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SILNE-R

Enhancing the Effectiveness of Programs and Strategies to  
Prevent Youth Smoking: A Comparative Realist Evaluation of  
Seven European Cities

GA Number AMD 0635056-18

## **Recommendations to prevent youth smoking in the Netherlands (national, local and school)**

Joan Hanafin and Luke Clancy

Work Package 3 (WP3)  
DELIVERABLE REPORT D3.2  
**APPENDIX E**

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# **Fine-grained (evidence-based, context specific) recommendations at national, local and school levels to prevent youth smoking in the Netherlands**

## **The Netherlands: Context**

The Netherlands, the capital of which is Amsterdam, has a population of 17.1 million. Amersfoort has a population of 155,000 and a physical area of 64km<sup>2</sup>. The Netherlands had a national tobacco score of 47 in 2013. In Amersfoort, weekly adolescent smoking prevalence in SILNE schools in 2013 was 13.9% and in 2016, in SILNE-R schools, had decreased to 10.9%

## **Data sources for findings and recommendations in this report**

The fine-grained policy recommendations to prevent youth smoking in the Netherlands that are contained in this report are based on findings and recommendations from many quantitative and qualitative data sources collected for the SILNE-R project (2015-2018). The fine-grained recommendations for the Netherlands in this report should be read in conjunction with the reports containing cross-national, national, local, and school-level findings and recommendations (D3.2 Appendices A, B, C and D).

Overseen by WP8, surveys of more than 13,000 school students in 7 cities were carried out (2016/17) to examine student health, social networks, smoking (prevalence, access to cigarettes, attitudes to smoking, parental smoking, location of smoking, smoking in the home, e-cigarettes, *etc.*), perceptions of school tobacco policies, *etc.*. The general participation rate for student surveys was 89.6 % (all countries). In the Netherlands, 1763 students participated (99.04% participation rate). From late 2016-2017, overseen by WP9, 56 single-sex focus group interviews took place, 8 in each of the 7 cities, involving 319 participants. The focus groups paid particular regard to school smoke-free policies and age-of-sale laws. Participants were recruited by teachers, who identified students they believed to be smokers or at risk of becoming smokers. Half the focus groups were conducted with girls and half with

boys. Overall, 168 girls and 151 boys participated, with 3-9 participants per group. Half of all groups were conducted with students attending schools that served a predominantly high socioeconomic status (SES) population, and half in schools serving a low SES population. Adolescents were aged 14-19 (average age of participants was 15.2 years) with most focus groups having participants under the legal age limit of that country. In Amersfoort, 8 focus group interviews (4 with girls and 4 with boys) took place in 3 participating schools.

Staff questionnaires regarding school characteristics, school tobacco policies, health promotion and prevention, *etc.* were also completed for WP8 and interview data with staff was collected for WP7. Consultations and focus group interviews (initial and follow-up) were held with policymakers and stakeholders from the 7 SILNE-R countries and also from other EU and non-EU countries, overseen by WP5 at the national level and by WP6 at the local level.

Data relating to enforcement and implementation costs of certain tobacco control measures (ban on sale to minors; point-of-sale advertising; ban on smoking in public places) was overseen by WP10. In some cases, school staff were interviewed regarding the cost of school bans and educational programmes for WP10 (cost questionnaires/ interviews).

## **National-level findings and recommendations to prevent adolescent smoking**

The Netherlands is a moderately progressive country where tobacco control policies are not particularly progressive but have advanced in recent years. Consideration is being given to a point-of-sale display ban. WP5's<sup>1</sup> analysis of policy monopolies of pro and anti-tobacco interest groups across six European SILNE-R countries found that one of the main factors influencing variation in tobacco control policies across European countries is the relative policy dominance of pro and anti-tobacco control interest groups. WP5 examined whether there are patterns and similarities with regard

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<sup>1</sup> WP5 (UNIMASS), D5.3, Article 3: Who calls the shots in tobacco control policy? policy monopolies of pro and anti-tobacco interest groups across six European countries. Paper submitted to 'Social Science and Medicine'. Final SILNE-R Report, September 2018.

