OSLO AND AKERSHUS
UNIVERSITY COLLEGE
OF APPLIED SCIENCES

Vladan Rovcanin

Inculcation of sense of responsibility for smoke-free lifestyle

Analysis of Norwegian Tobacco Control Policy through Libertarian Paternalism and Personal Responsibility for Health

Oslo and Akershus University College of Applied Sciences,
Faculty of Social Sciences

Abstract

Tobacco use is one of the main health risk factors for development of non-communicable diseases which are the leading cause of global mortality. Smoking, as the most common form of tobacco use, is seen as a highly addictive behavior and personal desire to shift to smoke-free lifestyle is seriously hindered by nicotine addiction, which undermines autonomy of smokers to rationally choose healthier option and take responsibility for personal health. Tobacco control policy is an important global and national public health instrument that aims to increase smoking cessation rates and prevent smoking initiation. Global directions and recommendations greatly impact national tobacco control policies in order to prevent non-communicable diseases induced by smoking and tobacco use in general. Framework Convention on Tobacco Control initiated by World Health Organization in 2003 is the most important global treaty for generation and improvement of Norwegian tobacco control. Communicative and restrictive tobacco control measures reflect motivation and stimulation of personal responsibility for health. These measures operate through Libertarian Paternalistic approach, which aims to strategically steer people towards healthier options by preserving freedom of choice. This thesis seeks to identify global directions and recommendations for national tobacco control and particularly explore how Norwegian tobacco control measures fit into Libertarian Paternalistic approach and in what way they motivate and stimulate Personal Responsibility for Health. It concludes that inculcation of sense of responsibility for smoke-free lifestyle in Norwegian tobacco control policy is seen as individual-state partnership for healthier lifestyle through motivated and stimulated personal responsibility for health.

Key words: Tobacco Control Policy, Smoking, Libertarian Paternalism, Personal Responsibility for Health, World Health Organization, Framework Convention on Tobacco Control, Norway.

Oslo and Akershus University College
Oslo 2014

Acknowledgement

First of all, I would like to thank Ms Berit Bringedal for being the most supportive, kind and positive supervisor I could have wished for, both for my thesis and my internship at WHO. I would also like to thank Mr Stuart Deakin for the extensive support for the internship, seminars, conferences and symposium I attended before submitting this thesis. The whole experience extremely impacted my personal and professional development and contributed to a fulfilling completion of my master´s degree.

I would also like to thank Anne-Kethe for being an amazing friend and giving me extensive feedback for my thesis. Furthermore, I also thank Anna, Sandra, Ivan and Tatjana for reading this thesis despite being smokers themselves. I hope that this thesis manage to nudge you to at least think about quitting smoking. I would also like to thank my girlfriend Jovana, who motivated me to keep going and believed in me. A special thanks goes to my life-long friend Filip who, besides all the support and motivation, proof read this thesis and improved its language quality.

I am especially grateful to Kimberly, who made my internship at WHO a reality. AG, you made my dream come true. I would also like to thank employees from WHO Regional Office for Europe, where I did my internship and was lucky enough to be part of Non-communicable Diseases and Health Promotion Division, with my desk just next to tobacco control unit. Thank you for giving me the opportunity to contribute to official annual reports on Non-communicable Diseases and European Tobacco Control Report. This really meant a lot to me and gave me important skills to conduct this thesis.

And finally, I thank my parents who were always there for me, to understand all my ambitions and emotionally and financially support them.

Vladan Rovcanin

Dedication

To underinformed and unaware smokers in Montenegro
who freely harm themselves and others.

LIST OF ABBREVIATIONS

PRH	Personal Responsibility for Health
LP	Libertarian Paternalism
WHO	World Health Organization
FCTC	Framework Convention on Tobacco Control
NCDs	Non-communicable Diseases
NGO	Non-Governmental Organization
MMC	Mass Media Campaign
HWM	Health Warning Message
SCS	Smoking Cessation Services
SFE	Smoke Free Environment
TOT	Taxation of Tobacco
POS	Point of Sale tobacco displays
CAI	Choice Architecture Intervention
NRT	Nicotine Replacement Therapy
COPD	Chronic Obstructive Pulmonary Disease

TABLE OF CONTENTS

1. INTRODUCTION 1
1.1 Background 1
1.2 Aim of the Study 3
1.3 Research Questions 3
1.4 Organization of the Thesis 4
2. METHOD 4
2.1 Literature Search and Data Sources 5
2.2 Limitations of the Study 6
3. PERSONAL RESPONSIBILITY FOR HEALTH 7
3.1 Libertarian Paternalism 11
4. GLOBAL DIRECTIONS AND NATIONAL TOBACCO CONTROL POLICY 14
4.1 Framework Convention on Tobacco Control 14
4.1.1 MPOWER Policy Package 17
4.2 Norwegian Tobacco Control Policy 18
4.2.1 Historical Backdrop of Norwegian Tobacco Control Policy 20
4.2.2 Strategic Approach to Tobacco Control in Norway 21
4.2.4 Norwegian Tobacco Control Law 23
5. SELECTED TOBACCO CONTROL MEASURES 23
5.1 Communicating Smoking Hazard and Motivating PRH 24
5.1.1 The WHO FCTC Recommendations 26
5.1.2 Norwegian Tobacco Control Efforts and Results 27
5.2 Restricting Smoking Demand and Stimulating PRH 31
5.2.1 The WHO FCTC Recommendations 33
5.2.2 Norwegian Tobacco Control Efforts and Results 34
6. DISCUSSION: MOTIVATING AND STIMULATING PRH BY LP MECHANISMS ... 36
6.1 Norwegian Tobacco Control Measures and LP Mechanisms 37
6.2 Justification of SFE legislation 44
7. CONCLUSION 45

Bibliography: ... 48

APPENDICES ... 63

Appendix 1. Law on Protection against Harmful Effect of Tobacco (Lovdata 2014) ... 63

Appendix 2. Table 1. Smoke Quit line and MMC ... 78

Appendix 3. Table 2. Attitude towards SFE act in hospitality premises from 2004 – 2014 ... 78

Appendix 4. Figure 1. Tobacco Cessation with Brief Intervention ... 79

Appendix 5. Figure 2. Arenas and Parties involved in tobacco cessation ... 79

Appendix 6. Figure 3. Original provisional typology of choice architecture intervnetions in microenvironments (left side) and mapping of available evidence (righ side) ... 80

Appendix 7. Figure 4. Norwegian pictorial health warning messages on cigarette packages ... 81

Appendix 8. Figure 5. Norwegian MMC 2012 ... 82

LIST OF TABLES:

Table 1. MPOWER policy package with recommended key interventions……………………..17
Table 2. Summary of Adopted Global Directions and Recommendations……………………...19
Table 3. Provisional Typology of Choice Architecture Interventions in Microenvironments…..37

1. INTRODUCTION

This study aims to identify main global directions and recommendations for tobacco control policy and particularly explore comprehensiveness and nature of Norwegian tobacco control policy. Furthermore, by looking through the prism of libertarian paternalistic approach for tobacco control, this study examines in what way Norwegian tobacco control efforts motivate and stimulate personal responsibility for health.

1.1 Background

Consumption of tobacco is the leading cause of preventable and premature deaths in the world. Tobacco is a substance characterized by its addictive nature and carcinogenic and toxic effects. Cigarettes are the most popular form of tobacco and represent one of the most addictive and deadly commodities ever created by humankind (WHO 2006, 13, 18). Cigarette smoking consists of inhalation of a variety of chemicals that result in adverse health outcomes, primarily cancer, pulmonary and cardiovascular diseases. The health risk of smoking is increased by continuing and high tobacco smoke exposure level. There is no safe level of exposure to tobacco smoke. Furthermore, not only people who smoke face serious health risks, but also people who inhale second-hand smoke (passive smokers). Exposure to second-hand smoke is attributed to a number of diseases, such as lung cancer, coronary heart disease, impaired lung function and others (WHO 2006, 13; CDCP et al. 2010, 9). Nicotine is the main chemical element in tobacco that is responsible for development of addiction, hence an essential reason for sustainable tobacco consumption. Cigarette smoking provides the fastest nicotine delivery rate to the nicotine receptors in the brain. As highly addictive behavior smoking is characterized by its long-term persistency and negligence of its harmful health effect. Smoking most often starts in young age, and at that age addictive effect of nicotine is evident even at low consumption levels. In general, addiction is seen as a specific behavior type characterized with poor self-control and lack of self-guidance. Accordingly, a high number of smokers who quit smoking, relapse soon after cessation attempt, mainly due to the challenging withdrawal symptoms that can last for few months after cessation (CDCP et al. 2010, 105, 180, 181, 183; Poland and Graham 2011, xi).

The World Health Organization (WHO) recognizes tobacco use as one of the main risk factors for development of non-communicable diseases (NCDs), the greatest disease burden and leading cause of global mortality. According to the WHO, it is estimated that in the near future smoking will be held accountable for approximately 71% of lung cancer, 42% of chronic respiratory disease and almost 10% of cardiovascular disease. Globally, around 5 million smokers and around 600.000 passive smokers die every year from the mentioned and other tobacco related diseases. Tobacco use is accounted for 12% of all global deaths, resulting in higher global mortality prevalence than the combination of all deaths caused by AIDS, tuberculosis and malaria. If this trend continues without serious tobacco control actions, by the year 2030 tobacco will kill more than 8 million people, and it could end up killing 1 billion people by the end of this century (WHO 2010a; WHO 2012; WHO 2014a; WHO 2009a; WHO 2014b).

It is estimated that smoking prevalence in Norway is 26%, which means that approximately a million people smoke[1]. Out of this number, about 20% are young people[2]. Moreover, out of all annual deaths in Norway, approximately 13% are caused by smoking, which means that every year approximately 5100 Norwegians die, on average 11 years prematurely (Helsedirektoratet 2013a; Helse og omsorgsdepartementet 2011, 6).

The WHO recognizes comprehensive tobacco control policy as a range of strategies for tackling tobacco use and reduction in incidence and prevalence of NCDs. The WHO has developed a Framework Convention on Tobacco Control (FCTC) in 2003, a historically important treaty, which embraces wide range of tobacco control measures directed to reduce demand and supply of tobacco. This treaty binds its Parties to engage in continuous development of ''comprehensive multisectoral national tobacco control strategies'' (WHO 2014a, 6; WHO 2003). Norway represents one of the European successful and leading examples in regards to comprehensive tobacco control policy, with its roots tracked back to 1960. Accordingly, Norway has become the first country in the world to sign the FCTC. However, in the last period Norway is relatively lagging behind with higher smoking prevalence compared to others in the league of the tobacco

[1] Data from 2012 - Age group 16-74 – 16% daily smokers; 10% occasional smokers
[2] Data from 2012 - Age group 16-24 – 7% daily smokers; 13% occasional smokers

control leading countries[3]. Furthermore, Norway has been criticized for the lack of financial resources devoted to tobacco control, lost focus on anti-tobacco mass media campaigns, poor cessation services and other (Helse og omsorgsdepartementet 2011, 7, 10; WHO 2010b, 5, 6). However, by firmly acknowledging past shortcomings, Norway developed the new tobacco control strategy in 2011 with focus on renewed and advanced key measures. In the last couple of years, concrete actions have been taken to improve tobacco control policy, such as launching fewer anti-tobacco mass media campaigns, generating strategy document for improvement of cessation services and implementation of new legislations (Helsedirektoratet 2014e; Helsedirektoratet 2014d; Helsedirektoratet 2013b; Oftedal et al. 2012; Helse og omsorgsdepartementet 2011, 14).

1.2 Aim of the Study

The aim of this study is to identify global directions and recommendations for tobacco control and particularly explore Norwegian tobacco control policy, through libertarian paternalistic conceptual framework, and its effect on public health, or more specifically on disease prevention and personal responsibility for health. The purpose is to investigate how national tobacco control measures influence people's attitude toward smoking and how do they impact prevention of smoking initiation and smoking cessation. Furthermore, this study aims to explore in particular how an environment where people will rather choose smoke-free lifestyle and become more responsible for their personal health is created.

1.3 Research Questions

This study aims to explore and be directed according to the following research questions:

1. What are the main global directions and recommendations for generation and improvement of national tobacco control policy?
2. What are the main measures in tobacco control policy in Norway for tackling tobacco smoking prevalence and preventing smoking initiation?

[3] 2011: Sweden (daily smokers (ds)) 13.6%; Iceland (ds) 14% (Ornberg and Sohlberg 2012, 72); United Kingdom (general smoking prevalence) 20% (ASH 2014). It has been reported that smoking prevalence is 35% lower in Sweden and 22% lower in United Kingdom in comparison to Norway (WHO 2010b, 9)

3. How do those tobacco control measures fit into Libertarian Paternalistic approach and in what way they motivate and stimulate Personal Responsibility for Health?

1.4 Organization of the Thesis

Section 2 describes methods and limitations of the study. In section 3 the concept of personal responsibility for health is presented, followed with a description of libertarian paternalistic approach and its mechanisms. FCTC, identified as main global direction for national tobacco control is outlined in the first part of section 4. The latter part of this section briefly describes Norwegian tobacco control policy. Section 5 sets out selected communicative and restrictive tobacco measures organized in three information folds: general information, WHO recommendations, and Norwegian examples. In the end, section 6 discusses those measures through libertarian paternalistic conceptual framework followed with the last section that justifies controversial tobacco control measure, while section 7 summarizes and concludes the study.

2. METHOD

This thesis represents a study that is based on reviewing and exploration of targeted literature. A review-based thesis is characterized by the following phases. Firstly, in regards to the research question, it is believed that available literature, as a main data source for the research, contains enough relevant information in order to answer the research questions and comprehend the research topic. Secondly, strategically designed literature-search is comprehensive and it is performed in order to identify and collect the crucial resources. Thirdly, a critical evaluation of selected literature is performed in order to determine relevant inputs to the research topic. This includes identification of diverse perspectives of the topic and interpretation of the main arguments, and analysis of those two according to the critical framework. Lastly, the components of literature analysis are incorporated into different divisions, aiming to present different perspectives, such as complementary, conflicting, relevant and unclear views of the research topic. Accordingly, this will provide clear knowledge about roots and evolution of the topic and will potentially suggest recommendation for action (Hart 2005, 140). The review-based thesis are usually not driven by theories and they often generate persistent personal comprehensibility of the research topic as well as the contributive potential that a review-based thesis can have to the

literature (Hart 2005, 146, 147). Hart (2005, 147, 153) claims that those types of theses ''can bring awareness, understanding and clarity to a problem, in that we can see its cause and the means to eradicate it''. He adds that the process of literature search and review represents a critical assessment of available information, which is significant to the research question. This review-based thesis does not rely on the systematic review and search of the literature in the most rigorous way, as the process of literature search does not strictly lay out and follow criteria characterized for systematic literature review. The ambition of this review-based study is to bring clarity and comprehensibility of global directions and nature of national tobacco control policy, by analyzing how libertarian paternalism incorporates itself into national tobacco control policies aiming to raise awareness about tobacco hazard and motivate and stimulate personal responsibility for health.

2.1 Literature Search and Data Sources

The main search engines for collection of relevant literature were PubMed, HiOA library search data base (Oria), Google Scholar, and BMJ Tobacco Control. The key words used in literature search were *''Libertarian Paternalism''* and *''Personal Responsibility for Health''* or *''Individual Responsibility for Health''* and *''Tobacco Control Policy''* or *''Tobacco Control''* or *''Tobacco Control Measures''* and *''Norway''* or *''Norwegian''*. However, after this primary literature search, selection and review, I adopted further search method by combining the following key terms: *''smoking''*, *''nicotine addiction''*, *''health warning messages''*, *''mass media campaign''*, *''health communication''*, *''tobacco control legislation''*, *''tobacco taxation''*, *''smoking cessation services''*, *''point of sale tobacco display''*, *''social norms''*, and *''choice architecture''*. Moreover, the use of a snowballing technique was highly important in the searches, which consisted of going through bibliography lists of selected articles, documents and books, which resulted in identification of relevant data sources (Jones 2007, 39).

In tobacco control policy, grey literature constitutes highly important source of data. Grey literature is published by independent national or international research units or other types of institutions and can be immensely beneficial (Jones 2007, 42). The searches in the grey literature included Norwegian tobacco control related documents, reports, government papers, newspaper articles and other relevant forms of textual records, both in English and Norwegian language.

They were searched at the following data sources: The Norwegian Directorate of Health, Ministry of Health and Care Services, Norwegian Institute for Drug and Alcohol Research (SIRUS), Journal of Norwegian Medical Association, National Institute of Public Health, Norwegian Law Data Base, Norwegian Knowledge Centre for the Health Sciences, Norwegian Cancer Society and others. The literature for global recommendations is extensively based on search of documents in WHO database available on their two websites: the global website (www.who.int) and the European website (www.euro.who.int). This resulted in identification of the WHO source of information relevant to tobacco control policy that is in most part based on FCTC.

2.2 Limitations of the Study

When considering the Norwegian case of tobacco control, the focus, as indicated in research question number two is on cigarette smoking only[4]. However, due to a comprehensive ban on indoor smoking and de-normalization of smoking, the prevalence of snuff use has become relatively high over the latest decade. Hence, explicit focus on cigarette smoking can be regarded as a limitation. Although snuff use has been discussed as harm reduction strategy to smoking, a new evidence on harmful effect of snuff have set clear focus in national tobacco control policy to regulate snuff products in a stricter way, similarly as with cigarettes. Daily snuff use prevalence, especially among young Norwegians, has sharply increased over the last years, and prevention of snuff use initiation and help to quit snuff use are among main objectives in the new national tobacco control strategy [5] (Helse og omsorgsdepartementet 2011, 12; Lund 2009; Helsedirektoratet 2011c; Sandtrøen 2014).

A critical limitation and weakness of this study is the absence of discussion on social inequalities in health and health behavior in regards to tobacco control policy. In Norway, a distribution of smoking in regards to education level is striking. Norwegians with university degree smoke the least (8%), on contrary to 34% of those with elementary education and 20% of those with secondary school education (Helsedirektoratet 2013a). It is evident that smoking prevalence and morbidity attributed to smoking is not equally distributed among different social groups and that

[4] Please note that throughout the thesis the terms ''tobacco use'', ''tobacco consumption'' and ''smoking'' are used interchangeably

[5] 2012: 19% daily snuff use (age 16-24), 9% daily snuff use (age 16-74) (Helsedirektoratet 2013a, 21)

concept of personal responsibility for health and libertarian paternalistic approach to national tobacco control might overlook or even widen the inequality gap of socially disadvantaged smokers (Øverland et al. 2010; Strand et al. 2010; Lund 2005a; Halpern et al. 2004, 65). Bringedal (2013, 230) claims that ignorance of social inequalities in health policies that focus on personal responsibility for health will lead to broad discrepancies in health as well as in health behavior, which makes it ´ethically and politically problematic´. This study does not intend to undermine significance of social inequalities in health in any way. However, according to the research questions, this review-based study limits its ambition to exploration and investigation of global recommendations influence on generation of national tobacco policy. It also limits its scope on focusing on comprehension of initial aim of those recommendations and policies in regard to libertarian paternalistic framework and personal responsibility for health ideology.

Furthermore, to frame the thesis and to organize the discussion part, the conceptual framework of libertarian paternalism is used, rather than a typical theoretical one. Choosing libertarian paternalism as a framework was led by the fact that this approach can easily be applied to tobacco control policy as well as to ideology of personal responsibility for health.

3. PERSONAL RESPONSIBILITY FOR HEALTH

Personal responsibility for health (PRH), defined in the most simplified way, means adoption of healthy lifestyle such as healthy eating, physical exercising and non smoking (Steinbrook 2006; Weyden 2007). As Wikler (2006, 109) states, people tend to preserve their health if they live prudently and practice healthy living. He adds that avoidance of diseases, which are caused by personal unhealthy choices, is crucial as an objective of healthy lifestyle. Along the same lines, it is broadly recognized in literature that unhealthy lifestyle is a significant cause of diseases and that number of diseases could be avoided through personal lifestyle changes (Feiring 2008; Bringedal and Feiring 2011; Brown 2013; Cappelen and Norheim 2004; Upton and Thirlaway 2014; Loewenstein et al. 2007; Resnik 2007; Minkler 1999; Halpern et al. 2004).

The concept of PRH and lifestyle change was set in scene back in 1960s with emerging evidence of various health risk factors that were related to lifestyle and personal behavior, such as the

harmful effect of tobacco consumption. The emphasis on individual behavior was not crucial for prevention of NCDs only, but was also seen later as critical for prevention of HIV transmission (Wikler 2006, 111). From the onset of the recognition of PRH, as a new perspective in disease prevention, supporting evidence has been raising. Consequently, various health policy interventions have been introduced, supporting the vision to control health risk factors. Public health interventions started focusing on alteration of individual´s unhealthy lifestyle through supplying of relevant information and skills intended to motivate and enable individuals to shift to healthy lifestyles (Minkler 1999, 123, 124).

The *Forward-looking concept* is the aspect of PRH that focuses on choices that promote healthy lifestyle and disease prevention, contrary to *backward-looking concept* where the presence of adverse health outcomes is evaluated through the past unhealthy choices that contributed to occurrence of disease[6] (Cappelen and Norheim 2006, 314; Cappelen and Norheim 2005, 476). Cappelen and Norheim (2005, 476, 477) discuss the forward-looking aspect of PRH as the one that is concerned with how people will behave in the future. In simpler words, the idea is that a choice that promotes future healthy behaviors (e.g. choosing non-smoking lifestyle promotes prevention of diseases caused by smoking) is induced through the right negative or positive incentives (e.g. tobacco taxes and legislations discourage smoking). Wikler (2006, 112, 113) points out that reduction of burden on scarce health care resources, as another aspect of health policy, is promoted by PRH and by individuals who tend to live healthy and prevent diseases. The forward-looking concept of PRH is embraced by the health promotion approach in public health (A. Cappelen and Norheim 2005, 477). Health promotion is advocating for better health by motivating and assisting individuals to develop personal skills that will enable healthy choices and improve healthy lifestyles (WHO 2009b, 1, 4). One of the health promotion aspects is behavior change, which focuses on support of individuals to improve their health by choosing to shift to more healthy lifestyles (Naidoo and Wills 2009, 70, 71; Priest et al. 2008, 2).

---

[6] *Backward-looking concept* in PRH is discussed in regards to distributive justice in health care, scarce health care resources and priority setting at point of disease treatment. It operates via acquiring information about patients' past behaviors and unhealthy choices that caused disease, hence need for health care treatment. This approach is seen as controversial, as it ignores humanitarian aspect of health care, faces equity issues, conflicts normative beliefs of physicians and others (Cappelen and Norheim 2005, 477; Bringedal and Feiring 2011; Halpern et al. 2004, 35).

A lifestyle where behavioral change is not merely a matter of choice, but rather a challenge caused by addictive behavior, which hinder desired shift to healthy lifestyle, represents a responsibility sensitive field[7] (Levy 2011). Poland and Graham (2011, 12) discuss the elements of personal responsibility of an individual coerced by addiction. They argue that the responsibility aspect is rather a concern of other individuals and institutions in certain settings in which addiction happens than of the individual who suffers from an addiction. Accordingly, they hypothetically question what particularly an individual is alleged to be responsible for: (1) becoming addicted to smoking, (2) seeking and consuming smoking, (3) other behavior or consequences related to smoking (e.g. impact on others, harm to self), (4) overcoming addiction and quitting smoking[8] (Poland and Graham 2011, 10). Accordingly, Berridge and Robinson (2011, 21) definition of addiction perhaps provides an initial glimpse for some of the above issues:

> ''Addiction refers specifically to a pathological and arguably compulsive pattern of drug-seeking and drug-taking behavior, which occupies an inordinate amount of an individual's time and thoughts, and persists despite adverse consequences'' (Berridge and Robinson 2011, 21).

