking & Mental Health Guide The purpose of this 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. - Smoking women guide: The main objective of this guide is to reduce smoking-related morbidity and mortality in women. More specifically, the specific objectives are: - Disseminate good practices for the prevention and management of smoking in women; - Strengthen the knowledge of professionals on the impact of smoking on women at different ages; - Improve the identification and management of female smokers; - 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. - Promote the exchange of good practices by organizing regional conferences. In 2020 The RESPADD organised, in coordination with the ARS and the regional support missions, two regional LSST conferences on February 4 in Marseille (PACA) and on February 13 in Nantes (Pays de la Loire). In 2021, 4 webinars were organized: April 1 in Normandy, April 16 in Reunion Island, May 31 in Ile-de-France, June 1 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. Tools: https://www.respadd.org/hopital-sans-tabac-lieu-de-sante-sans-tabac/publications-et-outils/</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>Evaluation ongoing</td></tr>
<tr><td colspan="2">3. Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population
Vulnerable groups (Disability)
Vulnerable groups (Diseases)
Vulnerable groups (Pregnant women)</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">4. & 5- Equity & ethical aspects</td></tr>
</table>

Q1. What are the equity and ethical principles underpinning the practice?	no information on this question
6. Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Evaluation ongoing
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Number of assessments; Number of healthcare facilities participating Number of gold/ silver/ bronze certifications/ number of establishments by activity (priority Objectives: maternity wards and cancer treatment centres)
N1. Has the practice been formally evaluated?	Yes, by an external partner
N1 bis. If you answered "Yes" or "Not yet":	private audit firm
7. Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8. Sustainability	
P1. Sustainability.	The practice provides training of staff in order to sustain it. A sustainability strategy has been developed
9. Participation, empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Evaluation International/European public health authorities_Implementation National public health_Development National public health_Implementation National public health authorities_Evaluation Regional public health authorities_Development Regional public health authorities_Implementation Regional public health authorities_Evaluation Hospital_staff_Development Hospital_staff_Implementation Hospital_staff_Evaluation Primary care centre staff_Development Primary care centre staff_Implementation Primary care centre staff_Evaluation General practitioners_Implementation Pharmacists_Implementation Nurses_Implementation Civil_Organizations_Development Civil_Organizations_Implementation Civil_Organizations_Evaluation
10. Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Province/Region NGO
B5. Name of the entity(ies) in national language and English and acronym.	Respadd- réseau de prévention des addictions ARS - Agences régionales de santé
B6. Please specify also the responsibility of the entity(ies):	Respadd: In charge to deploy national strategy, encourage alliances, develop and distribute the national strategy tools ARS: financing the programme for participating Healthcare facility
E2. How was the practice funded?	Own resources, External resources – public

Links and additional information
https://www.respadd.org/le-respadd/lieu-de-sante-sans-tabac/
https://www.respadd.org/hopital-sans-tabac-lieu-de-sante-sans-tabac/publications-et-outils/
https://www.respadd.org/blog/2020/03/23/audit-lieu-de-sante-sans-tabac-cartographie-des-reponses-2019/

Table 5.18: France_SF_city: Ville libre sans tabac / Tobacco-free cities

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Smoke-free outdoor settings (conventional tobacco products) Car smoking ban with minors or pregnant women (conventional tobacco products) Outdoor aerosol-free regulation for heated tobacco products Other provisions regarding prevention of initiation, cessation
E1. What is the geographical scope of the practice?	Local scale project involving cities of different sizes
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	According to the Bulletin de Santé Publique Grand Est published by Santé Publique France in January 2019: - In 2017, the Grand Est region had 1.2 million daily smokers aged 18 to 75 years. With the same age structure, the Grand Est region ranked 4th among the regions where smoking was most common (30.1% of daily smokers in the region) after Provence-Alpes-Côte d'Azur (32.2%), Hauts-de-France (30.5%) and Occitanie (30.3%). - Three quarters of daily smokers in the Grand Est smoke more than 10 cigarettes a day, more than the national average (66.8%), and almost a quarter (23.1%) were highly dependent on tobacco, compared to 18.4% for the national average. - Just over one in two daily smokers (55.3%) wanted to stop smoking and one in four (25.1%) had made an attempt to quit for at least one week in the past year. - As a result of past tobacco consumption, death rates caused by tobacco are higher in the Grand Est than on average in France. The measures to be implemented to reduce tobacco use were clearly identified and described in 2005 by the WHO Framework Convention on Tobacco Control (FCTC), the first public health treaty with provisions that are based on scientific evidence and that evolve over time. . The measures prescribed in the FCTC are all the more effective if they are implemented simultaneously. Among these measures the development of tobacco free places plays a key part. The National Tobacco Reduction Programme (PNRT) of 2014 and then the National Tobacco Control Programme (PNLT) of 2018 to 2022, which are directly in line with the effective implementation of the FCTC, recommend a set of measures with proven scientific effectiveness and based on the best practices of the various countries. The coordination dimension between the different actors involved in the tobacco issue, as well as the appropriation by all these actors, whatever the level concerned (national, local, proximity...), are essential. The Grand Est Regional Tobacco Control Programme (PRLT) is in line with the objectives of the Regional Health Programme, which aims to reduce tobacco consumption by 20% between 2016 and 2022, and thus to reduce the current prevalence of 34% of regular smokers to less than 25%. Tobacco-free city program is defined in reference and coordination to these "upper" programmes with specific additional measures appropriate at a local level.
F2. What is the overall goal of the practice?	To develop a community-based approach to tobacco control at the level of a city with a view to improving health and quality of life. To take action to ensure local ownership of the tobacco control package and in particular the development of smoke-free places and to contribute to achieving the goal of a tobacco-free generation by 2032.
G1. Target settings.	All the population in the cities where the programme is developed
2- Intervention characteristics, description of the practice	

C1. Please summarize this best practice.	This programme is composed of essential measures common to all the cities involved in the scheme, as well as additional measures specific to each city and its territory. In order to set an example and improve the quality of life and well-being at work, the introduction of a tobacco-free town hall is the first measure to be implemented. All the proposed measures are structured along 4 main lines: 1. informing and raising awareness about the particularities of smoking, its consequences and the benefits of a life without tobacco 2. promoting and ensuring compliance with the regulations in force 3. establish new smoke-free outdoor spaces and promote smoke-free private spaces private smoke-free spaces 4. promote smoking cessation These measures apply equally to all tobacco and nicotine products, including smoked tobacco, electronic cigarettes and smoked tobacco, electronic cigarettes and heated tobacco products. Two principles characterise a tobacco-free city: 1. In complete independence from the tobacco industry, the local tobacco control programme is a co-construction resulting from a partnership between the city's elected representatives, local health authorities and civil society, 2. All measures are based on scientific evidence
C2. Possible source of information where the practice is described.	https://cnct.fr/ville-libre-sans-tabac/ https://cnct.fr/wp-content/uploads/2021/10/PLLT-v-NET-21.09.22.pdf
B1. Title/Name of the practice.	Ville libre sans tabac / Tobacco-free cities
B2. Type of practice. Please select all that apply for this practice.	**18-FR-SF City** **Type of practice** 1 Information/awareness raising programm 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know
B3. Which is the current phase of the best practice?	The practice has been developed/adopted but not yet enforced
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	15/04/2019
J1. What methods are/were used in the practice?	See previous comment regarding evaluation
K1. Enforcement of the practice.	The programme is currently implemented but the process is ongoing and not achieved yet
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population Socioeconomic position (including educational level) Vulnerable groups (Pregnant women)
4- & 5- Equity and ethical aspects	

What are the equity and ethical principles underpinning the practice?	Strict enforcement of FCTC article 5.3 regarding independence of the programme towards the tobacco industry, tobacco retailers.
6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Too early to answer precisely but the program already shows the involvement of mayors and the interest of other local authorities
M1. What indicators are used in the monitoring of the process and outcome of the practice?	See previous comment: the process for evaluation is currently carried out by researchers but not yet available
N1. Has the practice been formally evaluated?	Not yet, the intervention is still ongoing, but the evaluation is foreseen
N1 bis. If you answered "Yes" or "Not yet":Please specify the organizations that conducted the evaluation.	Not possible to answer at the current time
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	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. However, the practice has not been transferred yet.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	General population in the different cities with a specific attention for vulnerable populations. Group of population_Development Group of population_Implementation National public health_Development Regional public health authorities_Development Regional public health authorities_Implementation Local public health authorities_Development Local public health authorities_Implementation Hospital_staff_Implementation Primary care centre staff_Implementation Specialized physicians_Implementation General practitioners_Implementation Pharmacists_Implementation Nurses_Implementation Other health care prof_Implementation Informal caregivers_Implementation Researchers /academics_Implementation School staff_Implementation Employers/employees_Implementation Civil_Organizations_Development Civil_Organizations_Implementation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	External resources – public
B4. Who has the responsibility of the practice?	Municipality/City
B5. Name of the entity(ies) in national language and English and acronym.	Grand Est Sans Tabac and Comité National Contre le Tabagisme + Municipality/City Agglomeration community

B6. Please specify also the responsibility of the entity(ies):	The Tobacco Free City programme is in its experimental phase. It is implemented by the cities that assume responsibility for it and it is supported and implemented with two civil society organisations: Grand Est Sans Tabac and the Comité National Contre le Tabagisme with the financial support of the ARS, Agence régionale de santé du Grand Est.

Links and additional information
https://cnct.fr/ville-libre-sans-tabac
https://cnct.fr/wp-content/uploads/2021/10/PLLT-v-NET-21.09.22.pdf

Table 5.19: Hungary_SF_nation: Tobacco control in practice- Article 8: Protection from exposure to tobacco smoke - the story of Hungary

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Indoor aerosol-free regulation for all tobacco products, electronic nicotine and non-nicotine delivery systems and herbal products used for smoking Outdoor aerosol-free regulation for all tobacco products, electronic nicotine and non-nicotine delivery systems and herbal products used for smoking
Was the intervention aligned with a policy plan at the local, national, institutional or at international level?	
E1. What is the geographical scope of the practice?	Hungary Municipal governments
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Commissioned by the National Institute for Health Development and under its professional supervision, the Median Opinion and Market-research Ltd. prepared a study on the opinion about the planned toughening up of the Act involving the most affected target groups such as hospitality industry, health care and school education (9). The aim of the research was the exploration of smoking behaviour of the respondents and their environment, and the effects and attitude regarding the planned modifications. Data collection was realized in April 2009. According to the results, more than half of the employees smoked in hospitality venues and one fourth of the employees smoked in the health care and school education institutions. Most of the smokers reported that they mostly smoke in places designated for smoking in their workplace and they know where these designated places are. One fourth of the guests in hospitality venues claimed that someone always smokes around them. The highest rate of persons exposed to tobacco smoke during the whole workday was in hospitality venues (38%). One tenth of employees in health care and school education sectors never work in smoking environment. For non-smoker employees this rate was higher. Employees tolerated less if someone smokes around them in their workplace than guests and patients. Smoking disturbed more than half of them. They would have strengthened smoking prohibition mostly in the health care sector. Smoking ban (beside the one plus day off for non-smokers) in enclosed places in hospitality venues was less supported. However (beside the plus day off) the majority absolutely supported all the elements of the stricter law. Most of the smokers thought that their smoking behaviour would not have changed because of the stricter smoking restrictions. 3-7 % of them reported that they would have quitted owing to the new Act. One third - one fifth of them suggested that they would have smoked less after the enforcement of the modification.
F2. What is the overall goal of the practice?	The overall goal of the practice is the protection of non-smokers. Hungary, there were major improvements in the field of tobacco control in the last couple of years. The Parliament adopted the toughening up of the Act on the protection of non-smokers on 26.04.2011. With this modification, Hungary entered into the group of countries having total smoking ban in all enclosed public places. With this strict law Hungary comes up to the health political, professional expectations of the EU and WHO and substantially decreases the smoking related public health and economic burden as well.

