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Joint national capacity assessment of tobacco control policies in Estonia

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Ministry of Social Affairs, Estonia and
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This publication expresses the authors' personal views and opinions, which do not necessarily reflect the views of the institutions with which they are affiliated.

Executive summary

Context

Estonia ratified the WHO Framework Convention on Tobacco Control within five months after it entered into force in 2005. In the same year, the Riigikogu (parliament) passed into law the Tobacco Act to comply with the Convention and current European Directives on tobacco.

The National Health Plan, the National Strategy for the Prevention of Cardiovascular Diseases and the National Cancer Strategy articulate the case for reducing tobacco use, and research generated both in Estonia and internationally supports the case.

Evidently, in the mid-2000s, Estonia was making progress in developing tobacco control policy based on years of experience in developing smoking-cessation services as an integral part of the national health system. Nevertheless, the advances that were made during that time have not yet been translated into significant reductions in smoking prevalence – except among university educated Estonians. Overall, the smoking prevalence rose from the early to mid-1990s. That trend was reversed in the late 1990s, however, and by 2008, the prevalence was less than 1.5 percentage points lower than it was in 1990 while, during the same period, the smoking prevalence in Finland declined by 6 percentage points and in England by 8 percentage points.

Of particular concern is that the smoking prevalence among Estonians with less education is worse now than it was in the mid-1990s, thereby increasing social inequality and inequality in health. The smoking prevalence among teenagers rose quite sharply in the late 1990s and has started to decline, except among mid-teenage girls. Smoking in pregnancy has steadily increased over the last decade. Both trends will result in health problems for infants and children and for young adult women.

In this context, at the request of Estonia's Ministry of Social Affairs, a mission led by WHO conducted a joint rapid assessment of current practices and national capacity for tobacco control in Estonia. The WHO Regional Office for Europe worked together with the Public Health Department of the Ministry of Social Affairs and with the National Institute for Health Development to organize and conduct this capacity assessment.

From 13 to 17 December 2010, a group of six national and international health experts reviewed the status of key tobacco control policies and activities and conducted interviews with key informants.

Key challenges

The assessment team considers the following factors to be the most significant challenges to progress in tobacco control in Estonia.

- Estonia has no national roadmap for tobacco control. Although integration into the National Health Plan and the strategies for cardiovascular diseases and cancer is important, reducing tobacco use requires having a clear and comprehensive plan with measurable targets.
- The resources allocated to tobacco control are wholly inadequate. The limited human resources and budget dedicated to tobacco control do not match the good intentions of the health authorities In Estonia.

- The roles and responsibilities of the various agencies engaged in tobacco control need to be clarified and a coordinating mechanism agreed on.

Given the demonstrable intellectual talent in health policy in Estonia and the commitment in principle to following an evidence-informed approach, the assessment team believes that Estonia can make considerable progress in tobacco control during the next decade if these three challenges are overcome. The assessment team has made four priority recommendations and a further 16 medium-term recommendations.

Short-term recommendations

Four recommendations are considered critical and should be considered as priorities for 2011.

1. A Ministerial Tobacco Control Task Force, comprising government and nongovernmental experts, should be established under the auspices of the Cardiovascular Disease Strategy Council to develop and initiate a detailed national roadmap for tobacco control from 2012 to 2020.
    - Once this roadmap is fully integrated into the 2013–2016 action plan, the Cardiovascular Disease Strategy Council should supervise its implementation, but this would still benefit from having a multidisciplinary advisory group of tobacco control experts.
    - Reporting on tobacco control under the National Health Plan and the National Cancer Strategy should continue but should indicate the action taken and progress made under the Cardiovascular Disease Strategy so that tobacco control efforts are coordinated under one banner.
    - Should health strategies be realigned before 2020 – for example, into a noncommunicable disease strategy – tobacco control should be accorded priority status.
2. The terms of reference for the Task Force should include providing expert input into preparing revisions to the Tobacco Act to comply with the WHO Framework Convention on Tobacco Control and upcoming European Union (EU) directives, particularly with respect to pictorial pack warnings, flavoured tobacco products, eliminating point-of-sale promotion by removing from display all tobacco products and accessories, such as cigarette papers, and eliminating designated smoking rooms in public places.
3. The Ministry of Social Affairs should increase the budget allocation to tobacco control to adequately support both the development and the implementation of the national roadmap and its targets through 2020.
    - At the very least, the commitment made in 2005 under the Cardiovascular Disease Strategy to devote 1% of tobacco tax revenue to tobacco control should be honoured immediately.
    - In 2009, 1% of revenue from tobacco tax would have generated €1.33 million in excise, duty and value-added tax (VAT).
4. The Task Force needs to clarify the roles and responsibilities for various elements of tobacco control. A national coordination mechanism should be established through consultation with all the agencies – government and nongovernmental – involved in tobacco control.

Medium-term recommendations

For the medium term – that is, by 2013 – the assessment team has made a further 16 recommendations for action. These are summarized below under the four main areas of tobacco control: regulation; education; cessation; and research and evaluation.

The main body of the report, however, is organized under the relevant articles of the WHO Framework Convention on Tobacco Control. Estonia is legally bound to implement the Convention and should take advantage of the Convention's guidelines and future protocols to guide the design of its tobacco control programme.

1. Estonia should play a more active role in further developing the Convention – especially by joining the negotiations of the Illicit Trade Protocol – as Estonia has much experience to offer and will benefit from a strengthened Convention.

Regulation

As in all countries, the Ministry of Finance has a vitally important role to play in tobacco control and must be committed to delivering health outcomes through fiscal policy. In recent years, tobacco tax policy has been determined largely by EU entry requirements. Before conformity is reached, capacity in tobacco control economics needs to be developed to ensure that future fiscal policy is fully informed by available evidence and international best practice. Of immediate concern is the affordability of hand-rolling tobacco compared with manufactured cigarettes.

2. The difference in tax rates between cigarettes and hand-rolling tobacco should be progressively reduced.

A review of the Tobacco Act is planned for 2011, coinciding with preparations for a new EU directive on tobacco products. This should be a wide-ranging review, overseen by the Ministerial Tobacco Control Task Force. The key regulatory issues that require attention include the following:

3. the application of pictorial health warnings to all tobacco products, including tobacco for water pipes, to educate the general public on the level and nature of harm to health caused by tobacco;
4. the elimination of point-of-sale promotion of tobacco products and accessories to protect children and young people, achieved by removing them from open display,
5. the banning of tobacco products with flavours such as vanilla, strawberry and chocolate, to protect children and young people;
6. the elimination of designated smoking rooms (whether with separate ventilation systems or not) to ensure universal and equal protection from second-hand tobacco smoke for all workers and the general public;
7. the establishment of smoke-free protection zones outside the doorways of public buildings to protect the general public;
8. the creation of a licensing system to regulate the sale of tobacco products to protect children and young people; and
9. the development of a stronger, more cohesive system for monitoring the implementation of regulations on tobacco.

Education

Despite overwhelming evidence of the effectiveness of mass-media campaigns globally, scant resources are currently dedicated to efforts in this area. The National Institute for Health Development has applied to the Norwegian Agency for Development Cooperation for funds to run antismoking mass-media campaigns from 2012 to 2015. Mass-media material, including television spots, based on solid research is now available, at low or no cost, through international agencies. These shared materials have been used successfully in many countries.

The people with the least education in Estonia are the most likely to smoke and the most likely to allow smoking in the home, leaving their families unprotected from second-hand smoke. All future campaigns should therefore target and be pretested with people of low socioeconomic status.

10. Two major mass-media campaigns should be developed and delivered concurrently in 2012 and 2013: one to educate the general public on health effects (ideally linked to the introduction of pictorial pack warnings) and the other to educate adults on how to protect children from second-hand smoke in the home.

There is wide support for school programmes aimed at preventing initiation by students younger than 16 years in Estonia.

11. The effectiveness and cost–effectiveness of such school programmes should be rigorously evaluated or investment diverted into interventions with proven effectiveness such as mass-media campaigns.

Cessation

Estonia should be proud of its smoking-cessation services within its hospitals and health services. These are offered free of charge to all smokers who want help to quit and provided by specially trained health professionals. Although these services can still be improved and must be sustainably resourced, Estonia is ahead of many countries in the WHO European Region in its commitment to providing evidence-informed treatment for smoking cessation. The two areas of concern are: duplication of effort around the two telephone helplines (both poorly resourced) and the lack of subsidized pharmaceuticals through the cessation services.

12. *One* new national quitline should be established that is fully integrated with the cessation services and will thus act as a portal to these services. Referral to the quitline should take place at every relevant health care interaction.
13. The case for subsidizing pharmaceuticals should be fully investigated.

Research and evaluation

Estonia has a track record of producing high-quality public health research and has many experienced researchers, some with international reputations. However, in the absence of a nationally agreed research agenda for tobacco control, the interests of the individual researcher and the availability of funds is likely to drive the selection of research topics.

14. A priority-driven research agenda should be developed as soon as possible to inform the national tobacco control roadmap.

Two areas of research, in particular, suffer from low levels of capacity and should be addressed by identifying relevant expertise and ensuring that funding is available.

15. Tobacco control economics – research is urgently required to assess the impact of recent and planned increases in the tobacco tax, the level and nature of illicit trade and the cost–effectiveness of anti-smuggling measures.
16. Tobacco industry monitoring – a comprehensive system for monitoring the tobacco industry – is required to assist Estonia in fulfilling its obligations under Article 5.3 of the WHO Framework Convention on Tobacco Control, which various agencies currently routinely ignore.

Annex 4 presents all 20 recommendations of the assessment team.

1. Introduction

1.1 The tobacco epidemic in Estonia

1.1.1 Trends in tobacco use and exposure to tobacco smoke

The population of Estonia is about 1.3 million, of whom about 0.345 million are smokers.

Adult behaviour. The biennial Health Behaviour Survey among the adult population of Estonia estimated the daily smoking prevalence in 2008 to be about 39% for men and 17% for women 16–64 years old. In the early 1990s, and again in the mid-2000s, the smoking prevalence rose among both men and women (Fig. 1). Overall, between 1990 and 2008, the smoking prevalence among adults fell by less than 1.5 percentage points whereas, over the same period, the prevalence fell by 6 percentage points in Finland (15–64 years old) *(1)* and by 8 percentage points in England (≥16 years) *(2)* (Fig. 2).