to framing of tobacco and institutional arrangements across countries that have a relative dominance by either one of the two groups. In doing so, they conducted 32 semi-structured interviews with relevant stakeholders in Belgium, Finland, Germany, Ireland, Italy, and the Netherlands. They found that, in countries where health Non-Governmental Organizations (NGOs) have a policy dominance in tobacco control, NGO communities are well developed and have tight links to government while the industry is largely economically absent. In addition, the health ministry plays a central role in the policymaking process, FCTC Article 5.3. is strictly interpreted and the framing of tobacco focuses on the health aspects of smoking. In contrast, in countries where the tobacco industry and associated businesses have a policy dominance, the industry is more strongly embedded in the domestic economy while NGO communities are weak or absent in the field of tobacco control. In these countries, the health ministry plays a subordinate role in the policymaking process, FCTC's article 5.3. is only interpreted in terms of transparency and tobacco is framed as a private problem. They concluded that the way tobacco is framed in a country and the way institutions are arranged correspond to the policy monopoly in place, with strong similarities across countries with the same policy monopoly. Despite an active community of health NGOs in the Netherlands, the political agenda of the current ruling party often objects to the introduction of strict tobacco control regulations. Since tobacco control has not been a priority, the response to policymaking has been stagnant and uncoordinated.

**Amersfoort relevant recommendations:**

- **Put in place an endgame goal, building on the (moderate) gains achieved to date. SILNE-R data show that governments that have embraced endgame goals have committed themselves to ending smoking altogether and that a set endgame goal likely facilitates the adoption of measures in order to achieve this goal. The most progressive SILNE-R countries (Finland and Ireland) both have governments that have translated endgame goals to policy.**
- **A strict interpretation of FCTC article 5.3 among all ministries is required.**
- **Provide better support for the NGO community in the Netherlands to create strong networks at national and international levels so that they can actively try to influence policymakers and politicians to ensure them**

to use article 5.3 as much as possible.

## Costs and cost effectiveness of various TC policies

As regards the current landscape of tobacco control policies and their costs in 7 European cities / countries, the findings of WP10 provided a snapshot of costs for the implementation of various policies to prevent adolescent smoking. In Amersfoort/Netherlands:

- A year of implementation of non-school bans (bans on smoking public places, bans on sales to minors, bans on advertising at point-of-sale) cost €0.35 per person covered (PPP).
- A year of implementation of school bans cost, in mean, €21.90 per student covered (PPP), if considering a conservative perspective. Considering a realistic perspective, the implementation of this ban cost €0.23 per student.
- The implementation of a school smoking prevention programme cost, in mean, €4.33 per student covered (PPP).
- Long-term effectiveness estimates ranged from 124,100 to 6,207,000 healthy years gained after the implementation of a strategy with a short-term effectiveness of 1 to 50% relative reduction of smoking prevalence, respectively.
- For these cost and effectiveness estimates, the implementation of non-school bans, school bans (realistic and conservative perspectives), and school programmes was highly cost effective (according to the WHO threshold of 1 times the GDP per capita) for the reduction of at least 1% of the prevalence of smoking among adolescents.

### Recommendations:

- **Data on cost and cost effectiveness are scarce but it is clear from WP10 that school tobacco control policies (STPs) are highly cost-effective.**
- **To maximise the potential for use of financial data to support a demand for appropriate STPs, it is important that cost and cost-effectiveness data collection be made a component of STP monitoring and be available to support policy makers.**
- **It is important that the cost effectiveness of smoke-free laws is emphasised and kept prominent when public health, and particularly disease prevention, is being considered.**

- **Cost-effectiveness is a valuable tool when advising policy-makers and may be particularly important when tobacco control policies are in competition with, and possibly getting a lower priority than, other prevention areas for resources and public (electoral) support.**
- **Cost-effectiveness should be included in intersubjective discourses being developed by tobacco control advocates.**
- **Collection of cost data for use in cost-effectiveness analysis should be part of monitoring of smoke-free laws.**

### **Access by adolescents to cigarettes**

National Minimum Age of Sale Laws (NMA SLs) are designed to prevent young people from accessing cigarettes, with the aim of reducing youth smoking uptake and prevalence. Nevertheless participants across SILNE-R cities accessed cigarettes with ease, using a variety of methods to obtain cigarettes from: ‘legitimate’ retailers or vending machines; people above the legal age of purchase; friends; ‘proxies’ (known or stranger adults who purchased cigarettes on their behalf); stealing from family members; buying from other young people; and purchasing cigarettes abroad. Methods to access cigarettes differ across cities, reflecting variation in the implementation or enforcement of NMA SLs at a national or local level.

