Lessons from the Nordics: A Report on Youth Health Prevention and Nicotine Policy



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“Healthy citizens are the greatest asset any country can have.”

Winston Churchill

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Preface



I have always been fascinated by behaviour change – a curiosity I deepened through my master's in health psychology and grew from an academic interest into a career in health policy. Working on tobacco and vaping legislation in the UK has shown me how rapidly products and behaviours can evolve, and how policy and systems can respond in turn.

Many colleagues, academics and practitioners have generated valuable insights in this field. My aim is to complement their work by exploring Nordic interventions and showing how familiar ideas, such as prevention, data use, integrated health care and youth co-participation, are being brought to life. At the time of writing, the UK Government has set out an ambition to create the "healthiest and happiest generation ever in Britain", published a 10-Year Health Plan for England setting out a long-term shift towards prevention and passed the Tobacco and Vapes Act - world-leading legislation to create a smoke-free generation. Together, these developments present a critical window to strengthen the focus on health promotion and prevention, while considering the next steps in nicotine regulation. This Fellowship seeks to contribute to that effort.

The Nordic countries consistently outperform the UK on measures of health and wellbeing for children and young people. They also rank highly in international happiness and trust indices, while maintaining broadly similar tax-funded, universal healthcare systems to our own. They have historically placed a stronger emphasis on prevention and early intervention and have developed distinctive approaches to youth nicotine use, creating a range of regulatory choices to explore.

My Fellowship began with a focus on youth vaping, but I used the opportunity to explore a wider set of prevention practices and youth interventions, including mental health promotion, digital wellbeing, bullying prevention, physical activity and the role of resilience in shaping young people's outcomes.

Acknowledgements

I am deeply grateful to the Churchill Fellowship for funding this project and providing me with this unique opportunity. I am grateful to my family for their encouragement and to my colleagues and manager for supporting my time away from the office to undertake this Fellowship. I am particularly thankful to the policymakers, researchers and practitioners I met across the Nordics, who generously shared their time, insights and expertise with me, and who made this Fellowship possible.

This report is written in my own personal capacity. The views expressed are my own and do not represent the position of my employer or of the Churchill Fellowship.

Glossary

- **COM-B:** Capability, Opportunity, Motivation–Behaviour model.
- **CYP:** Children and young people.
- **EU:** European Union.
- **FRAMM:** A Swedish oral-health programme, deriving from the Swedish for "Fluoride, advice, arena, motivation and diet".
- **HBSC:** Health Behaviour in School-aged Children study.
- **IPM:** Icelandic Prevention Model: a population-level approach developed in Iceland from the late 1990s.
- **KiVa:** Finnish anti-bullying programme derived from the Finnish phrase Kiusaamista Vastaan ("against bullying")
- **Municipality:** The primary unit of local government across much of the Nordic region, typically responsible for services including health promotion, education and social care.
- **NHS:** National Health Service.
- **Nicotine pouch:** A tobacco-free oral nicotine product that releases nicotine when placed between the lip and gum.
- **Nordic countries:** Denmark, Finland, Iceland, Norway and Sweden.
- **Prevention:** Action that reduces the likelihood, incidence or severity of a specific risk, condition or harm.
- **Promotion:** Action that strengthens positive health, wellbeing, capability or protective factors.
- **RCPCH:** Royal College of Paediatrics and Child Health.
- **RSHE:** Relationships, Sex and Health Education, statutory curriculum content in England.
- **Snus:** An oral tobacco product placed under the upper lip, distinct from tobacco-free nicotine pouches.

- **Tobacco and Vapes Act 2026:** Legislation that creates a smoke-free generation and creates powers to regulate tobacco, vaping and other nicotine products.
- **UK:** United Kingdom.
- **Vape:** An electronic device that heats a liquid to produce an aerosol for inhalation. Also referred to as an e-cigarette.

Executive Summary

Children and young people in the United Kingdom face intersecting challenges: nicotine use, worsening mental health, obesity, digital harms and widening health inequalities. The Government's ambition to create the healthiest and happiest generation, the 10-Year Health Plan for England's shift towards prevention and the Tobacco and Vapes Act create a timely opportunity to combine ambitious regulation with stronger prevention infrastructure.

This Fellowship explored how Denmark, Finland, Iceland, Norway and Sweden respond to youth vaping and novel nicotine products, and how their wider systems support children's health. It draws on four weeks of travel in 2025, open-ended interviews, site visits and desk research.