Fig. 1. Prevalence (%) of daily smoking in Estonia by sex, 1990–2008

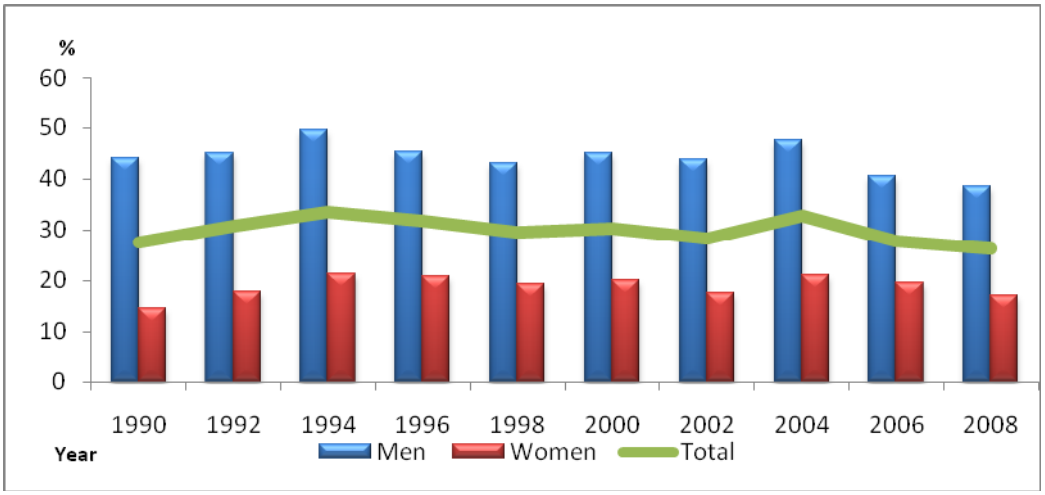
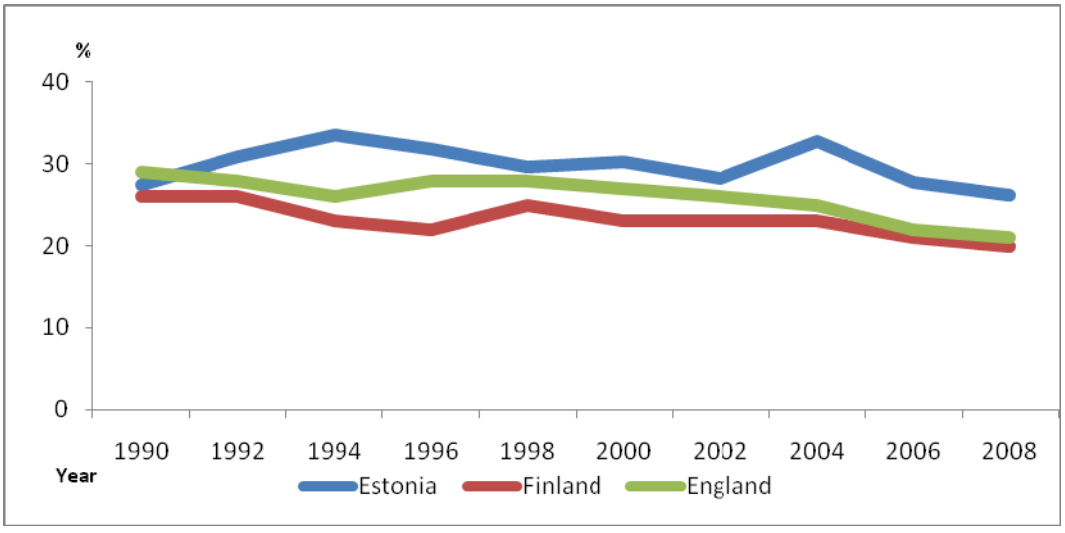


Fig. 2. Prevalence (%) of daily smoking among adults in England, Estonia and Finland, 1990–2008



The prevalence among population groups is of particular concern. Smoking rates among university-educated Estonians have declined dramatically from 31% in 1994 to 12% in 2008 but have actually increased by 7 percentage points among the least educated people over the same period (Fig. 3).

Similarly, pregnant Estonian women have had a disturbing increase in tobacco use in the last decade. One of every 10 pregnant women smokes regularly: up to 2000 women (Fig. 4).

Fig. 3. Prevalence (%) of daily smoking in Estonia by educational status, 1994–2008

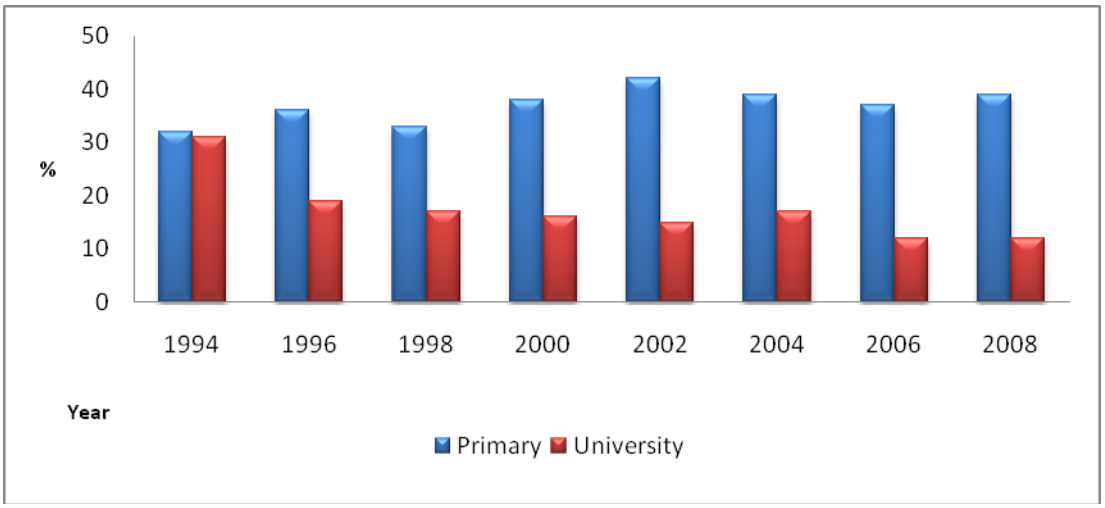
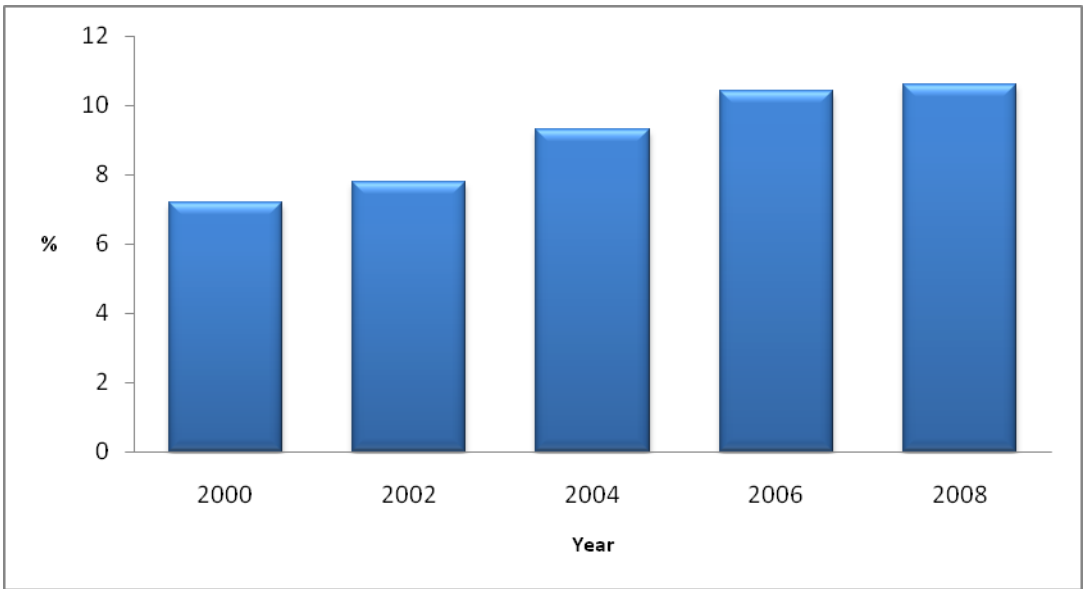


Fig. 4. Prevalence (%) of smoking in Estonia among pregnant women, 2000–2008



Youth behaviour. The age of initiating tobacco use is declining. Smokers who are now 55–64 years old took up smoking around the age of 20 years. However, smokers now aged 16–24 years took up smoking around age 15 years.

The 2007 Estonian school-based student health survey of students aged 13–15 years shows that 31.5% of boy and 30% of girls in that age group are smokers. More than one in three (35%) of

students had tried smoking before age 10 years. Having increased significantly in the late 1990s, daily smoking among teenage boys is slowly trending downwards. This does not appear to apply to teenage girls. At best, it may be levelling off, or it could be increasing (Fig. 5).