WP9 conducted focus group interviews with 319 young people from 17 schools, with similar numbers drawn from high and low socio-economic status populations and from girls and boys. Young people's perceptions and experiences of accessing cigarettes were explored. Access was largely in contravention of national minimum age of sale laws (NMA SLs).

- In the Netherlands, the national minimum age of sale is 18 years.
- Some Dutch participants indicated that a small number of retailers might sell cigarettes to minors (e.g. a particular gas station), but the general sense was that access via these means was limited.
- Participants reported frequent use of acquaintance and stranger proxies, sometimes describing quite well organised and regulated relationships with specific proxies.
- Participants described targeting particular types of stranger proxies, primarily

younger individuals, who appeared to smoke themselves, or embodied the cultural signifiers of low SES, *e.g.*, fur around their hoods.

- Participants occasionally discussed accessing vending machines (with stolen/borrowed IDs) but this did not appear to be viewed as a principal source for obtaining cigarettes.

Policy recommendations based on WP9<sup>2</sup> and other SILNE-R findings include

**Amersfoort relevant recommendations:**

- **Meaningful enforcement is the most important measure. Enforce national minimum age of sale laws. At a minimum, raise National Minimum Age of Sale Laws (NMASLs) to 18 years in Belgium where it is currently 16 years.**
- **All SILNE-R countries should consider following the example of 6 states (California, New Jersey, Massachusetts, Oregon, Hawaii and Maine) and at least 350 localities in the U.S. that, as of 19th September 2018, have raised the minimum age of sale to 21 years<sup>3</sup>. As the vast majority of smokers start smoking before the age of 20, enforcement of such a law would likely result in further decreases in youth smoking prevalence.**
- **Remove all vending machines as they are not, and cannot be, adequately policed.**
- **Strengthen supply side restrictions. Consider the introduction of a licencing levy or penalty to discourage smaller retailers from supplying cigarettes to underage purchasers.**
- **Take action on proxies via awareness raising.**
- **Policy-makers should consider how ‘holding students back’ (*i.e.*, requiring students to repeat an academic year) can change peer group configuration and dynamics – particularly with regard to accessing cigarettes - and shape their interventions accordingly.**

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<sup>2</sup> WP9 (UEDIN), 2018. Adolescent Tobacco Control Policy Recommendations: WP9 Recommendations to WP3. Internal SILNE-R report from WP9 to WP3, 26 March 2018.

<sup>3</sup> Campaign for Tobacco-Free Kids (2018). States and localities that have raised the minimum legal sale age for tobacco products to 21. [https://www.tobaccofreekids.org/assets/content/what\\_we\\_do/state\\_local\\_issues/sales\\_21/states\\_localities\\_MLSA\\_21.pdf](https://www.tobaccofreekids.org/assets/content/what_we_do/state_local_issues/sales_21/states_localities_MLSA_21.pdf) Accessed 29 September 2018.

- **A trans-national European approach - the fluid borders of Europe and the mobility of its citizens - means that successful policy-making should be seen as a supra-national/international endeavour.**
- **Specific education and media campaigns on the health harms of tobacco are required in the context of stranger proxies and older (known) persons buying cigarettes for young students in breach of the NMASLs.**
- **Further context-specific recommendations are detailed in Appendix D.**

## **Local-level findings and recommendations to prevent adolescent smoking**

WP3 synthesised and translated evidence from SILNE-R WP4-10 in order to make local-level recommendations for the prevention of youth smoking. Using the prism of WP4 policy models and briefs, and drawing on WP6's qualitative assessment of expert interviews (n=56) with European decision makers and stakeholders, and a consultation group, we make some observations. These observations and resulting recommendations are described in detail in D3.2 Appendix C.