They further add that an individual with addictive behavior finds it very challenging to quit taking drug despite ''strong desire to do so''[9]. Even if an individual succeeds in quitting taking an addictive drug, they continue to face challenges of withdrawal symptoms and prevail highly vulnerable to resume addictive behavior.

---

[7] Levy (2011, 89) discusses *moral* and *medical/scientific* models of comprehending responsibility for addictive behaviors. Moral model claims that addicted individuals are responsible for their behavior and are to be blamed for it, contrary to the latter model which reflects abnormality of addictive behavior, characterized by lacks of control, therefore addicted individuals are not to be held responsible.

[8] Smoking is set as an *object of addiction* in order to narrow down broad subject delivered by the authors.

[9] They refer to nicotine as one of the addictive drugs (Berridge and Robinson 2011, 23). Over time, it was discussed if smoking is addictive or habitual behavior and if it causes only psychological dependence or physical as well. However, after sound analysis of nicotine addiction through drug dependence framework it has been firmly confirmed that nicotine is an addictive drug causing compulsive and dependent tobacco consumption (Sohn et al. 2003, 251).

Brown (2013) argues that freedom to choose healthy options is not a simple action, but rather one that is intertwined with complex factors. Most individuals would indeed prefer to have a productive and healthy life, yet most of them occasionally behave in a manner that harm themselves or others close to them (Halpern et al. 2004, 60). The action to choose to behave in healthier manner is not necessarily completely voluntary in all occasions. Smoking as addictive behavior imposes pressure of dependence that restricts freedom to choose a perhaps desired, healthier option to quit smoking, because of the compulsion and strong temptation to smoke. Therefore, the addictive behavior can be perceived as controlled by compulsive desires and not by the individual him/herself. An individual who suffers from an addiction cannot be completely held responsible for personal health (Brown 2013, 3).

Similarly, Resnik (2007, 444) points out that it would be unfair to completely attach PRH to individuals who fail to make reasonable health choices because of addictive behavior. He adds that although an individual is considered to be an important element in sustaining personal health, he or she cannot be held completely responsible for it. People often struggle to independently recognize what is in their personal best interests (Jones et al. 2011, 489). A society has a crucial role in health promotion and disease prevention. Bearing in mind that society takes significant responsibility for prevention of diseases, PRH should be stimulated through public health promotion strategies initiated by society which would motivate individuals to take an active and independent role[10] (Resnik 2007). Halpern at al. (2004, 60, 67) also claim that society plays an important role for behavior change, by enabling and empowering individuals to engage in behaviors that are in their own best interests and that the personal responsibility is a co-product of individual-state partnership. It is crucial to create a social environment with healthy choice options, which would result in individuals being capable to choose healthy lifestyle and prevent disease (Resnik 2007, 445).

Schmidt (2013, 73) argues that public health measures often fail to be equally distributed and to equally consider different groups of individuals who live under various circumstances, either different regions, social status or other factors that can influence PRH. It can be complex to

[10] He also points out that health promotion strategies are cost-effective and that their disease prevention outcome has multiple effects, such as reduction of burden on scarce health care resources, prevention of necessary pain and suffering, to name but a few

distinguish what causes some individuals to initiate and lead certain type of lifestyle. This is a multifactorial issue which depends on one's social, environmental or genetic status (Wikler 2006, 113; Buyx 2008, 873). Wikler (2006, 121) recalls Dworkin´s view on distributive justice and his separation of ''brute'' and ''option'' luck in regards to individual choices and their consequences. Brute luck is seen as a situation where individuals cannot be fully held responsible for chosen lifestyle or adverse outcome, as some of the factors (e.g. genetics, unavoidable negative events, social status, and lack of education) which have affected individuals' health were simply out of their control. On the other hand, option luck is seen as full control of an individual who is having complete autonomy to choose certain health risks. The risks that are taken, such as smoking or alcohol drinking are perceived as choices that directly negatively influence ones health but are being chosen despite knowledge of their hazardous effects. However, complexity of environment in which someone lives can impose unhealthy behavior cues and if combined with lack of self-control, attempts of adopting healthy lifestyle are seriously hindered (Brown 2013, 2).

3.1 Libertarian Paternalism

The concept of libertarian paternalism (LP)[11] may appear to contain two seemingly contradictory terms, with *libertarian* aspect emphasizing freedom, while *paternalism* indicates restricted or limited autonomy[12] (Christman 2014; Sunstein and Thaler 2003). However, LP operates primarily through preservation of freedom of choice, while paternalistic element influences decision in order to utilize beneficial outcomes of taken actions. The need to steer people's choices by using LP arose from observation that people, in many life spheres, miss evident, rational and stable preferences. Moreover, people tend to be overconfident when making certain choices, given the biases of the previous experiences. The idea suggested by LP supporters is not to block or limit peoples opportunities to choose but rather just to steer people in direction that will promote their welfare, ensuring existence of freedom of choice (Sunstein and Thaler 2003; Lecouteux 2013, 6; Grill 2013, 29, 37).

---

[11] The concept was introduced by Sunstein and Thaler (2003) in their academic article ''Libertarian Paternalism is not an Oxymoron''. They portray LP as political position, a principle and as a type of policy strategy (Grill 2013, 37).

[12] Also referred to as ''asymmetric paternalism'' or ''soft paternalism'' by some authors (Loewenstein et al. 2007; Camerer et al. 2003; Lecouteux 2013, 3). However, Grill (2013, 30) points out certain distinctions between soft paternalism and libertarian paternalism.

LP is also referred to as ''a new technique of government-sponsored behavior change'' which will influence people's behavior to attain better quality of life and live longer[13] (R. Jones et al. 2011, 483, 484). By employing a LP approach into public health policies, the freedom of choice for individuals is fully recognized. On the other hand, paternalism is directed to make individuals to behave in a welfare-promoting manner and be provided with an appealing option that will make healthy lifestyles attractive (Schiavone et al. 2014). Thaler and Sunstain (2009, 5) state that LP will not force individuals not to smoke or not to eat unhealthy, but it will aim to steer their choice into direction that would improve their welfare. Halpern et al. (2004, 61) also claim that ''governments do not ban unhealthy foods or smoking, but seek to refashion the behavioral pressures towards healthier choices''.

Jones et al. (2011) identify four mechanisms in order to identify LP policies and explain the process of implementing them, namely: (1) spatial design and choice architecture, (2) temporal ordering, (3) measures to rationalize the brain and (4) prompting social norms.

The first mechanism operates through the idea of *choice architecture,* which considers a certain area that has been strategically and spatially designed in order to inspire people to behave in a welfare-promoting manner. The objective of this mechanism is to facilitate a macro or micro-environmental spatial design setting that will constitute positive behavior[14] (Jones et al. 2011, 487, 492, 497). A choice architecture mechanism set in a microenvironment, can be portrayed through ''location based regulation'' or ''restrictions on product displays'', such as tobacco products visibility and availability at the market. For instance, if cigarettes can be bought in all sorts of stores and in vending machines, the choice to smoke will be widely available, on contrary to strategically reduced density and ''re-engineered spatial environments'' of cigarettes retail objects which will minimize their availability (Beshears et al. 2006, 45, 46; Jones et al. 2011, 492). Thaler and Sunstein (2009, 6) embrace choice architecture in their concept of nudge as most prominent mechanism of LP approach. They define nudge as ''any aspect of the choice

[13] Grill (2013, 40, 41) points out a couple of critiques proposed by certain authors, such as that LP has no benefits and that it can decrease sense of personal responsibility.
[14] *Macroenvironments* represent for example a street design with cycling lanes (R. Jones et al. 2011, 492). *Microenvironments* represent ´settings in which people may gather for specific purposes and in which they may acquire or consume food, alcohol, tobacco…´ (Hollands et al. 2013a, 2)

architecture that alters people's behavior'' in a way that can be predicted with preserving the choice option freedom (Thaler and Sunstein 2009, 6). Holland et al. (2013b, 2) discuss that Thailer and Sunstein mostly focus on choice architecture as largely and generally applied, with limited relevance to public health[15]. Therefore, led by this, Holland et al. (2013a) have pioneered in development of typology of choice architecture interventions specific to public health. Those interventions aim to inspire healthy behavior within microenvironments. They offer a definition of choice architecture intervention which specifically aims to alter unhealthy behaviors (poor diet, physical inactivity, alcohol consumption and smoking) in certain settings and it is as it follows bellow:

> ''Interventions that involve altering the properties or placement of objects or stimuli within microenvironments with the intention of changing health related behavior'' (Hollands et al. 2013a, 3).

They further point out that those choice architecture interventions are implemented in the same setting (microenvironment) in which behavior, that is the target of this interventions, is carried out.

Temporal ordering is the second mechanism pointed out by Jones et al. (2011, 487) and this aspect advocates utilizing timing as a useful element in behavioral change. The idea is that behavior can be influenced in a certain window of time. Time-based regulations restrict or permit access to particular goods in order to facilitate behavior change and ''self-rationing'', such as sale of tobacco products in defined time periods (Beshears et al. 2006, 46).

The third mechanism of *measures to rationalize the brain* operates by promoting choices of rational behavior and overcoming predictable irrational ones (Jones et al. 2011, 487). Governments usually use the following three sets of instruments to promote rational behavior and augment individual welfare: (a) *legal punishment* in order to raise cost of particular unappealing behaviors and demote them; (b) *price signals* consider either incentives (benefits) or disincentives

[15] Their popular example for choice architecture is based on the strategic organization of healthy food in cafeteria at ''eye level'' in order to make it more visible and give priority in the line contrary to food that is unhealthy and put in less visible places and further away (Thaler and Sunstein 2009).

(cost) which will ''encourage or discourage'' particular behavior respectively; (c) *information* to communicate ''cost and benefits'' of particular choice and to introduce alternative and more appealing behavior (Halpern et al. 2004, 15).

The last libertarian paternalistic mechanism of *prompting social norms* is based on ''promotion of particular social norms and collective nudges'' (Jones et al. 2011, 487). Governments use strategic methods to encourage healthy lifestyle and eventually change behavior culture. The change of social norms is often induced by de-normalization strategies that will make certain behavior less socially acceptable and less visible. De-normalization is seen as a relevant element of anti-smoking strategies which represent an important instrument for generation of social norms, hence making smoking less socially acceptable, which could result in reduction of smoking rates and prevention of smoking initiation (Voigt 2013, 47, 58).

4. GLOBAL DIRECTIONS AND NATIONAL TOBACCO CONTROL POLICY

In this section, the main global direction for tobacco control policy will be presented, namely the WHO treaty adopted in 2003. In the latter part the brief overview of the Norwegian Tobacco Control Policy will follow.

4.1 Framework Convention on Tobacco Control

The WHO initiated development of FCTC back in 1993 in order to lead the generation of an international legal instrument for tobacco control (Roemer et al. 2005, 936; WHO 2009c, 40). FCTC was adopted in May 2003, being the first global treaty ever negotiated by the WHO, becoming one of the biggest treaties in the history of United Nations, with 179 Parties up to date (WHO 2009c, v; WHO 2014i). In February 2005 the FCTC entered into force and became the first international ''legal instrument for multilateral cooperation and national action for reduction of global tobacco epidemic'' (Roemer et al. 2005, 936).

The principal objective of the FCTC is primarily to protect current and upcoming generations from the harmful and disastrous health, social, environmental and economic consequences of

tobacco use and harmful exposure to second-hand smoke. To reach the objective each Party has to implement tobacco control measures provided in the FCTC at different levels (national, regional and international). This should accordingly result in reduction of tobacco use prevalence and tobacco smoke exposure (WHO 2003, 5). The FCTC is divided into two main sets of strategies, namely demand reduction (Articles 6-14) and supply strategies (Articles 15-17). Other articles in the convention cover other important areas contained in Articles 18-26. In total, the FCTC contains 38 Articles (WHO 2003; WHO 2009c, 28). In the following text only the demand reduction strategies will be briefly presented[16].

Article 6. Price and tax measures to reduce the demand for tobacco - This is the only measure that uses price and tax mechanisms in order to influence public and decrease demand for the use of tobacco products. This article advocates for prices and taxes as highly important and effective tools in regards to reduction of tobacco use among diverse population, targeting young people as the crucial group. The Parties take responsibility to define their taxation policies according to national health objectives (WHO 2003, 7).

Article 8. Protection from exposure to tobacco smoke - The Parties will acknowledge a deeply imbedded scientific fact that death, disease and disability is caused by exposure to second-hand smoke. Accordingly, the Parties will incorporate effective legislative, administrative and other relevant measures aiming to establish national laws which will ensure comprehensive public protection from exposure to second-hand smoke (WHO 2003, 8)

Article 9. Regulation of the contents of tobacco products - The guidelines for testing and measuring the contents and emission of tobacco products and for their regulation will be proposed by the Conference of the Parties with consulting competent international entities. Furthermore, effective legislative, administrative and other relevant measures will be adopted and implemented by each Party in order to test and measure contents of tobacco products (WHO 2003, 9)

[16] Article 7 is excluded from presentation as it serves as introduction to non-price measures.

Article 10. Regulation of tobacco products disclosures - According to national laws, the Parties will adopt and implement legislative, administrative and other relevant measures, which will require producers and importers of tobacco products to reveal all necessary information to government bodies in regard to emission and contents of tobacco products. Furthermore, the Parties will adopt and implement measures in order to make the information about toxicity and emission of tobacco products available to public (WHO 2003, 9).

Article 11. Packaging and labeling of tobacco products - Those effective measures will firstly secure that unit packets, packages and labels of tobacco products provide public with relevant information of tobacco products ensuring the absence of tobacco promoting aspect. Each tobacco package has to contain information in form of warnings/messages of harmful effects of tobacco use on human health. Accordingly, the warnings/messages will be rotating, large, evident, obvious and legible. The main display site of the package should be covered by the warnings/messages with 50% or more, and not less than 30%, and it can be in form of or supplied with pictures or pictograms (WHO 2003, 9, 10).

Article 12. Education, communication, training and public awareness - Communication methods are to be used by each Party in order to promote and improve awareness of public, through wide range of comprehensive and effective programs, on subject of tobacco control and harmful health effects of tobacco use (including information about addictive nature of tobacco and exposure to second-hand smoke) as well as about benefits of tobacco use cessation and tobacco free lifestyle. The Party will proceed with adaptation and implementation of effective legislative, administrative and other relevant measures of Article 12 (WHO 2003, 10, 11).

Article 13. Tobacco advertising, promotion and sponsorship - Each party will acknowledge that reduction of tobacco products use is a result, among other measures, of complete prohibition of advertising, promotion and sponsorship of tobacco products. The Parties will aim to apply a complete prohibition of all tobacco advertising, promotion and sponsorship. If the Party is not able to set a complete prohibition because of national constitution or its principles, it will aim to limit all tobacco advertising, promotion and sponsorship (WHO 2003, 11).

Article 14. Demand reduction measures concerning tobacco dependence and cessation - Comprehensive and integrated guidelines are to be generated and dispersed by each Party, which will rely on scientific evidence and best practices, followed by enrollment of effective measures for tobacco use cessation and appropriate treatment for nicotine addiction. In order to accomplish this, each party will commit to comprehensive implementation of cessation services; diagnosis, treatment, counseling and prevention of tobacco dependence; and available and affordable treatment for tobacco dependency (WHO 2003, 13).

4.1.1 MPOWER Policy Package

In order to enforce the WHO FCTC with additional practical measures the WHO introduced MPOWER policy package, which reflects on some of the FCTC articles in order provide further assistance for reduction of tobacco demand. The idea is to provide measures that are practical, achievable and affordable (WHO 2014c, 4; WHO 2008). MPOWER contains six following measures presented in the Table 1. In addition, defined key interventions (e.g. M1, P1 etc.) for each of the measures will be presented.

Table 1. MPOWER policy package with recommended key interventions.

M	**Monitor tobacco use and prevention policies**	Article 20.[17]
M 1	Obtain nationally representative and population based periodic data on key indicators of tobacco use for youth and adults	
P	**Protect people from tobacco smoke**	Article 8.
P 1	Enact and enforce completely smoke-free environments in health-care and educational facilities and in all indoor public places including workplaces, restaurants and bars	
O	**Offer help to quit tobacco use**	Article 14.
O 1	Strengthen health system so they can make tobacco cessation advice available as part of primary health care. Support quit lines and other community initiatives in conjunction with easily accessible, low-cost pharmacological treatment where appropriate.	
W	**Warn about the danger of tobacco**	Article 11.

[17] *Article 20* has not been previously presented as it is not under the group of articles that reduce demand for tobacco use. However, it is presented here, as one of the MPOWER measures, highlighting importance of monitoring of national tobacco epidemic.

W1	Require effective package warning labels	W2	Implement counter-tobacco advertisement	W3	Obtain free media coverage of anti-tobacco activities
E	**Enforce bans on tobacco advertising, promotion and sponsorship (APS)**				Article 13.
E1	Enact and enforce effective legislation that comprehensively bans any form of direct tobacco APS			E2	Enact and enforce effective legislation to ban indirect tobacco APS
R	**Raise taxes on tobacco**				Article 6.
R1	Increase tax rates for tobacco products and ensure that they are adjusted periodically to keep pace with inflation and rise faster than consumer purchasing power.			R2	Strengthen tax administration to reduce the illicit trade in tobacco products.

Source: (WHO 2008, 12)

4.2 Norwegian Tobacco Control Policy

Norwegian tobacco control policy emphasizes a comprehensive approach as crucial starting point of tobacco control and reduction of tobacco consumption. Following this, Norwegian tobacco control policy operates across three principal objectives: prevention of tobacco use initiation among youth, accessibility to cessation services for tobacco users, and protection of third parties from exposure to second-hand smoke. Norwegian tobacco control policy can be divided into four cardinal sections that are directed towards reduction in tobacco use demand: restrictive measures (legislation and taxation), cessation activities, mass media campaigns, and preventive programs (Helsedirektoratet 2011b; WHO 2010b, 5). The WHO FCTC Articles for reduction of tobacco demand adopted and incorporated into national tobacco control policy are summarized in the Table 2.

Table 2. Summary of adopted Global Directions and Recommendations

WHO		Norwegian Tobacco Control Policy	
FCTC	**MPOWER**	**Adopted**	**Legislation[18]/Regulation/Example**
Article 6.	R1	Yes/In progress	Strategy's aim is to maintain high tobacco taxes (73%)[19]
	R2	Yes/In progress	In 2013 the fine for illicit trade increased following the illicit trade record the same year (Carlsen and Hirsti 2014; Brækhus 2013).
Article 8.	P1	Yes	§25; §26; §27; §28
Article 9.	/	Yes	§32
Article 10.	/	Yes	§38; §39; §40
Article 11.	W1	Yes	§30; §31
	W2	Yes	Mass media campaigns (anti-smoking TV advertisement emphasized)[20]
	W3	Yes	Newspapers, Anti-Smoking TV programs, YouTube, Facebook[21]
Article 12.	/	Yes	Mass media campaigns (anti-smoking TV advertisement emphasized), Educational program in schools (Torkilseng and Sælensminde 2013)
Article 13.	E1	Yes	§4; §5; §6; §20; §21; §22
	E2	Yes	
Article 14.	O1	Yes/In Progress	Quit line, Website, Nicotine Replacement Therapy (NRT), Strategy document for improvement of cessation services[22]
Article 20.	M1	Yes	Statistisk sentralbyrå (SSB) Publication - Tall om tobakk 1973-2012 (Helsedirektoratet 2013a)

[18] See Appendix 1. Law on Protection against Harmful Effects of Tobacco
[19] See page 22 and 35 for more information
[20] See page 27, 28 and 29 for more information
[21] See page 29 for more information
[22] See page 30 for more information

4.2.1 Historical Backdrop of Norwegian Tobacco Control Policy

In order to get a complete picture of all efforts that Norway has been putting in tobacco control policy over nearly half of a century time period, a brief historical overview about most relevant tobacco control efforts will be presented. Norwegian tobacco control story started in 1965 when the Parliament acknowledged harmful effect of tobacco use on public health. As early as in 1967 the committee´s report suggested prohibition on tobacco advertising and mandatory health warnings on tobacco products. In 1971, the National Governmental Council on Tobacco and Health was established as a part of the Ministry of Health, which 31 years later became department in Norwegian Directorate for Health and Social Affairs. In 1975 the Tobacco Control Act was enacted, enforcing immediate prohibition on tobacco products advertisement of all sorts, including indirect advertisement. Ten years later, in 1985, the first report on protection from exposure to tobacco smoke was issued ''Clean Air for Everyone – The Right to Breathe Smoke-Free Air'' with suggestion for a ''clean air act'' (smoke-free air in public institutions and transport, but bars and restaurants excluded), which was adopted three years later. The first smoking restriction in bars and restaurants was implemented in 1993, and smoking was permitted in 2/3 of the premises, but improved with 1/2 five years later, and finally in 2004 complete ban on smoking was implemented in bars and restaurants. A year earlier, in 2003, Norway signed FCTC, and became the first country in the world to sign this important treaty. Same year the first national mass media campaign was launched. In 2006 the National Strategy for Tobacco Control (the first strategy was generated in 1999 for the period until 2003) was issued, for the time period from 2006 to 2010, followed with mass media campaign targeting tobacco induced diseases. The pictorial health warnings on all smoking tobacco products were regulated by the government in 2010, and implemented in 2011. In the same year, regulation for ban on point of sale tobacco and tobacco accessories displays was implemented. Mass media campaigns continued in 2012 and 2013, this time focusing on tobacco health risks, children, passive and occasional smoking. Most recent mass media campaign was launched in January this year with focus on current and ex smokers' experiences. Finally, the most recent legislative regulation set in force from 1 July this year has embraced four new regulations: the ban on smoking and use of snuff in the schools and kindergartens outdoor area; ban on smoking at outdoor entrance areas in all public institutions and all public and private health institutions; ban of smoking rooms in all public institutions with certain exceptions; and ban on self-service of all tobacco products and tobacco accessories in the

stores (Helsedirektoratet 2013b; WHO 2010b, 5, 8; Scheffels and Lavik 2012, 1; Helsedirektoratet 2014e; Aftenposten NTB 2014; Bjartveit 2003; Helse-og omsorgsdepartementet 2009; Helsedirektoratet 2014a; Helsedirektoratet 2011a).

4.2.2 Strategic Approach to Tobacco Control in Norway

So far, Norway´s commitments to strategic approach of tobacco control have been including three tobacco control strategies: ''A long term strategy plan for tobacco control 1999-2003'', ''Norway´s National Strategy for Tobacco Control 2006-2010'', and ''National tobacco control strategy: A tobacco-free future 2013-2016''. In addition, Norwegian Department of Health invited the WHO to conduct a review of national tobacco control measures. The document named ''Joint National Capacity Assessment on the Implementation of Effective Tobacco Control Policies in Norway'' was issued in 2010 and it represented a basis for generation of the current Norwegian strategy for tobacco control (Helsedirektoratet 2011d). The evaluation included examination of a number of relevant Norwegian institutions that are involved in tobacco control. Accordingly, five main challenges and five key recommendations were identified. Challenges such as lack of human and financial resources for tobacco control programs, lack of effective mass media campaigns, presence of smoking rooms in public institutions, second-hand smoke unprotected children in private areas, and poor cessation services are identified as crucial shortcomings of previous national tobacco control efforts. In order to secure present initiatives and upcoming improvements, five crucial recommendations should be taken into consideration seriously and set as priority in order to ensure efficient future results: (1) increase human and financial resources for tobacco control; (2) implement mass media campaigns; (3) eliminate smoking rooms in public institutions and complete public protection from second-hand smoke; (4) educate adults through mass media campaigns on how to protect children from second-hand smoke; and (5) set smoking cessation services as priority in the new national strategy (WHO 2010b, 5–7).