Fig. 5. Prevalence (%) of daily smoking in Estonia among 13- and 15-year-old boys and girls, 1993–2006

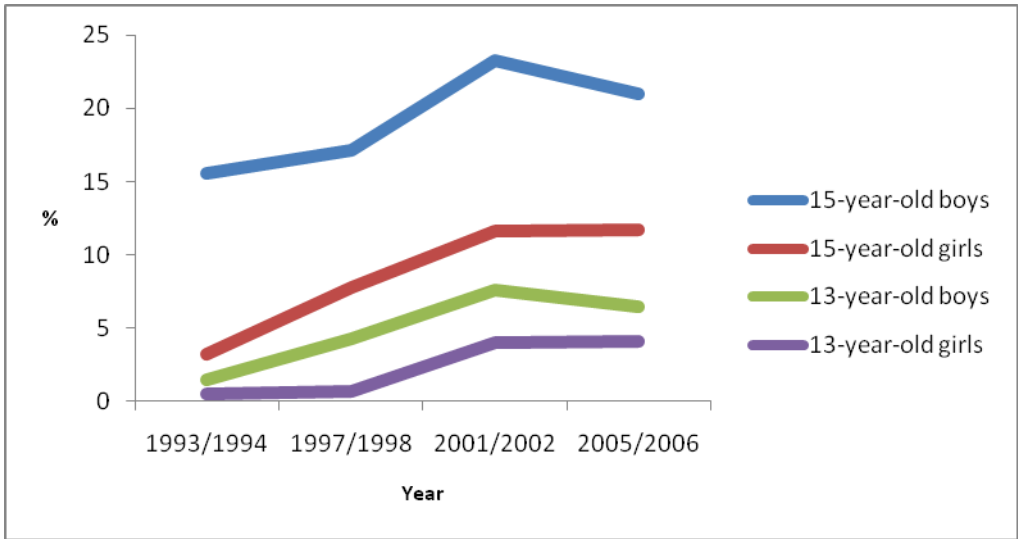
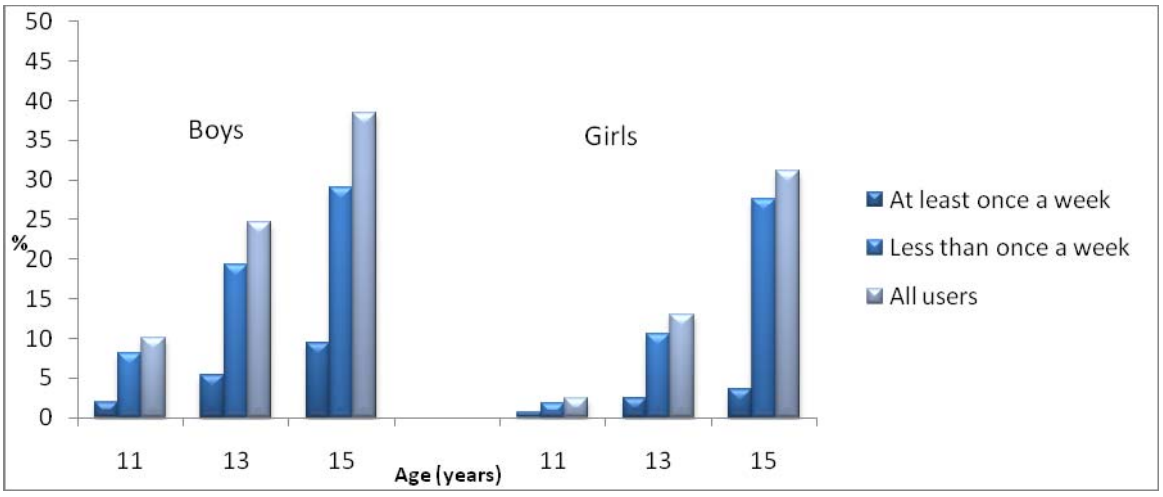


Fig. 6. Prevalence (%) of water pipe smoking in Estonia among 11-, 13- and 15-year-old boys and girls, 1993–2006



Estonian teenagers widely use water pipes, with about one in three having used it. Among 15-year-old boys, 1 in 10 use it at least once a week (Fig. 6). Anecdotal evidence from the HELP Campaign Manager suggests that teenagers understand very little about the health effects of smoking a water pipe, with many believing it is safer than smoking cigarettes because the smoke is filtered through water and some simply not acknowledging that it can cause any harm at all.

Exposure to second-hand tobacco smoke at work and in the home has decreased significantly since the mid-1990s (Fig. 7 and 8). The Global Youth Tobacco Survey shows a marked improvement between 2003 and 2007 in exposure to second-hand smoke (Fig. 9). However, that still leaves more than 40% of young Estonians living in homes where others smoke in their presence.

Fig. 7. Prevalence (%) of being exposed to tobacco smoke at work for at least one hour per workday in Estonia, 1994–2008

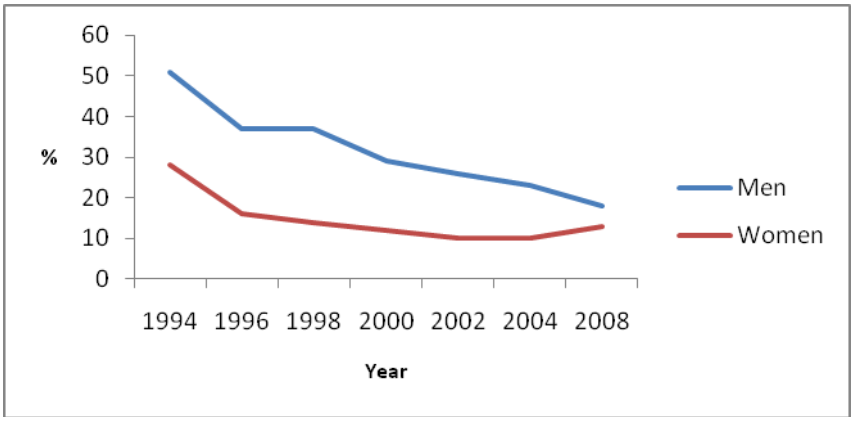


Fig. 8. Prevalence (%) of being exposed to tobacco smoke at home in Estonia, 1994–2008

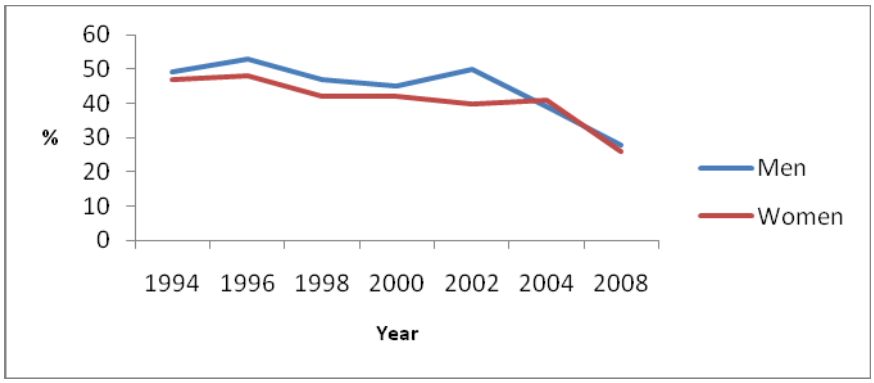
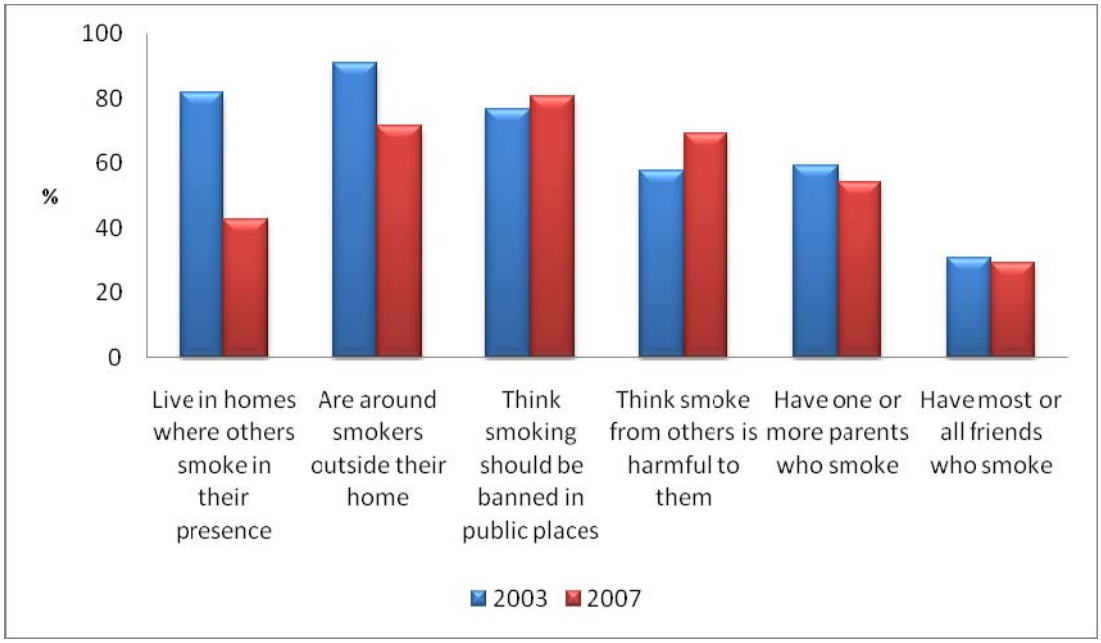


Fig. 9. Prevalence (%) of behaviour and attitudes among people 13–15 years old in Estonia, 1994–2008



With a few exceptions, these data give cause for serious concern. Even though tax increases in 2009 and 2010 should have had a positive impact, smoking rates among poor and young people remain high.

1.2 The tobacco industry in Estonia

There has been no cigarette production in Estonia since 1996. According to Euromonitor International's 2010 report *Tobacco in Estonia (3)*, "Eesti Tubakas planned to launch a production facility in the country by the end of 2005 … However, this never took place." Euromonitor International reports provide assessments of the tobacco market for many countries; they use official and industry data and conduct interviews with company representatives.

In Estonia, their assessment is that sales will hold up fairly well over the next few years, with sales forecast as going from 1.8 million cigarettes in 2009 to an estimated 2 million cigarettes in 2014. The Institute of Economic Research is quoted as suggesting that "enough cigarettes were imported in 2007 to meet demand during the first nine months of 2008 in anticipation of the tax increases in January and July 2008, which pushed up prices substantially. Following the tax increases, retailers were allowed to sell their existing stock at previous prices until the end of September 2008, an opportunity which was widely exploited."

1.3 Tobacco control strategies in Estonia

In common with many countries, Estonia's strategies to reduce tobacco use are articulated in several settings, ranging from legislation to official policy and planning documents. The most significant are briefly described and commented on below.

1.3.1 The WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control entered into force on 28 February 2005, and Estonia ratified it on 27 July 2005. The Convention is a legally binding international treaty that provides the basis for a comprehensive tobacco control strategy. Guidelines for implementing some articles are available; others are still being developed.

1.3.2 The Tobacco Act

The Tobacco Act entered into force on 5 June 2005 and is based on Directive 2001/37/EC of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products. A review of the Tobacco Act is planned for 2011. The recommendations in this report indicate the areas that require attention.