<table>
<tr><td>G1. Target settings.</td><td>Restaurants and bars (indoor)
Hotels (indoor)
Train stations and public transports (indoor and in outdoor waiting areas)
Underpasses open to pedestrian traffic (outdoor)
Airports (indoor)
Schools/ public-education institutions/ educational venues except universities (indoor and outdoor)
Paygrounds (outdoor)
Universities (indoor)
Cinemas/theatres (indoor)
Hospitals including outpatient clinics (indoor)
Primary health care institutions (indoor)
Institutions from social sector (indoor)
Premises of public institutions open to the public (indoor)
Workplaces (Indoor)</td></tr>
<tr><td colspan="2">2- Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>Hungary has been party to the WHO Framework Convention on Tobacco Control since 2005. In recent years, the Government of Hungary has adopted and implemented a series of strong tobacco-control measures. The most important of these are the smoking ban in indoor public places and some outdoor public places, the significant tax increase on cigarettes, the introduction of combined warnings (text and pictures) on cigarette packages and from 2022 the plain package, and the drastic reduction in the number of stores selling tobacco products. This case study focuses on the most important of these measures, namely, the smoking ban, which has resulted in decreases in the rates of smokers among the population and the rate of cigarette smoking; in addition, it has had a positive impact on employment in the hospitality industry and hospitality venues, and on the incomes of the hospitality industry and accommodation services.</td></tr>
<tr><td>C2. Possible source of information where the practice is described.</td><td>https://www.euro.who.int/__data/assets/pdf_file/0020/263333/Tobacco-control-in-practice-Article-8-Protection-from-exposure-to-tobacco-smoke-the-story-of-Hungary.pdf</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Tobacco control in practice- Article 8: Protection from exposure to tobacco smoke - the story of Hungary</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><td></td><td>4-HU-SF-National</td></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been evaluated</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>01/01/2012</td></tr>
</table>

J1. What methods are/ were used in the practice?	Our website in English: https://fokuszpont.dohanyzasvisszaszoritasa.hu/en/node/20 Short overview of measures and studies relating to the 2012 amendments of the Act on the Protection of Non-Smokers in Hungary, and recommendation about the impact assessment of the Act (made on 18th February 2013): https://fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/overview_measures_studies_relating_act_protection_of_non_smokers_recommendation_impact_assessment_HUNGARY_26022013.pdf Tobacco control in practice. Case studies on implementation of the WHO Framework Convention on Tobacco Control in the WHO European Region (Article 8: Protection from exposure to tobacco smoke: the story of Hungary): https://www.euro.who.int/__data/assets/pdf_file/0020/263333/Tobacco-control-in-practice-Article-8-Protection-from-exposure-to-tobacco-smoke-the-story-of-Hungary.pdf The following studies are only available in Hungarian: https://fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/nvt_szigoritas_hatasa_a_vendeglatoiparra_oefi_df_2009.pdf https://fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/Indoor_air_quality_in_hospitality_venues_before_and_after_%20prohibition_%20of_%20smoking_2012.pdf
K1. Enforcement of the practice.	https://fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/overview_measures_studies_relating_act_protection_of_non_smokers_recommendation_impact_assessment_HUNGARY_26022013.pdf Persons acting within the scope of duties of the public institution as well as persons professionally involved in the operation of means of public transport (hereinafter jointly referred to as „authorized persons") are obliged to request anyone violating the smoking restriction and the restriction on the use of electronic cigarette and electronic device imitating smoking to immediately cease such infringement. State health care administration organisation shall monitor compliance with the provisions of smoking prohibition, and in case of any infringement, shall impose a healthcare penalty upon the infringer natural or legal person. The professional management of the state health care administration authorities is performed by the NNK
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population
4-Ethical aspects	
What are the equity and ethical principles underpinning the practice?	The unfavourable general health indicators of the Hungarian population, to provide protection to non-smokers and persons who, due their age or state of health, require increased protection against the harmful effects of passive smoking through the regulation of the consumption of tobacco products primarily in public places, smoking should be avoided, in due respect of the right to privacy, in the presence of minors, pregnant women, sick people or persons whose mobility is limited for any reason, even in areas of private life, especially in enclosed areas or inside of cars, promoting the implementation and protection of the constitutional rights related to good health and a healthy environment.
5-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Smoking ban and health at birth: Evidence from Hungary as the following article says, the smoking ban in 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 foetal health endowment distribution benefit more. https://www.sciencedirect.com/science/article/pii/S1570677X18300194
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Number of monitoring of the smoking restrictions Number of the violation of smoking restrictions Number of the certain places where violation was mainly detected Number of the health care penalties Number of exposures to passive smoking Data on smoking prevalence
N1. Has the practice been formally evaluated?	Yes, by an external partner
N1 bis. If you answered "Yes" or "Not yet"	- Adult Tobacco Survey (2012, 2013, 2019) (conducted by national research institutes and the National Korányi Institute of Pulmonology) - Global Youth Tobacco Survey (2008-2020) (conducted by national research institutes and the National Korányi Institute of Pulmonology)
6-Equity	

Q1. What are the equity and ethical principles underpinning the practice?	The unfavourable general health indicators of the Hungarian population, to provide protection to non-smokers and persons who, due their age or state of health, require increased protection against the harmful effects of passive smoking through the regulation of the consumption of tobacco products primarily in public places, smoking should be avoided, in due respect of the right to privacy, in the presence of minors, pregnant women, sick people or persons whose mobility is limited for any reason, even in areas of private life, especially in enclosed areas or inside of cars, promoting the implementation and protection of the constitutional rights related to good health and a healthy environment.
7- Transferability, potential of scalability	
O1. Level of transferability and/or scalability.	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. However, the practice has not been transferred yet.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9- Empowerment, participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Development Group of population_Implementation Group of population_Evaluation International/European public health authorities_Development National public health_Development National public health_Implementation National public health authorities_Evaluation National public health_Implementation Regional public health authorities_Development Regional public health authorities_Implementation Regional public health authorities_Evaluation Local public health authorities_Development Local public health authorities_Evaluation Specialized physicians_Evaluation Researchers /academics_Development Researchers /academics_Evaluation Employers/employees_Implementation Civil_Organizations_Development Civil_Organizations_Evaluation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	Own resources
B4. Who has the responsibility of the practice?	Government
B5. Name of the entity(ies) in national language and English and acronym.	Ministry of Human Capacities, Focal Point for Tobacco Control; National Public Health Center State health care administration organisation

B6. Please specify also the responsibility of the entity(ies):	RESPONSIBILITIES OF THE FOCAL POINT FOR TOBACCO CONTROL Performing comprehensive monitoring and evaluation tasks. Supervising the collection of social, economic and health indicators related to tobacco consumption; conducting research, fulfilling organising duties and coordination. Performing activities of strategic planning and negotiation regarding tobacco control in many sectors. Implementing smoking prevention activities targeting youth and working out prevention programmes, collecting best practices, preparing cadastres and advising programmes for education institutions. Developing methodologies of national dissemination and participating in the implementation of these. Implementing pilot programmes and assessment of the effectiveness of these. Implementing national and international programmes, cooperation with foreign, national, regional and local partners active in the field of tobacco control, using international experiences in the design of national programmes. Following up the activities of civil organisations, cooperation and joint programme design with them. Creating and maintaining a database of laws, provisions and of instructions for their use. Participating in the preparation, implementation and evaluation process regarding the WHO Framework Convention on Tobacco Control and in the national implementation of it. Responsibilities of the National Public Health Center: -The professional management of the state health care administration authorities is performed by the NNK. -The use of any novel additive in the manufacture of tobacco products shall be reported to NNK. Upon receipt of the report, the NNK shall examine the additive planned to be used and make a statement that the reported additive may be used or prohibit further use of the additive. -Manufacturers shall submit a notification to the NNK every novel tobacco product they intend to place on market. Based on data the information submitted, the NNK shall consider whether or not the product in question should be prohibited. State health care administration organisation shall monitor compliance with the provisions of smoking prohibition, and in case of any infringement, shall impose a healthcare penalty upon the infringer natural or legal person.

Links and additional information

Tobacco control in practice. Case studies on implementation of the WHO Framework Convention on Tobacco Control in the WHO European Region (Article 8: Protection from exposure to tobacco smoke: the story of Hungary): https://www.euro.who.int/__data/assets/pdf_file/0020/263333/Tobacco-control-in-practice-Article-8-Protection-from-exposure-to-tobacco-smoke-the-story-of-Hungary.pdf

https://fokuszpont.dohanyzasvisszaszoritasa.hu/en/node/20

Short overview of measures and studies relating to the 2012 amendments of the Act on the Protection of Non-Smokers in Hungary, and recommendation about the impact assessment of the Act (made on 18th February 2013): https://fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/overview_measures_studies_relating_act_protection_of_non_smokers_recommendation_impact_assessment_HUNGARY_26022013.pdf

The following studies are only available in Hungarian:

https://fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/nvt_szigoritas_hatasa_a_vendeglatoiparra_oefi_df_2009.pdf https://fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/Indoor_air_quality_in_hospitality_venues_before_and_after_%20prohibition_%20of_%20smoking_2012.pdf

https://www.sciencedirect.com/science/article/pii/S1570677X18300194

Table 5.20: Ireland_SF_health care: Health Service 'National Policy on Tobacco Free Health Services'

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Smoke-free outdoor settings (conventional tobacco products) Car smoking ban also without minors or pregnant women (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for e-cigarettes Car vaping ban also without minors or pregnant women Indoor aerosol-free regulation for heated tobacco products Outdoor aerosol-free regulation for heated tobacco products Car heated tobacco product ban also without minors or pregnant women
E1. What is the geographical scope 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

F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	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. The policy has two clear aims: To treat tobacco as a healthcare issue. To de-normalise tobacco use in all healthcare services and settings.
F2. What is the overall goal of the practice?	The Health Service Executive (HSE), as the leading healthcare provider is committed to reducing the use of tobacco and its harmful health effects. The HSE 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 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 Section 38 campus grounds, bicycle sheds and bus shelters.
G1. Target settings.	Hospitals including outpatient clinics (indoor) Primary health care institutions (indoor) Cars Outdoor areas of hospitals and healthcare institutions (outdoor) Smoking is prohibited in cars parked on all Health service grounds.
2-Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	The intervention 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.
C2. Possible source of information where the practice is described	Please see this link for access to the policies - toolkits, webinars etc that have been implemented. https://www.hse.ie/eng/about/who/tobaccocontrol/campus/ 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. See https://www.tobaccofreehealthcare.org/ https://www.hse.ie/eng/about/who/tobaccocontrol/campus/tobacco-free-campus-toolkit-guidance-document-oct-16.pdf
B1. Title/Name of the practice.	Health Service 'National Policy on Tobacco Free Health Services'. This is required to be adopted by all publicly funded health services in Ireland and supported by national tool kits, incentivized quality improvement bursaries and local Health Promotion staff with a brief for tobacco free policy support.

<table>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>20-IE-SF Health care</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been evaluated</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>01/04/2012</td></tr>
<tr><td>J1. What methods are/ were used in the practice?</td><td>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). A literature review was conducted, and a draft policy completed which was shared across the organisation inviting feedback. 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. 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. The tobacco free Ireland programme set about conducting 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 into a more generic training called ‘making every contact count’. There was national service plan KPIs for policy implementation and brief intervention training which services were accountable for, and this supported implementation. Some historic resources are included here. https://www.hse.ie/eng/about/who/tobaccocontrol/news/briefreport.pdf https://www.hse.ie/eng/about/who/tobaccocontrol/intervention/biscslides.pdf https://www.hse.ie/eng/about/who/tobaccocontrol/campus/</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>Senior managers within their own respective sites are responsible for implementation and compliance on each of their respective sites. Some individual sites completed local evaluations and surveys and or commissioned more formal audits of policy implementation. 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.</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population
Vulnerable groups (Disability)
Vulnerable groups (Diseases)
Vulnerable groups (Pregnant women)
Urban setting
Rural settings</td></tr>
</table>

4- & 5- Equity & ethical aspects	
What are the equity and ethical principles underpinning the practice?	Any data captured with regard to implementation considers 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. I am not aware of any other ethical training etc. for staff.
6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	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. 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.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Policy implementation is/was measured through quarterly Key performance indicator 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 which have a legal requirement for a response. Participation in the GNTH network 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. See description of same in this resource. https://www.google.com/search?q=tobacco+free+campus+bursary&rlz=1C1GCEA_enIE932IE932&oq=tobacco+free+campus+bursary&aqs=chrome..69i57j33i160l2.6631j0j15&sourceid=chrome&ie=UTF-8 https://www.hse.ie/eng/about/who/tobaccocontrol/news/tobacco-programme-past-conferences-and-events.html https://www.hse.ie/eng/about/who/tobaccocontrol/campus/tobacco%20free%20campus%20abstracts%202019.pdf
N1. Has the practice been formally evaluated?	Yes, the evaluation was carried out internally
N1 bis. If you answered “Yes” or “Not yet”:Please specify the organizations that conducted the evaluation.	Individual sites sometimes commissioned their own audits. I am only able to upload one document below so can’t attach another example unfortunately. All sites were encouraged to complete the annual GNTH audits of policy implementation and this action was built into annual service plan actions. These audits were not published in a journal but on the HSE website. No economic evaluation of the policy was completed however there was an assessment of the cost effectiveness of the treatment of tobacco dependence as part of the development of clinical guidelines and by the health information and quality authority as part of its health technology assessment. https://www.hiqa.ie/reports-and-publications/health-technology-assessment/hta-smoking-cessation-interventions
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	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. However, the practice has not been transferred yet.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources. The practice provides training of staff in order to sustain it
9-Empowerment and participation	

H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Development Group of population_Implementation Group of population_Evaluation National public health_Development National public health_Implementation National public health authorities_Evaluation Regional public health authorities_Development Regional public health authorities_Implementation Local public health authorities_Development Local public health authorities_Implementation Hospital_staff_Development Hospital_staff_Implementation Hospital_staff_Evaluation Primary care centre staff_Development Primary care centre staff_Implementation Primary care centre staff_Evaluation Specialized physicians_Implementation Nurses_Development Nurses_Implementation Nurses_Evaluation Other health care prof_Development Other health care prof_Implementation Other health care prof_Evaluation Researchers /academics_Evaluation Other_Org_Evaluation
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Public agency
B5. Name of the entity(ies) in national language and English and acronym.	All Senior level Health Service managers are responsible for implementing the HSE Tobacco Free Campus (TFC) Policy in their own respective services. The national tobacco free Ireland programme is responsible for promoting and driving quality improvement in its implementation.
B6. Please specify also the responsibility of the entity(ies):	Individual health service managers responsible for adapting the national TFC policy locally for their respective services and ensuring compliance. National Tobacco Free Ireland Programme (my office) has a role and remit to support and drive quality improvements in its implementation, collate data on its implementation. Coordinate responses to any queries we may receive from government ministers on its implementation, develop tools and supports for it, develop training for staff. Commission internal audits etc.
E2. How was the practice funded?	Own resources