### **Local context**

Separate from a national policy and legislative context, schools exist within local contexts that must be taken into account in order to reduce and prevent adolescent smoking. Local primary prevention in schools in the Netherlands must be framed with adequate national tobacco control policies, such as effective tobacco taxation and advertising bans, but features of the local context may support or hinder reductions in smoking prevalence among young people. In particular, local factors can create environments that, rather than discouraging young people from smoking, serve to facilitate youth tobacco use. This occurs despite national legislative frameworks, as a consequence of poor local enforcement, or lack of specific policy or legislation at the local level.

A critical realist qualitative study of the implementation of smoking bans at the local level of 7 SILNE-R cities based on semi-structured expert interviews (n=56) with

local decision makers<sup>4</sup> showed that existing implementation processes at the local level in the Netherlands may be categorised as "upper-saturated" rather than "progressive-hungry", "moderate-rational", or "lower saturated". These types differ mainly in regard to their engagement in enhancing smoke-free environments as well as along their level of perceived tobacco de-normalisation and public smoking visibility. Smoke-free environments are adopted at national levels, but are implemented differently at local levels due to varying contextual factors, such as the level of collaboration, enforcement strategies, and national policy environments. Different legislative and administrative conditions lead to four implementation types and binary mechanisms of "expansion" and "closure". Major mechanisms to expand future smoke-free regulations were found to be intersubjective arguments, such as scientific evidence, public support, and the child frame. However, counter-mechanisms of closure, like data on declining prevalence or "new trends in addiction", can result in low priorities. Four smoke-free trans-local types and two mechanisms of "expansion" vs. "closure" were identified. To support smoke-free expansion at the local level, a number of approaches are recommended. In order to be able to enhance existing smoke-free areas at the local level in the EU, local levels must be assisted by national levels, better use must be made of intersubjective arguments, particularly around the "child frame", and ongoing monitoring and evaluation must be ensured. Therefore, they identified the following approaches to improve the implementation of smoke-free bans at the local level: 1. Local TCPs must be framed, as in Ireland and Finland, within adequate and ambitious national policy environments, such as effective tobacco taxation, comprehensive smoke-free laws, banned vending machines, plain packs, point-of-sale and advertising bans. 2. Smoke-free laws need to be adapted and modernized specifically for outdoor places (*e.g.*, playgrounds) and private contexts (*e.g.*, cars) that are frequented by children. 3. Regular and active smoke-free-monitoring enhances effective long-term enforcement of smoke-free environments. An implementation plan (based on Ireland and Finland) including tobacco-focussed long-term monitoring at local levels, and reported

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<sup>4</sup> WP6 (MLU). Appendix 3 Martin Mlinarić, Laura Hoffmann, SILNE-R study group, Matthias Richter, Enhancing smoke-free environments at the local level: a comparative realist study and qualitative type construction across 7 European cities. SILNE-R Draft paper, September 2018, Final SILNE-R report and Presentation to SILNE-R: Sixth Consortium Meeting, Madrid, June 12-13, 2018, Hospital Clínico Universitario San Carlos.

documentation of developments is needed. Regional differences should be considered here, since financial and personnel resources are often unequally distributed across different administrative districts.

### **Barriers at the local level**

Barriers identified across the 7 cities to successful local-level implementation of tobacco control activities to prevent youth smoking are: lack of a unified structure that deals with implementation, monitoring and enforcement of national-level policy and legislation; lack of an ‘implementation plan’ or strategy or endgame vision for prevention of youth smoking; lack of resources for tobacco control at local level; uneven efforts regarding denormalisation and, specifically, advertising bans; inadequate expansion of smoke-free spaces, especially those where children may be (all indoor and outdoor areas in schools, health facilities, crèches, recreational facilities, sports stadia); and need for increased efforts for population sub-groups suffering specific disadvantage regarding smoking prevalence (low SES groups; some school types and tracks).

We know from focus group interview data with young people in Amersfoort that successful implementation of access barriers requires consistency and strength in enforcement. One particular factor at the local level appeared to influence the efficacy of NMASLs in reducing minors’ ability to obtain cigarettes in the Netherlands. This was the different NMASLs of the Netherlands and Belgium, which borders the Netherlands. Belgium has a lower minimum age to the Netherlands, allowing minors to access tobacco by moving jurisdictions.