It has been more than 3 years since the WHO identified these challenges and formulated key recommendations. New National Strategy for Tobacco Control is set in place for the period between 2013-2016 and all those recommendations were highly acknowledged when generating the strategy document. Up to recently, some of the challenges have been tackled and

recommendation implemented such as: implemented mass media campaigns in 2012, 2013 and 2014 as well as recent regulation on ban of smoking rooms in public institutions. In addition, the national document for systematic and knowledge based approach for tobacco use cessation services was generated in 2012 (Aftenposten NTB 2014; Helsedirektoratet 2014d; Helsedirektoratet 2013b; Oftedal et al. 2012; Helsedirektoratet 2014a).

A Tobacco-Free Future – National Tobacco Control Strategy 2013-2016 - The current National Tobacco Control Strategy has defined three ambitious goals for 2016 in order to reduce tobacco consumption and harmful effect of tobacco. The first one is to *Prevent young people from starting to smoke or using snuff* - everyone born after the year of 2000 should not start smoking or snuff use. Secondly, the prevalence of daily smoking, which was 11% in 2011, among population aged 16 to 24 should be decreased for approximately 50%. Lastly, intense increase in incidence of daily use of snuff in the same age group recorded in 2011 (male: 25%, female: 11%) should be halted. The second goal is to *Motivate and offer help for smoking and snuff cessation* – current daily smoking among population aged 17 to 74 years old should be decreased from 17% from the year of 2011 to less than a 10% by the target year. On the other hand, the percentage of daily snuff users for the same age group should not be higher than 8% prevalence from 2011. Finally, the third goal is to *Protect public and society from harmful effects of tobacco* – the focus is primarily on protecting children exposed to second-hand smoke and on reduction of smoking prevalence among women in late pregnancy for approximately 50% (Helse og omsorgsdepartementet 2011, 12).

Following those clearly defined goals the strategy presents previously used and now renewed commitments, in order to provide comprehensive measures for better tobacco control policy. Those four identified renewed priority measures are as follows: *Legislation* which focuses on continuous development and employment of Ministry of Health and Care services to follow parliament´s consideration of proposed amendments, such as: introduction of municipal licensing system for tobacco products sale, introduction of ban on tobacco self-service and smaller tobacco packages, implementation of more smoke free environments in the society and strengthening protection from exposure to second-hand smoke. *Economical measure* focuses on maintaining of high taxation of tobacco as significant instrument for tackling tobacco consumption in population.

Mass media campaigns are seen as highly effective for tobacco use reduction in all public groups and the focus of this measure is set on preventing tobacco use initiation among children and youths, motivation of tobacco use (smoking and snuff use) cessation, especially among pregnant women and to inform parents about right of children to grow up in smoke free environment. Lastly *Tobacco use cessation services* focus on better organization of cessation services in health care, emphasizing primary health care, such as brief intervention and further treatment such as nicotine replacement therapy and follow up, among others (Helse og omsorgsdepartementet 2011, 16, 19, 22, 25)

4.2.4 Norwegian Tobacco Control Law

Norwegian law for regulation of demand and supply of tobacco was enacted in 1975, which makes it one of the first comprehensive tobacco control laws in the world. Ever since the law has been supplemented with different relevant programs and activities for tobacco use reduction (Helsedirektoratet 2011b; WHO 2010b, 5). The law is defined under the title *''Lov om vern mot tobakksskader (Tobakksskadeloven)''*[23]. The last update of the law has been done in July this year, introducing new laws, which were mentioned above. The law is divided into nine chapters. Each of the chapters is specific to the group of certain tobacco control acts (Lovdata 2014). The complete law is available in the Appendix 1.

5. SELECTED TOBACCO CONTROL MEASURES

In this part, selected tobacco control measures directed to decrease demand for tobacco products and help people to rather choose smoke-free lifestyle will be discussed through two defined sections. Those two sections are driven through three-fold sets of information, which are presenting general information, the WHO recommendations, and Norwegian examples. These sections are: Communicating Smoking Hazard and Motivating PRH and Restricting Smoking Demand and Stimulating PRH.

[23] My translation: *''Law on Protection against Harmful Effect of Tobacco''*. See Appendix 1.

5.1 Communicating Smoking Hazard and Motivating[24] PRH

Health communication is a multidisciplinary approach that has for its goal to distribute health information to targeted public, aiming to influence and support individuals to improve lifestyles that will positively affect health outcomes (Schiavo 2011, 5–7). It has been proven that public health communication has a positive impact on health behavior (Hornik 2002). The main purpose of distribution of health information is to increase public health literacy and impact personal health choices. Informed health choices tend to reduce health risks and improve quality of life (Mahmud et al. 2013, 2). Lack of information results in unsatisfactory health literacy which consequently hinders individuals to make healthy choices, lead healthy lifestyles and prevent disease (Lytton 2013, 35). Communication of health risk for certain behaviors, such as smoking is of essential relevance to support smoking cessation and prevent diseases caused by tobacco use. By communicating those health risks tobacco users are stimulated to quit smoking and non-tobacco users are enforced not to engage in consumption of tobacco. This eventually generates anti-tobacco social norms and attitudes. It is reported that many tobacco consumers lack information on hazardous scope of tobacco both for using it and for exposing non-consumers to second-hand smoke. In addition, tobacco users may have misconceptions about addictive nature of tobacco, complexity of quitting and severity of health hazards (Hammond et al. 2013, 817). Tobacco control policy uses different measures to inform public about harmful effects of tobacco use and assist them in quitting or not taking up tobacco. Some of those measures are mass media campaigns (MMC), health warning messages (HWM) and smoking cessation services (SCS) (Durkin et al. 2012; Hammond 2011; Marcano et al. 2012).

Mass media (television, radio, newspapers, internet and others) are used as means for distribution of preventive health messages and they have an effect on prevention of smoking initiation among young people (Durkin et al. 2012, 127; Brinn et al. 2010; Atusingwize et al. 2014). MMC are recognized in health communication as a very effective measure, as they have a direct impact on tobacco users and their decision to quit by making them question their own attitudes and potentially alter behavior. This measure is also known to be cost-effective, taking into consideration that it distributes highly important health messages/information to a large number

[24] ''To make somebody want to do something, especially something that involves hard work and effort'' (Turnbull 2010).

of people (Atusingwize et al. 2014). Moreover, they induce social norms change about tobacco consumption, provoke decision about cessation and contribute to reduction of smoking prevalence. Particularly, MMC which include anti-smoking advertisements with strong messages characterized with fearful and repulsive elements have positive impact and increase support for tobacco control policy among non-smokers (Halkjelsvik 2014).

Another important way of health communication in comprehensive tobacco control policy is HWM on tobacco packages that inform about tobacco health risks. This is a wide reaching method that enables distribution of health information directly to a tobacco consumer. In addition, HWM on tobacco packages not only influence tobacco consumers but also provide health information for non-consumers and public in general. In particular, larger HWM supplemented with graphics have been proven to be more effective in health communication. Pictorial HWM attract more attention and are powerful among young people. They impact adult and youth smoking cessation behaviors by decreasing daily consumption and stimulating quitting attempts. It has also been reported that HWM discourage non-smokers from initiating tobacco consumption (Hammond 2011, 327, 329, 331).

SCS are known as one of the most cost-effective preventive services in primary health care. In order to establish effective cessation programs assigned government authority should initiate creation of SCS. Those services could include free phone-quit lines, health insurance covered cessation treatments, creation of smoking cessation guidelines and others (Pechacek 2001, 24; Rigotti 2012, 1573). About 70% of smokers who are aware of health risk want to quit, but only 5% succeed to maintain non-smoking for a year period of time. The addictive nature of tobacco consumption makes it complex and challenging to quit, and a strong decision to quit is not enough in most cases. Therefore, evidence-based treatment and professional assistance is essential for smoking cessation. SCS can be behavioral (individual or group counseling, health workers motivational interventions and education about withdrawal symptoms, phone quite lines etc.) and pharmacological (products for relieving withdrawal symptoms, such as nicotine replacement therapy: patch, gum, nasal spray etc.). Both types of interventions have been proven highly effective in assisting smokers to stop smoking (Rigotti 2012, 1574, 1575; Marcano et al. 2012, 3; Larzelere and Williams 2012, 593).

5.1.1 The WHO FCTC Recommendations

Communication represents a crucial element of comprehensive tobacco control policy and this is also acknowledged by the WHO in FCTC through Article 12. In addition, Article 4 emphasizes relevance of the fact that each individual should be informed about tobacco use hazard, its addictive character, second-hand smoke, health consequences and other important aspects of tobacco control. Guiding principles for implementation of Article 12 underpin health communication approach and advocate for communication as a crucial element for distribution of comprehensive health information about health risks and harmful economic and environmental consequences of tobacco consumption, exposure to second-hand smoke and health benefits of quitting tobacco use. Awareness about harmful aspects of tobacco has to be raised through public education, communication and training. An important segment of rising public awareness of tobacco issues is its social norm change which promotes attitude change in regards to tobacco use and second-hand smoke exposure (WHO 2013a, 73–76; WHO 2003, 5, 10).

The WHO recognizes communication programs as a way of health information distribution to targeted public with beneficial effects in decreasing unhealthy behavior and support of healthy lifestyle and in particular MMC[25] are seen as one of the communication means that support health literacy (Kickbusch et al. 2013, 59, 60). Furthermore, the WHO sets special recommendation emphasis on television advertisement with pictorial elements of harmful effect of tobacco, as they are particularly effective in stimulating cessation attempts of tobacco consumers from all income levels. Accordingly, the WHO recommends that anti-tobacco MMC, in order to be highly effective and give sustainable results, should be broadcasted for a long period of time (WHO 2013b, 67).

HWM is separately placed under Article 11 in FCTC and requires adoption of HWM on tobacco products packages by all Parties, following Article 4 guiding principle of an individual's right to be informed about harmful effects of tobacco use[26] (WHO 2013a, 55; WHO 2003, 5, 9). The WHO acknowledges that the change of social norms is an important effect of HWM on tobacco products as it decreases tobacco use prevalence and strengthens support for tobacco control

[25] MPOWER policy package – Warn about the danger of tobacco (WHO 2008, 20)
[26] MPOWER policy package – Warn about the danger of tobacco (WHO 2008, 20)

policy. Accordingly, the WHO recommends that large HWM supplemented with pictures that cover both sides of package with at least 1\2 of the both surfaces are more effective than textual HWM only or smaller pictorial HWM (WHO 2013b, 63).

SCS are placed under Article 14 in the FCTC. It has been somehow unclear what smoking cessation includes, because of terminology of different languages and cultures[27]. Therefore, the WHO accepts smoking cessation to be perceived both as general programs to decrease tobacco use and as individual programs that consider SCS and treatments. Here, the focus will be set on individual SCS (WHO 2013a, 117; WHO 2003, 13). The WHO endorses smoking as an addictive behavior, which imposes serious cessation challenges. Accordingly, minimum three clinical SCS, which are proved to be highly cost-effective interventions in health care are highlighted as main recommendations: Tobacco cessation services in primary health care (brief interventions[28]), tobacco cessation counseling through toll-free quit telephone lines, and pharmaceuticals (NRT – if possible free of charge or subsidized/affordable cost) (WHO 2013b, 59; WHO 2013a, 125).

5.1.2 Norwegian Tobacco Control Efforts and Results

Norway has rather a long history of informing the public about tobacco health hazard through media channels as well as via HWM on tobacco product. As early as in 1971, Norwegian national television aired the program about smoking cessation named ’’Vel blåst’’ featuring four individuals in their attempts to quit smoking. Norwegian national radio also had a program about smoking cessation that had its run in 1984 and 1985. In early 1980s, newspapers were writing about the summer campaign bus which was driving around Norway in order to spread health information about smoking cessation (Bjartveit 2003, 16; Aarø et al. 2009, 24). However, the first concrete MMC was implemented in early 2003, which was followed with additional one later the same year, with focus on tobacco industry. The next one took place in June 2004 and aimed to inform public about upcoming legislation for smoke-free hospitality premises and second-hand smoke health hazard. In early 2006 a campaign focusing on information about diseases caused by tobacco use was implemented. Furthermore, in 2007, 2008 and 2009 combination of two campaigns from 2003 was implemented again. Finally, the most recent MMC were implemented

[27] MPOWER policy package – Offer help to quit tobacco use (WHO 2008, 16)
[28] See Appendix 4. Figure 1. Tobacco Cessation with Brief Intervention

in 2012, 2013 and 2014 (Aarø et al. 2009, 26; K. E. Lund and Rise 2004, 10; Larsen, Lund, et al. 2006, 5; Helsedirektoratet 2013b; Helsedirektoratet 2014a). In the following text, the four selected MMC will be further discussed.

The MMC debuting in Norway was run under the name *''Every cigarette is doing you damage''*. It lasted from early January till mid February 2003, aiming to motivate smokers to quit smoking and prevent initiation of smoking. The campaign had five video advertisements, but mainly three of them, ''Aorta'', ''Tar'' and ''Stroke'' attracted most attention. The campaign message was dispersed on television, radio, cinema, magazines and newspapers. In general, the campaign had impact and attracted large public attention. Accordingly, it impacted alteration of smoking behavior and it was reported that certain age group (35-55 years of age) of smokers had quit smoking. In addition, an increased number of attempts to quit smoking, by using NRT, was noted in 16 - 19 age group. Moreover, it was reported that this campaign influenced the reduction of smoking prevalence by 3%[29] (Larsen, Rise, et al. 2006; WHO 2010b, 5). Two years later, in 2004, another MMC was generated in order to introduce and inform public about new tobacco legislation. Introduction of a new legislative act of complete ban on indoor smoking in hospitality venues was the main objective of the campaign, besides other central objectives of this MMC, such as providing information on: health risks associated with second-hand smoking, the new act will not negatively affect hospitality industry economy, and hospitality workers right to be protected from second-hand smoke, as workers in any other industry. The campaign included distribution of information directly to hospitality industry, a broadcasting video on television and in cinemas, nine different radio advertisements, advertisements in public areas, etc. It was reported that the campaign attracted attention and was successful in informing public about the new law. It also increased smoking cessation, but to a great extent replaced it with use of smokeless tobacco (snuff) (Lund and Rise 2004). A third MMC named *''Smoking takes your breath away''* was implemented in January 2006. The focus of this campaign was to motivate smokers to quit smoking, provide them with information where to find help if attempting to quit, and raise public awareness about chronic obstructive pulmonary disease (COPD). The videos broadcasted on television showed testimonies of COPD patients and experience of living with this disease, and they were supposed to initiate public emotional reaction and eventually change

[29] Together with the debate on a stronger smoke free law (WHO 2010b, 5)

behavior. The campaign was also broadcasted on radio providing public with information about COPD. Furthermore, information was also dispersed on certain webpages. The campaign was particularly successful in raising awareness about COPD in general population, especially among younger population. In addition, it was reported that campaign was correlated with increased smoking cessation and more attempts to quit among older smokers (Larsen, Lund, et al. 2006). Finally, the fourth MMC was implemented in early 2012 and it lasted for seven weeks. It included four different videos being broadcasted on television, YouTube, Facebook and Norwegian electronic newspapers[30]. In addition, three different types of advertisements were placed in printed newspapers and magazines. The campaign aimed to motivate behavior change by fearful messages and provide information about adverse health outcomes of smoking, such as stroke, cancer and emphysema. The campaign´s videos contained enforcement message (´´Du kan klare det´´[31]) at the end of the video and provided information on SCS. The effect of this campaign was primarily based on increased perception about smoking related health risks and desire to quit. It is believed that campaign motivated smokers to engage into discussing the subjects related to smoking and health (Halkjelsvik et al. 2013).

HWM on Norwegian tobacco products were present since 1975 followed by constitution of the law on Protection against Harmful Effect of Tobacco in 1973. When buying tobacco, Norwegian smokers would make an informed consent, being relatively aware of health risk they are taking. In 1984, HWM were improved by introducing 12 new text messages to be placed on tobacco packages, and some of them were *’’daily smoking is dangerous for health’’* and *’’more smoking, bigger health risk’’*. A new form of textual HWM was introduced in 2003 and was characterized with bigger text size, covering minimum of 30% of front side and minimum of 40% on backside of the package. Some of the new HWM were ’’smoking kills’’, ’’smoking leads to deadly lung cancer’’ and ’’smoking leads to premature skin aging’’. Norwegian research about public perception of bigger HWM reported that 36% of respondents thought more actively about smoking cessation and 28% were more concerned about their own health when reading warnings. Young smokers (30% of them) who participated in the survey reported that the HWM decreased their desire to smoke (Larsen et al. 2005). Led by the fact that pictorial HWM are highly more

[30] One video at http://worldlungfoundation.org/ht/d/sp/i/20981/pid/20981. See Appendix 8. Figure 5. Norwegian MMC 2012

[31] My translation: ’’You can do it’’

effective than only textual warnings, they were introduced in 2010 and implemented in July 2011 for cigarettes, and from January 2012 for other tobacco products, with snuff products being excluded from this regulation [32] (Halkjelsvik et al. 2013, 1; Persen 2009; Helse-og omsorgsdepartementet 2009; Dagens medisin 2009). Norway's specific evaluation of effectiveness of pictorial warnings has not been conducted yet.

Norway offer several cessation services where tobacco users can get relevant information and seek assistance or treatment, such as consultation with health workers in primary health care, NRT, smoke quit line and internet[33] (Klepp 2012). A project smoke quit line has been initiated in 1996, and seven years later, in 2003 became established as a permanent service, being available to public ever since (Aarø et al. 2009, 25, 27). The information about quit line and main web page service were displayed at the end of advertisements in MMC from 2012 (Halkjelsvik et al. 2013, 3). It was also reported that quit line use increased under some MMC[34] (Larsen et al. 2006b, 12; Oftedal et al. 2012, 8). Moreover, research shows that the role of general practitioners did not have particularly strong influence on smoking cessation in Norway and that they find it challenging to take up the issue of smoking with their patients, yet they had some effect on smoking cessation among older smokers. It is also reported that there is a lack of knowledge about the role of health workers in informing, supporting and advising smoking cessation (Grøtvedt 2012, 43, 49; Helgason and Lund 2002). NRT as a treatment for addiction is available in Norway, but it is not yet subsidized by the state, despite recommendations from 2009 and 2012 (Oftedal et al. 2012, 12, 13; Klepp 2012). In general, Norwegian cessation services have been criticized as undermined and underutilized in national tobacco control work (WHO 2010b, 6). According to this, the current tobacco strategy set improvement of SCS as one of the priorities and the strategy document for cessation services advancement is generated[35] (Oftedal et al. 2012; Helse og omsorgsdepartementet 2011)

[32] See Appenix 7. Figure 4. Norwegian pictorial HWM on cigarette packages
[33] www.slutta.no (main webpage), www.roykeslutt.helsenorge.no, www.facebook.com/slutta.no

[34] See Appendix 2. Table 1.Smoke Quit Line and MMC
[35] See Appendix 5. Figure 2. Arenas and Parties involved in tobacco cessation

5.2 Restricting Smoking Demand and Stimulating[36] PRH

Law regulations are crucial element in public health and they represent an important tool for combating central public health challenges. Strong evidence shows that public health can be improved with help of laws. In the past century the public health laws could be held accountable for tackling main health risks through legislative regulations and tobacco control law (e.g. excise taxes, smoke-free environments laws etc.) was one of them (Moulton et al. 2009, 17; Goodman et al. 2006; Wilson et al. 2012, 532). One of the main obligations of each government is to protect public health and ensure that debates for public health legislations are devoted to the major public health challenges. However, at the same time government´s legislative power to coerce public is limited by protected personal freedoms (Goodman et al. 2006). If a new public health law is to be recommended for adoption, policy makers have to consider a number of factors and the main focus is put on evidence based policy. Therefore, in order to ensure effectiveness of a certain public health law it is of essential relevance to back it up with compelling scientific evidence (Moulton et al. 2009). A prominent subject of public health legislations is tobacco, and its comprehensive legislation began when the linkage between tobacco consumption and adverse health outcomes was acknowledged (Hodge and Eber 2004, 516). Comprehensive tobacco legislation regulates tobacco control programs, and even though the communication measures, which are discussed in the previous section, are also regulated by the tobacco legislation, here the focus will be set on three restrictive legislative regulations such as: smoke-free environment (SFE), taxation of tobacco (TOT) and ban on point-of-sale tobacco displays (POS).

Exposure to second-hand smoke leads to adverse health outcomes and only 100% protection from exposure to second-hand smoke secures public health. In spite of this fact not all countries introduce complete SFE in places that are usually a subject to regulation, such as indoor area of hospitality venues and public institutions. It is firmly acknowledged that SFE act is the most effective legislative instrument for protection from exposure to second-hand smoke (Martínez et al. 2013, 1). In addition SFE regulation shows a correlation with smoking prevalence reduction (Hahn et al. 2008; Bajoga et al. 2011). Moreover, comprehensive SFE regulations are well received and supported by public and they eventually result in modification of social norms and

[36] ’’To make it develop or become more active, to encourage something’’ (Turnbull 2010).

change public attitudes towards smoking (Asma et al. 2014; Callinan et al. 2010). SFE act is mainly justified through protection of non-smokers from harmful exposure to second-hand smoke. It is reported that comprehensive SFE regulation reduces exposure to second-hand smoke particularly among hospitality workers which results in their health being more protected from tobacco smoke induced diseases (Callinan et al. 2010, 3, 10). Furthermore, it is believed that SFE regulation in public indoor areas might even stimulate people not to smoke in their homes and also may help reduction of health inequalities by stimulation smoking cessation in different socio-economic groups (Mons et al. 2012; Hawkins et al. 2010, 112).

TOT is recognized to be highly effective and most cost-effective tobacco control measure, which results in important public health improvements. Moreover, if tobacco tax revenues are further used to sponsor tobacco control or other public health programs their positive effect on health is profound and leads to higher public health achievements (Wilson and Thomson 2005, 649; Chaloupka et al. 2012). The research shows that TOT which accordingly increases price of tobacco products have particular positive effect on public health by increasing rate of smoking cessation and reducing smoking prevalence (Ahmad and Franz 2008, 8). An exceptionally relevant impact of TOT is its effect on young people and prevention of smoking initiation and stimulation of smoking cessation (Vardavas 2010, 1). Moreover, TOT may also reduce smoking prevalence of population with lower socio-economic status, in addition to reduction of aggregated smoking prevalence, which results in reduced social disparities in smoking (Siahpush et al. 2009).