1.3.1 National Health Plan 2009–2020

The National Health Plan features tobacco use under the section on healthy lifestyles along with other risk factors: "limited physical activity, imbalanced nutrition and risk behaviour, for instance, use of alcohol, tobacco and illegal drugs, gambling, risky sexual behaviour and unsafe traffic behaviour (speeding, failure to use safety belts and reflectors, etc.)".

Placing the single most important preventable cause of premature death and disease *(5)* in a long list of risk factors, with no further qualification, can lead to underestimating the scale of the

problem caused by tobacco. It is important to continually remind policy-makers and the general public alike of the level of damage caused by tobacco.

By way of illustration, in 2000 in Estonia, national records show that 2092 people died from non-medical causes; that includes *all* accidents at work, at home, on roads, planes, boats and trains; all homicides, suicides, poisoning, drowning, fires, floods and all other natural disasters. This compares to an estimated 2800 deaths from tobacco – and 1700 of these deaths were in middle age *(6)*.

The National Health Plan identifies several concerns about the level of tobacco use.

- The number of daily smokers is declining more slowly among women than among men.
- The percentage of smokers is higher among people with lower income levels, among other nationalities and among unemployed people.
- People start smoking at a younger age.
- The popularity of water pipes and smokeless products, particularly dipping tobacco, is increasing among young people.
- The percentage of people who live and smoke in the same room is high among people with lower levels of education.

All are valid causes for concern, but the National Health Plan then fails to recommend any specific action to address these concerns. Although 10 actions are recommended on physical activity and 13 on nutrition, there is only 1 explicit recommended action for tobacco: that individuals should "avoid alcohol and tobacco use in public places and use protective equipment (safety belts, condoms, etc.)".

The 2009 report on the National Health Plan notes improved cooperation between agencies against counterfeit cigarettes and border allowances. It goes on to note the lack of regulation of e-cigarettes and other products that appeal to young people; however, only the annual school smoke-free school competition and information workshops for teachers are reported on.

1.3.4 National Cancer Strategy, 2007–2015

The National Cancer Strategy acknowledges that "almost 40% of all cancer cases could be avoided". It does not go on to identify the proportion of cancer deaths that are attributable to tobacco, but leading cancer epidemiologists have estimated that smoking accounts for about one fourth of all cancer deaths in Estonia *(6)*, with an estimated 44% of cancer deaths among men caused by smoking and about 6% (but rising) of cancer deaths among women caused by smoking.

The Cancer Strategy also gives the impression of underestimating the scale of damage caused by tobacco by listing it among other risk factors without explaining it further; for example, it aims to assist "residents to … avoid potentially dangerous technological methods in preparing meals, to decrease the role of smoking, to increase the part of physical activity, to reduce alcohol consumption, to reduce exposure to UV-radiation".

The Cancer Strategy strongly emphasizes how various chemicals affect the risk of cancer and a table on lung cancer that includes tobacco smoke as one of 32 known risk factors. Again, this

may inadvertently mislead policy-makers, as tobacco smoke causes an estimated 87% of lung cancer in Estonia.

The subgoal related to raising awareness of cancer risks has an indicator of effectiveness related to weekly smoking by children. With nearly half of cancer deaths among men in Estonia caused by smoking, this seems inappropriate.

1.3.5 National Strategy for the Prevention of Cardiovascular Diseases, 2005–2020

The National Cardiovascular Disease Strategy recognizes that cardiovascular diseases are the main reason for premature death and disability in Estonia and therefore "pose a serious challenge to the socioeconomic development of the nation".

The Strategy – written in 2005 – acknowledges that "there has been no significant change for the better over the past 20 years" and explains that "Smoking is the only single risk factor of heart health that can be eliminated at once. The risk is reduced immediately when one quits smoking and becomes equal to the cardiovascular disease risk of nonsmokers within about 10 years."

The Strategy commits to "effective and productive implementation of the Tobacco Act in cooperation with the surveillance agencies and the media" and goes on to outline activities relating to schools and smoking cessation.

Crucially, the Strategy commits to "increasing the agreed level of tobacco excise taxes according to the requirements set out in the EU accession agreement within 5 years instead of 10. Of the excise taxes collected, 1% will be used to finance activities and health campaigns aimed at the reduction of smoking."

Data provided by the Ministry of Finance indicate that, in 2009, tobacco tax revenue was EEK 2.09 billion (€133.4 million). One per cent of this would have yielded about €1.33 million for tobacco control programmes in 2009. Even if the calculation excluded VAT on tobacco, the amount available for investment would be enough to transform the ability of the Ministry of Social Affairs and the National Institute for Health Development to put in place effective measures to reduce tobacco use.

The strategy sets goals for the years 2005–2020 and a four-year action plan corresponding to the national budget strategy. Thus, the current action plan expires in 2012 (the assessment team did not review the 2009–2012 action plan), and the 2013–2016 action plan will be developed and approved in 2012.

The current goals relating to tobacco use are:

- a steadily decreasing trend in daily smoking by 13-year-olds;
- reducing daily smoking by men aged 16–64 years to 30% by 2020;
- reducing daily smoking by women aged 16–64 years to 10% by 2020; and
- reducing the proportion of people who spend at least one hour a day in an environment that contains tobacco smoke to 6% of men by 2020 and 2% of women by 2020.

These targets could be stronger. Fixed targets should be agreed for driving down youth smoking. The prevalence among university-educated Estonians fell by 19 percentage points from 1994 to

2008, demonstrating that significant reductions are possible at the population level. The prevalence of smoking among men in 2008 was 39%, and a target of 30% over the 12 years to 2020 therefore lacks ambition.

Further, the targets for environments that contain tobacco smoke relate to workplace exposure. These should be 100% smoke-free long before 2020, with no difference in protection for men and women.

If a mid-term review of the Cardiovascular Disease Strategy takes place in 2012, all these targets should be strengthened. For advocacy purposes, it may be useful to set an aspirational target of 10% by 2030 for the whole population, with the new 2020 target framed as a stepping stone.

The proposed Ministerial Tobacco Control Task Force should carefully consider whether general population targets should be stratified by socioeconomic status.

1.3.6 Conclusions about current strategies

The National Health Plan and the National Cancer Strategy do not set out the case for tobacco control robustly enough, given the scale of the tobacco-use epidemic in Estonia. The Cardiovascular Disease Strategy offers more scope for an evidence-based substrategy on tobacco control. In addition, it has the benefit of a Cardiovascular Disease Strategy Council (Annex 3), chaired by the Minister and with senior representation from across government and civil society, to oversee progress on the implementation of the National Cardiovascular Disease Strategy.

Several countries are moving towards having integrated strategies across all noncommunicable diseases. Since tobacco use is the single risk factor common to cardiovascular disease, cancer, diabetes and chronic respiratory disease, tobacco control should feature prominently in any future strategies to prevent and control noncommunicable diseases.

1.4 Tobacco control programmes in Estonia

In Estonia, the Ministry of Social Affairs has overall responsibility for national tobacco control and has assigned a lead role to the National Institute for Health Development. Other agencies have discrete responsibilities for particular tasks.

1.4.1 The Ministry of Social Affairs

The Ministry of Social Affairs undertakes its coordination role in tobacco control through the Public Health Department (one of four departments in the Health Division of the Ministry). The Ministry's main role is to coordinate interministerial responses to the country's needs and to decide on major tobacco control policies, eventually submitting them to the Riigikogu (parliament) for consideration.

It is assumed that the Ministry of Social Affairs also has the role of ensuring a coordinated Estonian position in the discussions and negotiations on the WHO Framework Convention on Tobacco Control process and on health consultations within the EU (although the assessment team learned that the Ministry of Economic Affairs and Communications was preparing its own submission to the consultation on the EU directive on tobacco and that their submission did not support the position of the Ministry of Social Affairs). Apart from the intermittent involvement of the Director of the Public Health Department, the Ministry of Social Affairs has one part-time staff member working on tobacco control issues. A limited budget is allocated to tobacco control

activities (no figure was available to the assessment team), and this includes work on the WHO Framework Convention on Tobacco Control.

1.4.2 The National Institute for Health Development

The National Institute for Health Development undertakes its coordination role in tobacco control through its Noncommunicable Disease Prevention Department. Currently, one full-time staff member of the National Institute for Health Development manages the Smoking Cessation Service, which includes delivering specialized training courses for health professionals, developing professional guidelines for smoking-cessation counsellors and producing and disseminating educational materials for the public and health professionals. The budget for this work has increased from €52 700 in 2009 to €95 000 in 2011, thanks largely to a grant from the European Social Fund that runs to the end of 2011. Other National Institute for Health Development staff members are involved in tobacco control from time to time, including the Director, research staff and communication staff.

1.4.3 Other government departments

Other government departments involved include the Department of Prisons, which offers smoking-cessation services to prisoners; the Ministry of Economic Affairs and Communications, which provides expert opinion on trade issues; the Tax and Customs Board, which tackles illicit trade in tobacco; and the Ministry of Finance, which develops fiscal policy in relation to tobacco products.

1.4.4 Other government structures

Other government structures involved directly in tobacco control include the Health Board, in relation to enforcing smoking restrictions in workplaces and public places; the Consumer Protection Board, in relation to enforcing restrictions on advertising and promotion, particularly at the point of sale; and the Municipal Police, in relation to restricting sales of tobacco to and by minors, including educational programmes conducted in schools. These activities are undertaken as part of the regular inspection activities of each agency, so there are neither dedicated personnel nor allocated budgets.

The Estonian Health Insurance Fund conducted three antismoking mass-media campaigns in 2005 and 2006.

1.4.5 Civil society and academe

Civil society and academe: 11 nongovernmental organizations have recently formed an umbrella advocacy organization called Tobacco-Free Estonia, which has a volunteer board but no paid staff. Tobacco-Free Estonia collects small membership fees to support its activities. The member organizations of this coalition also carry out tobacco control activities of their own. In 2010, Tobacco-Free Estonia prepared a published a 10-point charter of tobacco control priorities and presented it to the government.

The Estonian Cancer Society runs occasional media campaigns and offers a helpline for smokers wanting help to quit.

Several professional associations are active in tobacco control, including the Association of Family Doctors.

Estonia has a track record of academic research into the smoking behaviour and attitudes of sections of the population and a certain degree of academic experience in tobacco control economics. The University of Tartu collaborates regularly with international colleagues on research projects related to tobacco control.