### **Suggested solutions at the local level**

Suggested solutions to mitigate these barriers at the local level include tobacco taxation, institutional structures, expansion of smoke-free spaces, and community involvement. The use of intersubjective discourses - especially regarding evidence bases and child frames - is necessary, and health advocates must employ intersubjectivity as a way of building support and achieving policy consensus around smoke-free (and other policy) initiatives at the local level as much as at (inter-)national and school levels. These suggestions and derived recommendations are detailed in D3.2 Appendix C.

## Amersfoort relevant local-level recommendations

A summary of Amersfoort relevant local-level recommendations to support the prevention of youth smoking is listed here.

### Recommendations:

- **Emphasise the continuing need to improve national-level tobacco control policies to avoid the emergence of complacency and achieve the tobacco control ‘endgame’.**
- **Institute a national-level office of an ombudsman/woman charged with national, local and school-level oversight of tobacco control and particularly the prevention of youth smoking.**
- **Prioritise low SES groups as they have higher smoking prevalence than everyone else and pool limited resources for socially disadvantaged contexts.**
- **Expand child-related smoke-free contexts, such as cars carrying minors and certain smoke-free outdoor areas (e.g., playgrounds, public parks).**
- **Consider localised community-group interventions for tobacco control, e.g. in the arts arena.**
- **Use intersubjective discourses at the local level and ensure that there is continuing health education concerning tobacco and nicotine addiction.**
- **The problem of minors accessing tobacco by moving jurisdictions needs to be addressed through monitoring and stricter enforcement of existing legislation. Further data are required about this. The use of National ID cards in this regard warrants consideration.**

## School-level findings and recommendations to prevent adolescent smoking

School-level findings and recommendations to prevent adolescent smoking focus on smoke-free schools, school tobacco policies (STPs), and tobacco-related health education.

### Smoke-free schools

In the Netherlands, legislation banning smoking does not cover outdoor areas on

school grounds. Student smoking in school was not reported as a problem, but problems were reported regarding the visibility of students smoking off-campus, and with monitoring of students by staff.

### **Implementation of school smoking ban in Amersfoort.**

In its report to WP3<sup>5</sup>, WP7 provided a brief overview of the implementation of a school smoking ban in each of the 7 SILNE-R countries. Its report was based on topics that were discussed in the school staff interviews and did not aim to provide a comprehensive understanding on policies in each country/school. In The Netherlands, legislation compelling schools to enforce an outdoor smoking ban within school premises will be implemented in 2020. Smoking is prohibited by law in school buildings, but implementation and enforcement of smoking bans on the outside premises is organised in different ways in different schools. In general, smoking was not considered the main problem in schools, but several issues concerning student (and also staff) smoking were discussed. Some schools provided smoking places for students within or outside school areas so that students would not cause nuisance to neighbours and could be monitored. However, smoking places inside school areas did not work, because the borders of the smoking areas widens over time, and also because non-smokers keep company with smokers, exposing them to second-hand smoke (SHS). Some schools also prohibited students from leaving school premises to avoid student smoking outside school premises. In some schools, monitoring was assigned to supportive staff members, but in some schools teachers also contributed to this work. In many schools, the contribution of all staff to enforcement was considered important. Recent legislation on tobacco sales (banned for under 18 year olds) had encouraged some schools to become stricter with their policies. Staff smoking was treated in a contradictory way in some schools, *e.g.*, one school provided a smoking space for staff visible to students.

### **Adolescent adherence to smoke-free school policies**

Focus group research carried out with 319 students in 17 schools across 7 cities to explore adolescents' reports of variations in adherence to smoke-free schools policies

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<sup>5</sup> WP7 (UTA). Smoking Ban. Final report on school smoking ban implementation in seven European countries. Internal SILNE-R report from WP7 to WP3, May 2018.

was analysed by WP9 and synthesised for WP3<sup>6</sup>. Participants were recruited from three schools (one low SES and two high SES) in the Netherlands.