Across the Fellowship, several common system features emerged, including stronger local data systems, more consistent youth participation in decision-making, greater emphasis on resilience and protective factors, higher levels of trust and the application of Health in All Policies approaches. The report identifies practical lessons for the UK, both for nicotine policy and for strengthening the prevention systems that support young people more broadly.

The central finding is that Nordic countries rarely approach emerging challenges as isolated policy problems. Issues such as youth nicotine use, mental health and wellbeing are understood as outcomes shaped by wider systems of prevention, education, family support and community infrastructure.

Key Lessons

Part 1: Nicotine policy and regulation

The Nordic countries have adopted a range of approaches to regulating vaping and novel nicotine products, providing a valuable natural comparison for policymakers. Several common lessons emerged:

- Use the Tobacco and Vapes Act powers rapidly and comprehensively to regulate emerging nicotine products, such as nicotine pouches, with proportionate controls on nicotine strength, packaging, promotion and display.
- Improve surveillance of youth nicotine use across all nicotine products, including product transitions, dual use, and source of access.
- Strengthen independent research to address evidence gaps relating to product harms, patterns of use and cessation.
- Develop and evaluate a dedicated youth nicotine cessation pathway through youth-facing settings, alongside adult smoking and vaping cessation services.

Part 2: Wider Prevention Systems and Approaches

Across the Nordic region, prevention is embedded in everyday settings and supported by strong local infrastructure. Common themes included the use of schools as health promotion and prevention settings, local data systems that drive action, meaningful youth participation in decision-making, and approaches that build both protection and resilience. Key lessons for the UK include:

- Pilot an Ungdata-style survey-to-action model that returns validated local findings within the same academic term, strengthening feedback loops between national policy, local delivery and young people.
- Strengthen schools as universal prevention settings through whole-school approaches, social-norm interventions, accessible health provision and practical implementation support.

- Integrate family, health, education and community support locally through Family Hubs and neighbourhood structures, with longer-term funding and greater intensity where need is highest.
- Create stronger child-health accountability across government by embedding youth participation within local and national governance.

Taken together, these lessons would match the UK's regulatory ambition with an adaptive prevention system capable of identifying emerging harms, acting early and learning over time.

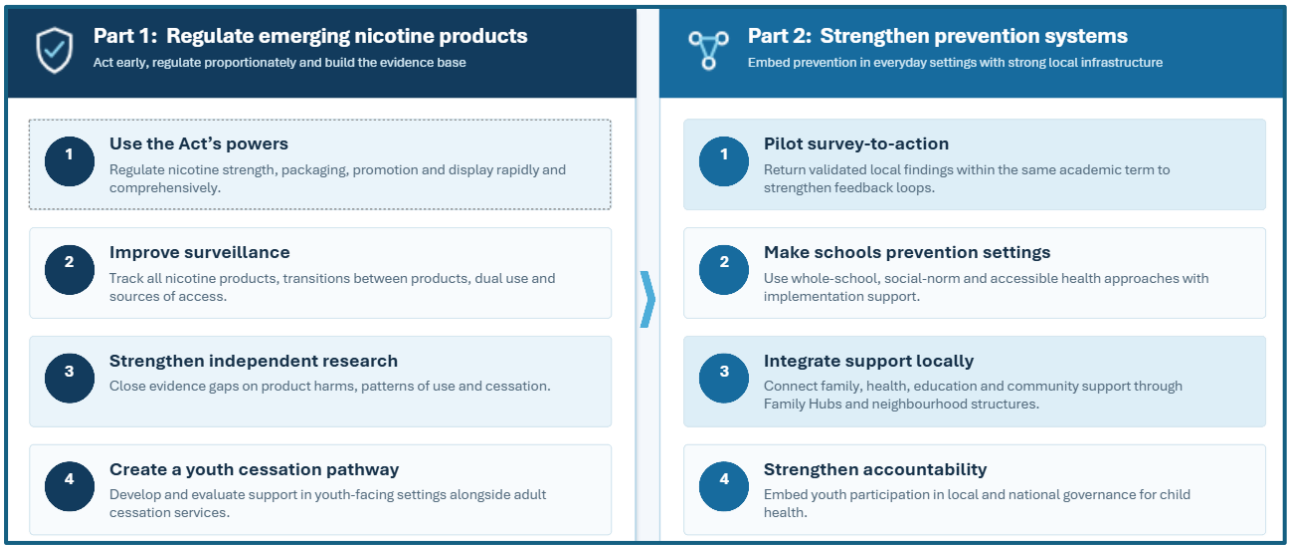


Figure 1. Eight recommendations across two linked priorities: regulating emerging nicotine products and strengthening prevention systems.