Tobacco products advertisements are forbidden in most countries, yet tobacco industry directs its products promoting efforts on retail tobacco advertisements at point of sale. This have made it very challenging for smokers and their intention to quit smoking, and have stimulated tobacco use initiation among young people (Germain et al. 2010; Henriksen et al. 2010; Carter et al. 2009; Hoek et al. 2010). The research shows that ban on POS tobacco display would help smokers in their cessation intentions by providing environment without temptation to purchase tobacco. Furthermore, the removals of POS tobacco displays primarily protect young people from retail tobacco products advertisements. Ban on POS tobacco displays is well supported in general public as well as among smokers. It is believed that removal of POS tobacco displays contributes to smoking de-normalization among children and supports non-smoking attitude among young

people (McNeill et al. 2010). Moreover, it has been reported that youth smoking have reduced in some countries since introduction of this regulation (CPHTP 2010, 9).

5.2.1 The WHO FCTC Recommendations

The WHO recognizes legislation as a key element to successful tobacco control policy. Tobacco legislation influence tobacco consumption reduction in general population, specifically young people (WHO 2014d). In its introductory guide for tobacco control legislation WHO identifies key elements of comprehensive tobacco legislation. Some of these elements are directly focused on legislative regulation of tobacco products such as: complete prohibition on tobacco advertising, promotion and sponsorship; increasing tax on tobacco; protection from second-hand smoke through prohibition of smoking in all indoor premises etc. (Blanke and Silva 2004, 95 – 112) The WHO defines health legislation as a legislation that includes a range of laws, ordinances, directives, regulations and other relevant legislative tools that completely handle aspects of health protection and promotion, disease prevention, and health care delivery (WHO 2014e)

The WHO acknowledges comprehensive SFE legislation as very effective tobacco control measure. SFE act is based on Article 8 of FCTC[37]. The WHO provides facts on effectiveness of SFE legislation by reflecting some good practice and examples from experiences from its member countries. SFE give results such as 80 to 90 % reduction in second-hand smoke exposure in previously exposed environments, decrease of heart attack occurrence nearly instantly, quick improvement of respiratory health, stimulate smoke-free homes and so forth (WHO 2014). The WHO confirms that protection from exposure to second-hand smoke ´is grounded in fundamental human rights and freedoms´. Therefore, the WHO recommendation is to completely prohibit indoor smoking at workplaces, public transport, hospitality premises and other public places (WHO 2013a, 19, 23).

Tax and price of tobacco belong to Article 6 of the FCTC as the only economic measure to influence demand for tobacco[38] (WHO 2003, 7). The WHO recognizes increase on TOT as the

[37] MPOWER package – Protect people from tobacco smoke (WHO 2008, 13)
[38] MPOWER package – Raise taxes on tobacco products (WHO 2008, 27)

most effective measure in tobacco control policy for reduction of tobacco consumption and emphasizes that increase of 10% in tobacco prices result in 4% decrease in tobacco consumption in high income countries. Moreover, often mentioned WHO justification for tax raise is its tobacco use reduction effect on young people, which is higher for up to three times than among adults (WHO 2014f, 6, 7). The WHO assists ministries of finance in its member countries by providing technical assistance on improving TOT (WHO 2014g). Moreover, this year TOT was the theme of the world no tobacco day (WHO 2014h).

The WHO recognizes that the POS tobacco displays are a form of direct advertising and promotion of tobacco products portraying it as socially acceptable, which hinder cessation attempts. The regulation of point of sale tobacco displays, as form of tobacco advertisement and promotion belongs to Article 13[39]. Accordingly, the WHO recommend prohibition of POS tobacco displays at every retail point of tobacco sale, such as in regular stores, as well as in places where duty free tobacco is sold (WHO 2013a, 98, 99; WHO 2003, 11).

5.2.2 Norwegian Tobacco Control Efforts and Results

As mentioned earlier, further development of national tobacco legislation is identified as one of the priority measures in the current national strategy for tobacco control. The following text will focus on selected national tobacco legislations, which successfully protect public from harmful effect of tobacco and decrease demand for tobacco use. Norwegian SFE act will focus on ban of smoking in hospitality area.

Norway legislation for SFE was implemented in 1988 covering public institutions, work places and public transport, but excluding hospitality industry (Bjartveit 2003, 27; Helsedirektoratet 2013b). After partial restriction on smoking in hospitality premises starting from 1993, the first comprehensive SFE act was implemented in 2004, making Norway the first country in the world to legislate national ban on smoking in bars (Helsedirektoratet 2013b; WHO 2009c, 19). One of the main justifications for introduction of this legislation was protection of non-smokers from harmful exposure to second-hand smoke, particularly hospitality workers who had the same right to be protected as workers in any other industry in the country (Hetland and Aarø 2005, 5). The

[39] MPOWER package – Enforce bans on tobacco advertising, promotion and sponsorship (WHO 2008, 26)

introduction of this legislation was advertised by the MMC[40]. The legislation was accompanied by smokers deprecation trying to protect their social identity as smokers, while certain number of smokers started using snuff (Lund and Rise 2004, 8). Hospitality workers were somewhat reluctant toward legislation, but their support increased over time (Braverman et al. 2010). Findings showed that as early as only several months after the introduction of the law, hospitality workers were experiencing less respiratory symptoms (Eagan et al. 2006; Skogstad et al. 2011). However, today as much as 94% of Norwegians fully support this legislation and daily smokers also have positive attitude about it[41] (Helsedirektoratet 2014b). The SFE are being improved, and the recent ban on tobacco free schools hours and kindergartens have been implemented from July this year[42] (Helsedirektoratet 2014e).

In Norway, price of the cigarettes rose significantly, for more than 60%, in a period between 1985 and 2005. Accordingly, the sale started decreasing from 1990. However, the decreasing trend (3,6%) in sale of cigarettes was much lower than the price rising trend (66%). This trend inconsistency could be attributed to different factors happening at the same time, such as sharp income increase (Melberg 2007, 12). In a period from 1990 to 2011 TOT, particularly of cigarettes, has significantly increased (Finansdepartementet 2011). In 2012, TOT together with VAT made 73% of the retail price of tobacco products (Helse og omsorgsdepartementet 2011, 17). Norwegian cigarettes are the most expensive in Europe. However, purchasing power of Norwegians is high. Apparently, the highest European price of the cigarettes does not really make it very unaffordable to Norwegians. For example, a pack of the cheapest cigarettes in Iceland costs almost twice as less than in Norway, yet cigarettes are slightly more affordable in Norway (Blecher et al. 2012, 3–5). However, purchasing of duty free cigarettes, at borders[43], and abroad has increased among Norwegians. According to this, it has been reported that purchase of cigarettes at borders have tendency to negatively impact domestic price rising mechanisms and reduce its effect. However, even when considering this reducing effect, Norwegian prices still have impact on reduction of domestic tobacco consumption and it has been estimated that the

[40] See page 28.
[41] See Appendix 3. Table 2. Attitudes towards SFE act in Hospitality Premises from 2004-2014
[42] In addition, Norwegian Railway Authority (Jernbaneverket) has announced implementation of smoking ban on all train station from first September this year (Eikås and Aasdalen 2014; Jernbaneverket 2014)
[43] Cigarettes purchased in Sweden and Finland (Melberg 2007, 18)

increase in prices by 10% will reduce consumption for about 4.6% (Lund 2005b, 6; Melberg 2007, 17, 27). Moreover, the research shows that among young Norwegians, one of the most important reasons for smoking cessation are the finances (Grøtvedt 2012, 43). In addition, cigarettes in Norway are now available only in a package with 20 pieces, without cheaper smaller package, an option that was available before[44] (Lindberg 2013).

A ban on POS tobacco displays was implemented in Norway in early 2010 with universal justification to de-normalize tobacco products and prevent smoking initiation among young people, as well as to stimulate smokers to quit and eliminate tobacco environmental cues that might trigger ex smokers temptation (Lavik and Scheffels 2011, 19). The introduction of this ban was followed by a lawsuit of the tobacco company Philip Morris the very same year, which ended up with the lost case of Philip Morris two years later (Skretting et al. 2013, 170, 171). This regulation was well accepted by the public and about 30% of smokers supported it. In general, consumers experienced the ban on POS tobacco display as positive and perceived it as a good measure to prevent smoking initiation among young people and support smoking cessation attempts. Moreover, introduction of this measure was reported to be significant, in combination with other tobacco control measures, towards further reduction of tobacco use (Scheffels and Lavik 2012). This measure has been enforced by recent legislation that prohibits self-service of tobacco products (Helsedirektoratet 2014d; Sørdal 2013)

6. DISCUSSION: MOTIVATING AND STIMULATING PRH BY LP MECHANISMS

This section will discuss Norwegian tobacco control measures that are, as shown above, designed, generated and improved in accordance to FCTC. The first part discusses and conceptualizes tobacco control measures through LP mechanisms. The underlying aim of these mechanisms is supposed to reflect how Norwegian tobacco control policy uses them to motivate and stimulate its subjects to change their behavior, lead smoke-free lifestyle and eventually become more responsible for their own health. The latter part briefly sets out justification for SFE act as the most controversial tobacco control measures.

[44] Norwegian market used to have cigarette packages with 10 pieces (Lindberg 2013)

6.1 Norwegian Tobacco Control Measures and LP Mechanisms

Choice architecture – As mentioned earlier in the section 3.1 Holland et al. (2013a, 3) have generated ''Provisional typology of choice architecture interventions in micro-environments''[45]. The Table 3. is adjusted in line with selected Norwegian tobacco control measures and only the choice architecture interventions that fit within those selected measures will be used for classification in this provisional typology.

Table 3. Provisional Typology of Choice Architecture Interventions in Microenvironments

Provisional typology of choice architecture interventions – tobacco control measures			
Intervention class	**Intervention type**	**Identified measure**	**Regulated by**[46]
Primarily alter **properties** of objects or stimuli	(1) Labeling[47]	HWM	§30; §31
	(2) Sizing[48]	Pack size 20 only	§33
Primarily alter **placement** of object or stimuli	(3) Proximity[49]	Ban on Self-service POS tobacco display	§18 §19 §5; §24
Alter both	(4) Priming[50]	Smoke-free entrances	§25
	(5) Prompting[51]	Anti-tobacco MMC	Helsedirektoratet

As seen in the previous part, Norwegian tobacco control measures are directed towards public in order to change behavioral pattern. It has been acknowledged that physical and social settings or

[45] See Appendix 6. Figure 3.Original provisional typology of choice architecture interventions in microenvironments.

[46] See Appendix 1. Law on Protection against Harmful Effect of Tobacco

[47] ''Interventions that present labeling or endorsement information specific to a product, either directly applied to the product itself or at point of choice'' (Hollands et al. 2013b)

[48] ''Interventions that change the size or quantity of the product itself. This can relate to size of the overall package…'' (Hollands et al. 2013b)

[49] ''Interventions that facilitate engagement… primarily through altering proximity, but also accessibility or visibility'' (Hollands et al. 2013b)

[50] ''Interventions that involve the placement of incidental cues, objects or stimuli…where person is exposed to induce or influence an non-conscious behavior response…'' (Hollands et al. 2013b)

[51] ''Interventions that contain… explicit verbal, visual… information intending to promote or raise awareness of, and thus motivation for, a given behavior'' (Hollands et al. 2013b)

microenvironments widely contribute to unhealthy behaviors, such as tobacco products density, diffusion and consumption. Strategic alteration of these settings, that would positively influence personal behavior and eventually impact choices, is defined as choice architecture intervention (CAI) for healthier behavior. Implementation of these interventions usually needs to be enforced by legislative regulations (Hollands et al. 2013a, 1, 5).

The common characteristic of all tobacco control measures that are presented in Table 3. is preservation of freedom of choice, as it is claimed in definition of LP (Thaler and Sunstein 2009, 6; Sunstein and Thaler 2003). Therefore, freedom to smoke, in spite of all choice architecture interventions directed to steer individuals to choose smoke-free lifestyle, is preserved. (1) Labeling of tobacco products with pictorial HWM ensures that the consumer is informed about health hazard caused by smoking, yet completely free to buy cigarettes and smoke. This Norwegian CAI is reported to make people to be more concerned about their own health, think about smoking cessation or weaken smoking desire (Larsen et al. 2005). (2) Norwegian tobacco products (product size - quantity of the cigarettes in one pack) are only available in a pack with 20 pieces of cigarettes. This CAI is primarily initiated to eliminate availability of cigarette packs with 10 pieces, a cheaper option. Therefore, smokers still have the option to buy a pack of cigarettes, but smaller package that was available before will not provide a cheaper option, especially not to young, price sensitive Norwegians, who may intend to take up smoking (Lindberg 2013). (3) Proximity (also accessibility and visibility) of tobacco products is regulated by two legislations, such as ban on POS tobacco displays and recent ban on self-service of tobacco products (Helsedirektoratet 2014d; Scheffels and Lavik 2012). It is believed that before implementation of these regulations, tobacco industry was using choice architecture in their favor, by placing tobacco products at eye-level, by the register (Sæbø 2012a, 32). Those CAI do not give option to consumers to see or reach tobacco products, but they still have an option to buy it and consume it. To conceal tobacco products, a special systems are used such as ’’cabinets with door’’, ’’shelves with flaps’’, and ’’vensafe’’ (Scheffels and Lavik 2012, 3). The ban on POS tobacco displays is well received by Norwegians and it is believed that it will influence prevention of youth smoking initiation and encourage smoking cessation (Scheffels and Lavik 2012; Johannessen 2011). Moreover, Norwegian Ministry of Health and Care Service believes that recent implementation of ban on self-service will reduce tobacco use, prevent young people

from buying tobacco and motivate those who already consume tobacco to quit (Sørdal 2013). (4) Priming would consider elimination of smoking incidental cues, such as elimination of ashtrays in front of outdoor entrances of Norwegian hospitals and public institutions (Helsedirektoratet 2014d). A research shows that smoking incidental or associate cues, such as ashtrays and burning cigarettes, might stimulate and encourage behavior option to smoke (smoking desire), hence make it challenging for those who are attempting to quit (Payne et al. 2007, 400, 407). However, it is debatable if we can categorize this measure as CAI since, a removal of ashtrays is just an order that is delegated by the recent ban on smoking in outdoor entrance area. Therefore, an option to smoke in these areas is forbidden. (5) The last CAI regulated by Norwegian tobacco control policy considers ´information intending to promote or raise awareness of, and thus motivation for, a given behavior… providing more general motivational prompting´ (Hollands et al. 2013b). Therefore, Norwegian MMC are CAI that is used in order to raise awareness about harmful health effect of smoking and motivate people to quit or not initiate smoking (Helse og omsorgsdepartementet 2011, 18). According to this, people´s choice is fully preserved and people are motivated to quit or not initiate smoking, by providing them with all relevant information about health hazard of smoking and benefits of smoke-free lifestyle. It is well documented that MMC as CAI in Norway has had a positive impact on people choices and behavior in regards to smoking cessation and prevention of smoking initiation (WHO 2010b, 5; Larsen et al. 2006b; Lund and Rise 2004; Larsen et al. 2006a; Halkjelsvik et al. 2013)

Temporal ordering - LP policies ’’reveal the general utility of timing in shaping of behaviors’’ (Jones et al. 2011, 487). In Norwegian tobacco policy, the only measure that affects timing of tobacco use is a recent legislation for regulation of tobacco use within schools hours. Tobacco-free schools hours regulate mandatory tobacco-free behavior (smoking and snuff use) among pupils and school staff (Helsedirektoratet 2014d). This temporal ordering that restricts smoking during schools hours is well justified. The main objectives are to prevent children to initiate tobacco use, protect against second-hand smoke and provide them with most possible tobacco-free growing up (Informasjonsavdelingen 2014). Tobacco free schools are seen as crucial for preventing initiation of tobacco use among youth, as it is well known that initiation happens in early age, rarely after 20 years of age. School staff and visitors are not allowed to use tobacco products in the school area, and it will be up to school authority if the regulation will permit them

to consume tobacco products outside of school area during school hours. However, it will be legitimate, to some extent, that a school employer require from its employees not to use tobacco products in school hours anywhere as they represent role models for children (Helsedirektoratet 2014e; Kreftforeningen 2014). As other forms of SFE regulations, this regulation could be perceived as a paternalistic measure that limits personal freedom. However, the SFE will be further discussed later and proper ethical justification will be set out.

Measures to rationalize the brain – Sunstein and Thaler (2003, 1167–1170) discuss the rationality of choice and claim that people decisions are not always being the best options in order to promote their welfare. They further discuss smoking, among other health risk behaviors, and state that rationality of choice is questionable, given all the information about harmful effects on health, adding that smokers are in most cases willing to have a third party to help them choose more rational option that will promote their welfare. On the other hand, one could claim that smoking is a pleasure with a calming effect that has positive influence on mental health, which implies that rational people do not care only about their physical health but also about other things that improve their mental health and welfare. If we look at a fully informed smoker, one could expect from him/her to be rational and forward looking, and to make the decision by calculating between present gains of smoking pleasure and future health loss (Gruber 2003, 52; Sæbø et al. 2012, 21). However, if a smoker is to make a properly informed choice, meaning a rational one, the addictive nature of smoking should be considered as implication for tobacco policy interference, by seeing smoking as addictive behavior which undermines smoker´s autonomy (Ashcroft 2011, 88, 92). It is believed that ´addicted individuals have substantial impairments in cognitive control of behavior´ (Hyman 2007, 8). It has been acknowledged in Norwegian current tobacco control strategy that young people underestimate complexity of nicotine addiction and that young smokers reveal signs of addiction after just a short period of time from the smoking initiation point (Helse og omsorgsdepartementet 2011, 14). As mentioned earlier, majority of smokers who want to quit find it very challenging because of the nicotine addiction. The element of self-control in smoking cessation is very complex and a smoker who attempts to quit smoking will find that experience extremely challenging (Cherukupalli 2010, 609). As outlined in the presentation of LP mechanisms, the government mostly uses three sets of instruments to promote rational behavior. *Legal punishment* for the tobacco control law is set

under the section §42 and it highlights that anyone who breaks the law will be fined[52] (Lovdata 2014). Gill (2003, 70) argues that by generating particular laws, government aims to promote rational behavior. He further adds that justified legal punishment is applied when the given action obviously imposes harm to others. The objective of Norwegian tobacco control law is to reduce tobacco use and eventually contribute to achievement of tobacco-free society and protect children and youth from initiation of tobacco use and general public from exposure to second-hand smoke (Lovdata 2014). *Price signals* such as economical model that suggest high TOT (as disincentive) can serve as a tool for enforcement of self-control among addicted smokers, discouragement of smoking and stimulation of smoking cessation, which promote rational-decision making (Cherukupalli 2010, 609; Gruber 2003). Norway is known as one of the countries with most expensive cigarettes and TOT together with VAT makes 73% of entire price. Young Norwegians report that finances are the most important factor for non-smoking (Helse og omsorgsdepartementet 2011, 17; Grøtvedt 2012, 43). A subsidized or free NRT can serve as an incentive for rational behavior that promotes smoking cessation both among cessation motivated smokers as well as among unmotivated ones (Jardin et al. 2014). This idea is being enforced by the Norwegian national council and their recommendation that NRT should be a subject for reimbursement (Klepp 2012). *Information* about health risk of smoking is usually seen through rational choice perspective (Ornberg and Sohlberg 2012, 67). Providing information is not sufficient for behavior change and is generally effective in combination with other interventions (Lewis 2007, 10, 11). For example, it is recognized that MMC in Norway, as one of the information measures, in combination with other tobacco control measures, mostly pricing policies and tobacco control laws, will significantly contribute to tobacco free society (Braaten 2013, 374). In Norway, MMC had effect on smokers to seek additional information and assistance through smoke quit line and acquire relevant information about smoking cessation[53] (Oftedal et al. 2012, 7, 14).

Prompting social norms - Social context in which certain behavior is happening, such as tobacco use, has an important impact on public and its attitude. If smoking is a common behavior in a society it is expected that it will influence initiation of smoking among young people (society

[52] See Appendix 1. Law on Protection against Harmful Effect of Tobacco

[53] See Appendix 2. Table 1.Smoke Quit Line and MMC

seen as responsible for creation of positive attitude towards smoking) and will make smoking cessation more challenging. A society where tobacco control policy uses measures to promote health and smoke-free lifestyle, and eventually contribute to reduction in smoking prevalence, will create a social norm where smoking is not generally accepted and is less common behavior. A common smoke-free lifestyle will then generate social setting which de-normalizes smoking and makes it less appealing and less accepted behavior, resulting in better further prevention of smoking initiation among young people and encouragement of smoking cessation (Verweij 2007, 193; Ashcroft 2011, 92).

Back in 1970, when smoking was generally accepted in Norway and seen as a modern lifestyle, the urge to shift this attitude was necessary, as it was already well known that smoking is addictive and bad for health. Accordingly, that year a first step was taken in order to initiate long process of smoking de-normalization (Sæbø 2012a, 29, 30, 37). One could say that the process of smoking de-normalization is doing well in Norway, by looking at the prevalence of daily smoking, which was 51% in 1973 in comparison to 24% in 2011 (Sæbø et al. 2012, 11). To make it more extreme, the Norwegian tobacco control policy aims for tobacco-free society (Helse og omsorgsdepartementet 2011, 12). It is evident that both the WHO and Norway aim for creation of social norms that will significantly shift smoking culture and discourage future generations to initiate smoking (WHO 2013a, 73–76; WHO 2013b, 32, 62; Helse og omsorgsdepartementet 2011).

Norwegian social context in regards to smoking has changed. Tobacco control communicative measures have informed Norwegians about smoking hazard and a SFE act has transformed smoking into a socially deviant behavior (Lund 2011, 564). The SFE act, which was implemented in 2004 in hospitality venues, is now highly accepted by 94% of population and well supported by daily smokers[54]. In this ten years period time, the prevalence of smoking has been decreased by around 40% (Helsedirektoratet 2014b). On the other hand, smokers are highly resistant to new recommendations for advancing SFE act, such as expanding SFE in outdoor areas of bars and

[54] Acceptance of SFE act for hospitality premises, in 2004, was initially not well supported by smokers who responded that the regulation ''may indicate reactance generation, rationalization or defense of their social identity as smokers'' (Lund and Rise 2004, 8). See Appendix 3. Table 2. Attitude towards SFE act in hospitality premises from 2004-2014.

restaurants, parks and bus stops, as well as to other restrictive measures, such as tobacco sale restriction in certain places. Moreover, this resistance shows to be more intensive than resistance recorded in 2004. However, this resistance is not that high if it implies restriction on outdoor smoking near children or increasing age limit for buying tobacco[55]. On the contrary, non-smokers, who are majority of population, are far less resistant (Halvorsen 2010; Lund 2011; Sæbø et al. 2012).

An interesting newspaper article portrays how de-normalization of smoking and established social norms affect Norwegians. A student, who did not want to be named in the newspapers because of future employment career, said that being a smoker would not have been a representative characteristic in her professional biography. Another interviewee, an employee on a smoke break, said that he felt like a drug addict when standing in the corner and smoking, and also pointed out that he would rather not reveal his identity in the newspapers (Kolstad 2011). Well, a deeper look in this newspaper article could bring new insights about underlying effect of shifted social norm in Norway, namely stigmatization of smokers[56]. Sæbø (2012b) discusses stigmatization of smoking and smokers in Norway and points out that negative stereotype is attached to smokers which distances them from non-smokers. Along the same line with how the student and the employee felt, Sæbø (2012b) points out that due to degrading feeling of being a smoker, majority of young occasional smokers do not even wish to declare themselves as smokers. Shifted social norm in Norway, which generated stigma associated to smoking does not result as planned on individual level. This means that stigmatized smokers develop resistance and neutral attitude towards national tobacco control measures, which seriously hinders their intention to quit smoking. Accordingly, stigma can give negative results in public health by worsening health of those who do not want to quit smoking (Sæbø 2012b; Sæbø et al. 2012). Sæbø (2012b) adds that enhancement of stigma by continuing restrictive tobacco control policy can eventually result in additional contra-productive and unintended consequences, such as discrimination. This would cause smokers to hesitate to stand out as smokers when searching job or would feel shame and guilt in general, just like the student and the employee from above.