- Students from both the Low and High SES Dutch schools expressed confusion regarding whether they were permitted to smoke on-site. This appeared to arise from ambiguity regarding the position of school borders.
- Regardless, students believed they were permitted to smoke on the immediate periphery of the school, and that they would not be sanctioned for doing so.

#### **Recommendations:**

- **School policies on smoke-free schools need to be clear about what is expected of students, and about the extent of smoke-free areas on school campuses (school boundaries), as well as about off-site smoking at the periphery of school campuses.**
- **Smoke-free policies should be comprehensively communicated using multiple modalities (written / signage / talks etc.) and communicated over time so that students are clear about actual policies rather than reported ones.**
- **Enforcement of smoke-free policies should be consistent and meaningful (e.g., include surveillance of the whole school site).**

### **Policy development processes ~ a case study of The Netherlands**

WP4 reported on findings, summarised here, from 13 in-depth interviews with staff in 4 schools in the Netherlands, and explored why secondary schools choose not to make school hours a smoke-free time for all students<sup>7</sup>. Adolescents smoking outside the school premises is a commonly reported side-effect of STPs and schools in some countries do not allow adolescents to leave the school premises during school hours. This practice is associated with less smoking. To understand why schools in the Netherlands do not adopt such a policy when they have the authority to do so, WP4 applied the Advocacy Coalition Framework to their analyses of data from teacher

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<sup>6</sup> WP9 (UEDIN), 2018. Adolescent Tobacco Control Policy Recommendations: WP9 Recommendations to WP3. Internal SILNE-R report from WP9 to WP3, 26 March 2018.

<sup>7</sup> WP4 (AMC). Why secondary schools choose not to make school hours a smoke-free time for all students: in-depth interviews in the Netherlands. Presentation to SILNE-R: Sixth Consortium Meeting, Madrid, June 12-13, 2018, Hospital Clínico Universitario San Carlos.

interviews. None of the schools prohibited all adolescents from leaving the school premises.

The Advocacy Coalition Framework (ACF) is a theory used to explain policymaking processes and is discussed in some detail in WP3's Report D3.1<sup>8</sup>. In brief, ACF posits that the likelihood of stakeholders using their power to adopt new and adapt existing policies depends largely on their belief systems. Belief systems operate at three levels. Deep core beliefs are based on fundamental values in society. Policy core beliefs are based on perceptions of the problem, solution (*e.g.*, expected impact) and the capacity, power and credibility of those responsible for advocating for the change. Secondary beliefs are based on the (context-specific) feasibility of actually implementing the policy in question.

Analyses of teacher interview data identified 2 Deep core beliefs, 3 Policy core beliefs, and 1 Secondary belief expressed by staff members.

The first Deep core belief expressed by staff members was that they believed that *schools should guide older adolescents to make responsible use of their autonomy*. Implicit in this belief was that "younger" adolescents need protection and that "older" adolescents need to learn to make independent choices. This included preparing for the "real world" in which smoking is a choice. Nevertheless, staff believed that schools should "demotivate" students regarding smoking.

The second Deep core belief expressed was that *staff members believe that schools should intervene when adolescents bother others*. Implicit in this belief is that smoking is not a problem as long as it is not bothering others. However, a feature that disrupts this particular core belief is that an unintended consequence of STPs is that it may affect non-smokers and residents in areas surrounding schools. These groups may be affected by the movement of smokers from the school premises to outside the school premises. It is important that STPs do not unintentionally increase this interference with other people. For instance, if smoking was forbidden in the school and thereby driven out into the neighbourhood, this would tend to undermine the core belief that smokers are not interfering with others as long as they are not smoking on

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<sup>8</sup> WP3 (TFRI). Kate Babineau, Keisha Taylor, Sheila Keogan, Elizabeth Breslin, and Luke Clancy. Deliverable Report D3.1, Final SILNE-R report, 1 July 2016.

the school premises, as they would be causing interference to people in the neighbourhood. A result of this core belief was that allowing smoking in designated areas or prohibiting smoking during school hours was seen by staff members as a possible way of not interfering with non-smokers' rights but would not decrease smoking prevalence *per se*.