Links and additional information
https://www.tobaccofreehealthcare.org/ https://www.hse.ie/eng/about/who/tobaccocontrol/campus/tobacco-free-campus-toolkit-guidance-document-oct-16.pdf
https://www.google.com/search?q=tobacco+free+campus+bursary&rlz=1C1GCEA_enIE932IE932&oq=tobacco+free+campus+bursary&aqs=chrome..69i57j33i160l2.6631j0j15&sourceid=chrome&ie=UTF-8
https://www.hse.ie/eng/about/who/tobaccocontrol/news/tobacco-programme-past-conferences-and-events.html
https://www.hse.ie/eng/about/who/tobaccocontrol/campus/tobacco%20free%20campus%20abstracts%202019.pdf

Table 5.21: Ireland_SF_cars: Ban on smoking in cars when children are present

<table>
<tr><th>QUESTIONS</th><th>ANSWERS</th></tr>
<tr><td colspan="2">1-Relevance, comprehensiveness of the intervention</td></tr>
<tr><td>F3. Does the best practice focus on public or private settings?</td><td>Both public and private</td></tr>
<tr><td>F4. What are the objectives of the practice?</td><td>Smoke-free indoor settings (conventional tobacco products)
Car smoking ban with minors or pregnant women (conventional tobacco products)</td></tr>
<tr><td>E1. What is the geographical scope of the practice?</td><td>Ireland</td></tr>
<tr><td>F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?</td><td>To protect children from Tobacco smoke exposure in the confined spaces of a car</td></tr>
<tr><td>F2. What is the overall goal of the practice?</td><td>Protection of children from Tobacco smoke exposure</td></tr>
<tr><td>G1. Target settings.</td><td>Cars</td></tr>
<tr><td colspan="2">2-Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>No smoking allowed in cars when children are present. Its another aspect of “awareness” of the dangers of passive smoking</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>https://www.facebook.com/HSElive/videos/459652617568210/</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Ban on smoking in cars when children are present</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>21-IE-SF Cars</th></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been developed/adopted but not yet enforced</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>01/01/2016</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>n/a</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>Enforced by national police, but no evidence of any prosecutions</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
</table>

G2. If any, which is the specific target population?	Age specific groups
4- & 5- Equity & ethical aspects	
What are the equity and ethical principles underpinning the practice?	protection of children from exposure
6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Less children exposed to tobacco smoke, and it also sets the scene that tobacco smoke exposure is harmful (de-normalisation of smoking)
M1. What indicators are used in the monitoring of the process and outcome of the practice?	none
N1. Has the practice been formally evaluated?	No
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/ regional/national level and transferability has not been considered in a systematic way.
8-Sustainability	
P1. Sustainability.	None of the above options
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Development Group of population_Implementation National public health_Development National public health_Implementation National public health authorities_Evaluation
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Nation
B5. Name of the entity(ies) in national language and English and acronym.	Department of Health
B6. Please specify also the responsibility of the entity(ies):	National Police force are responsible for enforcing the ban
E2. How was the practice funded?	No funds required

Links and additional information

Video https://www.facebook.com/HSElive/videos/459652617568210/ with information that since January 2016 it More at http://bit.ly/1VDY7o5

Table 5.22: Italy_SF_beaches: Smoke-free beaches

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) Outdoor aerosol-free regulation for heated tobacco products Raise awareness on tobacco damages to health and environment; avoid pollution of air and sea water
E1. What is the geographical scope of the practice?	ItalyRegions: Liguria, Veneto, Emilia Romagna, Marche, Sardinia, Lazio, Abruzzo, Puglia, Sicily.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).
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	There is now ample scientific evidence showing that smoking on beaches exposes non-smokers to second-hand smoke, thus causing a lot of health damage. Moreover, beaches are often frequented by many children who are generally better protected elsewhere. Last but not least, the environment matter. 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.
F2. What is the overall goal of the practice?	The aim of smoke-free beaches 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. Moreover, smoke-free beaches are a "tool" to 1) raise public awareness of the damages caused by tobacco to humans and the environment and 2) contribute to the de-normalization of tobacco consumption.
G1. Target settings.	Beaches (outdoor)
2- Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	On a voluntary basis, some municipalities may decide that beaches under their jurisdiction (some or all beaches) are 'Smoke-free beaches'. In this way, cigarettes are banned under the beach umbrella and on the seashore but are allowed in specifically identified areas. The aim is to avoid causing damage to the health of non-smoking neighbours and to nature. This is communicated through the media, the tourist office, and signage on site.
C2. Possible source of information where the practice is described	https://www.bibione.com/it/scopri/spiaggia-mare/smoke-free/ https://ecobnb.com/blog/2019/06/no-butts-smoke-free-beaches-italy/ https://www.trovaspiagge.it/en/news/smoke-free-beaches-what-are-they/ https://www.euro.who.int/__data/assets/pdf_file/0019/249013/Bibione-Breath-by-the-Sea-updated-version.pdf
B1. Title/Name of the practice.	Smoke-free beaches

<table>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>22-IT-SF beaches</th></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice is at the first stage of implementation but not yet totally developed</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date</td><td>06/01/2019</td></tr>
<tr><td>J1. What methods are/ were used in the practice?</td><td>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 for more details see: https://www.euro.who.int/__data/assets/pdf_file/0019/249013/Bibione-Breath-by-the-Sea-updated-version.pdf</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>The ban on smoking along the Bibione seashore was enforced under the municipal regulation banning smoking in designated non-smoking areas, 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. https://www.euro.who.int/__data/assets/pdf_file/0019/249013/Bibione-Breath-by-the-Sea-updated-version.pdf 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, drastically reducing the presence of litter on the beach. If beachgoers decide not to take advantage of the special “Smoking Islands” and choose to smoke on the beach, 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 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. and are at the disposal of beach users who can stop them to report any kind of problem, which, depending on the case, will be dealt with either immediately or at the Bibione Headquarters. 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 (in particular for the beach dune systems included in the “Life Redune” project) and towards the development of greater environmental awareness. The awareness-raising action undertaken with “Bibione respira il mare - Smoke-Free Beach” continues to work and is well received by both non-smokers and smokers themselves, who are proving increasingly respectful and cooperative. This is demonstrated by the number of fines issued by the Bibione Municipal Police: in previous years about a dozen were recorded per bathing season, to date (4 August 2022) the figure is still zero. https://www.ilfriuli.it/articolo/viaggi/bibione-successo-per-la-spiaggia-senza-fumo/11/270006).</td></tr>
</table>

3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population
4-& 5- Equity & ethical aspects	
What are the equity and ethical principles underpinning the practice?	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. This is demonstrated by the number of fines issued by the Bibione Municipal Police: in previous years about a dozen were recorded per bathing season, to date (4 August 2022) the figure is still zero.
6- Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Bibione 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 favor of the ban (1,145 totally in favour and 584 in favour provided smoking areas were set up), while those against were only 564. (https://www.ilpopolopordenone.it/Veneto-Orientale/Bibione-addio-alle-sigarette-in-spiaggia) 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)
M1. What indicators are used in the monitoring of the process and outcome of the practice?	The Bibione initiative was supported by scientific evidence. A study conducted in 2015 by a working group led by Dr. Roberto Boffi, head of the Pneumology and Anti-Smoking Centre 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. 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 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. https://www.euro.who.int/__data/assets/pdf_file/0019/249013/Bibione-Breath-by-the-Sea-updated-version.pdf
N1. Has the practice been formally evaluated?	Don't know
7-Potential of scalability and transferability	

O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	None
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Development Regional public health authorities_Development Regional public health authorities_Implementation Regional public health authorities_Evaluation Local public health authorities_Development Local public health authorities_Implementation Local public health authorities_Evaluation Researchers /academics_Development Civil_Organizations_Development Other_Org_Development
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Municipality/City
B5. Name of the entity(ies) in national language and English and acronym.	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. This was later joined by other seaside resorts in other municipalities in Italy: 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). 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.
B6. Please specify also the responsibility of the entity(ies):	Municipality. So far, the practice is voluntary (some seaside resorts have a smoking ban, while others allow it). 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 fines can range from a minimum amount of 25 euros to a maximum amount of 500 euros. If you throw cigarette butts on the beach, you will be punished throughout the country with a fine between 60 euros and 300 euros. Those municipalities which decide to ban also electronic cigarettes on the beach must specifically write it in the municipal ordinance.
E2. How was the practice funded?	Don't know

Links and additional information

For more details see: https://www.euro.who.int/__data/assets/pdf_file/0019/249013/Bibione-Breath-by-the-Sea-updated-version.pdf

Additional links:

https://www.bibione.com/it/scopri/spiaggia-mare/smoke-free/

https://ecobnb.com/blog/2019/06/no-butts-smoke-free-beaches-italy/

https://www.trovaspiagge.it/en/news/smoke-free-beaches-what-are-they/

Table 5.23: Lithuania_SF_nation: Legal requirement for smoke free environments as part comprehensive Tobacco Control Law

<table>
<tr><th>QUESTIONS</th><th>ANSWERS</th></tr>
<tr><td colspan="2">1- Relevance, comprehensiveness of the intervention</td></tr>
<tr><td>F3. Does the best practice focus on public or private settings?</td><td>Both public and private</td></tr>
<tr><td>F4. What are the objectives of the practice?</td><td>Smoke-free indoor settings (conventional tobacco products)</td></tr>
<tr><td>E1. What is the geographical scope of the practice?</td><td>Lithuania</td></tr>
<tr><td>F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?</td><td>Protection of health for employees, right to smoke free environment, reducing harm from passive smoking. Smoke free legislations are effective.</td></tr>
<tr><td>F2. What is the overall goal of the practice?</td><td>Reduce consumption, protect individual and public health.</td></tr>
<tr><td>G1. Target settings.Please select all that apply.</td><td>Workplace (indoor)</td></tr>
<tr><td colspan="2">2-Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>There is a legal requirement not to smoke in all indoor workplaces.</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>article 19 of the Lithuanian Tobacco Control Law https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.24500/asr</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Legal requirement for smoke free environments as part comprehensive Tobacco Control Law</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>23-LT-SF National</th></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>01/01/1996</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>law enforcement</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>law enforcement</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population</td></tr>
<tr><td colspan="2">4-Ethical aspects</td></tr>
</table>

What are the equity and ethical principles underpinning the practice?	none
5-Effectiveness, efficiency , evaluation	
L1. What are the main outcomes of the practice?	reduction of smoking over time
M1. What indicators are used in the monitoring of the process and outcome of the practice?	smoking prevalence
N1. Has the practice been formally evaluated?	No
6-Equity	
Q1. What are the equity and ethical principles underpinning the practice?	none
7-Transferability, potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	Unknown
9-Participation, empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	National public health_Development National public health_Implementation National public health authorities_Evaluation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	Own resources.
B4. Who has the responsibility of the practice?	Municipality/CityNationPublic agencyUniversityGovernmentPrivate institution
B5. Name of the entity(ies) in national language and English and acronym.	Drug, tobacco and alcohol control department
B6. Please specify also the responsibility of the entity(ies):	National agency coordinating development and implementation of all control policies in substance use.

Links and additional information
Article 19 of the Lithuanian Tobacco Control Law
https://e- seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.24500/asr

Table 5.24: Luxembourg_SF_cars: Smoking ban in cars when children under 12 years are aboard

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Private only
F4. What are the objectives of the practice?	Car smoking ban with minors or pregnant women (conventional tobacco products) Car vaping ban with minors or pregnant women Car heated tobacco product ban with minors or pregnant women
E1. What is the geographical scope of the practice?	

F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	This measure was taken to protect the children from second hand smoking and also to denormalize the act of smoking.
F2. What is the overall goal of the practice?	Prevent second-hand smoke exposure to children and preserve their health capital. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4937108/
G1. Target settings.	Cars
2-Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	This best practice applies to the general population. Smoking and Vaping is not permitted in private cars when children under 12 years are aboard.
C2. Possible source of information where the practice is described	Luxembourg anti-tobacco law transposing tobacco Directive 2014/40/UE Art6 3) https://legilux.public.lu/eli/etat/leg/loi/2017/06/13/a560/jo
B1. Title/Name of the practice.	Smoking ban in cars when children under 12 years are aboard
B2. Type of practice.	