Introduction

The health and wellbeing of children is the foundation of a nation's prosperity, productivity and social wellbeing[1]. The United Kingdom (UK) is at a pivotal moment in how it protects and promotes the health and wellbeing of children and young people (CYP). Alongside long-standing public health challenges, a rapidly changing social, technological and commercial environment presents new and evolving risks. These include rising youth vaping and the emergence of novel nicotine products, growing concerns about adolescent mental health and exposure to digital harms, and the lasting effects of the Covid-19 pandemic on children's health and education services[2]. The UK has experienced a relative decline in several key indicators of child health, compared with many European countries, renewing interest in prevention and early intervention as means of improving health outcomes across the life course[3,4].

Denmark, Finland, Iceland, Norway and Sweden (collectively referred to as the 'Nordics') provide a valuable comparison point for the UK. Like the UK, they operate predominantly universal, tax-funded welfare and healthcare systems and face many similar pressures, including increasing healthcare demand, workforce shortages and constraints on public finances[5].

The Nordics are also responding to the rise in youth vaping and novel nicotine products but have adopted different approaches[6]. Finland and Denmark have acted earlier to reduce the appeal of vaping and nicotine products to CYP, while Sweden has adopted a more permissive, harm-reduction-oriented approach. These differing approaches provide valuable natural policy comparisons.

Over several decades, Nordic countries have generally invested more consistently in prevention and in the wider social, educational and community conditions that shape health across the life course[7,8,9]. Well-known examples such as the Icelandic Prevention Model[10], Finland's 'baby box' maternity package[11] and Norway's more recent restrictions on the marketing of unhealthy food and drink to children[12], illustrate how prevention has been embedded within wider public policy.

No international comparison is perfect, and Nordic systems and policies are not directly transferable to the UK. Nevertheless, three features make the Nordic countries particularly valuable comparators for this Fellowship. First, they have sustained long-term investment in prevention within universal welfare systems. Second, several Nordic countries achieve stronger outcomes in child health and wellbeing than the UK. Third, the countries have adopted divergent approaches to youth nicotine regulation, providing opportunities to examine the potential effects of different regulatory choices.

1) Strong welfare systems combined with long-term investment in prevention

The Nordic countries have developed successful economies alongside strong social outcomes and are frequently cited as examples of high-performing welfare states. Interest in the so-called 'Nordic Model' is longstanding, but widening inequality has renewed curiosity about how these nations appear to outperform many European counterparts, including the UK[13 14 15]. Although there is no single Nordic model, the countries share several characteristics, including extensive welfare provision, strong labour market participation, social investment and a commitment to universal access to healthcare, education and social security[16 17].

A distinguishing feature is their sustained emphasis on prevention and early intervention. Nordic countries have historically invested consistently in preventive services, early years support and local public health infrastructure, allocating a greater proportion of their healthcare budget towards preventive care than the UK[18.19]. This makes the Nordics a particularly relevant comparison point for the UK that is seeking to "shift upstream" towards prevention and address the wider conditions that shape children's health and wellbeing.

Much of this activity is delivered through decentralised systems of governance. Municipalities and regional authorities often hold statutory responsibility for health promotion and prevention, enabling local adaptation, longer-term planning and greater integration between services[20]. This differs from the UK's more centralised system and shorter funding cycles, which can create challenges for maintaining long-term preventive investment.

Another distinguishing feature is the high level of institutional and interpersonal trust reported across Nordic countries, among the highest in the world[21]. Evidence suggests trust plays an important role in social cohesion, policy implementation and engagement with public services[22]. Nordic countries also rank highly in international assessments of happiness, with trust, social security and lower inequality frequently cited as contributing factors[23].

It is important, however, to recognise that the Nordic countries differ from the UK in several important respects. They generally have smaller populations and different demographic and geographic contexts, as well as, on average, higher levels of wealth per person, which can provide greater fiscal flexibility than in the UK[24]. They also face challenges, including rising healthcare costs, ageing populations and continuing debates about the sustainability of welfare systems[25 26]. Nonetheless, they remain useful comparators because they demonstrate how long-term investment in prevention can be maintained within universal healthcare systems[27].

2) Greater wellbeing in children and young people compared with UK peers

The UK has experienced a relative decline in child health and wellbeing compared with many high-income countries[28]. International evidence suggests that UK CYP report lower life satisfaction, poorer subjective health and weaker wellbeing outcomes than many of their Nordic counterparts[2930].