The first of three Policy core beliefs was that Staff members believed that schools should only deal with pressing health and social issues. Different priorities were evident between schools. Smoking was not seen as a priority because increasing societal unacceptability makes smoking unattractive and they believed that STPs were working sufficiently, indicating a degree of complacency. Reducing priority of smoking was seen to be in line with parental expectations, where smoking is seen as less of a priority than alcohol, drugs, and mental health.

The second Policy core belief was that staff members believe that schools should demarcate their jurisdiction to interfere in adolescents' lives. Specifically, they believed that the school's jurisdiction is physically and temporally limited and that, within the school area there is full jurisdiction, *i.e.*, parents have to accept what the school rules are. Otherwise, the school becomes the parents' jurisdiction leading to "complementary relationships". It was noted, however, that this was "in stark contrast" to the position regarding alcohol and drugs.

The third Policy core belief was that staff members believed that schools should establish and maintain workable relationships with smokers. They believed that strengthening the existing rules about smoking would lead to difficulties in the relationships between school and smokers. Smoking was framed as something that "some adolescents need" and that schools should take that into account. Staff believed that smoking sanctions were particularly problematic for adolescents living with pro-smoking families and for those facing multiple problems; in those instances, staff were "happy" if students wanted to come to school.

One secondary belief was identified, namely that staff members believed that schools should only adopt rules that they are able to enforce consistently. They believed that stricter rules would require more time than was available; that the current rules were

already difficult to enforce; and that such measures would be resisted by staff who smoke.

**Recommendations:**

- **Implications from this ACF policy-informed analysis of teachers' deep core, policy core and secondary beliefs about smoke-free school policies suggested the need for government policy.**
- **Specifically, attention was drawn to the fact that, in the Netherlands, smoking policies are used as a means to compete for new first-year students (the "PR-picture").**
- **Attention should be paid to the most vulnerable members of the school population, particularly to low SES students who are smokers.**
- **Schools are bound to the societal perception that smoking during school hours is still seen as "normal", giving rise to a "tension in the relationship".**

**Recommendations:**

- **Government policy should necessitate the implementation of smoke-free bans in all schools. This would provide a counterpoint to prevailing societal perception that smoking in schools is still normal. It would also assist in obviating schools' concerns about the "PR-picture" and perceptions of the liberalism of their school policies, particularly in relation to the views of parents. A strong top-down legislative policy is necessary, and has been shown to have been effective in other - albeit less liberal - jurisdictions. This is important for reducing further adolescent smoking prevalence in the Netherlands, a country which is already moderately progressive and on the cusp of change.**

### **School tobacco policies**

Tobacco control policies at schools (STPs) were examined by WP8, and each school was given a STP score<sup>9</sup>. The STP score comprises three dimensions, namely

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<sup>9</sup> WP8 (UCL). The current landscape of tobacco control policies within seven European countries / cities. Internal SILNE-R report from WP8 to WP3, April 2018. WP8 (UCL). D8.3. Report with general overview. Final SILNE-R report, September 2018. WP8 (UCL). D8.3, Appendix 9.a. paper 1, Nora Mélard, Adeline Grard, Pierre-

comprehensiveness (who, where and when the policy applies to, whether they have smoking rooms installed and whether students perceive that there is a policy), enforcement (whether students perceive the policy as strict and the different types of consequences applied if a student is caught smoking) and communication (whether the policy is formal and how it is communicated to others). Each dimension ranges from 0 to 10 and the STP score is an average of all three dimensions. Overall, there was a significant improvement in the implementation of STPs in Amersfoort between 2013 and 2016. There was a significant decrease between 2013 and 2016 in the comprehensiveness of the STP (6.8 to 4.2,  $p < .05$ ), but a significant increase in its enforcement (1.7 to 1.9,  $p < .05$ ) and in its communication (4.6 to 7.6,  $p < .05$ ). Overall the total score of the policy increased from 4.4 to 4.6 ( $p < .05$ ).

### **Tobacco-related health education**

From an analysis of interview data with school staff members, WP7 provided for WP3 an account of the current landscape of tobacco-related health education within the seven SILNE-R cities<sup>10</sup>. In each city, three schools were selected, and three staff members were interviewed in each school. In the Netherlands, four schools were chosen.