	24-LU-SF Cars
	Type of practice
1	Information/awareness raising programm
2	Policy
3	Action plan
4	Regulation/ ban
5	Monitoring/surveillance
6	Service delivery approach/method
7	Tool/instrument
8	Guideline
9	Training
10	E-health, mHealth
11	Health in All policies
12	Don't know

B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	06/13/2017
J1. What methods are/were used in the practice?,	This measure was debated in the Luxembourg Chamber of Deputies.
K1. Enforcement of the practice.	Adoption of this measure into the law.
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population Age specific groups
4- & 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	This is a measure that applies to the population of Luxembourg.

6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Protection of children against second-hand smoke.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	We use statistics from the police (number of fines for no respecting of the ban).
N1. Has the practice been formally evaluated?	No
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	National public health_Development National public health_Implementation National public health authorities_Evaluation
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Nation
B5. Name of the entity(ies) in national language and English and acronym.	Ministry of Health of Luxembourg
B6. Please specify also the responsibility of the entity(ies):	Ministry of Health of Luxembourg
E2. How was the practice funded?	No funds required

Links and additional information
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4937108
Luxembourg anti-tobacco law transposing tobacco Directive 2014/40/UE Art6 3) https://legilux.public.lu/eli/etat/leg/loi/2017/06/13/a560/jo

Table 5.25: Luxembourg_SF_playgrounds: General smoking ban in children playground

<table>
<tr><th>QUESTIONS</th><th>ANSWERS</th></tr>
<tr><td colspan="2">1-Relevance, comprehensiveness of the intervention</td></tr>
<tr><td>F3. Does the best practice focus on public or private settings?</td><td>Public only</td></tr>
<tr><td>F4. What are the objectives of the practice?</td><td>Smoke-free outdoor settings (conventional tobacco products)
Outdoor aerosol-free regulation for e-cigarettes
Outdoor aerosol-free regulation for heated tobacco products</td></tr>
<tr><td>E1. What is the geographical scope of the practice?</td><td>Luxembourg</td></tr>
<tr><td>F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?</td><td>Smoking prevention among children, denormalization of smoking, second-hand smoking protection.</td></tr>
<tr><td>F2. What is the overall goal of the practice?</td><td>To prevent as much as possible the young from smoking.</td></tr>
<tr><td>G1. Target settings.</td><td>Children’s playgrounds (outdoor)</td></tr>
<tr><td colspan="2">2-Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>The smoking ban in playground areas is intended to denormalize the act of smoking and to provide a smoke free environnement for the children. It also intends to responsabilize the adults especially the parents to not smoke in front of children, as children have a tendency to imitate their parents.</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>https://legilux.public.lu/eli/etat/leg/loi/2017/06/13/a560/jo Luxembourg antitobacco law transposing Directive 2014/40/UE into national law : art1 u)</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>General smoking ban in children playground</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>25-LU-SF playground</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>13/06/2017</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>Political decision</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>The Police in charge of the supervision and the control of compliance with this regulation.</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population
Age specific groups</td></tr>
<tr><td colspan="2">4- & 5- Equity and ethical aspects</td></tr>
</table>

What are the equity and ethical principles underpinning the practice?	n/a
6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	There is a general respect and also approbation of this measure among the population (91%) according to a survey realized in 2017 in Luxembourg about the general acceptance of our national antitobacco law of 2017.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Statistics about Police fines issued for no respecting the measure.
N1. Has the practice been formally evaluated?	No
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability	Transferability has not been considered. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	National public health_Development National public health_Implementation National public health authorities_Evaluation
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Nation
B5. Name of the entity(ies) in national language and English and acronym.	Ministry of Health of Luxembourg.
B6. Please specify also the responsibility of the entity(ies):	Municipalities should ensure the ban is respected.
E2. How was the practice funded?	No funds required

Links and additional information

Luxembourg antitobacco law transposing Directive 2014/40/UE into national law : art1 u https://legilux.public.lu/eli/etat/leg/loi/2017/06/13/a560/jo

Table 5.26: Malta_SF_nation: Products and Smoking Devices (Simulating Cigarettes or Tobacco) (Control) Regulations

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes Indoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	Malta
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	to de-normalise smoking; protect health for second hand exposure; extend the scope of the ban of smoking indoors
F2. What is the overall goal of the practice?	to de-normalise smoking; protect health for second hand exposure; extend the scope of the ban of smoking indoors

G1. Target settings.	Restaurants and bars (indoor)Hotels (indoor)Train stations and public transports (indoor)Airports (indoor)Workplace (indoor)Schools/ public-education institutions/ educational venues except universities (indoor)Universities (indoor)Cinemas/theatres (indoor)Hospitals including outpatient clinics (indoor)Primary health care institutions (indoor)Institutions from social sector (indoor)Prisons (indoor)Outdoor areas of school (outdoor)Children's playgrounds (outdoor)
2- Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	this regulation defines "tobacco devices" and states that such products are to comply with the provisions of the Tobacco Act and any regulations made there under in so far as advertising and smoking in public places are concerned.
C2. Possible source of information where the practice is described	https://legislation.mt/eli/ln/2010/22/eng/pdf
B1. Title/Name of the practice.	Products and Smoking Devices (Simulating Cigarettes or Tobacco) (Control) Regulations, 2010 (L.N. 22 of 2010)
B2. Type of practice.	**26-MT-SF National** **Type of practice** 1 Information/awareness raising programm 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know
B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	12/12/2010
J1. What methods are/were used in the practice?	national legislation - enactment and enforcement
K1. Enforcement of the practice.	enforced by Environmental health officers, police
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population
4-Ethical considerations	
What are the equity and ethical principles underpinning the practice?	NA
5-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Prohibition of smoking in public places (and advertising) extended to non-conventional tobacco and related products

M1. What indicators are used in the monitoring of the process and outcome of the practice?	none
N1. Has the practice been formally evaluated?	No
6-Equity	
Q1. What are the equity and ethical principles underpinning the practice?	NA.
7-Transferability, potential of scalability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/ regional/national level and transferability has not been considered in a systematic way.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9-Participation, empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	NA
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	No funds required
B4. Who has the responsibility of the practice?	Government
B5. Name of the entity(ies) in national language and English and acronym.	Health regulation department (Environmental health directorate)
B6. Please specify also the responsibility of the entity(ies):	Regulation of public health issues

Links and additional information
https://legislation.mt/eli/ln/2010/22/eng/pdf

Table 5.27: The Netherlands_SF_sports: Smoke-free sports grounds (Rookvrije Sport)

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) Outdoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	The Netherlands
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	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 smokefree 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.

F2. What is the overall goal of the practice?	Sports clubs are realising a smoke-free sports ground, so that children are no longer exposed to smoking and second-hand smoke and its potentially harmful consequences. They will contribute to the goal to realize a completely smokefree generation.
G1. Target settings.	Stadiums and outdoor arenas (outdoor)sports club / sports ground
2-Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	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. Nowadays in the Netherlands, some (outdoor) sports clubs have voluntarily implemented an outdoor smoke-free policy at their venues (approximately 2000 outdoor sports clubs in the first half of 2022). Health Funds for a Smokefree Netherlands (Dutch Heart Foundation, KWF Dutch Cancer Society, and the Lung Foundation Netherlands) initiated the 'Smokefree Generation movement'. The goal is to realize a completely smokefree generation. By creating smokefree 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. Health Funds for a Smokefree Netherlands are committed, among other things, to increase support for smoke-free environments and activate the general public and relevant organizations. They developed a program to motivate and facilitate sports clubs in making sports grounds smoke-free (among other environments). With information and tools like a guideline, smoke-free signs (for free for outdoor areas until this moment) and communication guidelines and advice. Young People at a Healthy Weight-Teamfit (Jongeren op Gezond Gewicht (JOGG)-Teamfit) offer 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 Smokefree Netherlands/Smokefree Generation). The sports federations will make their own sports events smoke-free (practice what you preach). The Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten, VNG) launched a guideline for municipalities to realize smoke-free sports grounds. Regional Public Health Services and municipalities decide if they join the Smokefree 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 realized smoke-free stadiums.
C2. Possible source of information where the practice is described	- www.rookvrijegeneratie.nl/sport - https://www.loketgezondleven.nl/interventies-zoeken#/InterventionDetails/1900018 - https://sportrookvrij.nl/ - https://nocnsf.nl/gezonde-sportomgeving - https://vng.nl/nieuws/aan-de-slag-met-rookvrije-sport-handreiking-voor-gemeenten - https://www.rookvrijevoetbalstadions.nl/ Scientific articles: - 1. Garritsen, H.H., Rozema, A.D., van de Goor, L.A.M., & Kunst, A.E. (2021). Smoke-free sports: why most sports clubs have not adopted an outdoor smoke-free policy. International Journal of Environmental Research and Public Health, 18, 2454. (https://pubmed.ncbi.nlm.nih.gov/33801520/) - 2. Garritsen, H.H., Rozema, A.D., van de Goor, L.A.M., & Kunst, A.E. (2021). Implementation of an outdoor smoke-free policy at sports clubs: critical situations and determinants influencing implementation. International Journal of Drug Policy, 92: 103129. (https://pubmed.ncbi.nlm.nih.gov/33486332/) - 3. Garritsen, H.H., Distelvelt, R.R., Olsen, I.G., Kunst, A.E., van de Goor, L.A.M., & Rozema, A.D. (2021). Adolescents' support for an outdoor smoke-free policy at sports clubs. Tobacco Prevention & Cessation, 7. (https://pubmed.ncbi.nlm.nih.gov/34084979/) - 4. Olsen, I.G., Garritsen H.H., Kunst, A.E., van de Goor, L.A.M., & Rozema, A.D. (2021). Adolescents' beliefs, attitudes, and social norms towards smoking and sports. BMJ Open, 11: e046613. (https://bmjopen.bmj.com/content/11/8/e046613) - 5. 5. Smit, R.A., Garritsen, H.H., Kunst, A.E. (2022). Diffusion of smoke-free policies at outdoor sports clubs in the Netherlands. Tobacco Control. (https://pubmed.ncbi.nlm.nih.gov/35039459/)
B1. Title/Name of the practice.	Smoke-free sports grounds (Rookvrije Sport)

<table>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>27-NL-SF Sports</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been registered in a best practice registering portal</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>10/01/2015</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>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 Smokefree Netherlands, Regional Public Health Services and municipalities. 2. Adoption phase The adoption phase is aimed at 1) the board of the sports club has the confidence to implement a smoke-free policy (not only indoor but also outdoor) (self-efficacy), 2) the board members, volunteers and (parents of) members of the sports club have a positive attitude towards a smoke-free sports ground and 3) the board actually decides to proceed to the introduction of a smoke-free sports ground. A positive attitude towards a smoke-free sports ground can be reached by a.o. (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) 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 the sports ground differs. In the guideline of the intervention, the following steps are described under ‘implementation’: • Make a plan of action. • Formulate a clear smoke-free policy. Also 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 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.</td></tr>
</table>

K1. Enforcement of the practice.	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.
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	Age specific groups
4- & 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	Don't know
6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	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: n field hockey, football, tennis, athletics or korfball). Scientific articles: - 1. Garritsen, H.H., Rozema, A.D., van de Goor, L.A.M., & Kunst, A.E. (2021). Smoke-free sports: why most sports clubs have not adopted an outdoor smoke-free policy. International Journal of Environmental Research and Public Health, 18, 2454. (https://pubmed.ncbi.nlm.nih.gov/33801520/) - 2. Garritsen, H.H., Rozema, A.D., van de Goor, L.A.M., & Kunst, A.E. (2021). Implementation of an outdoor smoke-free policy at sports clubs: critical situations and determinants influencing implementation. International Journal of Drug Policy, 92: 103129. (https://pubmed.ncbi.nlm.nih.gov/33486332/) - 3. Garritsen, H.H., Distelvelt, R.R., Olsen, I.G., Kunst, A.E., van de Goor, L.A.M., & Rozema, A.D. (2021). Adolescents' support for an outdoor smoke-free policy at sports clubs. Tobacco Prevention & Cessation, 7. (https://pubmed.ncbi.nlm.nih.gov/34084979/) - 4. Olsen, I.G., Garritsen H.H., Kunst, A.E., van de Goor, L.A.M., & Rozema, A.D. (2021). Adolescents' beliefs, attitudes, and social norms towards smoking and sports. BMJ Open, 11: e046613. (https://bmjopen.bmj.com/content/11/8/e046613) - 5. 5. Smit, R.A., Garritsen, H.H., Kunst, A.E. (2022). Diffusion of smoke-free policies at outdoor sports clubs in the Netherlands. Tobacco Control. (https://pubmed.ncbi.nlm.nih.gov/35039459/)
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Until now the Health Funds for a Smokefree Netherlands provide free smoke-free signs for outdoor sports clubs. In this way the register sports clubs who implementated smoke-free policy. In the coming period, the sports federations will also monitor the progress.
N1. Has the practice been formally evaluated?	Yes, by an external partner
N1 bis. If you answered "Yes" or "Not yet": Please specify the organizations that conducted the evaluation.	Researcher Heike Garritsen conducts research and works from Amsterdam UMC and Tranzo, Tilburg University, together with various organizations in the field (including the Health Funds for a Smokefree Netherlands, NOC*NSF, VSG, and several Public Health Services (GGD's)). In her PhD thesis entitled 'Smoke-free Sports Clubs for a Smoke-Free Generation' she studies what factors promote the introduction of smoke-free policies, how the introduction of smoke-free policies proceeds, and how this could be improved. No economic evaluation took/will take place.
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	A sustainability strategy has been developed
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Evaluation Other_Org_Development Other_Org_Implementation Other_Org_Evaluation
10-Intersectoral collaboration, governance and project management	