1.4.6 Tobacco control coordination bodies

No formal coordination mechanism was identified between the Ministry of Social Affairs, the National Institute for Health Development and other government agencies or between the government and civil society. Nevertheless, tobacco issues are discussed under other coordination mechanisms, mainly the Cardiovascular Disease Strategy Council, and consultations with other players are held on an ad hoc basis.

1.4.7 Active participation of civil society

The government should encourage the active participation of civil society. Civil society in Estonia can play a much more active role in promoting tobacco control activities and can be a strong partner to the government around common goals. This role may include promoting new legislative initiatives and enforcing them and helping build a social critical mass for new policy proposals.

2. Objective, guiding principles and general obligations of the WHO Framework Convention on Tobacco Control

2.1 Whole-of-government responsibility

The Government of Estonia clearly wishes to devote attention to the tobacco problem. It has ratified, and is legally bound by, the WHO Framework Convention on Tobacco Control and taken action to implement EU directives on tobacco. The National Health Plan, the National Cancer Strategy and National Cardiovascular Disease Strategy all include commitments to reduce tobacco use and to protect nonsmokers.

Nevertheless, some clear challenges need to be overcome to achieve the smooth implementation of tobacco control measures in Estonia.

2.1.1 Tobacco control in Estonia has lost momentum in recent years

In 2007, Estonia was rated number 11 among 31 countries in Europe in progress in tobacco control. In 2010, Estonia had slipped to number 19. Only Bulgaria fell further down the Tobacco Control Scale in Europe over the same period.

2.1.2 Vacuum of tobacco control leadership

There appears to be a vacuum of tobacco control leadership since the retirement in 2008 of the leading Ministry of Social Affairs official responsible for tobacco control. Since then, little staff time has been allocated to tobacco control.

2.1.3 The resources directed to tobacco control are inadequate

The limited human resources and budget dedicated to tobacco control do not match the good intentions of the Estonian government. The assessment team was unable to discern the total amount spent on tobacco control. Only the National Institute for Health Development expenditure on the cessation programme was made available.

2.1.4 There is no clearly articulated roadmap for tobacco control

As described in subsection 1.3, the National Health Plan and National Cancer Strategy do not set out the case for tobacco control robustly enough, given the scale of the tobacco-use epidemic in Estonia. The Cardiovascular Disease Strategy offers a better framework for tobacco control, but this needs to be further developed and resourced.

Recommendation. A Ministerial Tobacco Control Task Force, comprising government and nongovernmental experts, should be established under the auspices of the Cardiovascular Disease Strategy Council to develop and initiate a detailed national roadmap for tobacco control from 2012 to 2020.

- Once this roadmap is fully integrated into the 2013–2016 action plan, the Cardiovascular Disease Strategy Council should supervise its implementation, but this would still benefit from having a multidisciplinary advisory group of tobacco control experts.
- Reporting on tobacco control under the National Health Plan and the National Cancer Strategy should continue but should indicate the actions taken and progress made under the

Cardiovascular Disease Strategy so that tobacco control efforts are coordinated under one banner.

- Should health strategies be realigned before 2020 – for example, into a noncommunicable disease strategy – tobacco control should be accorded priority status.

Recommendation. The Ministry of Social Affairs should arrange to increase the budget allocation to tobacco control to adequately support both the development and the implementation of the national roadmap and its targets through 2020.

- At the very least, the commitment made in 2005 under the Cardiovascular Disease Strategy to devote 1% of tobacco tax revenue to tobacco control should be honoured immediately.
- In 2009, 1% of revenue from tobacco tax would have generated €1.33 million.

Recommendation. A stronger, more cohesive system for monitoring the implementation of regulations on tobacco needs to be developed.

2.2 Guiding principles: the entire population should be well informed and regional and international cooperation

2.2.1 Most Estonians are not well informed on tobacco harm

Most key informants expressed the view that Estonians "know that smoking is bad for you". Nevertheless, knowledge and attitudes are not regularly measured, only behaviour. The level of understanding by the population of the harm tobacco causes either to smokers or passive smokers cannot therefore be determined.

Further, the stark difference in prevalence by educational status described in subsection 1.1.1 would suggest an urgent need for investment in public education, targeting adults with low levels of education.

2.2.2 Inconsistent use of evidence and best practice

Estonia has accessed and embraced international best practices for the development of its cessation services – except for the quitline – and for the Estonian Health Promoting Hospitals Network. Nevertheless, this does not appear to be the case for public education, for either adults or children. Ample international evidence indicates what constitutes effective public education on tobacco, and Estonia needs to develop its expertise in this area.

2.2.3 Mixed success in regional and international cooperation

In terms of regional cooperation, there appears to be regular contact with Finland but little evidence of routine collaboration between the Baltic countries on tobacco control. Although EU networks are accessed, this seems to focus more on cessation and health promotion than on policy issues.

It was noted during the capacity assessment that Estonia has not been active in developing the Illicit Trade Protocol of the WHO Framework Convention on Tobacco Control even though Estonia has much experience to offer and much to gain from a strong Illicit Trade Protocol being adopted. As these negotiations are ongoing, it is recommended that Estonia involve itself in this important international initiative.

Recommendation: Estonia should play a more active role in further developing the WHO Framework Convention on Tobacco Control – especially by joining the negotiations on the Illicit Trade Protocol – as Estonia has much experience to offer and will benefit from a strengthened Convention.

2.3 General obligations: strong national coordination and capacity development, effective legislation and protection from industry influence

2.3.1 Coordination on tobacco control appears to be intermittent

There is an understanding that coordination takes place through the Cardiovascular Disease Strategy Council (Annex 3), which is chaired by the Minister of Social Affairs and has senior representation from across government and civil society, to oversee progress on implementing the Cardiovascular Disease Strategy. However, the Cardiovascular Disease Strategy does not articulate any clear action plan for tobacco, and it is not surprising that coordination needs to be strengthened between the many agencies involved in tobacco control.

Informal collaboration between the Ministry of Social Affairs and the National Institute for Health Development seems to be good. If the recommended Ministerial Tobacco Control Task Force is established, clarifying the roles and responsibilities of all the agencies involved in tobacco control will be particularly important.

Recommendation: The Task Force needs to clarify the roles and responsibilities for various elements of tobacco control. A national coordination mechanism should be established through consultation with all the agencies – government and nongovernmental – involved in tobacco control.

2.3.2 Planned capacity development in cessation is evident and appears to work well

However, this is less the case with policy development or public education. The retirement of the key Ministry of Social Affairs official concerned with tobacco control has left a gap in institutional expertise that has not been filled. At the same time, the National Institute for Health Development appears to have shifted its focus from tobacco to alcohol issues.

Of particular concern is the lack of expertise in the economics of tobacco control. Estonia is not alone in this regard. Few countries have a strong track record in this, but addressing this gap is vital. In 2009, tobacco tax revenue in Estonia exceeded €130 million, and more than 40 million packs of cigarettes may have been traded illegally in 2009. Commitment to reducing the toll of premature death and disease from tobacco use requires thoroughly understanding the market for the product.

2.3.3 The strategy for tobacco control research has not been fully established

Tobacco control research activities in Estonia are conducted in response to the concerns of specific researchers and are therefore investigator-driven rather than priority-driven. Estonia currently has no clear strategic plan for research on and monitoring of tobacco control.

Recommendation: A priority-driven research agenda should be developed as soon as possible to inform the national tobacco control roadmap.

2.3.4 The planned review of legislation will require strong policy and research input

The proposed Task Force should give priority to expediting the review of legislation that is planned for 2011. Numerous aspects of the Tobacco Act need to be improved, and developing this will take time and resources. Many resources are now available to assist with the development of high-quality tobacco laws, including the guidelines of the WHO Framework Convention on Tobacco Control. Experience from other countries and advice on legislation is now readily available through the International Legal Consortium at http://www.tobaccocontrollaws.org.

Recommendation: The terms of reference for the Task Force should include providing expert input into the preparation of revisions to the Tobacco Act to comply with the WHO Framework Convention on Tobacco Control and upcoming EU directives, particularly with respect to pictorial pack warnings, flavoured tobacco products, eliminating point-of-sale promotion by removing the display of tobacco products and designated smoking rooms in public places.

2.3.5 The tobacco industry's marketing tactics and strategies in Estonia are evident

Global experience has shown that, although the tobacco industry's work may not be obvious, it is omnipresent, monitoring what health authorities are doing and finding opportunities to influence policy and activities that are to its advantage.

The tobacco market and the tobacco industry's marketing strategies in Estonia are not well known, and there is no mechanism for monitoring the industry's activities at either the national or international level. In this regard, not all sections of government in Estonia understand Article 5.3 of the WHO Framework Convention on Tobacco Control, which protects against undue interference from the tobacco industry.

Similarly, research by the Institute of Economic Research on the potential effects of point-of-sale regulations on the retail sector may have been unduly influenced by the use of tobacco industry data.

In all countries, including small countries such as Estonia, understanding the tobacco industry's marketing strategies nationally and internationally can be an invaluable help in guiding tobacco control policies and protecting the government proactively against attacks. This includes price promotions, new publicity tactics, packaging and product manipulation and placement strategies to increase profits and reach new customers. Further, studies on the files of tobacco industry documents released as part of the Tobacco Master Settlement Agreement in the United States could be an important source of information for the country.

In this regard, the assessment team recommends establishing a system for monitoring the tobacco industry. This can be undertaken by the Ministry of Social Affairs, the National Institute for Health Development or a civil society organization or a combination. Such a system would also allow Estonia to comply with the guidelines for Article 5.3 of the WHO Framework Convention on Tobacco Control.

Recommendation: A comprehensive system for monitoring the tobacco industry in Estonia is required to assist Estonia in fulfilling its obligations under Article 5.3 of the WHO Framework Convention on Tobacco Control, which various agencies currently routinely ignore.

3. Demand reduction provisions of the WHO Framework Convention on Tobacco Control

3.1 Price and tax measures to reduce the demand for tobacco

Tobacco products for sale in Estonia must carry banderols on the packaging, indicating that tax has been paid. The maximum unit price is stated on the packs. Three forms of tax are applied to tobacco products: specific tax, ad valorem tax and VAT. Taxes have risen swiftly over recent years to bring Estonia into line with EU minimum standards. The tax was increased twice in 2008. The Riigikogu (parliament) approves annual increases each January.