The Netherlands, like Portugal, has moderately progressive tobacco control policies and is a country on the edge of change in relation to tobacco-related health education. In each of the schools in Amersfoort, the *Healthy School* concept had been implemented. The *Healthy School* concept includes a focus on a range of health-related behaviours through specific modules on alcohol, drugs, and food, as well as tobacco, and a school can achieve the status of a health promoting school even if it implements only one of the modules. The decision to introduce the *Healthy School* concept is a matter for local school management, and was seen by staff as a way of considering school aims and activities from a perspective of prevention or health

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Olivier Robert, Mirte Kuipers, Michael Schreuders, Teresa Leão, Laura Hoffmann, Matthias Richter, Arja Rimpela, Anton Kunst and Vincent Lorant. School tobacco policies and adolescent smoking in 6 European countries. Final SILNE-R report, September 2018.

<sup>10</sup> WP7 (UTA). Education. Final report on tobacco related health education. Internal SILNE-R report from WP7 to WP3, May 2018.

promotion. The *Healthy School* emblem was also used as a "marketing" strategy by schools.

Variation was noted in how the *Healthy School* concept had been implemented, how schools had valued it, the extent to which schools had been ready to invest in it, and how they had made good use of it. It was found that the initiative needed dedicated teachers and champions. This was especially the case in the beginning, because of how change in school culture happens gradually and takes time.

**Recommendations:**

- **Support dedicated teachers who champion tobacco-related health education.**

Tobacco-related health education forms part of the curriculum in a general way, being included in subjects such as Biology and Care. Variations exist between schools depending on school type and tracking. The content and pedagogical approaches of tobacco-related health education vary from basic awareness raising (*e.g.*, from textbook content) to group processes, peer pressure, and making justified decisions. The latter, more complex pedagogical approaches were found not to be systematically implemented, with much depending on individual teachers and their own pedagogical styles and educational goals.

**Recommendations:**

- **Provide support for teachers in raising awareness of the suite of pedagogical approaches in tobacco-related health education, knowledge of the most effective approaches, and systematic implementation thereof.**

In Amersfoort, mixed views and perceptions about the current state of tobacco-related health education were in evidence. On the one hand, participants reported that the status quo regarding the current situation on tobacco use was accepted, that no regular efforts were made to prevent smoking, and that no smoking prevention strategy existed. On the other hand, some participants highlighted the need to rethink and develop tobacco-related health education. Education on the long-term consequences of smoking was not considered interesting to, nor effective for, adolescents, as the consequences do "not make sense" in adolescents' everyday life and social-cultural contexts. Rather than focussing on information about long-term consequences,

participants suggested that the emphasis should be on group dynamics, namely on what happens in groups, and how to deal with tobacco-related health education within those contexts.

**Recommendations:**

- **Develop ways of combating future-denial by adolescents of the long-term consequences of smoking.**
- **Focus on group dynamics in providing tobacco-related health education for adolescents.**

It was noted that, in Amersfoort, there was a lot of activity at the local city /municipal level, including a prevention strategy against drug use and various preventive programmes, mostly relating to drugs. A network of NGOs works very proactively, having many initiatives and providing support for schools. NGOs also contribute to continuous professional development for teachers. For example, in one school, when staff were implementing a new programme, the teachers in charge received training on how to deal with different questions students might ask.

**Recommendations:**

- **Develop further the network of NGOs providing support for teachers and schools, increasing the focus on tobacco-related health education and drawing on lessons learned from other health education activities, for example lessons learned regarding prevention of drug use.**

The importance afforded tobacco-related health education in a school is influenced by characteristics of the student body in the school. For example, in one school, where students had learning difficulties and had fallen behind with their academic performance, no specific education on tobacco was included in the curriculum. Students had individual study plans and the main aim of the school was to support and guide these students through education and to make the transition to the labour force.

**Recommendations:**

- **Address the social inequality in the provision of health education by providing tobacco-related health education for all students regardless of their education (or socio-economic) status.**

The need for external resources was noted and attention was drawn to the possibilities that opened up for developing health education at the moment when a school acquired *Health Promoting School* status.

**Recommendations:**

- **Avail of time-limited opportunities for developing tobacco-related health education at key moments, for example when a school acquires *Health Promoting School* status.**