B4. Who has the responsibility of the practice?	Municipality/City Public agencyNGOs
B5. Name of the entity(ies) in national language and English and acronym.	- Health Funds for a Smokefree Netherlands (Gezondheidheidsfondsen voor Rookvrij): The Dutch Heart Foundation (Hartstichting), KWF Dutch Cancer Society (KWF Kankerbestrijding) and the Lung Foundation Netherlands (Longfonds) initiated the 'Smokefree Generation movement' (de beweging 'Op weg naar een Rookvrije Generatie'). - The 'Nederlands Olympisch Comité*Nederlandse Sport Federatie' (NOC*NSF) is the umbrella organisation for sports in the Netherlands. - Regional Public Health Services (GGD's) and municipalities. - Young People at a Healthy Weight-Teamfit (Jongeren op Gezond Gewicht (JOGG)-Teamfit) - The Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten, VNG) - The highest level (Eredivisie) and second highest level (First division, Eerste divisie) of professional football in the Netherlands. - Amsterdam UMC and Tranzo, Tilburg University
B6. Please specify also the responsibility of the entity(ies):	- Health Funds for a Smokefree Netherlands (Gezondheidheidsfondsen voor Rookvrij): The Dutch Heart Foundation (Hartstichting), KWF Dutch Cancer Society (KWF Kankerbestrijding) and the Lung Foundation Netherlands (Longfonds) initiated the 'Smokefree Generation movement' (de beweging 'Op weg naar een Rookvrije Generatie'). The goal is to realize a completely smokefree generation. By creating smokefree environments, like schoolyards, playgrounds and sports clubs, children are less tempted to smoke and passive smoking is prevented. They are committed, among other things, to increase support for smoke-free environments and activating the general public and relevant organisations. They developed a program to motivate and facilitate sports clubs in making sports grounds smokefree. With tools like a guideline, smoke-free signs and communication guidelines and advice. - In 2018 the 'Nederlands Olympisch Comité*Nederlandse Sport Federatie' (NOC*NSF) and sports federations signed The National Prevention Agreement (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). They set the target for smoke-free sports clubs by 2025. And made agreements about stimulating boards of sports clubs to become smoke-free, organizing a campaign together with Health Funds for a Smokefree Netherlands/Smokefree Generation, smoke-free sports events and the possibility of counseling by sports coaches. - The Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten, VNG) launched a guideline for municipalities to realize smoke-free sports grounds. - Regional Public Health Services (GGD's) and municipalities decide if they join the Smokefree Generation movement 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. - Young People at a Healthy Weight-Teamfit (Jongeren op Gezond Gewicht (JOGG)-Teamfit) offer sports clubs the possibility of guidance by sports coaches for implementing smoke-free policies - The highest level (Eredivisie) and second highest level (First division, Eerste divisie) of professional football in the Netherlands realized smoke-free stadiums. - Amsterdam UMC and Tranzo, Tilburg University conduct research about smoke-free sports grounds
E2. How was the practice funded?	Own resources. External resources-public

Links and additional information
www.rookvrijegeneratie.nl/sport
https://www.loketgezondleven.nl/interventies-zoeken#/InterventionDetails/1900018
https://sportrookvrij.nl/
https://nocnsf.nl/gezonde-sportomgeving
https://vng.nl/nieuws/aan-de-slag-met-rookvrije-sport-handreiking-voor-gemeenten
https://www.rookvrijevoetbalstadions.nl/

Table 5.28: The Netherlands_SF_transports: Smokefree public transportation

QUESTIONS	ANSWERS
1. Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Both public and private
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) Outdoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for heated tobacco products Decline number of tobacco points of sale
E1. What is the geographical scope of the practice	the Netherlands
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Problem was second-hand smoke at the railway platforms and the need to "de-normalize" smoking in order to create a Smokefree Generation. Health Funds for a Smokefree Netherlands put all their effort in creating a Smokefree Generation. And as children and adolescents make use of the railway system in the Netherlands, we want them to travel without 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 doesn't go away as quickly as outdoors. Furthermore, smoking at train platforms make it looks like smoking is normal and something you do when you're waiting for a train to arrive. That's not the message what you want to give to children and adolescents.
F2. What is the overall goal of the practice?	creating a Smokefree Netherlands; where children don't start smoking and where children are protected against second- and thirdhand smoke.
G1. Target settings.	Train stations and public transports (indoor)Bus, tramway, trolley-bus stop waiting areas (outdoor)outdoor train platforms
2. Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	The plan for a Smokefree 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 smokefree environment for everybody (passengers and staff) 2) quit selling cigarettes at the train platforms 3) offering smoking cessation training for staff Health Funds for a Smokefree Netherlands was involved as an advisor in this trajectory.
C2. Possible source of information where the practice is described	The practice is not described on website or in other documents
B1. Title/Name of the practice.	Smokefree public transportation in the Netherlands. Starting with integral plan for a Smokefree train stations and platforms (already implemented). Smokefree bus stations and bus stops in the Netherlands is next (will be implemented coming years).

B2. Type of practice.	**28-NL-SF Transports** **Type of practice** 1 Information/awareness raising programm 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know 13 Other: Research
B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	01/10/2020
J1. What methods are/were used in the practice?	An integral plan was made in order to reach the objectives. There was no real methodology used. Only a detailed plan and process, including many conversations with, for example the board and the work Counsil. The handbook "Smokefree work" of the Health Funds for a Smokefree Generation was used (in Dutch, see attached file).
J1 bis. If relevant, please upload possible documentation.	2200892.AR Handboek Rookvrij Werken A4L DIGI.pdf
K1. Enforcement of the practice.	The Smokefree stations and train platforms is not a formal smoking ban controlled by law. It is a total smokefree zone on the territory of the NS and ProRail companies. Employees of NS remind passengers of the smokefree policy.
3. Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population
4. & 5- Equity and ethical aspects	
Q1. What are the equity and ethical principles underpinning the practice?).	all passengers are equal. Smokers are not forced to quit smoking. They are just asked to smoke before they enter the train station.
6. Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	More than 400 train stations (and their platforms) in the Netherlands became total smokefree area's. Millions of passengers are protected against second-hand smoke.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	We used qualitative indicators on what went well / what went wrong, what can we do better? One of the more quantitative measures is how often the smokefree policy is ignored.
N1. Has the practice been formally evaluated?	No
7. Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.
8. Sustainability	

P1. Sustainability.	None of the above options
9. Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	
10. Intersectoral collaboration = Governance and project management	
B4. Who has the responsibility of the practice?	Municipality/CityProvince/Region/Nation Private institution
B5. Name of the entity(ies) in national language and English and acronym.	Nederlandse Spoorwegen - Dutch Railways - NS ProRail - Railoperator - ProRail Dutch lokal and regional governments
B6. Please specify also the responsibility of the entity(ies):	Together with ProRail, NS manages the stations in the Netherlands. Prorail is responsible for the platforms, NS is responsible for the buildings and shops.
E2. How was the practice funded?	Own resources

Links and additional information

2200892.AR Handboek Rookvrij Werken A4L DIGI.pdf

Table 5.29: The Netherlands_SF_playgrounds: Smoke-free petting zoos/city farms and playground associations

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) Outdoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	The Netherlands
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	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.
F2. What is the overall goal of the practice?	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 a smokefree petting zoo and playground 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 petting zoos and playground associations contribute to a Smokefree Generation.
G1. Target settings.	Children's playgrounds (outdoor)Petting zoos / city farms
2-Intervention characteristics, description of the practice	

<table>
<tr><td>C1. Please summarize this best practice.</td><td>Outdoor smoke-free policies at play areas offer children a healthy and safe environment to play and learn. Health Funds for a Smokefree Netherlands (Dutch Heart Foundation, KWF Dutch Cancer Society, and the Lung Foundation Netherlands) initiated the 'Smokefree Generation movement'. The goal is to realize a completely smokefree generation. By creating smokefree environments, like schoolyards, playgrounds and sports clubs, children are less tempted to smoke and passive smoking is prevented. Health Funds for a Smokefree 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). With information and tools like a guideline, smoke-free signs and communication guidelines. Pettingzoos Active (KinderboerderijenActief) and The Dutch Union of Playground Organisations (LOS, previously NUSO) joined the Smokefree 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 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 join the Smokefree 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.</td></tr>
<tr><td>C2. Possible source of information where the practice is described</td><td>www.rookvrijegeneratie.nl https://www.vereniginglos.nl/ (https://www.nuso.nl/rookvrij) http://kinderboerderijenactief.nl/rookvrij</td></tr>
<tr><td>B1. Title/Name of the practice</td><td>Smoke-free petting zoos/city farms and playground associations</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>29-NL-SF Playgrounds</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don't know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>15/10/2015</td></tr>
</table>

J1. What methods are/were used in the practice?	1. Recruitment phase Playground associations and petting zoos are encouraged by various organizations to introduce a smoke-free playing area. 2. Adoption phase The adoption phase is aimed at 1) the board/volunteers of the playground or petting zoo has/have the confidence to implement a smoke-free policy (not only indoor but also outdoor) 2) the board members, volunteers and visitors have a positive attitude towards a smoke-free play area 3) the board/volunteers actually decide to proceed to the introduction of a smoke-free location. (More information is provided in the guideline for smoke-free play areas.) 3. Implementation phase In this phase, the smoke-free policy will be introduced. The way in which playground associations an petting zoos implement a smoke-free policy differs. In the guideline of the intervention, the following steps are described under 'implementation': • Make a plan of action. • Formulate a clear smoke-free policy. Also 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 organization rules. Also inform external parties. • Determine what changes are needed on the location and implement them. • Approach 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 and explain the policy. • To evaluate the smoke-free policy and, if necessary, improves it by means of additional steps. • Support from external organizations remains available.
K1. Enforcement of the practice.	Employees/volunteers of petting zoos and playgrounds have to approach people who still smoke, explain the policy and have to ask them to stop smoking. Visitors can also do this and show the smoke-free signs.
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	Age specific groups
4- & 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	
6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	Nowadays most of the petting zoos ans playground associations are (voluntarily) smoke-free in the Netherlands. Compliance can be a challenge, and also the visibility of smoking just outside the petting zoo or playground areas.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Pettingzoos Active (KinderboerderijenActief) and The Dutch Union of Playground Organisations (LOS, previously NUSO) monitor the progress.
N1. Has the practice been formally evaluated?	Don't know
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	A sustainability strategy has been developed
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	Other_Org_Development Other_Org_Implementation Other_Org_Evaluation
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	NGOs

B5. Name of the entity(ies) in national language and English and acronym.	- Gezondheidsfondsen voor Rookvrij, Health Funds for a Smokefree Netherlands - KinderboerderijenActief, Pettingzoos Active - LOS (previously NUSO, vSKBN), Dutch Union of Playground Organisations and Association of cooperating city farms in the Netherlands. - Regional Public Health Services (GGD's) and municipalities
B6. Please specify also the responsibility of the entity(ies):	- Health Funds for a Smokefree Netherlands (Gezondheidheidsfondsen voor Rookvrij): The Dutch Heart Foundation (Hartstichting), KWF Dutch Cancer Society (KWF Kankerbestrijding) and the Lung Foundation Netherlands (Longfonds) initiated the 'Smokefree Generation movement' (de beweging 'Op weg naar een Rookvrije Generatie'). The goal is to realize a completely smokefree generation. By creating smokefree environments, like schoolyards, playgrounds and sports clubs, children are less tempted to smoke and passive smoking is prevented. They are committed, among other things, to increase support for smoke-free environments and activating the general public and relevant organisations. They developed a program to motivate and facilitate play areas like playgrounds and petting zoos. With tools like a guideline, smoke-free signs and communication guidelines. - Pettingzoos Active (KinderboerderijenActief) is a platform for information and inspiration for petting zoos. They offer guidance for implementing smoke-free policies. They signed The National Prevention Agreement (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). They set the target that all petting zoos in the Netherlands are smoke-free. - The Association of cooperating city farms (LOS, previously vSKBN) helps to raise awareness for smoke-free policies at the petting zoos. - The Dutch Union of Playground Organisations (LOS, previously NUSO), a national nongovernment organisation, provide information and guidance for implementing a smoke-free policy for playground associations. They signed The National Prevention Agreement (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). They set the target that all playground associations in the Netherlands are smoke-free. - Regional Public Health Services (GGD's) and municipalities decide if they join the Smokefree Generation movement and thereby encourage and/or support play areas like playgrounds and petting zoos to become smoke-free.
E2. How was the practice funded?	Own resources. External resources-public

Links and additional information
www.rookvrijegeneratie.nl
https://www.vereniginglos.nl/
https://www.nuso.nl/rookvrij
http://kinderboerderijenactief.nl/rookvrij

H1 BIS: PARTICIPATION
The platform for petting zoos (Pettingzoos Active / KinderboerderijenActief) and The Dutch Union of Playground Organisations (NUSO, now LOS)