3.1.1 Price rises rapidly affect behaviour

According to the Euromonitor International 2010 report, *Tobacco in Estonia (3)*, the higher prices (and the recession) have caused some consumers to shift from premium brands to economy brands and from cigarettes to hand-rolling tobacco and have caused an increase in personal and organized smuggling of cigarettes from Latvia and the Russian Federation. There is some evidence of shifts in all these types of behaviour.

The relative affordability of hand-rolling tobacco is of concern and should be addressed.

Recommendation: The difference in tax rates between manufactured cigarettes and hand-rolling tobacco should be progressively reduced.

However, the most important changes in behaviour increased prices cause is more smokers trying to quit and fewer young people starting to smoke. Evidence of these changes should be detected in the 2010 Health Behaviour Survey, the 2011 Global Youth Tobacco Survey and ongoing school surveys.

3.1.2 Government revenue from tobacco has soared while expenditure on tobacco control is wholly inadequate

Another important result of the tax changes is the increasing government revenue. Data provided by the Ministry of Finance indicate that tobacco tax revenue in 2009 was EEK 2.09 million (€133 million), including excise, duties and VAT.

The assessment team learned of the proportion of tax on tobacco (and alcohol and gambling) that goes to the Cultural Endowment Fund. Earmarking or allocating tax in this way is clearly accepted in Estonia. However, the clear government commitment in the National Cardiovascular Disease Strategy to devote 1% of excise taxes to tobacco control has not been honoured, and the assessment team was unable to discover why.

The government should recommit to delivering health outcomes through fiscal policy and institute the 1% earmark immediately.

3.1.3 Tobacco control economics capacity needs to be built

A joint report by the Ministry of Social Affairs and the World Bank, *Economics of tobacco in Estonia*, written in 2000 but published in 2004, is an important piece of work and deserves to be systematically updated to ensure that current evidence and international best practices fully

inform fiscal and other government policy. Although external expertise might be needed to assist in this endeavour, developing and sustaining domestic capacity in tobacco control economics in Estonia is vital. Although a comprehensive report is desirable, the most immediate priority is to commission research on how recent tax rises affect sales and smuggling.

Recommendation: Research is urgently required to assess the impact of recent and planned increases in tobacco tax, the level and nature of illicit trade and the cost-effectiveness of anti-smuggling measures.

3.2 Protection from exposure to tobacco smoke

The 2005 Tobacco Act laid out regulations (that entered into force in 2007) for smoke-free indoor environments in many public areas and in public transport as well as in workplaces. Designated smoking rooms are allowed under certain conditions.

The Health Board is responsible for enforcing the smoke-free places regulations of the Tobacco Control Act. The Board undertook a survey of catering establishments in 2006 and found widespread smoking. Relatively few restaurants decided in 2007 to establish smoking rooms because of the cost of installing the required level of ventilation equipment. No data exist on the number of catering establishments that have smoking rooms.

3.2.1 Universal and equal protection should be ensured for all workers

Universal and equal protection should be ensured for all workers and the public from exposure to second-hand tobacco smoke, in accordance with the guidelines for Article 8 of the WHO Framework Convention on Tobacco Control, by eliminating the designated smoking rooms (whether with separate ventilation systems or not) that are currently permitted by the law.

The only way to protect fully the workers and the public from tobacco smoke is to create 100% smoke-free indoor environments with no exceptions. A complete smoking ban in all indoor public places, indoor workplaces, public transport and, as appropriate, in other public places would ensure consistent coverage, efficient enforcement and better understanding among government agencies and the public.

Recommendation: Designated smoking rooms (whether with separate ventilation systems or not) should be prohibited by legislation to ensure universal and equal protection from second-hand tobacco smoke for all workers and the general public.

3.2.2 Monitoring of compliance should be strengthened

No agency collects and reports data regularly on compliance with the law. No data exist on the proportion of restaurant managers who have experienced problems in enforcing the law. Each year, the Board chooses several different categories of venue to inspect, ranging from ferries to casinos to prisons to nursing homes. Some categories are selected in response to complaints received. In 2010, the Health Board decided to replace inspections with a survey by questionnaire, and the results are not yet available. These activities are undertaken as part of the regular inspection activities, so there are neither dedicated personnel nor an allocated budget.

3.2.3 Public support for smoke-free zones around doorways

Although there is no evidence of efforts to mobilize and involve the community in monitoring and enforcement of the law and members of the public are generally not encouraged to report violations, the Health Board does receive a number of complaints about smoking in public places. Most such complaints concern smoking around doorways to premises. This problem is experienced in many jurisdictions and can be readily solved by legislatively mandating protection zones outside public buildings to move the people who wish to smoke away from the main entrances.

Recommendation: Smoke-free protection zones outside doorways of public buildings should be legislatively mandated, to protect the general public.

3.2.4 Children in private spaces remain relatively unprotected from second-hand smoke

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

3.2.5 Public awareness campaigns on smoke-free environments are essential

A mass-media campaign to educate adults on how to protect children from second-hand tobacco smoke at home would not only improve levels of protection for children but would build public and political support for the necessary changes to legislation for smoke-free environments.

Parents and relatives of children should be informed of the importance of the health problems second-hand tobacco smoke causes for children. They should be advised never to smoke inside private spaces such as homes and cars when children are not present.

3.3 Regulation of the content of tobacco products and of tobacco product disclosures

The current legislation requires tobacco companies to submit a detailed report on the ingredients of all tobacco products available for sale to the Ministry of Social Affairs in October each year, including additives such as flavourings. It is not clear whether this information is analysed, given the very low level of staff time devoted to tobacco. However, these reports would provide useful data on the size and nature of the tobacco market in Estonia and should form the basis of the recommended industry monitoring system.

3.3.1 Flavoured cigarettes appeal to young people, especially girls, and should be controlled by law

The last decade has seen a rise in the variety of fruit- and sweet-flavoured cigarettes available in Europe (Fig. 10) and around the world. The United States Government became so concerned about the appeal of these products to young people, especially girls, that the United States Food

and Drug Administration has banned their sale. Although the assessment team saw no evidence of their use in Estonia, the current law does not prevent the sale of these products.

In responding to the consultation on the new EU Directive, the Ministry of Social Affairs and the Ministry of Economic Affairs and Communications adopted opposite positions on the question

Fig. 10. Flavoured brands in Europe

of banning flavoured tobacco products. Legitimate concerns for the health and well-being of Estonian children should always take precedence over the commercial interests of the tobacco industry.

Recommendation: To protect children and young people, tobacco products with flavours such as vanilla, strawberry and chocolate should be banned from sale.

3.3.2 Test water pipe packages

Competent authorities should test water pipe packages to demonstrate the false claim that they do not contain tobacco.

3.4 Packaging and labelling of tobacco products

Estonia has health warnings on tobacco product packaging in accordance with those mandated by the EU and is proposing to review its legislation to adopt pictorial warnings for tobacco products in accordance with the EU directive. The standardized EU pictorial warnings provide an opportunity to choose between several sets of warnings. The size and shape of the health warnings should be consistent with the guidelines for Article 11 of the WHO Framework Convention on Tobacco Control, even if the directive may state otherwise. The new legislation on pictorial health warnings should apply to all tobacco products.

Recommendation: Pictorial health warnings should be applied to all tobacco products, including tobacco for water pipes, to educate the public of the level and nature of harm to health caused by tobacco.

The Ministry of Social Affairs should consider which agency is best placed to systematically inspect or monitor the enforcement of pack warnings. Inspectors or enforcement agents should conduct regular spot-checks of tobacco products at importing facilities and points of sale, to ensure that packaging and labelling comply with the law. Stakeholders should be informed that tobacco products will undergo regular spot-checks at points of sale.

The Ministry of Social Affairs should also consider directing the National Institute for Health Development to design and implement an evaluation plan to measure the effects of health warnings and the rotation of messages to identify any potential wearing-off effects.

The Government of Australia is planning to introduce legislation requiring tobacco products to be sold in plain packaging, with no branding, colours or logos. The Government of the United Kingdom is actively considering the issue. Increasingly, the pack itself is a promotional tool. Fig. 11 provides examples of brands in Poland aimed at women and girls. Estonia should closely follow this development and consider mandating plain packaging.

Fig. 11. Brands in Poland aimed at girls and women

3.5 Education, communication, training and public awareness

3.5.1 Mass-media campaigns are infrequent and severely underfunded

The National Institute for Health Development has been responsible for public education on smoking through the mass media since 2007. Before this, the Estonian Health Insurance Fund ran three mass-media campaigns on smoking – two on television and one poster campaign – during 2005 and 2006. The first television campaign tackled passive smoking by parents and the effects on children. The second focused on impotence caused by smoking and was humorous in tone. The budget for each television campaign was very small: €27 000.

The National Institute for Health Development does not appear to have any set budget for mass media on smoking, and output over the last few years has been minimal. A 30-minute video aimed at teenagers, entitled "Dr Smoke" *(Suits) (7)* and intended to appeal to young people, was posted on YouTube, with more than 93 000 hits to date, and disseminated to schools upon request.

The two quitlines are only promoted through some ad hoc efforts such as the Estonian Cancer Society's campaigns and earned media activity by the National Institute for Health Development.

3.5.2 Campaigns aimed at the broad population will reach subgroups

International evidence confirms that people of all ages respond strongly to messages that produce negative emotions—feelings of loss, anger, sadness or fear. Mass-media campaigns with strong graphic images have been shown to be effective with mass audiences, including subgroups such as young people and pregnant women. Creative media strategies and good media planning can ensure that campaigns targeting people with low levels of education and of low socioeconomic status are still effective across the broader population.

3.5.3 Media campaigns are planned as part of an overall strategy

Mass-media campaigns seem to be conducted on an ad hoc basis, as funding permits. There is no communication plan or strategy to sustain information campaigns about the harms of tobacco use or passive smoking or to advocate for strengthened legislation. Planning a long-term mass-media campaign strategy is difficult without allocated resources.

The Ministry of Social Affairs and the National Institute for Health Development should give priority to mass-media campaigns as a proven strategy for prompting people to quit and for supporting tobacco control policies. A communication strategy and plan should be developed. A multi-year plan is optimal to be able to plan strategically for campaigns over the long term.