[55] National recommendation to increase age limit from 18 to 20 years old (Andersen 2010)

[56] Voigt (2013, 53, 54) discusses stigmatization as an ethical issue of smoking de-normalization strategies and points out that smoking prevalence which is concentrated mostly among disadvantaged social groups might cause them to bear additional burden to already present inequalities.

6.2 Justification of SFE legislation

Although most of the discussed tobacco measures do preserve freedom of choice and are experienced as initially non-coercive, the intensity and comprehensiveness of tobacco control policies might be perceived as manipulative (Verweij 2007, 196; Grill 2013, 40). However, Sæbø et al. (2012, 21) claims that fear appeals MMC and pictorial HWM imposed to adult ''hardcore smokers'' represents typical hard paternalism contrary to mere information provision to youth about health risk of tobacco product, that is more seen as soft paternalism or libertarian paternalism, a term used throughout this thesis[57]. Paternalism, as a term, is generally avoided in political debates, being taken as ''unacceptable'' and ''with no argument'' (Grill 2013, 33). Norway tobacco control policy is seen as a mixture of paternalistic and libertarian approaches. The government´s legitimacy to limit freedom to smoke is justified in accordance to smokers´ ignorance despite all provided information on tobacco use hazard and health risk they impose to themselves and others. On the other hand, smokers´ have freedom to buy and consume legal product available at the market for which they pay high taxes (Sæbø et al. 2012, 21, 22).

Can we imagine a government, which does not implement tobacco control measures because ''smokers have right to enjoy the pleasure of smoking'' (Verweij 2007, 195; Ashcroft 2011, 86)? If a certain tobacco control measure is generated in order to protect smokers from doing harm to their own health, by fully restricting choice to smoke, that policy would be seen to seriously impact ''autonomy, liberty or personal freedoms'' of those smoker (Oriola 2009, 830, 831). However, tobacco, unlike other unhealthy commodities regulated by the government, such as alcohol and food, is very harmful to health and addictive, even when moderately consumed (Ashcroft 2011, 87). Accordingly, the justification for restrictive regulations of tobacco consumption largely relies on the argument that tobacco is not an ordinary commodity, but the one that is highly addictive and hazardous (Sæbø 2012a, 36). Nicotine addiction is seen as an element that seriously interferes with autonomous process as non-voluntarily choice to smoke (Verweij 2007, 196).

---

[57] Grill (2013, 32) points out that smokers might prefer not being told that their behavior is harmful, which present provision of this kind of information as paternalistic. However, she adds that according to value-based approach ''policies that are trivially undesirable because they do not have positive effects are not paternalistic'' (Grill 2013, 37)

SFE act might be experienced as the most restrictive regulation in Norwegian tobacco control policy that seems to limit freedom of choice. The main focus in discussions about justification of SFE acts is embraced by the harm principle as a main and valid argument for legislation of SFE and restriction of smokers´ freedom. A coercion of one's freedom is only justified when it prevents harm to others, such as prevention of exposure to second-hand smoking, which is seen as ''involuntary smoking'' (Oriola 2009, 833, 834; Ashcroft 2011, 93).

> ''Tobacco laws prohibiting smoking in enclosed public spaces… are ethically and morally justifiable in defense of public health, which should of necessity, trump individual rights to smoke freely'' (Oriola 2009, 838)

Libertarians take harm principle very seriously and protection of one from being harmed by other is justified even if that protection would consider limitation of other´s personal freedom (Verweij 2007, 183). Hersch (2005) argues that choice limitation for smokers who intend to quit can be seen as positive and that smoking restrictive regulations are experienced as welfare promoting, since they enable addicted smokers to employ and strengthen desired self-control mechanism for smoking cessation[58]. Norway has been using the harm principle in justification for SFE act (Hetland and Aarø 2005, 5; Helsedirektoratet 2014e; Kreftforeningen 2014)

7. CONCLUSION

The aim of this study was to particularly explore nature of Norwegian tobacco control policy, which is designed, generated and improved in accordance to identified global recommendations and directions. The exploration process was led by libertarian paternalistic approach and ideology of personal responsibility for health. In particular, the focus was to describe and thereafter explore selected Norwegian tobacco control measures using libertarian paternalistic conceptual framework. The discussion of those measures was set against identified four mechanisms of

[58] Ashcroft (2011, 95) discusses that behind SFE act these wider objectives, aside from protection of exposure to second-hand smoke are questionable in terms of initial argumentation of harm to other principle that justify this restrictive regulation. He points that these are apparently ''unintended consequence'' of reduction of smoking imposed by this regulation that would not be regretted by any tobacco control policy maker.

libertarian paternalistic policies. Organizing those measures into each of the mechanisms revealed nature of Norwegian tobacco control policy and its strategic approach and efforts to motivate and stimulate personal responsibility for health.

After presenting concept of personal responsibility for health and challenges of lifestyle change induced by smoking as addictive behavior, I emphasized importance of creation of social environment with healthy options in order to offer opportunity to individuals to become capable to lead smoke-free lifestyle. Following this, I presented Libertarian Paternalistic approach, as a type of public health policy strategy, which has potential for creation of society that will, while preserving freedom of choice and personal autonomy, steer individuals towards adoption of smoke-free lifestyle. Framework Convention of Tobacco Control as the most important tobacco control global treaty was set out as main global recommendation and direction for generation and improvement of national tobacco control policy. A brief overview of Norwegian tobacco control policy followed before selected tobacco control measures were presented. Presentation of selected tobacco control measures was organized in two categories that focused on measures that communicate smoking hazard and motivate personal responsibility for health and measures that restrict smoking demand and stimulate personal responsibility for health. The presentation was organized in three-fold sets of information, which described general properties, the WHO recommendations and Norwegian examples for each of the measures. Eventually, those measures were conceptualized into four libertarian paternalistic mechanisms and discussed, and the section concluded by justifying the most controversial tobacco control measure.

This review based study has shown that Norwegian tobacco control policy, by following global recommendations and directions, design, generate and improve its tobacco control measures through libertarian paternalistic approach. It further reveals that Norwegian tobacco control measures intend to create a society where smoking will be less acceptable which would result in increased smoking cessation and prevention of smoking initiation, which will eventually lead to tobacco-free society. Tobacco control measures that communicate smoking hazards inform public about health risks. Mass media campaign and health warning messages aim to communicate smoking hazard and make sure that population is well informed about serious health risks imposed by smoking. Criticized Norwegian smoking cessation services have shown serious

tendency to improve. Smoke quit line, webpages, brief intervention and available nicotine replacement therapy aim to communicate and assist smokers whose autonomy to shift to smoke-free lifestyle is seriously hindered by nicotine addiction. Furthermore, measures that restrict smoking aim to more directly decrease demand for smoking by banning smoking in all indoor areas and creating smoke free environments, keep high cigarettes prices and ban on point of sale tobacco displays and self-service of tobacco products. Smoke free environments, as only measures that directly restrict smoking and limit freedom of choice are justified through harm to others principle supported by libertarians. Accordingly, discussion of these measures through four libertarian paternalistic mechanisms has revealed nature of Norwegian tobacco control policy. Choice architecture interventions has shown how spatial design impact people's choices in microenvironments. Limitation of smoking in a certain window of time embraced a time ordering mechanism. Measures to rationalize the brain have shown what are the elements that government uses in order to promote rational behavior that will consequently induce healthier choices. And finally, prompting social norms has emphasized smoking de-normalization process and creation of social norms that can also have some unintended negative effects, beside extensive positive ones.

The inculcation of sense of responsibility for smoke-free lifestyle shows how Norwegian society through libertarian paternalistic approach creates an individual-state partnership that offers opportunities to individuals to become capable to autonomously choose smoke-free lifestyle by motivated and stimulated personal responsibility for health.

Bibliography:

Aarø, Leif Edvard, Karl Erik Lund, Tord Finne Vedøy, and Simon Øverland. 2009. *Evaluering av myndighetenes samlede innsats for å forebygge tobakksrelaterte sykdommer i perioden 2003 til 2007*. Oslo, Norway: Statens institutt for rusmiddelforskning SIRUS.

Aftenposten NTB. 2014. "Snusskap, Røykerom Og Skolerøyk Blir Forbudt." *Aftenposten*. Accessed August 9. http://www.aftenposten.no/share/article7620740.ece.

Ahmad, Sajjad, and Gregor A. Franz. 2008. "Raising Taxes to Reduce Smoking Prevalence in the US: A Simulation of the Anticipated Health and Economic Impacts." *Public Health* 122 (1): 3–10. doi:10.1016/j.puhe.2007.02.020.

Andersen, E J. 2010. "Foreslår Å Heve Aldersgrensen for Kjøp Av Tobakk Til 20 År." http://tidsskriftet.no/article/1971532.

ASH. 2014. "Smoking Statistics - Who Smokes and How Much." ASH - Action on Smoking and Health. http://ash.org.uk/files/documents/ASH_106.pdf.

Ashcroft, Richard. 2011. "Smoking, Health and Ethics." In *Public Health Ethics: Key Concepts and Issues in Policy and Practice*, 1 edition. Cambridge ; New York: Cambridge University Press.

Asma, Samira, Yang Song, Joanna Cohen, Michael Eriksen, Terry Pechacek, Nicole Cohen, John Iskander, and Centers for Disease Control and Prevention (CDC). 2014. "CDC Grand Rounds: Global Tobacco Control." *MMWR. Morbidity and Mortality Weekly Report* 63 (13): 277–80.

Atusingwize, Edwinah, Sarah Lewis, Tessa Langley. 2014. "Economic Evaluations of Tobacco Control Mass Media Campaigns: A Systematic Review." *Tobacco Control*, July. doi:10.1136/tobaccocontrol-2014-051579.

Bajoga, Ummulkhulthum, Sarah Lewis, Ann McNeill, and Lisa Szatkowski. 2011. "Does the Introduction of Comprehensive Smoke-Free Legislation Lead to a Decrease in Population Smoking Prevalence?" *Addiction (Abingdon, England)* 106 (7): 1346–54. doi:10.1111/j.1360-0443.2011.03446.x.

Berridge, Kent C., and Terry E. Robinson. 2011. "Drug Addiction as Incentive Sensitization." In *Addiction and Responsibility*. Cambridge, Mass: The MIT Press.

Beshears, John, James J. Choi, David Laibson, and Brigitte Madrian. 2006. *Early Decisions: A Regulatory Framework*. Working Paper 11920. National Bureau of Economic Research. http://www.nber.org/papers/w11920.

Bjartveit, Kjell. 2003. "Tobacco Control in Norway - Government Initiatives: An Outline of the Period 1964-1993." Directorate for Health and Social Affairs, Department for Tobacco Control.

Blanke, D. Douglas, and Vera da Costa e Silva. 2004. *Tobacco Control Legislation: An Introductory Guide*. World Health Organization.

Blecher, Evan, Hana Ross, Maria E. Leon. 2012. "Cigarette Affordability in Europe." *Tobacco Control*, October, tobaccocontrol – 2012–050575. doi:10.1136/tobaccocontrol-2012-050575.

Braaten. 2013. "Støtter Ny Røykekampanje." http://tidsskriftet.no/article/2970183.

Brækhus, Leni Aurora. 2013. "Nå Øker Bøtene for Smugling." *ABC Nyheter*. http://www.abcnyheter.no/nyheter/2013/09/26/na-oeker-boetene-smugling.

Braverman, Marc T., Leif Edvard Aarø, Daniel E. Bontempo, and Jørn Hetland. 2010. "Bar and Restaurant Workers' Attitudes towards Norway's Comprehensive Smoking Ban: A Growth Curve Analysis." *Tobacco Control* 19 (3): 240–47. doi:10.1136/tc.2009.033845.

Bringedal, Berit. 2013. "Commercialism, Holism, and Individual Responsibility Comment on 'Buying Health: The Costs of Commercialism and an Alternative Philosophy.'' *International Journal of Health Policy and Management* 1 (3): 229–30. doi:10.15171/ijhpm.2013.43.

Bringedal, Berit, and Eli Feiring. 2011. "On the Relevance of Personal Responsibility in Priority Setting: A Cross-Sectional Survey among Norwegian Medical Doctors." *Journal of Medical Ethics* 37 (6): 357–61. doi:10.1136/jme.2010.038844.

Brinn, Malcolm P., Kristin V. Carson, Adrian J. Esterman, Anne B. Chang, and Brian J. Smith. 2010. "Mass Media Interventions for Preventing Smoking in Young People." *The Cochrane Database of Systematic Reviews*, no. 11: CD001006. doi:10.1002/14651858.CD001006.pub2.

Brown, Rebecca C. H. 2013. "Moral Responsibility for (un)healthy Behaviour." *Journal of Medical Ethics*, January, medethics – 2012–100774. doi:10.1136/medethics-2012-100774.

Buyx, A. M. 2008. "Personal Responsibility for Health as a Rationing Criterion: Why We Don't like It and Why Maybe We Should." *Journal of Medical Ethics* 34 (12): 871–74. doi:10.1136/jme.2007.024059.

Callinan, Joanne E, Anna Clarke, Kirsten Doherty, and Cecily Kelleher. 2010. "Legislative Smoking Bans for Reducing Secondhand Smoke Exposure, Smoking Prevalence and Tobacco Consumption." In *Cochrane Database of Systematic Reviews*, 6th ed. Vol. 4. John Wiley & Sons, Ltd. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005992.pub2/abstract.

Camerer, Colin, Samuel Issacharoff, George Loewenstein, Ted O'Donoghue, and Matthew Rabin. 2003. *Regulation for Conservatives: Behavioral Economics and the Case for "Asymmetric Paternalism."* SSRN Scholarly Paper ID 399501. Rochester, NY: Social Science Research Network. http://papers.ssrn.com/abstract=399501.

Cappelen, Alexander W., and Ole Frithjof Norheim. 2004. *Responsibility and Rationing in Health Care*. Working paper. SNF. http://brage.bibsys.no/xmlui/handle/11250/165682.

———. 2006. "Responsibility, Fairness and Rationing in Health Care." *Health Policy (Amsterdam, Netherlands)* 76 (3): 312–19. doi:10.1016/j.healthpol.2005.06.013.

———. 2005. "Responsibility in Health Care: A Liberal Egalitarian Approach." *Journal of Medical Ethics* 31 (8): 476–80. doi:10.1136/jme.2004.010421.

Carlsen, Helge, and Kristine Hirsti. 2014. "Økning Av Ulovlig Tobakksalg I Oslo." *NRK*. http://www.nrk.no/ostlandssendingen/okning-av-ulovlig-tobakksalg-i-oslo-1.11487448.

Carter, O. B. J., B. W. Mills, R. J. Donovan. 2009. "The Effect of Retail Cigarette Pack Displays on Unplanned Purchases: Results from Immediate Postpurchase Interviews." *Tobacco Control* 18 (3): 218–21. doi:10.1136/tc.2008.027870.

CDCP, Centers for Disease Control and Prevention (US), National Center for Chronic Disease Prevention and Health Promotion (US) NCCDPHP, Office on Smoking and Health (US) OSH. 2010. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*. Publications and Reports of the Surgeon General. Atlanta (GA): Centers for Disease Control and Prevention (US). http://www.ncbi.nlm.nih.gov/books/NBK53017/.

Chaloupka, FL, Ayda Yurekli, Geoffrey T. Fong. 2012. "Tobacco Taxes as a Tobacco Control Strategy." *Tobacco Control* 21 (2): 172–80. doi:10.1136/tobaccocontrol-2011-050417.

Cherukupalli, Rajeev. 2010. "A Behavioral Economics Perspective on Tobacco Taxation." *American Journal of Public Health* 100 (4): 609–15. doi:10.2105/AJPH.2009.160838.

Christman, John. 2014. "Relational Autonomy and the Social Dynamics of Paternalism." *Ethical Theory and Moral Practice* 17 (3): 369–82. doi:10.1007/s10677-013-9449-9.

CPHTP, The Center for Public Health and Tobacco Policy. 2010. "Tobacco Product Display Restrictions." The Center for Public Health and Tobacco Policy - New Englad Law, Boston. http://publichealthlawcenter.org/sites/default/files/nycenter-syn-tobproductdisplaybans-2013.pdf.

Dagens medisin. 2009. "Bildeadvarsler På Tobakkspakkene Fra 2011." *DagensMedisin.no*. http://www.dagensmedisin.no/nyheter/bildeadvarsler-pa-tobakkspakkene-fra-2011/.

Durkin, Sarah, Emily Brennan, Melanie Wakefield. 2012. "Mass Media Campaigns to Promote Smoking Cessation among Adults: An Integrative Review." *Tobacco Control* 21 (2): 127–

38. doi:10.1136/tobaccocontrol-2011-050345.

Eagan, T. M. L., J. Hetland, L. E. Aarø. 2006. "Decline in Respiratory Symptoms in Service Workers Five Months after a Public Smoking Ban." *Tobacco Control* 15 (3): 242–46. doi:10.1136/tc.2005.015479.

Eikås, Eirin, and Dag Aasdalen. 2014. "Positive Til Røykfrie Holdeplasser." *NRK*, July 8. http://www.nrk.no/ostlandssendingen/positive-til-roykfrie-holdeplasser-1.11868001.

Feiring, E. 2008. "Lifestyle, Responsibility and Justice." *Journal of Medical Ethics* 34 (1): 33–36. doi:10.1136/jme.2006.019067.

Finansdepartementet. 2011. "4.4 Avgift på tobakkvarer (kap. 5531 post 70)." Underside. http://www.regjeringen.no/nb/dep/fin/dok/regpubl/prop/2011-2012/prop-1-ls-20112012/4/4.html?id=658540.

Germain, Daniella, Molly McCarthy, Melanie Wakefield. 2010. "Smoker Sensitivity to Retail Tobacco Displays and Quitting: A Cohort Study." *Addiction (Abingdon, England)* 105 (1): 159–63. doi:10.1111/j.1360-0443.2009.02714.x.

Gill, Frances E. 2003. *The Moral Benefit of Punishment: Self-Determination as a Goal of Correctional Counseling*. Lexington Books.

Goodman, Richard A., A. Moulton, G. Matthews, F. Shaw, P. Kocher, G. Mensah, S. Zaza, R. Besser, and Centers for Disease Control and Prevention. 2006. "Law and Public Health at CDC." *MMWR. Morbidity and Mortality Weekly Report* 55 Suppl 2 (December): 29–33.

Grill, Kalle. 2013. "Normative and Non-Normative Concepts: Paternalism and Libertarian Paternalism." In *Ethics in Public Health and Health Policy*, edited by Daniel Strech, Irene Hirschberg, and Georg Marckmann, 27–46. Public Health Ethics Analysis 1. Springer Netherlands. http://link.springer.com/chapter/10.1007/978-94-007-6374-6_3.

Grøtvedt, Liv. 2012. "Tobacco Use: Studies of Onset and Cessation - Series of Dissertations Submitted to the Faculty of Medicine, University of Oslo No. 1389." Akademika publishing, Division of Epidemiology, Norwegian Institute of Public Health.

Gruber, Jonathan. 2003. "Smoking´s ´Internalities´." *Health & Medicine*, Winter 2002-2003.

Hahn, Ellen J., Mary Kay Rayens, Karen M. Butler, Mei Zhang, Emily Durbin, and Doug Steinke. 2008. "Smoke-Free Laws and Adult Smoking Prevalence." *Preventive Medicine* 47 (2): 206–9. doi:10.1016/j.ypmed.2008.04.009.

Halkjelsvik, Torleif. 2014. "Do Disgusting and Fearful Anti-Smoking Advertisements Increase or Decrease Support for Tobacco Control Policies?" *The International Journal on Drug Policy*, February. doi:10.1016/j.drugpo.2014.01.021.

Halkjelsvik, Torleif, Karl Erik Lund, Pål Kraft, and Jostein Rise. 2013. "Fear Appeals in Advanced Tobacco Control Environments: The Impact of a National Mass Media Campaign in Norway." *Health Education Research* 28 (5): 888–97. doi:10.1093/her/cyt064.

Halpern, David, Clive Bates, Geoff Mulgan, Stephen Aldridge, Greg Beales, and Adam Heathfield. 2004. "Personal Responsibility and Changing Behavior: The State of Knowledge and Its Implications for Public Policy."

Halvorsen, Christina. 2010. "Motstand Mot Flere Røyketiltak." *BA*, November 20. http://www.ba.no/nyheter/irix/article5389303.ece?ns_campaign=article&ns_mchannel=recommend_button&ns_source=facebook&ns_linkname=facebook&ns_fee=0.

Hammond, David. 2011. "Health Warning Messages on Tobacco Products: A Review." *Tobacco Control* 20 (5): 327–37. doi:10.1136/tc.2010.037630.

Hammond, David, Melanie Wakefield, Sarah Durkin, and Emily Brennan. 2013. "Tobacco Packaging and Mass Media Campaigns: Research Needs for Articles 11 and 12 of the WHO Framework Convention on Tobacco Control." *Nicotine & Tobacco Research* 15 (4): 817–31. doi:10.1093/ntr/nts202.

Hart, Chris. 2005. *Doing Your Masters Dissertation: Realizing Your Potential as a Social Scientist*. Sage Publications India Pvt Limited.

Hawkins, Summer Sherburne, Tim J. Cole, Catherine Law. 2010. "Examining Smoking Behaviours among Parents from the UK Millennium Cohort Study after the Smoke-Free Legislation in Scotland." *Tobacco Control*, November, tc.2010.037028. doi:10.1136/tc.2010.037028.

Helgason, Asgeir R., and Karl E. Lund. 2002. "General Practitioners' Perceived Barriers to Smoking Cessation-Results from Four Nordic Countries." *Scandinavian Journal of Public Health* 30 (2): 141–47. doi:10.1080/14034940210133799.

Helsedirektoratet. 2011a. "Tidligere Kampanjer - Helsedirektoratet.no." http://helsedirektoratet.no/folkehelse/tobakk/tobakkskampanjer/tidligere-kampanjer/Sider/default.aspx.

———. 2011b. "Norwegian Tobacco Control Policy." http://www.helsedirektoratet.no/english/topics/tobacco-control/strategy-and-policies/Sider/norwegian-tobacco-control-policy.aspx.

———. 2011c. "Sykdommer Og Helseskader Ved Snus - Helsedirektoratet.no." http://helsedirektoratet.no/folkehelse/tobakk/snus/sykdommer-og-helseskader/Sider/default.aspx.

———. 2011d. "Tobakksstrategien I Perioden 2006–2010 - Helsedirektoratet.no." http://helsedirektoratet.no/folkehelse/tobakk/nasjonal-

tobakksstrategi/Sider/Tobakksstrategien-i-forrige-periode-2006-2010.aspx.

———. 2013a. *Tal Om Tobakk 1973-2012*. Rapport IS-2064 Helsedirektoratet

———. 2013b. “Milestones in Norwegian Tobacco Control - Helsedirektoratet.no.” http://www.helsedirektoratet.no/english/topics/tobacco-control/legislation-and-history/Sider/milestones-tobacco-control.aspx.