Table 5.30: The Netherlands_SF_sports/playgrounds: Smoke-free municipal/public playgrounds and sports facilities

QUESTIONS	ANSWERS
1. Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) Outdoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	The Netherlands

F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	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.
F2. What is the overall goal of the practice?	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 Smokefree Generation.
G1. Target settings.	Children's playgrounds (outdoor)outdoor public playgrounds and public sports facilities, such as football pitches, basketball courts and skateparks
2. Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	Outdoor smoke-free policies at public playgrounds and sports facilities offer children a healthy and safe environment to play. Health Funds for a Smokefree Netherlands (Dutch Heart Foundation, KWF Dutch Cancer Society, and the Lung Foundation Netherlands) initiated the 'Smokefree Generation movement'. The goal is to realize a completely smokefree generation. By creating smokefree environments, like schoolyards, playgrounds and sports clubs, children are less tempted to smoke and passive smoking is prevented. Health Funds for a Smokefree Netherlands are committed to increase support for smoke-free environments and activate the general public and relevant organizations. They developed information, communication and tools like a guideline to activate and support municipalities to contribute to the realization of a smokefree generation. Municipalities can decide if they create smoke-free public playgrounds and sports facilities such as football pitches, basketball courts and skateparks in public areas in neighbourhoods. Nowadays, some municipalities have implemented this smoke-free policy. Mostly in an informal way with public communication for the residents of the municipality and by displaying smoke-free signs. In this case enforcement takes place in an informal manner. Someone who smokes can be asked to stop smoking, without being fined. It's now more voluntarily policy to create a new social norm. Regional Public Health Services (GGD's) encourage and support municipalities to create smoke-free play areas like public playgrounds and sports facilities as well as The Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten, VNG). In the National Prevention Agreement in which 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, a target is set for smoke-free playgrounds by 2025, including the smaller public play areas in the municipalities.
C2. Possible source of information where the practice is described	www.rookvrijegeneratie.nl/gemeenten Some examples of municipalities: - Den Haag https://www.rookvrijegeneratie.nl/artikelen/mohamed-maakte-500-speelplekken-rookvrij - Alkmaar: https://alkmaar.nieuws.nl/nieuws/30406/speelplekken-en-cruijff-courts-gemeente-alkmaar-rookvrij/ - Breda: https://jogg-breda.nl/opening-rookvrije-speeltuinen-breda/ - Weesp: https://www.weespernieuws.nl/nieuws/zorg/164026/weesp-telt-46-openbare-speelplekken-en-die-zijn-allemaal-rookvrij - Nieuwegein: https://www.nieuwegein.nl/hulp-en-ondersteuning/nieuwegein-rookvrij/rookvrij-spelen
B1. Title/Name of the practice.	Smoke-free municipal/public playgrounds and sports facilities

<table>
<tr><td>B2. Type of practice. Please select all that apply for this practice.</td><td>
<table>
<tr><th></th><th>30-NL-SF Sports</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>15/10/2015</td></tr>
<tr><td>J1. What methods are/ were used in the practice?</td><td>Municipalities can decide if they create smoke-free public playgrounds and sports facilities such as football pitches, basketball courts and skateparks in public areas in neighbourhoods. Nowadays, some municipalities have implemented this smoke-free policy. Municipalities 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.</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>As described before, in this case enforcement takes place in an informal manner. Someone who smokes can be asked to stop smoking, without being fined. It’s 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.</td></tr>
<tr><td colspan="2">3. Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>Age specific groups</td></tr>
<tr><td colspan="2">4. & 5- Equity and ethical aspects</td></tr>
<tr><td>What are the equity and ethical principles underpinning the practice?</td><td>-</td></tr>
<tr><td colspan="2">6- Effectiveness, efficiency, evaluation</td></tr>
<tr><td>L1. What are the main outcomes of the practice?</td><td>I&O Research, on behalf of The Health Funds for a Smokefree 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 skateparks, 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).</td></tr>
</table>

M1. What indicators are used in the monitoring of the process and outcome of the practice?	As described before, 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 (2021). Efficacious elements of municipal tobacco control programs in the Netherlands are being investigated in extensive research by Trimbos Institute. https://www.zonmw.nl/nl/onderzoek-resultaten/preventie/programmas/project-detail/effectiviteitsonderzoek/efficacious-elements-of-municipal-tobacco-control-programs-in-the-netherlands/
N1. Has the practice been formally evaluated?	Yes, by an external partner
N1 bis. If you answered "Yes" or "Not yet": Please specify the organizations that conducted the evaluation.	I&O Research, on behalf of The Health Funds for a Smokefree Netherlands, have monitored smoke-free policy by the municipalities in the Netherlands in 2021. Furthermore, efficacious elements of municipal tobacco control programs in the Netherlands are being investigated in an extensive research project by Trimbos Institute. https://www.zonmw.nl/nl/onderzoek-resultaten/preventie/programmas/project-detail/effectiviteitsonderzoek/efficacious-elements-of-municipal-tobacco-control-programs-in-the-netherlands/
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Municipality/City
B5. Name of the entity(ies) in national language and English and acronym.	- Municipalities - Health Funds for a Smokefree Netherlands (Gezondheidheidsfondsen voor Rookvrij): The Dutch Heart Foundation (Hartstichting), KWF Dutch Cancer Society (KWF) and the Lung Foundation Netherlands (Longfonds) initiated the 'Smokefree Generation movement' - 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). - Regional Public Health Services (Gemeentelijke of Gemeenschappelijke Gezondheidsdiensten, GGD's)

B6. Please specify also the responsibility of the entity(ies):	- Municipalities decide if they create smoke-free public playgrounds and sports facilities such as football pitches, basketball courts and skateparks in public areas in neighbourhoods. - Health Funds for a Smokefree Netherlands (Gezondheidheidsfondsen voor Rookvrij): The Dutch Heart Foundation (Hartstichting), KWF Dutch Cancer Society (KWF) and the Lung Foundation Netherlands (Longfonds) initiated the 'Smokefree Generation movement' at the end of 2015. The goal is to realize a completely smokefree generation. By creating smokefree environments, like schoolyards, playgrounds and sports clubs, children are less tempted to start smoking and passive smoking is prevented. Health Funds for a Smokefree Netherlands is committed to increase support for smoke-free environments and activate the general public and relevant organizations. Municipalities are important to contribute to the realization of a Smokefree Generation as they play an important role in the implementation of smoke free locations (such as public playgrounds and sports facilities) in public areas. Health Funds for a Smokefree Netherlands offer information and tools like a guideline, smoke-free signs and communication guidelines for municipalities. - The Association of Netherlands Municipalities (Vereniging van Nederlandse Gemeenten, VNG) represents all municipalities. The Association of Netherlands Municipalities facilitates municipalities with the exchange of knowledge and experience regarding the implementation of national and local policies. They encourage municipalities to formulate a local or regional approach based on The National Prevention Agreement (see below) *, whereby smoke-free policy is included. - GGD GHOR Nederland is the Association of GGD's (Regional Public Health Services) and GHOR- (Regional Medical Emergency Preparedness and Planning) offices in the Netherlands. They represent the interests of the 25 GGD's and GHOR offices on national level to stimulate improvements in Public Health and safety and the quality of the Public Health services. GGD's and GHOR-offices contribute to safeguarding, improving and protecting the health of the Dutch people. As requested by the Dutch Ministry of Health, Welfare and Sport, and funded from The National Prevention Agreement*, GGD GHOR Nederland has set up a Smoke-Free Environment Support Programme in 2019. As such, GGD's that want to help municipalities with activities to become smoke-free have been able to apply for a subsidy. GGD GHOR Nederland supports GGD's during the application process and in the implementation by i.e., sharing knowledge, connecting parties and by being active in national networks. An extension for the programme has recently been requested. - Regional Public Health Services (GGD's). At present, there are 25 regional public health services in the Netherlands, covering all municipalities. Nowadays all of them participate in a Smoke-Free Environment Programme, see below. They can encourage and support municipalities to create smoke-free play areas like public playgrounds and sports facilities. *The National Prevention Agreement (Nationaal Preventieakkoord, NPA) was signed in 2018 to achieve the ambitions that, by 2040, fewer people will smoke, be overweight or drink problematically. To this end, the central government together with over 70 parties set targets and made agreements. One of the targets is: smoke-free playgrounds by 2025, including the smaller public play areas in the municipalities.
E2. How was the practice funded?	External resources-public

Links and additional information
www.rookvrijegeneratie.nl/gemeenten

Some example of municipalities
• Den Haag: https://www.rookvrijegeneratie.nl/artikelen/mohamed-maakte-500-speelplekken-rookvrij Alkmaar: https://alkmaar.nieuws.nl/nieuws/30406/speelplekken-en-cruijff-courts-gemeente-alkmaar-rookvrij/
• Breda: https://jogg-breda.nl/opening-rookvrije-speeltuinen-breda/
• Weesp: https://www.weespernieuws.nl/nieuws/zorg/164026/weesp-telt-46-openbare-speelplekken-en-die-zijn-allemaal-rookvrij
• Nieuwegein: https://www.nieuwegein.nl/hulp-en-ondersteuning/nieuwegein-rookvrij/rookvrij-spelen
• https://www.zonmw.nl/nl/onderzoek-resultaten/preventie/programmas/project-detail/effectiviteitsonderzoek/efficacious-elements-of-municipal-tobacco-control-programs-in-the-netherlands/

Table 5.31: Sweden_SF_nation: Smoke free outdoor settings

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free outdoor settings (conventional tobacco products) Outdoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	Sweden
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Smoking addiction is largely founded at a young age. The younger people we can prevent from starting to smoke, the better the chances of reducing smoking in society. An important way to achieve that goal is de-normalizing smoking. That is, to make 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.
F2. What is the overall goal of the practice?	Avoid passive exposure to smoke etc. De-normalize smoking.
G1. Target settings.	Restaurants' patios/terraces (outdoor)Bus, tramway, trolley-bus stop waiting areas (outdoor)Stadiums and outdoor arenas (outdoor)Outdoor areas of hospitals and healthcare institutions (outdoor)Children's playgrounds (outdoor)
2- Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	Intervention on general population
C2. Possible source of information where the practice is described	https://www.folkhalsomyndigheten.se/livsvillkor-levnadsvanor/andts/vad-vi-gor-inom-andts/tobak-och-liknande-produkter/passiv-rokning-2012-2014/ Prop. 2017/18:156 Ny lag om tobak och liknande produkter
B1. Title/Name of the practice.	Smoke-free outdoor settings
B2. Type of practice.	**31-SE-SF National (Outdoor)** **Type of practice** 1 Information/awareness raising programm 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know
B3. Which is the current phase of the best practice?	The practice has been implemented (enforced/promoted)
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	01/07/2019
J1. What methods are/were used in the practice?	Legislation

K1. Enforcement of the practice.	Municipalities supervise and control. The Public Health Agency provides guidance on how supervision should be carried out
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population Age specific groups Vulnerable groups (Diseases)
4-& 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	Everyone´s right to move freely in public space
6-Effectiveness, efficiency and evaluation	
L1. What are the main outcomes of the practice?	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. 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.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	As far as I know, there is still no such systematic follow-up of the current smoking bans.
N1. Has the practice been formally evaluated?	Not yet, the intervention is still ongoing, but the evaluation is foreseen
7- Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.
8- Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9- Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	Group of population_Development National public health_Development National public health_Implementation National public health authorities_Evaluation Regional public healthauthorities_Implementation Local public healthauthorities_Implementation Researchers /academics_Development Civil_Organizations_Development Civil_Organizations_Implementation
10- Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Municipality/CityPublic agencyGovernment
B5. Name of the entity(ies) in national language and English and acronym.	Government. The Swedish Public Health Agency (Folkhälsomyndigheten, abbreviated FoHM). and 290 Swedish municipalities
B6. Please specify also the responsibility of the entity(ies):	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
E2. How was the practice funded?	No funds required

Links and additional information
https://www.folkhalsomyndigheten.se/livsvillkor-levnadsvanor/andts/vad-vi-gor-inom-andts/tobak-och-liknande-produkter/passiv-rokning-2012-2014/ Prop. 2017/18:156 Ny lag om tobak och liknande produkter

Table 5.32: Sweden_SF_health care: Non-smoking/smoke-free outdoor environments in the health care sector in Region Östergötland

Table with all the information from questionnaire	
QUESTIONS	**ANSWERS**
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Smoke-free outdoor settings (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for e-cigarettes Indoor aerosol-free regulation for heated tobacco products Outdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice	Regional (specify the regions) Region Östergötland
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	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.
F2. What is the overall goal of the practice?	A total smoke-free outdoor environment in the health care sector in the Region of Östergötland,
G1. Target settings.	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)
2-Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	An intervention on general population lead 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?
C2. Possible source of information where the practice is described	Our abstract for the Nordic public health conference is linked
B1. Title/Name of the practice.	Non-smoking/smoke-free outdoor environments in the health care sector in the Region Östergötland, Sweden