3.5.4 Media campaigns need to be sustained over long periods to have measurable impact

The effectiveness of mass-media campaigns depends on their scale and duration. Expenditure has to be high enough to reach smokers sufficiently often and for long enough. Significant prevalence declines have been shown to be possible, with frequent messaging over many years. Hard-hitting mass-media campaigns over several months a year, and over more than two decades, have enabled significant declines in prevalence in such countries as Australia and New Zealand. Despite their already lower smoking rates, both these countries continue to give priority to the importance of running mass-media campaigns because they have been shown to work.

3.5.5 There is uncritical support of school programmes on smoking

The National Institute for Health Development administers a smoke-free school competition annually to prevent initiation among students younger than 16 years. Although this is a very desirable goal, the value and opportunity of such school programmes should be reviewed in light of a lack of evidence of long-term effects. Focusing on preventing children from initiating smoking will not show visible results in terms of reducing morbidity and mortality for at least five decades.

Such school programmes should be rigorously evaluated or the investment should be diverted into interventions with proven effectiveness such as mass-media campaigns. The potential use of social media should also be investigated.

Recommendation: The effectiveness and cost–effectiveness of all school programmes should be rigorously evaluated.

3.5.6 Two major campaigns each year

Running two major campaigns each year is specifically recommended to obtain a desired effect on reducing the uptake of tobacco use, denormalizing tobacco use and prompting quitting over

the long term. Broadly, the campaigns should cover the health effects of tobacco use and the need to protect children from second-hand smoke, especially in the home. Timing each campaign to coincide with policy initiatives can have the additional benefit of generating public and political support for the issue.

3.5.7 Proven media materials are available at very low cost

Initially, at least, Estonia does not need to generate its own media campaigns. With the backing of the Bloomberg Initiative to reduce tobacco use, a range of proven television and print advertisements are available for only the cost of applying voiceovers and end-frames.

Recommendation: Two major mass-media campaigns should be developed and delivered concurrently in 2012 and 2013: one to educate the general public on the health effects (ideally linked to the introduction of pictorial pack warnings) and the other to educate adults on how to protect children from second-hand smoke in the home (ideally linked to the introduction of stricter legislation on smoke-free environments).

3.6 Tobacco advertising, promotion and sponsorship

The Tobacco Control Act includes “a ban on the promotion of tobacco products”, and the Consumer Protection Board is responsible for ensuring compliance.

3.6.1 Illegal promotion still occurs

The assessment team learned about two instances of illegal tobacco promotion. Fig. 12 illustrates the first one – a Marlboro promotional light in a hotel bar. The second was a report received by the Ministry of Social Affairs of a recent street promotion offering free tickets to a nightclub to young people in exchange for their contact details. Whether these are isolated breaches of the law cannot be established, since the Consumer Protection Board does not proactively monitor compliance. They respond to complaints received.

Fig. 12. Illegal promotion still occurs

3.6.2 Point-of-sale promotion is highly visible and affects children and young people

The current legislation allows tobacco products to be promoted at points of sale. Consequently, the tobacco industry has ensured very high visibility through retail outlets (Fig. 13).
Good international evidence indicates that point-of-sale promotion of tobacco products adversely affects children’s and young people’s attitudes to smoking.

Figs. 13. Point-of-sale promotion is highly visible

Of particular concern is the fact that most premises at which tobacco products are on sale place them within 1 metre of confectionery products that clearly attract young consumers.
This regularly brings young people into close contact with a product that is age restricted.

3.6.3 Tobacco products should be removed from display

The simplest, most equitable and effective way to eliminate point-of-sale promotion is to require the removal from display of all tobacco products and accessories, such as cigarette papers.

In considering this proposal, as part of the consultation on the next EU directive on tobacco, the Ministry of Economic Affairs and Communications has concluded that it would adversely affect retailers, especially in rural communities.

Ministry officials cited research by the Institute for Economic Research on the 2840 retailers and 2200 restaurants and cafes that display tobacco, indicating that removal from display would incur sector costs of more than €12 million and cause widespread closure of retail outlets. The assessment team did not have access to the full study and therefore cannot comment on the methodology. However, these research findings deviate so strongly from international evidence on the actual effects of removing tobacco products from display that they should be treated with caution.

To mitigate the effects on the retail sector, regulations under a revised Tobacco Act can provide appropriate flexibility over complying options for different types of business and allow for adequate lead-in time for compliance.

Regulations also need to cover the promotion of new tobacco-related products, such as e-cigarettes.

Recommendation: To protect children and young people, point-of-sale promotion should be eliminated by removing all tobacco products and accessories from display.

3.7 Tobacco dependence and cessation

Without a doubt, smoking cessation is the most developed aspect of tobacco control in Estonia. There has been a long-standing commitment to helping smokers who want to quit by providing evidence-informed support from dedicated health professionals.

3.7.1 Strong national network to support cessation

Since 2000, considerable work has gone into developing the Estonian Health Promoting Hospitals Network, and Estonia is an active member of both the International Network of Health Promoting Hospitals and Health Services and the European Network of Smoke-free Hospitals. From 2005, the Estonian Network has provided the basis for systematically establishing a national smoke-free health care system. Twenty-one agencies are currently paid-up members of the Network, ranging from major regional hospitals to health care centres, providing good national coverage. Two national assessments have been conducted to ensure that agreed standards are being maintained.

3.7.2 Estonian smokers have access to high-quality cessation services

Of the estimated 230 000 smokers in Estonia, 60% say they want to quit (only 10% that say they do not want to quit), and 75% have tried to quit. Theoretically, all have access to a free face-to-face consultation (up to one hour) with a specially trained counsellor at one of the 16 cessation clinics around the country, with follow-up by appointment.

Cessation services are available nationally, with each county having a smoking-cessation counselling clinic – currently only open for 3–5 hours per week because of financial constraints. Health professionals can refer smokers wanting to quit for a free face-to-face consultation of up to one hour followed by telephone or e-mail support. The National Institute for Health Development produces cessation materials. Follow-up is organized at 2 weeks and at 2, 6 and 12 months. Use of the service varies according to media coverage; there is often no waiting list because of lack of publicity.

3.7.3 Professional guidelines and an ongoing training programme are in place

The National Institute for Health Development published national smoking-cessation guidelines for health professionals in 2010. The Estonian Medical Association endorsed them, and they were launched at a national meeting of health professionals.

Training in smoking cessation is available for all health professionals, and 240 have been trained as counsellors and attend regular in-service training sessions.

3.7.4 Monitoring and reporting can be strengthened

There is limited monitoring and reporting on the extent to which professionals in primary care, hospitals, midwifery and health care for children and young people routinely ask about and assess smoking habits and give brief interventions or offer smoking-cessation counselling.

3.7.5 Future funding for cessation services is uncertain

Although smoking cessation is described as high priority, future funding is not assured. The service currently relies on a grant from the European Social Fund that runs out at the end of 2011.

3.7.6 Access to affordable pharmacotherapies is limited

All nicotine replacement therapy products are available over the counter. Bupropion (Zyban®) and varenicline (Champix®) are available with a doctor’s prescription.

Through the cessation clinics, there is limited access to free pharmacotherapies for a short period of time. For patients in intensive care, nicotine replacement therapy is available. The Estonian Health Insurance Fund does not subsidize any of the medication that enhances smoking cessation.

Recommendation: The case for subsidizing nicotine replacement therapy should be fully investigated.

3.7.7 Quitline services need to be streamlined and strengthened

There are two quitline-type services: one run by the Emergency Helpline and one run by the Estonian Cancer Society. Both offer services in Estonian and Russian. The quality of these quitlines has not been assessed. Neither service follows up callers to determine the long-term quit rates. Both offer information about the cessation clinics. The same (two or three) people who have run training for the cessation clinics have trained counsellors for the quitlines. The EU has funded specialist training for counselling pregnant smokers, and the International Network of Quitlines has provided this.

Volunteers in 12 cities in Estonia staff the Emergency Helpline and the quitline service they offer. Of the estimated 10 000 calls they receive each year, about 1500 concern smoking. Funding for central coordination is applied for annually from the Ministry of Social Affairs but must be framed as a project not to exceed 12 months, as stipulated by European Commission funding procedures.

The Estonian Cancer Society quitline operates for four hours per day and only on weekdays. Neither service appears to be widely promoted or publicized, although the Estonian Cancer Society number is featured on the EU-funded HELP campaign materials and web site. Neither quitline has a branded identity or tagline.

The quitlines provide information and self-help materials, but whether these are widely used is unclear.

The Emergency Helpline has asked to have their number placed on tobacco packs, but consideration of this issue has been deferred until after the next EU directive on tobacco control has been passed. Work needs to start now to ensure that a high-quality, evidence-informed service is in place to meet the increase in demand that will occur if the new health warnings on tobacco products include a quitline number and web site – as they should.

All forms of communication with the public and health-care professionals about tobacco use should routinely include a quitline telephone number and web site address with a brief description of the services offered. It is also recommended that the quitline have a new branded identity, a tagline and an easy-to-remember number.

Careful consideration should be given as to whether either of the current providers of quitlines is the most suitable agency to be providing this essential national service. It should be fully integrated with the cessation services and could be run out of Tartu by the cessation team based there.

Recommendation: *One* new national quitline should be established that is fully integrated with the cessation services and hence act as a portal to those services. Every relevant health care interaction should provide referral to the quitline.

4. Supply reduction provisions of the WHO Framework Convention on Tobacco Control

4.1 Illicit trade in tobacco products

In common with some other European countries, illicit trade in tobacco products is clearly a problem in Estonia; however, the Tax and Customs Board is tackling this head-on and, apparently, with some success.

Officials from the Board shared their concerns with the assessment team about illicit tobacco products arriving into Estonia through the borders with Latvia and the Russian Federation and via ferries and container ships. It is not clear what proportion of the smuggled packs remains in Estonia or are in transit to other destinations, such as neighbouring Finland, where cigarette prices are even higher.

According to the Euromonitor International 2010 report *Tobacco in Estonia (3)*, illicit trade volume stood at 825 million cigarettes in 2009 (equivalent to about 40 million packs), up from 533 million cigarettes in 2008 but exhibiting signs of stabilizing by the end of 2009. These data should be treated with caution. Nevertheless, it is clear that significant government revenue is being lost: certainly tens of millions of euros.