———. 2014a. “Slutta – Din Røykeslutt - Helsedirektoratet.no.” http://helsedirektoratet.no/folkehelse/tobakk/tobakkskampanjer/Sider/slutta-din-r%C3%B8ykeslutt.aspx.

———. 2014b. “Ni Av Ti Liker Røykeloven - Helsedirektoratet.no.” http://www.helsedirektoratet.no/Om/nyheter/Sider/ni-av-ti-liker-roykeloven.aspx.

———. 2014c. “Holdninger.” http://helsedirektoratet.no/folkehelse/tobakk/tall-og-undersokelser/holdninger/Sider/default.aspx.

———. 2014d. “Forbud Mot Selvbetjening Og Utvidet Røykeforbud Fra 1. Juli 2014 - Helsedirektoratet.no.” http://helsedirektoratet.no/Om/nyheter/Sider/forbud-selvbetjening-utvidet-roykeforbud-1-juli-2014.aspx.

———. 2014e. “Tobakksfrie Skoler Og Barnehager - Helsedirektoratet.no.” http://helsedirektoratet.no/folkehelse/tobakk/skole/Sider/tobakksfri-skole-barnehage.aspx.

Helse-og omsorgsdepartementet. 2009. “Bildeadvarsler på tobakkspakkene.” Pressemelding. http://www.regjeringen.no/nb/dokumentarkiv/stoltenberg-ii/hod/Nyheter-og-pressemeldinger/pressemeldinger/2009/bildeadvarsler-pa-tobakkspakkene.html?id=581344.

———. 2011. “En Framtid Uten Tobakk - Nasjonal Strategi for Arbeidet Mot Tobakksskader 2013-2016.” Helse og omsorgsdepartementet. http://helsedirektoratet.no/folkehelse/tobakk/nasjonal-tobakksstrategi/Sider/default.aspx.

———. 2012. “A Tobacco-Free Future: National Strategy for Tobacco Control 2013-2016.” Official English Translation

Henriksen, Lisa, Nina C. Schleicher, Ellen C. Feighery, and Stephen P. Fortmann. 2010. “A Longitudinal Study of Exposure to Retail Cigarette Advertising and Smoking Initiation.” *Pediatrics* 126 (2): 232–38. doi:10.1542/peds.2009-3021.

Hersch, Joni. 2005. “Smoking Restrictions as a Self-Control Mechanism.” *Journal of Risk and Uncertainty* 31 (1): 5–21. doi:10.1007/s11166-005-2927-2.

Hetland, Jørn, and Leif Edvard Aarø. 2005. *Smoking Habits, Attitudes to and Enforcement of the Ban on Smoking in Eating and Drinking Establishements - a Prospective Panel Study*. 3. Evaluation of Smoking Control Policies in Norway 2003-2007. Oslo, Norway: Research

Centre for Health Promotion (HEMIL) University of Bergen and Sirus: The National Institute for Alcohol and Drug Research.

Hodge, James G., and Gabriel B. Eber. 2004. “Tobacco Control Legislation: Tools for Public Health Improvement.” *The Journal of Law, Medicine & Ethics: A Journal of the American Society of Law, Medicine & Ethics* 32 (3): 516–23.

Hoek, J., H. Gifford, G. Pirikahu, G. Thomson, and R. Edwards. 2010. “How Do Tobacco Retail Displays Affect Cessation Attempts? Findings from a Qualitative Study.” *Tobacco Control* 19 (4): 334–37. doi:10.1136/tc.2009.031203.

Hollands, Gareth J., Ian Shemilt, Theresa M. Marteau, Susan A. Jebb, Michael P. Kelly, Ryota Nakamura, Marc Suhrcke, and David Ogilvie. 2013a. “Altering Micro-Environments to Change Population Health Behaviour: Towards an Evidence Base for Choice Architecture Interventions.” *BMC Public Health* 13: 1218. doi:10.1186/1471-2458-13-1218.

Hollands, Gareth J, Ian Shemilt, Theresa M Marteau, Susan A Jebb, Michael P Kelly, Ryota Nakamura, Marc Suhrcke, and David Ogilvie. 2013b. “Additional File 3. - Description of Evidence by Intervention Type. Altering Micro-Environments to Change Population Health Behaviour: Towards an Evidence Base for Choice Architecture Interventions.” *BMC Public Health* 13 (December): 1218. doi:10.1186/1471-2458-13-1218.

Hornik, Robert. 2002. *Public Health Communication: Evidence for Behavior Change*. 1 edition. Mahwah, N.J: Routledge.

Hyman, Steven E. 2007. “The Neurobiology of Addiction: Implications for Voluntary Control of Behavior.” *The American Journal of Bioethics* 7 (1): 8–11. doi:10.1080/15265160601063969.

Informasjonsavdelingen. 2014. “Røyk Og Snus Ikke Tillatt I Barnehager Fra 1. Juli - Siste Nytt - Private Barnehagers Landsforbund,” June 30. http://www.pbl.no/no/VERKTOYMENY/Siste-nytt/Kvalitet-og-kompetanse/Barns-helse/Royk-og-snus-ikke-tillatt-i-barnehager-fra-1-juli/.

Jardin, Bianca F., Karen L. Cropsey, Amy E. Wahlquist, Kevin M. Gray, Gerard A. Silvestri, K. Michael Cummings, and Matthew J. Carpenter. 2014. “Evaluating the Effect of Access to Free Medication to Quit Smoking: A Clinical Trial Testing the Role of Motivation.” *Nicotine & Tobacco Research: Official Journal of the Society for Research on Nicotine and Tobacco* 16 (7): 992–99. doi:10.1093/ntr/ntu025.

Jernbaneverket. 2014. “Jernbaneverket Innfører Røykeforbud - Jernbaneverket.” http://www.jernbaneverket.no/no/Nyheter/Nyhetsarkiv/2014/Jernbaneverket-innforer-roykeforbud-pa-stasjoner-og-plattformer/.

Johannessen, Randi. 2011. “Vil Fjerne Tobakken Fra Butikkhyllene.” *Aftenposten*, October 20. http://www.aftenposten.no/nyheter/iriks/Vil-fjerne-tobakken-fra-butikkhyllene-6507279.html.

Jones, Katryn. 2007. “Doing a Literature Review in Health.” In *Researching Health: Qualitative, Quantitative and Mixed Methods*, New edition edition. Los Angeles: SAGE Publications Ltd.

Jones, Rhys, Jessica Pykett, Mark Whitehead. 2011. “Governing Temptation: Changing Behaviour in an Age of Libertarian Paternalism.” *Progress in Human Geography* 35 (4): 483–501. doi:10.1177/0309132510385741.

Kickbusch Ilona, Jurgen Pelikan M., Franklin Apfel, and Agis Tsoros D. 2013. “Health Literacy: The Solid Facts.” WHO Regional Office for Europe.

Klepp, Knut-Inge. 2012. “Tilbud Om Røykeavvenning I Norsk Helsetjeneste? - Saker - Nasjonalt Råd for Kvalitet Og Prioritering I Helsetjenesten.” http://www.kvalitetogprioritering.no/saker/tilbud-om-r%C3%B8ykeavvenning-i-norsk-helsetjeneste;jsessionid=7AB3BCCA44BE9120730127090EAD7505.

Kolstad, Tom A. 2011. “Bak Vegger. I Kroker. Med Bøyde Hoder. De Siste Røykerne Vil Dampe I Smug.” *Aftenposten*, April 6. http://www.aftenposten.no/nyheter/iriks/Bak-vegger-I-kroker-Med-boyde-hoder--De-siste-roykerne-vil-dampe-i-smug-5121231.html.

Kreftforeningen. 2014. “Tobakksfri Skole - Kreftforeningen.” https://kreftforeningen.no/forebygging/forebygging-i-skoler-og-barnehager/tobakksfri-skole/.

Larsen, Elisabeth, Karl Erik Lund, Jostein Rise. 2006a. *Evaluering av tobakkskampanjen ´´Røyken tar pusten fra deg´´*. 9. Oslo, Norway: Statens institutt for rusmiddelforskning SIRUS.

Larsen, Elisabeth, Marianne Lund, Karl Erik Lund. 2005. *Evaluering Av Helseadvarslene På Tobakkspakkene*. 6. Evaluering Av Det Offentlige Tobakksforebyggende Arbeidet I Norge HEMIL/SIRUS. Oslo, Norway: Statens institutt for rusmiddelforskning SIRUS.

Larsen, Elisabeth, Jostein Rise, Pål Kraft. 2006b. *En evaluering av tobakkskampanjen ´´Hver eneste sigarett skader deg´´*. 10. Oslo, Norway: Statens institutt for rusmiddelforskning SIRUS og Institutt for samfunnspsykologi Universitett i Bergen.

Larzelere, Michele M., and Dave E. Williams. 2012. “Promoting Smoking Cessation.” *American Family Physician* 85 (6): 591–98.

Lavik, Randi, and Janne Scheffels. 2011. *Evaulering av forvud mot synlig oppstilling av tobakksvarer*. 2. Oslo, Norway: Statens Institut for Forbruksforskning og Statens institutt for rusmiddelforskning SIRUS.

Lecouteux, Guilhem. 2013. “A Reformulation of Libertarian Paternalism,” Ecole Polytechnique Centre National De La Recherche Scientifique 1. http://hal.archives-ouvertes.fr/hal-00850533.

Levy, Neil. 2011. "Addiction, Responsibility, and Ego Depletion." In *Addiction and Responsibility*. Cambridge, Mass: The MIT Press.

Lewis, Miranda. 2007. *States of Reason: Freedom, Responsibility and the Governing of Behaviour Change*. http://www.ippr.org/publications/states-of-reason-freedom-responsibility-and-the-governing-of-behaviour-change.

Lindberg, Per. 2013. "Mandag Er 10-Pakningen Forbudt." *Aftenposten*, January 7. http://www.aftenposten.no/nyheter/iriks/Mandag-er-10-pakningen-forbudt-7244730.html.

Loewenstein, G, T Brennan, KG Volpp. 2007. "Asymmetric Paternalism to Improve Health Behaviors." *JAMA* 298 (20): 2415–17. doi:10.1001/jama.298.20.2415.

Lovdata. 2014. "Lovdata - Lov Om Vern Mot Tobakksskader (tobakksskadeloven)." http://lovdata.no/dokument/NL/lov/1973-03-09-14?q=tobakk.

Lund, Karl. 2011. "Kan Norge bli røykfritt?" *Tidsskrift for Den norske legeforening* 131 (6): 563–64. doi:10.4045/tidsskr.10.1334.

Lund, Karl Erik. 2005a. "Røyking Og Sosial Ulikhet I Norge." *Tidsskrift for Den Norske Laegeforening, no. 5: 560-63*

———. 2005b. *Tobakksavgiften som helsepolitisk styringsinstrument*. 5. Evaluering av det offentlige tobakksforebyggende arbeidet i Norge HEMIL/SIRUS. Oslo, Norway: Statens institutt for rusmiddelforskning SIRUS.

———. 2009. *A Tobacco-Free Society or Tobacco Harm Reduction? Which Objective Is Best for the Remaining Smokers in Scandinavia?*. 6. Oslo, Norway: Norwegian Institute for Alcohol and Drug Research.

———. 2011. "Røykernes Motstand Mot Nye Tobakksforebyggende Tiltak." *Nor Tannlegeforen Tid* 121 (121): 838–43.

Lund, Karl Erik, and Jostein Rise. 2004. *Mediekampanje om røykfire serveringssteder våren 2004*. 1. Oslo, Norway: Statens institutt for rusmiddelforskning SIRUS.

Lytton, Michael. 2013. "Health Literacy: An Opinionated Perspective." *American Journal of Preventive Medicine* 45 (6): e35–40. doi:10.1016/j.amepre.2013.10.006.

Mahmud, Amina Jama, Ewy Olander, Sara Eriksén, and Bo Ja Haglund. 2013. "Health Communication in Primary Health Care -a Case Study of ICT Development for Health Promotion." *BMC Medical Informatics and Decision Making* 13: 17. doi:10.1186/1472-6947-13-17.

Marcano, José S. Belisario, Michelle N. Bruggeling, Laura H. Gunn, and Serena Brusamento.

2012. “Interventions for Recruiting Smokers into Cessation Programmes.” *The Cochrane Database of Systematic Reviews* 12: CD009187. doi:10.1002/14651858.CD009187.pub2.

Martínez, Cristina, Jose María Martínez-Sánchez, Gillian Robinson, Christina Bethke, and Esteve Fernández. 2013. “Protection from Secondhand Smoke in Countries Belonging to the WHO European Region: An Assessment of Legislation.” *Tobacco Control* 23 (5): 403–11. doi:10.1136/tobaccocontrol-2012-050715.

McNeill, Ann, Sarah Lewis, Casey Quinn, Maurice Mulcahy, Luke Clancy, Gerard Hastings, and Richard Edwards. 2010. “Evaluation of the Removal of Point-of-Sale Tobacco Displays in Ireland.” *Tobacco Control*, November, tc.2010.038141. doi:10.1136/tc.2010.038141.

Melberg, Hans Olav. 2007. *Hvor mye betyr tobakksprisen for endringen i tobakksforbruket? Utviklingen i pris og forbruk i Norge mellom 1985 og 2005*. 12. Evaluering av det offentlige tobakksforebyggende arbeidet i Norge HEMIL/SIRUS. Oslo, Norway: Statens Institut for Forbruksforskning og Statens institutt for rusmiddelforskning SIRUS.

Minkler, Meredith. 1999. “Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century’s End.” *Health Education & Behavior* 26 (1): 121–41. doi:10.1177/109019819902600110.

Mons, Ute, Gera E. Nagelhout, Shane Allwright, Romain Guignard, Bas van den Putte, Marc C. Willemsen, Geoffrey T. Fong, Hermann Brenner, Martina Pötschke-Langer, and Lutz P. Breitling. 2012. “Impact of National Smoke-Free Legislation on Home Smoking Bans: Findings from the International Tobacco Control Policy Evaluation Project Europe Surveys.” *Tobacco Control*, February, tobaccocontrol – 2011–050131. doi:10.1136/tobaccocontrol-2011-050131.

Moulton, Anthony D., Shawna L. Mercer, Tanja Popovic, Peter A. Briss, Richard A. Goodman, Melisa L. Thombley, Robert A. Hahn, and Daniel M. Fox. 2009. “The Scientific Basis for Law as a Public Health Tool.” *American Journal of Public Health* 99 (1): 17–24. doi:10.2105/AJPH.2007.130278.

Naidoo, Jennie, and Jane Wills. 2009. *Foundations for Health Promotion*. Baillière Tindall/Elsevier.

Oftedal, Janne, Sigrid Skattebo, Astrid Nylenna. 2012. *Helsedirektoratets plan for et systematisk og kunnskapsbasert tilbud om røyke- og snusavvenning*. Oslo, Norway: Helsedirektoratet, Avdeling for grupperettet folkehelsearbeid.

Oriola, Ta. 2009. “Ethical and Legal Analyses of Policy Prohibiting Tobacco Smoking in Enclosed Public Spaces.” *Journal of Law, Medicine & Ethics* 37 (4): 828–40. doi:10.1111/j.1748-720X.2009.00454.x.

Ornberg, Jenny Cisneros, and Tove Sohlberg. 2012. “Swedish Tobacco Policy - From Rational Choice to ´harms to Others´.” In *A Welfare Policy Patchwork: Negotiating the Public*

Good in Times of Transition. Nordic Centre for Welfare and Social Issues (NVC).

Øverland, Simon, Tore Tjora, Jørn Hetland, and Leif Edvard Aarø. 2010. "Associations between Adolescent Socioeducational Status and Use of Snus and Smoking." *Tobacco Control* 19 (4): 291–96. doi:10.1136/tc.2009.034512.

Payne, B. Keith, F. Joseph McClernon, Ian G. Dobbins. 2007. "Automatic Affective Responses to Smoking Cues." *Experimental and Clinical Psychopharmacology* 15 (4): 400–409. doi:10.1037/1064-1297.15.4.400.

Pechacek, Terry F. 2001. *Best Practices for Comprehensive Tobacco Control Programs*. DIANE Publishing.

Persen, Kjell. 2009. "Nå kommer skremmebilder på røykpakkene." *TV 2*, December 10. http://www.tv2.nodummy_url.

Poland, Jeffrey, and George Graham. 2011. *Addiction and Responsibility*. Cambridge, Mass: The MIT Press.

Priest, Naomi, Rebecca Armstrong, Jodie Doyle, and Elizabeth Waters. 2008. "Policy Interventions Implemented through Sporting Organisations for Promoting Healthy Behaviour Change." In *Cochrane Database of Systematic Reviews*. John Wiley & Sons, Ltd. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004809.pub3/abstract.

Resnik, D B. 2007. "Responsibility for Health: Personal, Social, and Environmental." *Journal of Medical Ethics* 33 (8): 444–45. doi:10.1136/jme.2006.017574.

Rigotti, Nancy A. 2012. "Strategies to Help a Smoker Who Is Struggling to Quit." *JAMA: The Journal of the American Medical Association* 308 (15): 1573–80. doi:10.1001/jama.2012.13043.

Roemer, Ruth, Allyn Taylor, and Jean Lariviere. 2005. "Origins of the WHO Framework Convention on Tobacco Control." *American Journal of Public Health* 95 (6): 936–38. doi:10.2105/AJPH.2003.025908.

Sæbø, Gunnar. 2012a. "The Regulation of Smoking and Smokers in Norway 1964-2010." In *A Welfare Policy Patchwork: Negotiating the Public Good in Times of Transition*, edited by Matilda Hellman, Gun 1960- Roos, and Julius von Wright. Helsinki: Nordic Centre for Welfare and Social Issues.

———. 2012b. "Skal Det Være Nedverdigende Å Røyke?" *Dagbladet.no*. http://www.dagbladet.no/2012/12/06/kultur/debatt/kronikk/24702788/.

Sæbø, Gunnar, Røed Ola Bilgrei, Karl Erik Lund, Janne Scheffels, and Rikke Iren Tokle. 2012. *´´Vi Blir En Sånn Utstøtt Gruppe Til Slutt...´´ Røykeres Syn På Egen Røyking Og Denormaliseringnsstrategier Itobakkspolitikken*. 3. Oslo, Norway: Statens institutt for rusmiddelforskning SIRUS.

Sandtrøen, Nils Kristen. 2014. “Gullår for Tobakksbransjen Tross Færre Røykere.” *Aftenposten*, March 8. http://www.aftenposten.no/share/article7656605.ece.

Scheffels, Janne, and Randi Lavik. 2012. “Out of Sight, out of Mind? Removal of Point-of-Sale Tobacco Displays in Norway.” *Tobacco Control*, June, tobaccocontrol – 2011–050341. doi:10.1136/tobaccocontrol-2011-050341.

Schiavone, Giuseppe, Gabriele De Anna, Matteo Mameli, Vincenzo Rebba, and Giovanni Boniolo. 2014. “Libertarian Paternalism and Health Care Policy: A Deliberative Proposal.” *Medicine, Health Care, and Philosophy* 17 (1): 103–13. doi:10.1007/s11019-013-9502-4.

Schiavo, Renata. 2011. *Health Communication: From Theory to Practice*. John Wiley & Sons.

Schmidt, Harald. 2013. “Should Public Health Ethics Embrace the Right Not to Think About One´s Health?” In *Ethics in Public Health and Health Policy - Concepts, Methods, Case Studies*. http://www.springer.com/social+sciences/applied+ethics/book/978-94-007-6373-9.

Siahpush, Mohammad, Melanie A. Wakefield, Matt J. Spittal, Sarah J. Durkin, and Michelle M. Scollo. 2009. “Taxation Reduces Social Disparities in Adult Smoking Prevalence.” *American Journal of Preventive Medicine* 36 (4): 285–91. doi:10.1016/j.amepre.2008.11.013.

Skogstad, Marit, Kristina Kjærheim, Geir Fladseth, and Pål Molander. 2011. “Røykeforbud på serveringssteder og luftveissymptomer blant ansatte.” *Tidsskrift for Den norske legeforening* 131 (21): 2119–21. doi:10.4045/tidsskr.09.0310.

Skretting, Astrid, Karl Eirik Lund, Elin K. Bye. 2013. *Rusmidler I Norge*. Oslo, Norway: Statens institut for rusmiddelforskning.

Sohn, Min, Christine Hartley, Erika Sivarajan Froelicher, and Neal L Benowitz. 2003. “Tobacco Use and Dependence.” *Seminars in Oncology Nursing* 19 (4): 250–60. doi:10.1053/j.soncn.2003.08.002.

Sørdal, Kristin. 2013. “Selvbetjente Snus-Skap Blir Forbudt.” *DinSide*, September 4. http://www.dinside.no/914724/selvbetjente-snus-skap-blir-forbudt.

Steinbrook, Robert. 2006. “Imposing Personal Responsibility for Health.” *New England Journal of Medicine* 355 (8): 753–56. doi:10.1056/NEJMp068141.

Strand, Bjørn Heine, Else-Karin Grøholt, Olöf Anna Steingrímsdóttir, Tony Blakely, Sidsel Graff-Iversen, and Øyvind Naess. 2010. “Educational Inequalities in Mortality over Four Decades in Norway: Prospective Study of Middle Aged Men and Women Followed for Cause Specific Mortality, 1960-2000.” *BMJ (Clinical Research Ed.)* 340: c654.

Sunstein, Cass R., and Richard H. Thaler. 2003. "Libertarian Paternalism Is Not An Oxymoron." *SSRN eLibrary*. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=405940.

Thaler, Richard H., and Cass R. Sunstein. 2009. *Nudge: Improving Decisions About Health, Wealth, and Happiness*. Revised & Expanded edition. New York: Penguin Books.

Torkilseng, Einar Bjørner, and Kjartan Sælensminde. 2013. *Samfunnsøkonomisk Analyse Av Undervisningsprogrammet FRI*.

Turnbull, Joanna. 2010. *Oxford Advanced Learner's Dictionary: International Student's Edition and CD-ROM with Oxford iWriter*. 8th Revised edition edition. Oxford; Toronto: Oxford University Press.

Upton, Dominic, and Katie Thirlaway. 2014. *Promoting Healthy Behaviour: A Practical Guide*. Routledge.

Vardavas, Constantine. 2010. "Key Points in Preventing Tobacco Use among Adolescents." *Tobacco Induced Diseases* 8 (1): 1. doi:10.1186/1617-9625-8-1.

Verweij, Marcel. 2007. "Tobacco Discouragement: A Non-Paternalistic Argument." In *Ethics, Prevention, and Public Health*, 1 edition, 179–97. Oxford ; New York: Oxford University Press.

Voigt, Kristin. 2013. "'If You Smoke, You Stink.' Denormalisation Strategies for the Improvement of Health-Related Behaviours: The Case of Tobacco." In *Ethics in Public Health and Health Policy*, edited by Daniel Strech, Irene Hirschberg, and Georg Marckmann, 47–61. Public Health Ethics Analysis 1. Springer Netherlands. http://link.springer.com/chapter/10.1007/978-94-007-6374-6_4.

Weyden, Martin B. Van Der. 2007. "Personal Responsibility for Health." *Medical Journal of Australia* 187 (7). https://www.mja.com.au/journal/2007/187/7/personal-responsibility-health.

WHO. 2003. "WHO Framework Convention on Tobacco Control." WHO Press. http://whqlibdoc.who.int/publications/2003/9241591013.pdf

———. 2006. *Tobacco: Deadly in Any Form or Disquise - World No Tobacco Day 2006*. http://www.who.int/tobacco/communications/events/wntd/2006/Tfi_Rapport.pdf.