<table>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>32-SE-SF Health care</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don't know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>01/01/2016</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>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.</td></tr>
<tr><td>J1 bis. If relevant, please upload possible documentation.</td><td>Information+om+rökfria+utomhusmiljöer+på+olika+språk.pdf</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>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.</td></tr>
<tr><td colspan="2">3-Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population</td></tr>
<tr><td colspan="2">4 & 5- Equity & ethical aspects</td></tr>
<tr><td>Q1. What are the equity and ethical principles underpinning the practice?</td><td>We know that more people are using tobacco in low socio-economic groups. Our message address everyone but we also have so called ”Health communicators” in our region from different nationalities. They can translate the message into the right context.</td></tr>
<tr><td colspan="2">6-Effectiveness, efficiency, evaluation</td></tr>
<tr><td>L1. What are the main outcomes of the practice?</td><td>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.</td></tr>
<tr><td>M1. What indicators are used in the monitoring of the process and outcome of the practice?</td><td>no one</td></tr>
<tr><td>N1. Has the practice been formally evaluated?</td><td>Don’t know</td></tr>
<tr><td colspan="2">7-Transferability, potential of scalability</td></tr>
<tr><td>O1. Level of transferability and/or scalability.</td><td>Transferability has not been considered. The practice has been implemented on local/ regional/national level</td></tr>
<tr><td colspan="2">8-Sustainability</td></tr>
<tr><td>P1. Sustainability.</td><td>A sustainability strategy has been developed</td></tr>
</table>

9- Participation, empowerment	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Regional public health authorities_Development Regional public health authorities_Implementation Local public health authorities_Development Local public health authorities_Implementation Hospital_staff_Development Hospital_staff_Implementation Primary care centre staff_Development Primary care centre staff_Implementation Specialized physicians_Development Specialized physicians_Implementation General practitioners_Development General practitioners_Implementation Pharmacists_Development Pharmacists_Implementation Nurses_Development Nurses_Implementation Informal caregivers_Development Informal caregivers_Implementation Researchers /academics_Development Researchers /academics_Implementation School staff_DevelopmentSchool staff_Implementation Employers/employees_Development Employers/employees_Implementation Civil_Organizations_Development Civil_Organizations_Implementation Other_Org_Development Other_Org_Implementation
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Province/Region
B5. Name of the entity(ies) in national language and English and acronym.	All health facilities in region Östergötland
B6. Please specify also the responsibility of the entity(ies):	To keep the health care area as smokefree as possible.
E2. How was the practice funded?	Region Östergötland

Links and additional information
Information+om+rökfria+utomhusmiljöer+på+olika+språk.pdf

Table 5.33: Slovenia_SF_cars: Tobacco smoke and aerosol free vehicles with minors present

<table>
<tr><th>QUESTIONS</th><th>ANSWERS</th></tr>
<tr><td colspan="2">1-Relevance, comprehensiveness of the intervention</td></tr>
<tr><td>F3. Does the best practice focus on public or private settings?</td><td>Both public and private</td></tr>
<tr><td>F4. What are the objectives of the practice?</td><td>Car smoking ban with minors or pregnant women (conventional tobacco products)
Car vaping ban with minors or pregnant women
Car heated tobacco product ban with minors or pregnant women</td></tr>
<tr><td>E1. What is the geographical scope of the practice?</td><td>Slovenia</td></tr>
<tr><td>F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?</td><td>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</td></tr>
<tr><td>F2. What is the overall goal of the practice?.</td><td>To further protect children/minors from exposure to tobacco smoke and aerosols of related products in order protect their health</td></tr>
<tr><td>G1. Target settings.</td><td>Cars all private vehicles, not just cars, carrying minors (in public transports and vehicles used for work there is already a total ban on smoking and use of related products (e-cigarettes, HTPs and herbal products for smoking)</td></tr>
<tr><td colspan="2">2- Description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>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 ban is supported by yearly national media campaign and evaluation of effects among adolescents.</td></tr>
<tr><td>C2. Possible source of information where the practice is described information on the practice such as link to a website, link to any available documents (reports, articles).</td><td>Link to the Restriction on the Use of Tobacco and Related Products Act (Official Gazette of the Republic of Slovenia, No.9/2017 and 29/2017: http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO6717</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Tobacco smoke and aerosol free vehicles with minors present</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><th></th><th>33-SI-SF Cars</th></tr>
<tr><th></th><th>Type of practice</th></tr>
<tr><td>1</td><td>Information/awareness raising programme</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don't know</td></tr>
</table>
</td></tr>
</table>

B3. Which is the current phase of the best practice?	The practice has been evaluated
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	17/03/2017
J1. What methods are/were used in the practice?	Development of the measure: public consultation for the measure as a part of the new Act in 2017, meetings with selected stakeholders (Police and municipalities for checking the compliance) Evaluation of the effects of the measure: repeated cross-sectional survey among 16-year olds and in general population; checks of compliance Media campaign for raising awareness and knowledge Ministry of Health of the Republic of Slovenia is leading a wide mass media campaign in September since 2017 every year (exception 2020 due to covid). The aim of the campaign is to support the ban on smoking in all vehicles in the presence of minors (under 18). The key message: "When you smoke in car, your child is smoking with you". The campaign is aiming at prevention of second-hand smoking in vehicles and other private places (i. e at home). https://www.youtube.com/watch?v=ozZlhqaxrEo Coverage: Television (dissemination of spot), Radio (radio advertisement and talk shows with public health professionals from National institute of public health aiming to prevent second hand smoking), Roadsides (Police officers are disseminating leaflets with important public health messages aiming to prevent second hand smoking in cars and other private spaces), social media (dissemination of public health messages related with smoking). Target population: parents and other adults with underage children in private vehicles and other private spaces (i. e. at home) Possible evaluations of mass media (including social media) campaigns: No evaluation yet.
K1. Enforcement of the practice.	Police and Security Officers are responsible for enforcement and control of compliance. 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 we do not have data reports on violations from municipalities' Security Officers Services.
3-Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population Age specific groups
4- & 5- Equity & ethical aspects	
What are the equity and ethical principles underpinning the practice?	No equity or ethical principle were formally considered.
6-Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	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. Results of the 3 waves of the study are not yet published. Adults: Repeated cross sectional surveys 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 %.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	% of 16-year-old students reporting exposure to tobacco smoke in vehicles % of adults reporting that they or another person smokes in their family vehicles number of reported violations by Police and municipalities' Security Officers

N1. Has the practice been formally evaluated?	Yes, by an external partner
N1 bis. Please specify the organizations that conducted the evaluation.	National Institute of Public Health did the effect evaluation for Ministry of Health as described in answers to the two previous questions. Publications are available only in Slovene language with English summaries. Publication that contains results of effect evaluation among adults is attached, it includes summary in English. Publication that contains the results of three waves of study among 16-year-old students is in preparation. I have no knowledge than any other evaluation is planned, also economical.
7-Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/ regional/national level and transferability has not been considered in a systematic way.
8-Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources.
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_Development National public health_Development National public health authorities_Evaluation Civil_Organizations_Development Civil_Organizations_Implementation Civil_Organizations_Evaluation Other_Org_Development Other_Org_Implementation Other_Org_Evaluation
10-Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Public agency - Government
B5. Name of the entity(ies) in national language and English and acronym.	Ministry of Health (MoH) National Institute of Public Health and other relevant stakeholders (NGOs etc)
B6. Please specify also the responsibility of the entity(ies):	Ministry of Health (MoH) responsible for the relevant law, containing this measure Police and security officers for compliance checking National Institute of Public Health and other relevant stakeholders (NGOs etc). for promotion smoke-free environments, incl. vehicles
E2. How was the practice funded?	State and municipalities budget - funds provided by the Ministry of Health and for the compliance by the Police and municipalities if they have security officers

Links and additional information

Link to the Restriction on the Use of Tobacco and Related Products Act (Official Gazette of the Republic of Slovenia, No.9/2017 and 29/2017:
http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO6717

Table 5.34: Slovenia_SF_work: Comprehensive protection from tobacco smoke and aerosols of related products in all enclosed public places and workplaces and some open places

QUESTIONS	ANSWERS
1- Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Car smoking ban with minors or pregnant women (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes Car vaping ban with minors or pregnant women Indoor aerosol-free regulation for heated tobacco products Car heated tobacco product ban with minors or pregnant women Article 3 (point 25) of the Act: 25. Related products shall mean electronic cigarettes and nicotine-free electronic cigarettes, herbal products for smoking and novel tobacco products. Article 39: (1) Smoking and/or the use of tobacco, tobacco products and related products, except for chewing tobacco and nasal tobacco, shall be prohibited in all enclosed public places and workplaces and in all vehicles in the presence of persons under 18 years of age.(2) Smoking and/or the use of tobacco, tobacco products and related products, except for chewing tobacco and nasal tobacco, shall also be prohibited on premises that are not deemed to be enclosed places pursuant to this Act, provided that they form part of the curtilage associated with a structure in which educational or schooling activities are carried out.
E1. What is the geographical scope of the practice?	Slovenia
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Extension of smoke-free environments based on the relevant scientific evidence to protect general population from exposure to tobacco smoke and aerosols of related products.
F2. What is the overall goal of the practice?	The overall goal of the ban is to protect general population from exposure to tobacco smoke and aerosols of related products in all enclosed public places and enclosed workplaces.
G1. Target settings.	Restaurants and bars (indoor)Hotels (indoor)Train stations and public transports (indoor)Airports (indoor)Workplace (indoor)Schools/ public-education institutions/ educational venues except universities (indoor)Universities (indoor)Cinemas/theatres (indoor)Hospitals including outpatient clinics (indoor)Primary health care institutions (indoor)Institutions from social sector (indoor)CarsUnderpass (outdoor)Outdoor areas of school (outdoor)Children's playgrounds (outdoor)
2- Intervention characteristics, description of the practice	
C1. Please summarize this best practice.	The ban is intervention on general population. It is a policy.
C2. Possible source of information where the practice is described.	Restriction on the use of Tobacco products and related products act (OJ No.9/17 and 29/17). Articles: 3, 39-43
B1. Title/Name of the practice.	Comprehensive protection from tobacco smoke and aerosoles of related products in all enclosed public places and workplaces and some open places

<table>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><td></td><td>34-SI-SF Work</td></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don’t know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>24/02/2017</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>The ban was intruduced with the Act.</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>Supervision of the implementation of the ban shall be carries out by the Health Inspectorate of the Republic of Slovenia, the Labour Inspectorate of the Republic of Slovenia. In cars in the presence of minors under 18: the police and the municipal warden service.</td></tr>
<tr><td colspan="2">3- Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>General population</td></tr>
<tr><td colspan="2">4- Ethical aspects & 6-Equity</td></tr>
<tr><td>What are the equity and ethical principles underpinning the practice?</td><td>No.</td></tr>
<tr><td colspan="2">5- Effectiveness, efficiency, evaluation</td></tr>
<tr><td>L1. What are the main outcomes of the practice?</td><td>General population is protected from exposure to tobacco smoke and aerosols of related products in all enclosed workplaces and public places.</td></tr>
<tr><td>M1. What indicators are used in the monitoring of the process and outcome of the practice?</td><td>Supervision by surveillance authorities.</td></tr>
<tr><td>N1. Has the practice been formally evaluated?</td><td>No</td></tr>
<tr><td colspan="2">7- Potential of scalability and transferability</td></tr>
<tr><td>O1. Level of transferability and/or scalability..</td><td>The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.</td></tr>
<tr><td colspan="2">8-Sustainability</td></tr>
<tr><td>P1. Sustainability.</td><td>unknown</td></tr>
<tr><td colspan="2">9-Empowerment and participation</td></tr>
</table>

H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population_DevelopmentGroup of population_ImplementationNational public health_DevelopmentNational Public health_ImplementationNational public health authorities_EvaluationCivil_ Organizations_DevelopmentCivil Organizations_ImplementationOther Org_DevelopmentOther_Org_Implementation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	No funds required
B4. Who has the responsibility of the practice?.	NationGovernment
B5. Name of the entity(ies) in national language and English and acronym.	Ministry of health of Republic of Slovenia Health inspectorate of Republic of Slovenia
B6. Please specify also the responsibility of the entity(ies):	Ministry of Health introduced the ban on smoking and/or the use of tobacco, tobacco products and related products, except for chewing tobacco and nasal tobacco in all enclosed public places and workplaces and in all vehicles in the presence of persons under 18 years of age. Related products according to the Restriction on the use of tobacco products and related products act shall mean electronic cigarettes and nicotine-free electronic cigarettes, herbal products for smoking and novel tobacco products.

Links and additional information

Restriction on the use of Tobacco products and related products act (OJ No.9/17 and 29/17). Articles: 3, 39-43: 39. Waterpipe tobacco shall be a tobacco product that can be consumed by waterpipe. For the purpose of this Act, waterpipe tobacco is deemed to be a tobacco product for smoking. If a product can be used both by waterpipe and as roll-your-own tobacco, it shall be deemed to be roll-your-own tobacco. 40. Roll-your-own tobacco shall be tobacco as defined in paragraph three of Article 84

of the Excise Duty Act. 41. Chewing tobacco shall be a smokeless tobacco product exclusively intended for chewing. 42. Toxicity shall be the degree to which a substance can cause adverse effects in the human organism, including effects occurring over a longer period of time, usually through repeated or continuous consumption or exposure. 43. The import of tobacco or related products shall be any entry into the European Union of such products which do not have the status of EU goods or goods

imported from a third country pursuant to customs regulations and are not released on the free market within the EU in accordance with customs regulations.