In addition to large-scale smuggling organized by criminal gangs, there is evidence of bootlegging by individuals. Since 1 July 2009, private imports from outside the EU have been limited to 40 cigarettes. The previous limit was 200 cigarettes. This measure was enacted to limit the activity of the small-scale bootleggers crossing the border with the Russian Federation several times a day.

Tax and Customs Board officials also explained their increased use of scanners to detect smuggled tobacco products and their efforts to publicize seizures as a deterrent. Numerous technological strategies are available to enforcement agents and, given the scale of losses to government coffers, some are highly cost-effective and investment should be made in both equipment and staff training.

The long-term solution is to have a comprehensive global strategy for dealing with smuggling, as is being developed in the negotiations for an Illicit Trade Protocol under the WHO Framework Convention on Tobacco Control. Estonia has not been taking part in these important negotiations and should join as soon as possible, as it has much experience to share and much to gain from a strong Illicit Trade Protocol. The EU European Anti-Fraud Office would be a useful partner for advice on the current state of negotiations and proposals for the Illicit Trade Protocol.

4.2 Sales to and by minors

According to the Tobacco Act, “A person of less than 18 years of age shall not smoke or consume smokeless tobacco products” and it is prohibited to sell or to hand over tobacco products to people younger than 18 years of age or for them to sell such products. Given the high rates of youth smoking, this provision is clearly not working.

4.2.1 Attention should be focused on the retailers and not on young people

Although by law the Municipal Police are responsible for prosecuting violations of the age limit, it appears that enforcement efforts are extremely limited. They appear to focus their attention on educating the minors and not prosecuting the retailers.

Tobacco products cause unparalleled harm to health, but their sale is regulated minimally. Existing evidence indicates that age limits alone have no effect on the consumption of tobacco by minors. Although little research has been conducted on effectively reducing access to tobacco products, particularly by minors, experts consider that any reduction in access to tobacco products must consider a ban on the display of tobacco products and a system of restricting the retail sale of tobacco products, including a licensing system for the retail sale of tobacco products.

4.2.2 The Task Force should consider a licensing system for the retail sale of all tobacco products

Licensing tobacco retailers sends an unambiguous public signal that the government regards tobacco as an exceptionally harmful product deserving restrictions on retail sale at least comparable to those that apply to prescribed pharmaceuticals in most countries.

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

- developing legal instruments and anticipating and preparing for legal challenges from the tobacco industry and its allies based on national law and on international trade and other agreements; and
- anticipating opposition coming from existing retailers and preparing to debate the potential economic impact and effects on the unregistered market of tobacco products.

4.2.3 Licensing systems can reduce contraband sales and other violations of the law

If there is a problem with the sale of contraband products through otherwise legitimate retailers, the possibility of suspending a tobacco sales licence can be a very strong deterrent. Similarly, if point-of-sale promotion is outlawed through removal from display, the threat of revoking or suspending licences can be highly effective.

Recommendation: A licensing system should be created to regulate the sale of tobacco products to protect children and young people.

4.2.4 Voluntary agreements with the tobacco industry are not effective

International evidence demonstrates the ineffectiveness of industry-sponsored schemes on sales to minors. The “Stop 18” message does nothing to persuade young people not to smoke. It merely says that you have to be 18 years old to buy tobacco products legally. Most young teenagers aspire to being 18 years old, and many will interpret this message as permission to smoke as they grow up; some will interpret it as a challenge to circumvent.

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Annex 1. Institutions interviewed and key informants

Consumer Protection Board

Corpore PR agency

Emergency Helpline

Estonian Association of Family Doctors

Estonian Cancer Society

Estonian Health Insurance Fund

Estonian Institute of Economic Research

Estonian Respiratory Society

Estonian Tax and Customs Board

Health Board

Ministry of Economic Affairs and Communications

Ministry of Finance

Ministry of Justice

Ministry of Social Affairs

Municipal Police

National Institute for Health Development

Quitline

Tartu University Hospital

Tobacco-Free Estonia

WHO Country Office in Estonia

Annex 2. Assessment team members

National

Aive Telling, Ministry of Social Affairs

Tiiu Harm, National Institute for Health Development

International

Jarno Habicht, WHO Country Office (formerly)

Antoon Opperhuizen, Independent Tobacco Control Consultant

Patti White, Independent Tobacco Control Consultant

Judith Watt, Independent Tobacco Control Consultant

ANNEX 3. CARDIOVASCULAR DISEASE STRATEGY COUNCIL

The Cardiovascular Disease Strategy Council set up in the Ministry of Social Affairs manages and coordinates the implementation of the National Cardiovascular Disease Strategy and includes representatives of county governments, local governments and relevant ministries and other institutions, including non-profit associations and professional associations.

The chair of the Strategy Council is the Minister of Social Affairs, who annually submits an implementation report to the Government. The Strategy Council is competent to review and approve the measures and proposals drawn up for the annual implementation plan of the strategy, review and approve the implementation reports and assess the effectiveness of implementation of the strategy.

The Minister of Social Affairs approves the decisions of the Strategy Council with his signature. The Minister of Social Affairs approves composition and rules of procedure of the Strategy Council by issuing an order.

The servicing unit of the Strategy Council is the Public Health Department, Ministry of Social Affairs. The Public Health Department coordinates the preparation of the strategy and annual report.

Composition of the Strategy Council

Chair

Minister of Social Affairs

Members

Deputy Secretary-General, Ministry of Social Affairs
Head, Public Health Department, Ministry of Social Affairs
Head, Health Policy, Public Health Department, Ministry of Social Affairs
Chief Specialist, Chronic Diseases, Public Health Department, Ministry of Social Affairs
Chief Specialist, Health Information and Analysis Department, Ministry of Social Affairs
Representative of the Ministry of Finance
Representative of the Ministry of Education and Research
Representative of the Ministry of Culture
Representative of the Ministry of Agriculture
Representative of the Ministry of Internal Affairs
Representative of the Estonian Employers' Confederation
Representative of the Association of Estonian Cities
Representative of the Association of Rural Municipalities of Estonia
Representative of the Estonian Heart Association
Representative of the Estonian Cardiac Society
Representative of the National Institute for Health Development
Representative of the Department of Food Processing, Tallinn University of Technology
Representative of the Estonian Health Insurance Fund
Representative of the Estonian Chamber of County Doctors
Representative of the Estonian Health Promotion Society
Representative of the Estonian Society of Family Doctors

Annex 4. List of all recommendations

Short-term recommendations

1. A Ministerial Tobacco Control Task Force, comprising government and nongovernmental experts, should be established under the auspices of the Cardiovascular Disease Strategy Council to develop a detailed national roadmap for tobacco control from 2012 to 2020.
    - Once this roadmap is fully integrated into the 2013–2016 action plan, the Cardiovascular Disease Strategy Council should supervise its implementation, but this would still benefit from having a multidisciplinary advisory group of tobacco control experts.
    - Reporting on tobacco control under the National Health Plan and the National Cancer Strategy should continue but should indicate the action taken and progress made under the Cardiovascular Disease Strategy so that tobacco control efforts are coordinated under one banner.
    - Should there be any realignment of health strategies before 2020 – for example, into a noncommunicable disease strategy – tobacco control should be accorded priority status.
2. The terms of reference for the Task Force should include providing expert input into the preparation of revisions to the Tobacco Act to comply with the WHO Framework Convention on Tobacco Control and upcoming European Union (EU) Directives, particularly with respect to pictorial pack warnings, flavoured tobacco products, the elimination of point-of-sale promotion by removing from display all tobacco products and accessories, such as cigarette papers, and designated smoking rooms in public places.
3. The Ministry of Social Affairs should increase the budget allocation to tobacco control to adequately support both the development and the implementation of the national roadmap and its targets through 2020.
    - At the very least, the commitment made in 2005 under the Cardiovascular Disease Strategy to devote 1% of tobacco tax revenue to tobacco control should be honoured immediately.
    - In 2009, 1% of revenue from tobacco tax would have generated €1.33 million in excise, duty and value-added tax.
4. The Task Force needs to clarify the roles and responsibilities for various elements of tobacco control. A national coordination mechanism should be established through consultation with all the agencies – government and nongovernmental – involved in tobacco control.

Medium-term recommendations

5. Estonia should play a more active role in further developing the WHO Framework Convention on Tobacco Control – especially by joining the negotiations of the Illicit Trade Protocol – as Estonia has much experience to offer and will benefit from a strengthened Convention.
6. The difference in tax rates between cigarettes and hand-rolling tobacco should be progressively reduced.

The key regulatory issues that require attention include:

7. applying pictorial health warnings to all tobacco products, including tobacco for water pipes, to educate the public of the level and nature of harm to health caused by tobacco;
8. eliminating point-of-sale promotion by removing from display all tobacco products and accessories, to protect children and young people;
9. banning tobacco products with flavours such as vanilla, strawberry and chocolate, to protect children and young people;
10. eliminating designated smoking rooms (whether with separate ventilation systems or not) to ensure universal and equal protection from second-hand tobacco smoke for all workers;
11. establishing smoke-free protection zones outside the doorways of public buildings to protect the public;
12. creating a licensing system to regulate the sale of tobacco products, to protect children and young people;and
13. developing a stronger, more cohesive system for monitoring implementation of regulations on tobacco.
14. Two major media campaigns should be developed and delivered concurrently in 2012 and 2013: one to educate the general public on health effects (ideally linked to the introduction of pictorial pack warnings) and the other to educate adults on how to protect children from second-hand smoke in the home.
15. The effectiveness and cost–effectiveness of all school programmes should be rigorously evaluated.
16. *One* new national quitline should be established that is fully integrated with the cessation services and will thus act as a portal to these services. Referral to the quitline should take place at every relevant health care interaction.
17. The case for subsidizing pharmaceuticals should be fully investigated.
18. A priority-driven research agenda should be developed as soon as possible to inform the national tobacco control roadmap.

Increased capacity is needed in:

19. tobacco control economics – research is urgently required to assess the effects of recent and planned increases in tobacco taxes, the level and nature of illicit trade and the cost–effectiveness of anti-smuggling measures; and
20. tobacco industry monitoring – a comprehensive system for monitoring the tobacco industry in Estonia is required to assist Estonia in fulfilling its obligations under Article 5.3 of the WHO Framework Convention on Tobacco Control, which various agencies currently routinely ignore.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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