———. 2008. "MPOWER - A Policy Package to Reverse the Tobacco Epidemic." WHO Press. http://www.who.int/tobacco/mpower/mpower_english.pdf

———. 2009a. *Global Health Risks - Mortality and Burden of Disease Attributable to Selected Major Risks.* WHO Press http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

———. 2009b. "Milestones in Health Promotion: Statements from Global Conferences." WHO

Press.
http://www.who.int/healthpromotion/Milestones_Health_Promotion_05022010.pdf?ua=1.

———. 2009c. "History of the World Health Organization Framework Convention on Tobacco Control." WHO Press
http://whqlibdoc.who.int/publications/2009/9789241563925_eng.pdf

———. 2010a. *Global Status Report on Noncommunicable Diseases 2010*. WHO Press
http://www.who.int/nmh/publications/ncd_report_full_en.pdf

———. 2010b. "Joint National Capacity Assessment on the Implementation of Effective Tobacco Control Policies in Norway." World Health Organization.
http://www.regjeringen.no/upload/HOD/CapacityAssessmReportNORWAY.pdf.

———. 2012. *WHO Global Report - Mortality Attributable to Tobacco*. WHO Press
http://www.who.int/tobacco/publications/surveillance/fact_sheet_mortality_report.pdf

———. 2013a. "Guidelines for Implementation WHO Framework Convention on Tobacco Control." WHO Press.
http://apps.who.int/iris/bitstream/10665/80510/1/9789241505185_eng.pdf?ua=1.

———. 2013b. "WHO Report on the Global Tobacco Epidemic 2013: Enforcing Bans on Tobacco Advertising, Promotion and Sponsorship." WHO Press.

———. 2014a. *European Tobacco Control Status Report 2014*. WHO Press
http://www.euro.who.int/__data/assets/pdf_file/0009/248418/European-Tobacco-Control-Status-Report-2014-Eng.pdf?ua=1

———. 2014b. "WHO Tobacco Fact Sheet N339." *WHO*.
http://www.who.int/mediacentre/factsheets/fs339/en/.

———. 2014c. "WHO | MPOWER in Action."
http://www.who.int/tobacco/mpower/publications/brochure_2013/en/.

———. 2014d. "WHO | Legislation and Enforcement." *WHO*.
http://www.who.int/tobacco/control/legislation/en/.

———. 2014e. "WHO | Legislation, Health." *WHO*. http://who.int/topics/legislation/en/.

———. 2014f. "WHO | Raising Tax on Tobacco: What You Need to Know." WHO Press.
http://www.who.int/campaigns/no-tobacco-day/2014/brochure/en/.

———. 2014g. "WHO Engagement with Member States on Tobacco Taxation - Tobacco Control Economics Unit: WHO Departement of Prevention of Noncommunicable Diseases." WHO Press.

———. 2014h. "Theme for World No Tobacco Day 2014: Tobacco Taxes."

http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/news/news/2014/01/theme-for-world-no-tobacco-day-2014-tobacco-taxes.

———. 2014i. "WHO | Parties to the WHO Framework Convention on Tobacco Control." *WHO*. http://www.who.int/fctc/signatories_parties/en/.

———. 2014. "Fact Sheet on Smoke Free Legislation." Accessed August 11. http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/world-no-tobacco-day/2011-who-framework-convention-on-tobacco-control/fact-sheet-on-smoke-free-legislation.

Wikler, Daniel. 2006. "Personal and Social Responsibility for Health." In *Public Health, Ethics, and Equity*, edited by Sudhir Anand, Fabienne Peter, and Amartya Sen, 1st ed. Oxford University Press, USA.

Wilson, Nick, Nhung Nghiem, Rachel Foster, Linda Cobiac, and Tony Blakely. 2012. "Estimating the Cost of New Public Health Legislation." *Bulletin of the World Health Organization* 90 (7): 532–39. doi:10.2471/BLT.11.097584.

Wilson, Nick, and George Thomson. 2005. "Tobacco Taxation and Public Health: Ethical Problems, Policy Responses." *Social Science & Medicine* 61 (3): 649–59. doi:10.1016/j.socscimed.2004.11.070.

APPENDICES

Appendix 1. Law on Protection against Harmful Effect of Tobacco[59] (Lovdata 2014)

Dato	LOV-1973-03-09-14
Departement	Helse- og omsorgsdepartementet
Sist endret	Lov-2013-05-24-17 fra 01.07.2014, LOV-2013-06-14-32 fra 01.01.2014
Publisert	ISBN 82-504-1467-5
Ikrafttredelse	/
Endrer	/
Kunngjort	/
Korttittel	Tobakkskadeloven – tobskl.

KAPITTELOVERSIKT (Chapter overview):

Kapittel 1. Innledende bestemmelser (§§ **1-3**)

Kapittel 2. Bevillingsordning for salg av tobakksvarer (§§ **4-16**)

Kapittel 3. Salg av tobakksvarer (§§ **17-21**)

Kapittel 4. Forbud mot reklame mv (§§ **22-24**)

Kapittel 5. Særskilte forbud mot tobakksbruk (§§ **25-29**)

Kapittel 6. Merking og utforming av tobakksvarer (§§ **30-34**)

Kapittel 7. Helsedirektoratets tilsyn (§§ **35-37**)

Kapittel 8. Opplysningsplikter (§§ **38-40**)

Kapittel 9. Avsluttende bestemmelser (§§ **41-43**)

[59] Note that due to absence of the official English translation of the most recently updated law, the original Norwegian version is set out with my translation of the titles and subtitles.

KAPITTEL 1. INNLEDENDE BESTEMMELSER (Introductory provisions)

§ 1. ***Formål*** *(Objective)*

Formålet med denne lov er å begrense de helseskader som bruk av tobakksvarer medfører gjennom å redusere forbruket og på sikt bidra til å oppnå et tobakksfritt samfunn. Videre regulerer loven tiltak for å forebygge at barn og unge begynner å bruke tobakksvarer, fremme at de som allerede bruker tobakksvarer, slutter og beskytte befolkningen mot eksponering for tobakksrøyk.

§ 2. ***Definisjoner*** *(Definitions)*

Med tobakksvarer forstås i denne lov varer som kan røykes, innsnuses, suges eller tygges såfremt de helt eller delvis består av tobakk.

Med røykeutstyr forstås i denne lov varer som etter sitt formål hovedsakelig benyttes i forbindelse med tobakksvarer.

Med tobakkssurrogat forstås i denne lov produkt som etter sin bruksmåte tilsvarer tobakksvarer, men som ikke inneholder tobakk.

Med tobakksimitasjon forstås i denne lov produkter som etter sin utforming har en nær likhet med tobakksvarer eller røykeutstyr, men som ikke inneholder tobakk eller tobakkssurrogat.

Med salg forstås i denne lov overdragelse av tobakksvarer til forbruker mot vederlag.

Med engrossalg forstås i denne lov overdragelse av tobakksvarer mot vederlag som ikke omfattes av sjette ledd.

Med spesialforretning for tobakk forstås i denne lov utsalgssted som hovedsakelig selger tobakksvarer eller røykeutstyr.

Departementet kan gi forskrifter om hvilke produkter som skal regnes som tobakksvarer, tobakkssurrogater, tobakksimitasjoner og røykeutstyr, og nærmere kriterier for hva som menes med spesialforretning. I tvilstilfeller kan departementet avgjøre spørsmålene med bindende virkning.

§ 3. ***Virkeområde*** *(Scope)*

Loven får anvendelse på innførsel, utførsel, omsetning, utforming og bruk av tobakksvarer, røykeutstyr, tobakkssurrogater og tobakksimitasjoner.

Loven gjelder for Norge, herunder Svalbard og Jan Mayen. Kongen kan i forskrift bestemme at deler av loven ikke skal gjelde for Svalbard og Jan Mayen, og kan fastsette særlige regler under hensyn til de stedlige forhold.
Loven kommer til anvendelse for petroleumsvirksomhet til havs i den grad slik virksomhet omfattes av arbeidsmiljøloven § 1-3.

KAPITTEL 2. BEVILLINGSORDING FOR SALG AV TOBAKKSVARER (Licence ordning for the sale of tobacco products)

§ 4. *Forbud mot tobakksreklame* *(Ban on tobacco advertisement)*
Alle former for reklame for tobakksvarer er forbudt. Det samme gjelder for piper, sigarettpapir, sigarettrullere og annet røykeutstyr.
Tobakksvarer må ikke inngå i reklame for andre varer eller tjenester.
Et merke som hovedsakelig er kjent som et merke for tobakksvare kan ikke benyttes i reklame for andre varer eller tjenester, så lenge det aktuelle merke benyttes i forbindelse med en tobakksvare.
Tobakksvarer kan ikke lanseres ved hjelp av varemerker som er kjent som, eller i bruk som, merke for andre varer eller tjenester.
Kongen kan gi forskrifter om unntak fra reglene i denne paragraf.

§ 5. *Forbud mot synlig oppstilling av tobakksvarer og røykeutstyr* *(Ban on visible display of tobacco products and smoking accessories)*
Synlig oppstilling av tobakksvarer og røykeutstyr på utsalgssteder er forbudt. Tilsvarende gjelder for imitasjoner av slike varer og for automatkort som gir kunden adgang til å hente ut tobakksvarer eller røykeutstyr fra automat.
Forbudet i første ledd gjelder ikke for spesialforretninger for tobakk.
Det kan på utsalgssteder gis nøytrale opplysninger om pris, og om hvilke tobakksvarer som selges på stedet. Tilsvarende gjelder for røykeutstyr.
Departementet kan gi forskrifter om gjennomføring og utfylling av disse bestemmelser og gjøre unntak fra dem.

§ 6. *Forbud mot gratis utdeling av tobakksvarer* *(Ban on free distribution of tobacco products)*

Enhver form for gratis utdeling av tobakksvarer til forbruker fra en fysisk eller juridisk person som driver næringsvirksomhet, er forbudt.

§ 11. ***Aldersgrenser*** *(Age limit)*

Det er forbudt å selge eller overlate tobakksvarer eller imitasjoner som kan oppfordre til bruk av slike varer, til personer under 18 år. Er det tvil om kjøperens alder, kan salg bare finne sted dersom kjøperen dokumenterer å ha fylt 18 år.

Salg av tobakksvarer til forbruker kan bare foretas av personer over 18 år. Dette gjelder likevel ikke hvis en person over 18 år har daglig tilsyn med salget.

Departementet kan gi forskrifter om aldersgrensen for innførsel av tobakksvarer og sigarettpapir.

§ 12. ***Røykeforbud i lokaler og transportmidler*** *(Ban on smoking in premises and transport)*

I lokaler og transportmidler hvor allmennheten har adgang skal lufta være røykfri. Det samme gjelder i møterom, arbeidslokaler og institusjoner hvor to eller flere personer er samlet. Dette gjelder ikke i beboelsesrom i institusjoner, men institusjonen plikter å gi dem som ønsker det, tilbud om røykfrie rom.

Dersom det innen et område er flere lokaler som har samme formål, kan røyking tillates i inntil halvparten av disse. De røykfrie lokaler må ikke være mindre eller av dårligere standard enn lokaler hvor røyking tillates.

Røyking kan ikke tillates i serveringssteder. Med serveringssteder menes lokaler der det foregår servering av mat og/eller drikke, og hvor forholdene ligger til rette for fortæring på stedet.

Eieren eller den som disponerer lokalene eller transportmidlene, plikter å sørge for at reglene gitt i eller i medhold av disse bestemmelsene blir overholdt. Det skal markeres med tydelige skilt at røyking er forbudt på steder hvor det kan være tvil om dette, samt ved inngangen til alle serveringssteder. For å sikre at forbudet mot røyking på serveringssteder etterleves, skal serveringssteder føre internkontroll og etablere et internkontrollsystem. Internkontrollen skal kunne dokumenteres overfor tilsynsmyndighetene.

Person som på tross av advarsel fra eieren eller den som driver lokalet eller transportmidlet eller representant for denne, overtrer bestemmelse gitt i eller i medhold av paragrafen her kan bortvises fra lokalet eller transportmidlet.

Kongen kan gi nærmere regler om gjennomføring og utfylling av disse bestemmelser og kan gjøre unntak fra dem.

§ 13. ***Tilsyn med røykeforbudet*** *(Supervision of ban on smoking)*

Kommunestyret skal føre tilsyn med at reglene i og i medhold av § 12 overholdes. Kommunestyrets myndighet etter denne paragraf kan delegeres til et organ i kommunen eller til et fellesorgan for flere kommuner. Dreier det seg om arbeidslokaler, føres tilsynet av Arbeidstilsynet.

Reglene vedrørende kommunestyrets og Arbeidstilsynets virksomhet som tilsynsorgan etter henholdsvis folkehelseloven kapittel 3 og arbeidsmiljøloven §§ 18-4 til 18-8 og 18-10 får tilsvarende anvendelse ved tilsyn etter paragrafen her.

Petroleumstilsynet fører tilsyn med at reglene i og i medhold av § 12 overholdes innen det ansvarsområde Petroleumstilsynet har i petroleumsvirksomheten i henhold til arbeidsmiljøloven.

Sjøfartsmyndighetene fører tilsyn med at reglene i og i medhold av § 12 overholdes på skip samt fartøyer og innretninger for øvrig. I sin tilsynsmyndighet kan nevnte myndigheter bruke tilsvarende virkemidler som de har etter gjeldende regler om helseforhold og arbeidsmiljø på skip og innretninger innen petroleumsvirksomheten.

Forsvarsstaben fører tilsyn med at reglene i og i medhold av § 12 overholdes på Forsvarets fartøyer.

Sysselmannen fører tilsyn med at reglene i og i medhold av § 12 overholdes på Svalbard. Sysselmannen kan overlate til Longyearbyen lokalstyre å føre tilsyn for Longyearbyen.

Tilsynsmyndigheten kan i særlige tilfeller gi dispensasjon fra regler gitt i eller i medhold av § 12 og sette vilkår for eventuell dispensasjon. På arbeidsplasser med arbeidsmiljøutvalg skal uttalelse fra utvalget legges ved søknaden. På arbeidsplasser uten arbeidsmiljøutvalg skal uttalelse fra verneombud legges ved.

Kongen kan gi nærmere regler om gjennomføring og utfylling av disse bestemmelser og kan gjøre unntak fra dem.

§ 14. ***Direktoratets tilsynsansvar*** *(Directorate supervision responsibility)*

Direktoratet fører tilsyn med at bestemmelsene i §§ 4, 5, 6, 7, 8 og 9, og bestemmelser gitt i medhold av disse lovbestemmelsene, overholdes. Direktoratet kan foreta slik granskning og besiktigelse som det finner nødvendig for å utføre sine gjøremål etter loven.

§ 16. ***Retting og tvangsmulkt*** *(Rectification and coercive)*

Finner direktoratet at noen av bestemmelsene nevnt i § 14 er overtrådt, kan det pålegge retting av forholdet. Samtidig settes en frist for rettingen. Direktoratet kan kreve skriftlig bekreftelse fra overtrederen på at det ulovlige forholdet skal opphøre.

Samtidig med at pålegg om retting gis, kan tvangsmulkt fastsettes. Mulkten løper fra oversittelse av fristen for retting, og kan fastsettes i form av engangsmulkt eller dagmulkt. Mulkten tilfaller staten.

Dersom direktoratet ved avdekking av en overtredelse av § 4 eller bestemmelser gitt i medhold av denne, finner særlig grunn til å tro at det vil bli begått nye brudd på reklamebestemmelsene som ikke kan stanses etter første og annet ledd, kan det på forhånd fastsette at mulkt vil løpe fra det tidspunkt ny overtredelse tar til. Slik tvangsmulkt kan fastsettes for inntil ett år.

Når særlige grunner taler for det, kan direktoratet helt eller delvis frafalle ilagt tvangsmulkt. For Svalbard kan Sysselmannen fatte vedtak etter denne paragrafen.

Departementet kan gi forskrifter om fastsettelse, beregning og innkreving av tvangsmulkt.

KAPITTEL 3. SALG AV TOBAKKSVARER (Sale of tobacco products)

§ 17. ***Aldersgrenser*** *(Age limit)*

Det er forbudt å selge eller overlate tobakksvarer, røykeutstyr, tobakkssurrogater eller tobakksimitasjoner til personer under 18 år. Er det tvil om kjøperens alder, kan salg bare finne sted dersom kjøperen dokumenterer å ha fylt 18 år.

Salg av tobakksvarer til forbruker kan bare foretas av personer over 18 år. Det samme gjelder salg av tobakksimitasjoner, tobakkssurrogater og røykeutstyr. Dette gjelder likevel ikke hvis en person over 18 år har daglig tilsyn med salget.

Departementet kan gi forskrifter om aldersgrensen for innførsel av tobakksvarer og sigarettpapir.

§ 18. ***Forbud mot selvbetjening av tobakksvarer*** *(Ban on self-service of tobacco products)*

Selvbetjening av tobakksvarer på utsalgssteder for forbrukere er forbudt.
Forbudet i første ledd gjelder ikke i spesialforretninger for tobakksvarer og utsalgssteder for avgiftsfritt salg på flyplasser.

§19. ***Forbud mot salg av tobakksvarer fra selvbetjent automat*** *(Ban on sale of tobacco products from self-service vending machines)*
Salg av tobakksvarer fra selvbetjent automat er forbudt. Forbudet omfatter ikke løsninger der kunden henter ut tobakksvarer fra automat med forhåndsbetalt automatkort.
Automatkort må ikke påføres vare- eller firmamerke eller andre kjennetegn for tobakksvarer. Automatkort kan kun påføres en nøytral skriftlig angivelse av varemerkenavnet på den aktuelle tobakksvaren.
Automater må ikke påføres vare- eller firmamerke eller andre kjennetegn for tobakksvarer. Det kan kun gis en nøytral, skriftlig angivelse av at innretningen er en automat for tobakksvarer.
Departementet kan gi forskrifter om gjennomføring og utfylling av disse bestemmelser.

§ 20. ***Forbud mot gratis utdeling av tobakksvarer*** *(Ban on free distribution of tobacco products)*
Enhver form for gratis utdeling av tobakksvarer til forbruker fra en fysisk eller juridisk person som driver næringsvirksomhet, er forbudt. Tilsvarende gjelder for tobakksimitasjoner og tobakkssurrogater.

§ 21. ***Forbud mot omsetning med rabatt*** *(Ban on sale with discount)*
Det er forbudt å gi spesiell rabatt ved salg av tobakksvarer til forbruker.

KAPITTEL 4. FORBUD MOT REKLAVE MV. (Ban on advertisement)

§ 22. ***Forbud mot tobakksreklame*** *(Ban on tobacco advertisement)*
Alle former for reklame for tobakksvarer er forbudt. Det samme gjelder røykeutstyr, tobakksimitasjoner og tobakkssurrogater.
Tobakksvarer må ikke inngå i reklame for andre varer eller tjenester.
Et merke som hovedsakelig er kjent som et merke for tobakksvare kan ikke benyttes i reklame for andre varer eller tjenester, så lenge det aktuelle merke benyttes i forbindelse med en tobakksvare.

Tobakksvarer kan ikke lanseres ved hjelp av varemerker som er kjent som, eller i bruk som, merke for andre varer eller tjenester.
Kongen kan gi forskrifter om unntak fra reglene i denne paragraf.

§ 23. ***Forbud mot tobakkssponsing*** *(Ban on tobacco sponsorship)*
Alle former for tobakkssponsing er forbudt.
Med tobakkssponsing forstås i denne lov enhver form for offentlig eller privat bidrag til et arrangement, en virksomhet eller en person med den hensikt eller den direkte eller indirekte virkning å fremme salget av tobakksprodukter.

§ 24. ***Forbud mot synlig oppstilling av tobakksvarer og røykeutstyr*** *(Ban on visible display of tobacco products and smoking accessories)*
Synlig oppstilling av tobakksvarer og røykeutstyr på utsalgssteder er forbudt. Tilsvarende gjelder for tobakksimitasjoner, tobakkssurrogater og for automatkort som gir kunden adgang til å hente ut tobakksvarer eller røykeutstyr fra automat.
Forbudet i første ledd gjelder ikke for spesialforretninger for tobakk.
Det kan på utsalgssteder gis nøytrale opplysninger om pris, og om hvilke tobakksvarer som selges på stedet. Tilsvarende gjelder for røykeutstyr.
Departementet kan gi forskrifter om gjennomføring og utfylling av disse bestemmelser og gjøre unntak fra dem.

KAPITTEL 5. SÆRSKILTE FORBUD MOT TOBAKKSBRUK (Specific prohibitions on tobacco use)

§ 25. ***Røykeforbud i lokaler og transportmidler*** *(Ban on smoking in premises and transport)*
I lokaler og transportmidler hvor allmennheten har adgang skal lufta være røykfri. Det samme gjelder i møterom, arbeidslokaler og serveringslokaler. Utendørs inngangspartier til helseinstitusjoner og offentlige virksomheter skal være røykfrie.
Røyking kan likevel tillates i følgende lokaler:

a) Beboelsesrom i institusjoner som erstatter beboerens hjem. Institusjonen plikter å gi dem som ønsker det, tilbud om røykfrie rom. Denne unntaksbestemmelse gjelder ikke for institusjoner hvor det hovedsakelig bor personer under 18 år.
b) I særskilt angitte oppholdsrom på institusjoner som erstatter beboernes hjem og på innretninger til bruk i petroleumsvirksomheten til havs. Det må tilbys tilsvarende røykfrie oppholdsrom, og disse må ikke være mindre eller av dårligere standard enn lokaler hvor røyking tillates. På samme vilkår kan arbeidsgiver tillate røyking i særskilt angitte rom når virksomhetens art hindrer arbeidstakerne i å forlate arbeidslokalene i løpet av arbeidstiden. Denne unntaksbestemmelse gjelder ikke for institusjoner hvor det hovedsakelig bor personer under 18 år.
c) I inntil halvparten av overnattingsrom på hoteller og andre overnattingssteder. De røykfrie overnattingsrommene må ikke være mindre eller av dårligere standard enn overnattingsrom hvor røyking tillates.
Eieren, driveren eller den som disponerer eller er ansvarlig for lokalene, området eller transportmidlene, plikter å sørge for at reglene gitt i eller i medhold av disse bestemmelsene blir overholdt. Det skal markeres med tydelige skilt at røyking er forbudt på steder hvor det kan være tvil om dette, samt ved inngangen til alle serveringssteder. For å sikre etterlevelse av forbudet mot røyking på serveringssteder og forbudene mot tobakksbruk i barnehager og skoler, jf. §§ 26 og 27, skal slike steder føre internkontroll og etablere et internkontrollsystem. Internkontrollen skal kunne dokumenteres overfor tilsynsmyndighetene.
Person som på tross av advarsel fra eieren eller den som driver eller er ansvarlig for lokalet, området eller transportmidlet eller representant for denne, overtrer bestemmelse gitt i eller i medhold av paragrafen her kan bortvises fra lokalet, området eller transportmidlet.
Kongen kan i forskrift gi nærmere regler om gjennomføring og utfylling av disse bestemmelser, herunder om hva som anses som et lokale i tobakksskadelovens forstand, spesielt med hensyn til uteserveringer, om meldeplikt til tilsynsmyndighetene og om kriterier for når unntaksbestemmelsene i annet ledd kan komme til anvendelse, og kan gjøre unntak fra dem. Kongen kan i forskrift også gi nærmere bestemmelser om krav til røykfrie buffersoner ved inngangspartier til helseinstitusjoner, offentlige virksomheter og serveringslokaler.