Table 5.35: Slovenia_SF_educational: Smoking bans indoor at school/universities and outdoor areas / functional land of schools/universities

QUESTIONS	ANSWERS
1-Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Public only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Smoke-free outdoor settings (conventional tobacco products) Indoor aerosol-free regulation for e-cigarettes Outdoor aerosol-free regulation for e-cigarettes Indoor aerosol-free regulation for heated tobacco products Outdoor aerosol-free regulation for heated tobacco products
E1. What is the geographical scope of the practice?	Slovenia
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	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).
F2. What is the overall goal of the practice?	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.

<table>
<tr><td>G1. Target settings.</td><td>Schools/ public-education institutions/ educational venues except universities (indoor)
Outdoor areas of school (outdoor)</td></tr>
<tr><td colspan="2">2- Intervention characteristics, description of the practice</td></tr>
<tr><td>C1. Please summarize this best practice.</td><td>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....). In the letter was also announced inspectorate's oversight. The first part of 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.</td></tr>
<tr><td>C2. Possible source of information where the practice is described:</td><td>Please see document " 2019 Dopis mizs ms zirs"below

The document is unavailable</td></tr>
<tr><td>B1. Title/Name of the practice.</td><td>Smoking bans indoor od school/universities and outdoor area / functional land of schools/universities</td></tr>
<tr><td>B2. Type of practice.</td><td>
<table>
<tr><td></td><td>35-SI-SF Educational</td></tr>
<tr><td></td><td>Type of practice</td></tr>
<tr><td>1</td><td>Information/awareness raising programm</td></tr>
<tr><td>2</td><td>Policy</td></tr>
<tr><td>3</td><td>Action plan</td></tr>
<tr><td>4</td><td>Regulation/ ban</td></tr>
<tr><td>5</td><td>Monitoring/surveillance</td></tr>
<tr><td>6</td><td>Service delivery approach/method</td></tr>
<tr><td>7</td><td>Tool/instrument</td></tr>
<tr><td>8</td><td>Guideline</td></tr>
<tr><td>9</td><td>Training</td></tr>
<tr><td>10</td><td>E-health, mHealth</td></tr>
<tr><td>11</td><td>Health in All policies</td></tr>
<tr><td>12</td><td>Don't know</td></tr>
</table>
</td></tr>
<tr><td>B3. Which is the current phase of the best practice?</td><td>The practice has been implemented (enforced/promoted)</td></tr>
<tr><td>D1. Duration of the practice</td><td>The practice is ongoing</td></tr>
<tr><td>D1 bis. Please provide start date.</td><td>07/02/2019</td></tr>
<tr><td>J1. What methods are/were used in the practice?</td><td>Inspection control.</td></tr>
<tr><td>K1. Enforcement of the practice.</td><td>The practice was enforced by Health inspectorate, but only the first part of inspection overside. Health inspectorate has seven regional units, and it was agreed that every regional unit inspects at least: 1 college/high school, 2 secondary schools, 4 primary schools and 3 kindergartens. Total of 197 objects were visited.</td></tr>
<tr><td colspan="2">3- Evidence and/or theory based, target population</td></tr>
<tr><td>G2. If any, which is the specific target population?</td><td>Socioeconomic position (including educational level)</td></tr>
<tr><td colspan="2">4- Ethical aspects</td></tr>
<tr><td>Q1. What are the equity and ethical principles underpinning the practice?</td><td>Personal data were not collected. The inspector is constantly required to comply with ethical principles, equal treatment according to the powers conferred on the law.</td></tr>
<tr><td colspan="2">5- Effectiveness, efficiency, evaluation</td></tr>
<tr><td>L1. What are the main outcomes of the practice?</td><td>Unfortunately, COVID 19 situation stopped our activities, so we cannot yet talk about achieved improvements.</td></tr>
</table>

M1. What indicators are used in the monitoring of the process and outcome of the practice?	Indicator: percentage of non-compliant schools first inspection compared to percentage of non-compliant schools second inspection
N1. Has the practice been formally evaluated?	No
6-Equity	
Q1. What are the equity and ethical principles underpinning the practice?	Personal data ware not collected. The inspector is constantly required to comply with ethical principles, equal treatment according to the powers conferred on the law.
7-Transferability & potential of scalability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/regional/national level and transferability has not been considered in a systematic way.
8-Sustainability	
Is the continuation of the intervention ensured through institutional ownership that guarantees funding and human resources, and/or mainstreamed?	
P1. Sustainability.	The practice has institutional support and stable human resources.
9-Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	National public health_Development Researchers /academics_Implementation School staff_Development School staff_Implementation
10-Intersectoral collaboration, governance and project management	
E2. How was the practice funded?	Own resources
B4. Who has the responsibility of the practice?	Government
B5. Name of the entity(ies) in national language and English and acronym.	Ministry of health of Republic of Slovenia Health inspectorate of Republic of Slovenia
B6. Please specify also the responsibility of the entity(ies):	Ministry of Health and Health inspectorate together provided the information to schools. Health inspectorate carried out an inspection.

Table 5.36: UK (England)_SF_homes: Smoke free homes

QUESTIONS	ANSWERS
1. Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Private only
F4. What are the objectives of the practice?	Smoke-free indoor settings (conventional tobacco products) Voluntary home smoking ban (conventional tobacco products) Car smoking ban with minors or pregnant women (conventional tobacco products)
E1. What is the geographical scope of the practice	England, Yorkshire Leeds City Council
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Second hand smoke exposure to children at homes
F2. What is the overall goal of the practice?	To create smoke free homes and reduce children's exposure to tobacco smoke
G1. Target settings.	Cars Home
2. Intervention characteristics, description of the practice	

C1. Please summarize this best practice.	7 steps out is about reducing children and young people's exposure to second-hand smoke in the home. This initiative encourages smokers to take 7 steps out of the home to reduce second-hand smoke exposure
C2. Possible source of information where the practice is described	https://betterlivesleeds.wordpress.com/2015/04/14/smokefree-homes-take-7-steps-out/
B1. Title/Name of the practice.	Smoke Free Homes
B2. Type of practice	

	36-UK (England)-SF Homes
	Type of practice
1	Information/awareness raising programm
2	Policy
3	Action plan
4	Regulation/ ban
5	Monitoring/surveillance
6	Service delivery approach/method
7	Tool/instrument
8	Guideline
9	Training
10	E-health, mHealth
11	Health in All policies
12	Don't know
13	Other: behaviour change intervention

B3. Which is the current phase of the best practice?	The practice has been developed/adopted but not yet enforced
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	16/04/2015
J1. What methods are/were used in the practice?	This campaign encourages smokers to quit or take it outside, ensuring children and grandchildren are not regularly exposed to smoke in indoor spaces.
K1. Enforcement of the practice.	Not enforced but implemented through a campaign
3. Evidence and/or theory based = Target population	
G2. If any, which is the specific target population?	General population Age specific groups
4. & 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	Address inequality when it comes to SE status and ethnicity
6. Effectiveness, efficiency = Evaluation	
L1. What are the main outcomes of the practice?	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.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	Number of smokers who saw the campaign Number who said the campaign made them more concerned about smoking Number of smokers who quitted Number of smokers going outside to smoke, Number of smokers stopping smoking in the same room as a family member, Number of smokers switching to an electronic cigarette.

N1. Has the practice been formally evaluated?	Yes, the evaluation was carried out internally
N1 bis. If you answered "Yes" or "Not yet": Please specify the organizations that conducted the evaluation.	unknown
7. Transferability = Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	The practice has been transferred (i.e. scaled-up) within the same country/region. The practice has been scaled-up to other locations or regions or at national scale in the same country.
8. Sustainability	
P1. Sustainability.	The practice has institutional support and stable human resources. The practice provides training of staff in order to sustain it
9. Participation = Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/development, implementation or evaluation of the practice?	Group of population _Development Group of population _Implementation Group of population _Evaluation
10. Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Municipality/City Public agency
B5. Name of the entity(ies) in national language and English and acronym.	Local authorities
B6. Please specify also the responsibility of the entity(ies)	Public health
E2. How was the practice funded?	External resources-public

Links and additional information
More information on the awareness campaign is available at:
https://betterlivesleeds.wordpress.com/2015/04/14/smokefree-homes-take-7-steps-out/

Table 5.37: UK(Scottland)_SF_homes: Take it right outside

QUESTIONS	ANSWERS
1. Relevance, comprehensiveness of the intervention	
F3. Does the best practice focus on public or private settings?	Private only
F4. What are the objectives of the practice?	Voluntary home smoking ban (conventional tobacco products)
E1. What is the geographical scope of the practice	Scotland
F1. What is the justification (need or problem) and context (existing evidence and theory) for developing this practice?	Evidence from the Scottish Health Survey that about 12% of children were exposed to SHS in the home. TiRO also introduced a national target to reduce this figure by half by 2020.
F2. What is the overall goal of the practice?	The practice had a goal of reducing the proportion of children exposed to SHS from 12% in 2014 to 6% by 2020.
G1. Target settings.	Home
2. Intervention characteristics, description of the practice	

C1. Please summarize this best practice.	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 exposure to SHS.
C2. Possible source of information where the practice is described	https://www.nhsinform.scot/campaigns/take-it-right-outside
B1. Title/Name of the practice.	Take it right outside
B2. Type of practice.	**37-UK (Scotland)-SF Homes** **Type of practice** 1 Information/awareness raising programm 2 Policy 3 Action plan 4 Regulation/ ban 5 Monitoring/surveillance 6 Service delivery approach/method 7 Tool/instrument 8 Guideline 9 Training 10 E-health, mHealth 11 Health in All policies 12 Don't know
B3. Which is the current phase of the best practice?	The practice has been evaluated
D1. Duration of the practice	The practice is ongoing
D1 bis. Please provide start date.	25/03/2014
J1. What methods are/were used in the practice?	Take it Right Outside was a national mass media initiative launched in 2014 encouraging smokers to smoke cigarettes outside their own home to protect children and other family members from second-hand smoke. A wide variety of media was used (TV, radio, newsprint, billboard, social media, etc) to communicate key messages.
K1. Enforcement of the practice.	There was no enforcement element to this practice. It was developed to produce voluntary change in social norms around smoking in the home.
3. Evidence and/or theory based, target population	
G2. If any, which is the specific target population?	General population Age specific groups
4. & 5- Equity and ethical aspects	
What are the equity and ethical principles underpinning the practice?	This is an information campaign. The campaign was developed to target messages around the benefits of a smoke-free home for all. The Scottish Health Survey is a nationally representative sample that undergoes rigorous equity and ethical oversight at governmental level.
6. Effectiveness, efficiency, evaluation	
L1. What are the main outcomes of the practice?	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.
M1. What indicators are used in the monitoring of the process and outcome of the practice?	The annual Scottish Health Survey question on children's exposure to SHS at home is used to monitor the outcome of TiRO.
N1. Has the practice been formally evaluated?	Yes, by an external partner

N1 bis. If you answered "Yes" or "Not yet": Please specify the organizations that conducted the evaluation.	Universities of Aberdeen, Glasgow and Stirling.
Q1. What are the equity and ethical principles underpinning the practice?	This is an information campaign. The campaign was developed to target messages around the benefits of a smoke-free home for all. The Scottish Health Survey is a nationally representative sample that undergoes rigorous equity and ethical oversight at governmental level.
7. Potential of scalability and transferability	
O1. Level of transferability and/or scalability.	Transferability has not been considered. The practice has been implemented on local/ regional/national level and transferability has not been considered in a systematic way.
8. Sustainability	
P1. Sustainability.	None
9. Empowerment and participation	
H1. Have the target population and other stakeholders been involved in the adoption/ development, implementation or evaluation of the practice?	National public health_Development National public health_Implementation National public health authorities_Evaluation Regional public health authorities_Development Regional public health authorities_Implementation Regional public health authorities_Evaluation Local public health authorities_Development Local public health authorities_Implementation Local public health authorities_Evaluation Hospital_staff_Development Hospital_staff_Implementation Primary care centre staff_Development Primary care centre staff_Implementation Specialized physicians_Development Specialized physicians_Implementation General practitioners_Development General practitioners_Implementation Pharmacists_Development Pharmacists_Implementation Nurses_Development Nurses_Implementation Other health care prof_Development Other health care prof_Implementation Other health care prof_Evaluation Informal caregivers_Implementation Researchers /academics_Development Researchers /academics_Implementation Researchers /academics_Evaluation School staff_Implementation Employers/employees_Implementation Civil_Organizations_Development Civil_Organizations_Implementation
10. Intersectoral collaboration, governance and project management	
B4. Who has the responsibility of the practice?	Government
B5. Name of the entity(ies) in national language and English and acronym.	Scottish Government
B6. Please specify also the responsibility of the entity(ies):	National responsibility for public health
E2. How was the practice funded?	External resources-public

Links and additional information
https://www.nhsinform.scot/campaigns/take-it-right-outside