§ 26. *Tobakksforbud i barnehager* *(Ban on tobacco in kindergartens)*

Tobakksbruk er forbudt i barnehagers lokaler og uteområder.

Bestemmelsene i § 25 tredje og fjerde ledd gjelder tilsvarende.

Departementet kan i forskrift gi nærmere regler om gjennomføring og utfylling av disse bestemmelser og kan gjøre unntak fra dem.

§ 27. *Tobakksforbud på skoler og i skoletiden* *(Ban on tobacco in schools and in school hours)*

Tobakksbruk er forbudt i grunnskoler og videregående skolers lokaler og uteområder.

Elever ved grunnskoler og videregående skoler skal være tobakksfrie i skoletiden.

Bestemmelsene i § 25 tredje og fjerde ledd gjelder tilsvarende.

Departementet kan i forskrift gi nærmere regler om gjennomføring og utfylling av disse bestemmelser og kan gjøre unntak fra dem.

§ 28. *Vern av barn mot passiv røyking* *(Protection of children from passive smoking)*

Barn har rett til et røykfritt miljø. Den som er ansvarlig for barn skal medvirke til at denne retten blir oppfylt.

§ 29. *Tilsyn med tobakksforbudene* *(Supervison of bans on tobacco)*

Kommunen skal føre tilsyn med at reglene i og i medhold av §§ 25, 26 første ledd og 27 første og annet ledd overholdes. Dreier det seg om arbeidslokaler, føres tilsynet av Arbeidstilsynet.

Reglene vedrørende kommunens og Arbeidstilsynets virksomhet som tilsynsorgan etter henholdsvis folkehelseloven kapittel 3 og arbeidsmiljøloven §§ 18-4 til 18-8 får tilsvarende anvendelse ved tilsyn etter paragrafen her.

Petroleumstilsynet fører tilsyn med at reglene i og i medhold av § 25 overholdes innen det ansvarsområde Petroleumstilsynet har i petroleumsvirksomheten i henhold til arbeidsmiljøloven.

Sjøfartsmyndighetene fører tilsyn med at reglene i og i medhold av § 25 overholdes på skip samt fartøyer og innretninger for øvrig. I sin tilsynsmyndighet kan nevnte myndigheter bruke tilsvarende virkemidler som de har etter gjeldende regler om helseforhold og arbeidsmiljø på skip og innretninger innen petroleumsvirksomheten.

Forsvarsstaben fører tilsyn med at reglene i og i medhold av § 25 overholdes på Forsvarets fartøyer.

Sysselmannen fører tilsyn med at reglene i og i medhold av §§ 25, 26 og 27 overholdes på Svalbard. Sysselmannen kan overlate til Longyearbyen lokalstyre å føre tilsyn for Longyearbyen.

Tilsynsmyndigheten kan i særlige tilfeller gi dispensasjon fra regler gitt i eller i medhold av § 25 og sette vilkår for eventuell dispensasjon. På arbeidsplasser med arbeidsmiljøutvalg skal uttalelse fra utvalget legges ved søknaden. På arbeidsplasser uten arbeidsmiljøutvalg skal uttalelse fra verneombud legges ved.
Kongen kan gi nærmere regler om gjennomføring og utfylling av disse bestemmelser og kan gjøre unntak fra dem.

KAPITTEL 6. MERKING OG UTFORMING AV TOBAKKSVARER (Labeling and design of tobacco products)

§ 30. ***Krav til merking av tobakksvarer*** *(Requirements for labeling of tobacco products)*
Det er forbudt å føre inn i Norge, selge eller utdele tobakksvarer som ikke er merket med advarsel som peker på farene for helseskade ved bruk av slike. Tilsvarende skal sigarettpakker være merket med en innholdsdeklarasjon.
Det er forbudt å føre inn i Norge, selge eller utdele tobakksvarer som ved tekst, navn, varemerke, illustrasjoner eller andre tegn antyder at et spesielt tobakksprodukt er mindre helseskadelig enn andre.
Den som produserer eller selger tobakksvarer, kan ikke ved symbol eller tekst på pakninger gi egne opplysninger om de helsemessige konsekvenser ved å røyke.
Departementet gir nærmere forskrifter om merkingen etter denne paragraf.

§ 31. ***Forbud mot produkter for å skjule helseadvarslene*** *(Ban on products that conceal health warnings)*
Det er forbudt å føre inn i Norge, selge eller utdele etuier, esker, omslag, innpakninger og ethvert annet produkt som har til hensikt helt eller delvis å skjule eller tilsløre helseadvarslene i § 30 første ledd.

§ 32. ***Tobakksvarers innhold*** *(Content of tobacco products)*
Departementet kan gi forskrifter om tobakksvarers innhold, herunder maksimalgrenser for bestanddeler, vekt, filter, innpakning mv.

§ 33. *Forbud mot salg av mindre pakninger* *(Ban on sale of smaller packages)*

Til forbruker kan det kun selges forpakninger som inneholder minst 20 sigaretter. Sigaretter kan ikke selges i detaljsalgspakninger som inneholder mindre pakninger eller som kan deles opp i mindre pakninger.

Sigarer kan selges enkeltvis med advarselsmerking på pakningen.

Departementet kan gi forskrifter om minste antall og vekt tobakksvarer per forpakning som kan selges i detaljsalg.

§ 34. *Forbrukertesting* *(Consumers testing)*

Enhver form for testing av tobakksvarer og tobakksvarepakninger ved hjelp av forbrukere er forbudt.

KAPITTEL 7. HELSEDIREKTORATETS TILSYN (Directorate of Health supervision)

§ 35. *Helsedirektoratets tilsynsansvar* *(Directorate´s supervision responsibility)*

Helsedirektoratet fører tilsyn med at bestemmelsene i §§ 19, 20, 21, 22, 23, 30, 31, 33 og 34 og bestemmelser gitt i medhold av disse lovbestemmelsene, overholdes. Direktoratet kan foreta slik granskning og besiktigelse som det finner nødvendig for å utføre sine gjøremål etter loven.

Direktoratet kan kreve at den som tilvirker eller innfører tobakksvarer gir opplysninger om tobakksvarens innhold. Departementet kan gi forskrifter med nærmere bestemmelser om opplysningsplikten etter første punktum.

Direktoratet kan kreve at den som tilvirker eller innfører tobakksvarer skal legge frem en representativ prøve av produktet eller iverksette undersøkelser som er nødvendig for å vurdere et produkts egenskaper og virkninger. Kostnadene ved slike undersøkelser bæres av vedkommende tilvirker eller importør. Direktoratet kan bestemme at kostnadene helt eller delvis skal dekkes av det offentlige.

Direktoratet kan selv iverksette slike undersøkelser, og kan pålegge tilvirker eller importør å bære kostnadene ved undersøkelsen. Kostnadene er tvangsgrunnlag for utlegg.

§ 36. *Retting og tvangsmulkt* *(Rectification and coercive)*

Finner direktoratet at noen av bestemmelsene nevnt i § 35 er overtrådt, kan det pålegge retting av forholdet. Samtidig settes en frist for rettingen. Direktoratet kan kreve skriftlig bekreftelse fra overtrederen på at det ulovlige forholdet skal opphøre.

Samtidig med at pålegg om retting gis, kan tvangsmulkt fastsettes. Mulkten løper fra oversittelse av fristen for retting, og kan fastsettes i form av engangsmulkt eller dagmulkt. Mulkten tilfaller staten.

Dersom direktoratet ved avdekking av en overtredelse av § 22 eller bestemmelser gitt i medhold av denne, finner særlig grunn til å tro at det vil bli begått nye brudd på reklamebestemmelsene som ikke kan stanses etter første og annet ledd, kan det på forhånd fastsette at mulkt vil løpe fra det tidspunkt ny overtredelse tar til. Slik tvangsmulkt kan fastsettes for inntil ett år.

Når særlige grunner taler for det, kan direktoratet helt eller delvis frafalle ilagt tvangsmulkt. For Svalbard kan Sysselmannen fatte vedtak etter denne paragrafen.

Departementet kan gi forskrifter om fastsettelse, beregning og innkreving av tvangsmulkt.

§ 37. *Klage på vedtak om retting og tvangsmulkt* *(Appeal on decision on rectification and coercive)*

Vedtak etter § 36 kan påklages til Markedsrådet. Ved behandlingen i Markedsrådet gjelder de saksbehandlingsregler som er gitt i eller i medhold av markedsføringsloven så langt de passer.

KAPITTEL 8. OPPLYSNINGSPLIKTER (Information duties)

§ 38. *Opplysningsplikt mv.* *(Information duty)*

Enhver plikter etter pålegg av direktoratet å gi de opplysninger som er nødvendige for å forebygge helseskader som bruk av tobakk medfører eller gjennomføre gjøremål etter loven. Direktoratet kan kreve at den som tilvirker eller innfører tobakksvarer gir opplysninger om tobakksvarens innhold. Departementet kan gi forskrifter med nærmere bestemmelser om opplysningsplikten etter første punktum.

Direktoratet kan kreve at den som tilvirker eller innfører tobakksvarer skal legge frem en representativ prøve av produktet eller iverksette undersøkelser som er nødvendig for å vurdere et produkts egenskaper og virkninger. Kostnadene ved slike undersøkelser bæres av vedkommende

tilvirker eller importør. Direktoratet kan bestemme at kostnadene helt eller delvis skal dekkes av det offentlige.
Direktoratet kan selv iverksette slike undersøkelser, og kan pålegge tilvirker eller importør å bære kostnadene ved undersøkelsen. Kostnadene er tvangsgrunnlag for utlegg.

§ 39. *Opplysninger til statistiske formål mv.* *(Information for statistical purposes)*
Departementet kan gi forskrifter om plikt for tilsyns- og bevillingsmyndighet, bevillingshaver, den som har tillatelse til avgiftsfritt salg på flyplasser og den som driver engrossalg til å avgi opplysninger til statistiske formål.

§ 40. *Opplysningsplikt om importører av tobakksvarer mv.* *(Information duty about importers of tobacco products)*
Toll- og avgiftsetaten skal uten hinder av lovbestemt taushetsplikt på forespørsel fra Helsedirektoratet gi de opplysninger som er nødvendige for at direktoratet skal kunne holde oversikt over hvem som driver import av tobakksvarer, tobakksimitasjoner og tobakkssurrogater, herunder opplysninger om kvantum og type produkter.

KAPITTEL 9. AVSLUTTENDE BESTEMMELSER (Final provisions)

§ 41. *Forbud mot eksport av snus* *(Ban on export of snuff)*
Det er forbudt å eksportere snus til land som er medlem av det Europeiske Økonomiske Samarbeidsområde, og som har utferdiget forbud mot omsetning av snus.
Eksportforbudet gjelder ikke for snus som tas med av en reisende til dennes personlige bruk eller til gave for personlig bruk.
Med snus menes i denne bestemmelse tobakksvarer beregnet på oral bruk, laget helt eller delvis av tobakk, med unntak av de tobakksvarer som er beregnet på å røykes eller tygges.

§ 42. *Straff* *(Fine)*
Den som forsettlig eller uaktsomt overtrer forbud eller påbud gitt i eller i medhold av denne lov straffes med bøter. Medvirkning straffes på samme måte. Forsøk straffes som fullbyrdet forseelse.
Denne bestemmelse får ikke anvendelse på § 28.

Departementet kan ved forskrift bestemme at straff for uaktsom overtredelse ikke skal anvendes uten etter advarsel fra politiet.

§ 43. *Forskriftshjemmel* *(Regulation authority)*

Departementet kan gi overgangsregler og forskrifter ellers til gjennomføring og utfylling av bestemmelsene i denne lov.

Source: (Lovdata 2014)

Appendix 2. Table 1. Smoke Quit line and MMC

Year	Type of the campaign	Intensity	Total number of calls in opening hours
2003	Every cigarette is doing you harm + Industry	High	19033
2004	Every cigarette is doing you harm + Smoke free hospitality premises	High	14997
2005	Every cigarette is doing you harm	Low	8567
2006	COPD	High	13898
2007	Every cigarette is doing you harm + Cols	High	13859
2008	COPD	Low	8707
2009	COPD	Low	8315
2010	No campaign		6858

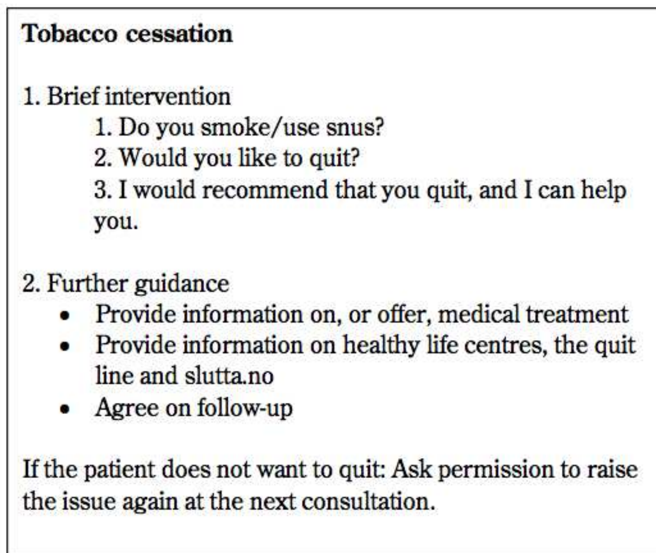
Source: (Oftedal et al. 2012, 8) (My translation)

Appendix 3. Table 2. Attitude towards SFE act in hospitality premises from 2004 – 2014

Year period	Proportion of positive attitudes on SFE in hospitality premises
2004 (NorStat)	54 percentage
2004 (NorStat)	62 percentage
2005 (MMI)	68 percentage
2005 (MMI)	76 percentage
2006 (Synovate MMI)	78 percentage
2007(Synovate MMI)	85 percentage
2008 (Synovate)	88 percentage
2009 (Sentio)	89 percentage
2011 (Sentio)	90 percentage
2014 (Sentio)	94 percentage (Helsedirektoratet 2014b)

Source: (Helsedirektoratet 2014c) (My translation)

Appendix 4. Figure 1. Tobacco Cessation with Brief Intervention



Tobacco cessation

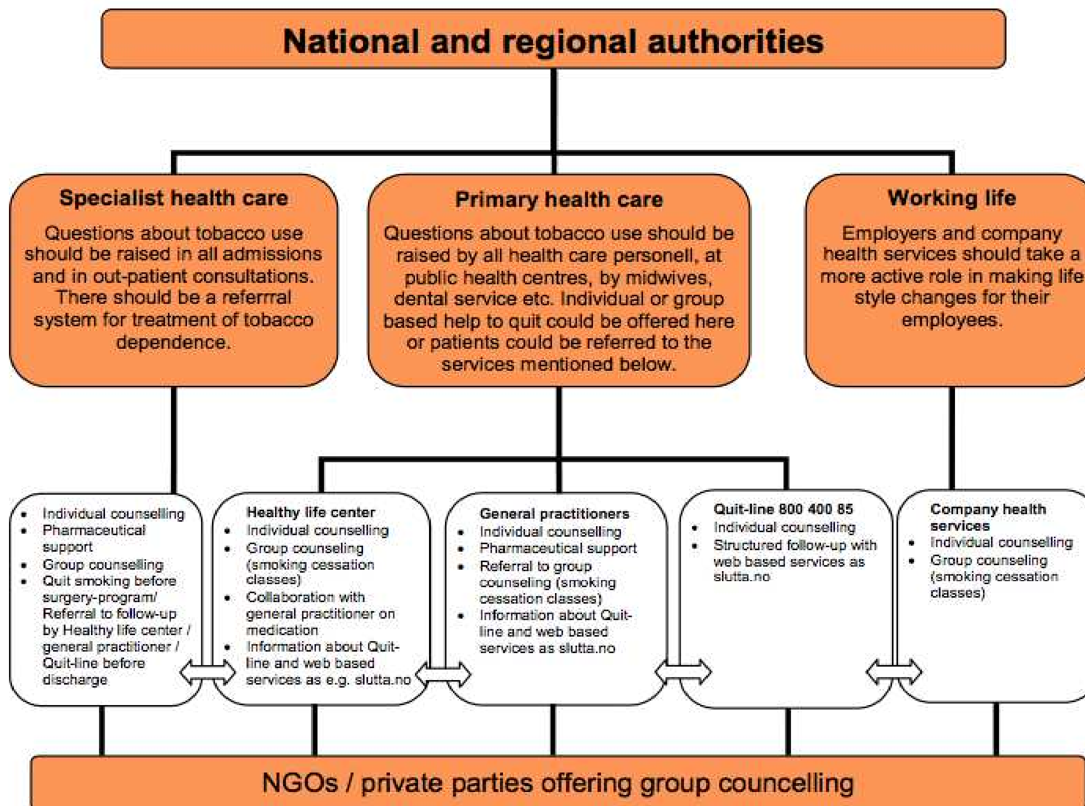
1. Brief intervention
    1. Do you smoke/use snus?
    2. Would you like to quit?
    3. I would recommend that you quit, and I can help you.

2. Further guidance
    - Provide information on, or offer, medical treatment
    - Provide information on healthy life centres, the quit line and slutta.no
    - Agree on follow-up

If the patient does not want to quit: Ask permission to raise the issue again at the next consultation.

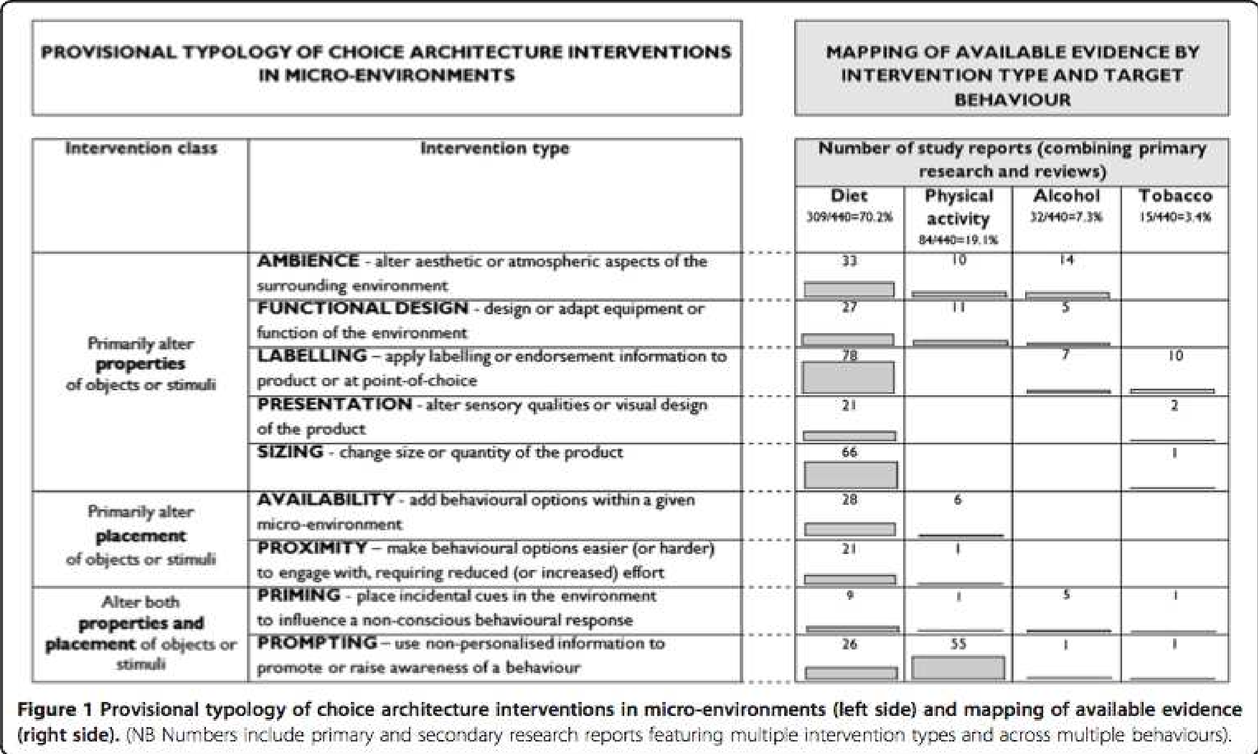
Source: (Helse og omsorgsdepartementet 2012, 21)

Appendix 5. Figure 2. Arenas and Parties involved in tobacco cessation



Source: (Helse og omsorgsdepartementet 2012, 19)

Appendix 6. Figure 3. Original provisional typology of choice architecture intervnetions in microenvironments (left side) and mapping of available evidence (righ side)



PROVISIONAL TYPOLOGY OF CHOICE ARCHITECTURE INTERVENTIONS IN MICRO-ENVIRONMENTS		MAPPING OF AVAILABLE EVIDENCE BY INTERVENTION TYPE AND TARGET BEHAVIOUR			
Intervention class	Intervention type	Number of study reports (combining primary research and reviews)			
		Diet 309/440=70.2%	Physical activity 84/440=19.1%	Alcohol 32/440=7.3%	Tobacco 15/440=3.4%
Primarily alter **properties** of objects or stimuli	**AMBIENCE** - alter aesthetic or atmospheric aspects of the surrounding environment	33	10	14	
	FUNCTIONAL DESIGN - design or adapt equipment or function of the environment	27	11	5	
	LABELLING – apply labelling or endorsement information to product or at point-of-choice	78		7	10
	PRESENTATION - alter sensory qualities or visual design of the product	21			2
	SIZING - change size or quantity of the product	66			1
Primarily alter **placement** of objects or stimuli	**AVAILABILITY** - add behavioural options within a given micro-environment	28	6		
	PROXIMITY – make behavioural options easier (or harder) to engage with, requiring reduced (or increased) effort	21	1		
Alter both **properties and placement** of objects or stimuli	**PRIMING** - place incidental cues in the environment to influence a non-conscious behavioural response	9	1	5	1
	PROMPTING – use non-personalised information to promote or raise awareness of a behaviour	26	55	1	1

Figure 1 Provisional typology of choice architecture interventions in micro-environments (left side) and mapping of available evidence (right side). (NB Numbers include primary and secondary research reports featuring multiple intervention types and across multiple behaviours).

Source: (Hollands et al. 2013a, 3)

Appendix 7. Figure 4. Norwegian pictorial health warning messages on cigarette packages

Source: (Persen 2009)

Appendix 8. Figure 5. Norwegian MMC 2012

Norway reactivates anti-tobacco mass media campaigns

After some years without using mass media for anti-tobacco advertising campaigns and a concurrent stagnation in declines in tobacco use prevalence, the Norwegian government launched a two-month anti-tobacco mass media campaign in January 2012 that featured four television advertisements as well as print media ads. The materials were adapted from Australian campaigns that have proven highly successful in a number of countries of all income levels and in most WHO Regions. Among the ads selected was "Sponge", originally created in Australia in 1979 and updated in 2007, and which has been used to warn people about the harms of smoking in a dozen countries. Approximately 70 news stories that provided free publicity for the campaign were run in Norwegian print and broadcast media within its first two weeks. A phone survey found 68% of Norwegians recalled being exposed to these anti-tobacco advertisements, and that among smokers who saw the campaign, 59% said it motivated them to make a quit attempt. A new campaign was launched in January 2013 targeting "social" smokers who use tobacco only occasionally.

"Your lungs?
Do you want to stop smoking? You can do it."

Source: (WHO 2013b, 69)