Pressures on services are also evident. Only around one-third of children with mental health needs are estimated to receive treatment and over 78,000 young people waited more than a year for NHS mental health support in 2023/24[31]. Broader social determinants reinforce this picture, with child poverty estimated at approximately 22% in the UK, compared with under 10% in countries such as Norway and Iceland[32]. The Royal College of Paediatrics and Child Health's (RCPCH) *State of Child Health 2026* reports that almost all major indicators had worsened or stagnated since 2020, with outcomes consistently worse in deprived communities.

The Nordic countries place extensive support for children and families at the centre of public policy through subsidised childcare, generous parental leave, family services and formal mechanisms for youth participation[33,34,35]. In contrast, childcare costs in the UK

are among the highest in the developed world [36,37,38]. Their education systems also differ in important ways, including later school starting ages, stronger emphasis on play-based learning and less reliance on centralised testing. Together, these policies reflect a broader commitment to creating the social and economic conditions in which children can thrive.

These differences are reflected in international comparisons. UNICEF rankings consistently place several Nordic countries above the UK across measures of child wellbeing, mental wellbeing and physical health (**Table 1**). While this does not prove that Nordic policies alone are responsible for these outcomes, it provides a compelling rationale for examining how their approaches to prevention and child wellbeing differ from those adopted in the UK[39].

Table 1. Comparison of child wellbeing outcomes in the UK and Nordic countries

Indicator	United Kingdom	Nordic countries
Overall child wellbeing	21st of 36 countries	Denmark 2nd, Sweden 10th, Finland 17th, Iceland 22nd
Mental wellbeing	27th of 36 countries	Denmark 3rd, Sweden 14th, Finland 21st, Iceland 26th
Physical health	22nd of 43 countries	Denmark 3rd, Iceland 6th, Norway 9th, Sweden 13th, Finland 23rd

Note. Rankings are drawn from UNICEF Report Card 19 (2025) which compares child wellbeing across high-income countries using indicators of mental wellbeing, physical health, and academic and social skills. Lower rankings indicate better performance. Norway could not be included in the overall league table because comparable life satisfaction data was unavailable.

3) Divergent approaches to youth nicotine regulation provide valuable policy comparisons

Youth vaping is an emerging public health challenge. Although smoking rates continue to decline in the UK, vaping and other novel nicotine products have become increasingly popular among young people, raising new questions about regulation, prevention and cessation support.

The UK is a global leader in tobacco control, demonstrated by its recent strengthening of the regulatory framework through the Tobacco and Vapes Act. The Act introduces a smokefree generation, prohibits vape and nicotine product advertising and

sponsorship, and provides powers to regulate product packaging, flavours, nicotine content and retail displays[40].

In 2022, UK researchers concluded that vaping is less harmful than smoking in the short to medium term[41], and high-quality evidence continues to support the use of vapes as an effective smoking cessation tool for adults[42]. The UK Government therefore positions vaping as a smoking cessation aid for adults, while advising young people not to vape because of the risks of nicotine dependence and uncertain long-term health effects[43].

Despite this, youth vaping remains a concern. In 2025, one in five 11–17-year-olds, representing over 1 million children, reported having tried vaping, prompting increasing regulatory attention to product appeal and promotion [44]. The use of other novel nicotine products, such as nicotine pouches, also appears to be increasing among young people, although overall prevalence remains lower than for vaping[45].

Across the Nordic region, the use of vaping products and oral nicotine products is rising. Finland, Denmark and Norway have generally taken a more precautionary approach, while Sweden has adopted a more permissive approach. These contrasting approaches create an opportunity to explore how different regulatory choices may shape behaviour and what lessons may be relevant as the UK implements the next phase of regulation.

Taken together, these three features show that the Nordic countries offer more than a collection of individual policies or programmes. They provide an opportunity to examine how regulation interacts with education, family support, local governance and wider prevention infrastructure to shape outcomes for CYP. The remainder of this report explores the practical lessons these experiences may offer for UK policy and practice.

Aims and Objectives

This Fellowship examined how Nordic approaches to nicotine regulation and wider prevention systems could inform UK policy and practice. It had three objectives:

1. To examine how Nordic countries are regulating youth vaping and novel nicotine products, and what this reveals about regulatory design, enforcement and industry influence.
2. To explore the wider prevention systems supporting young people's health and wellbeing, including schools, municipalities and family services.
3. To identify practical lessons and transferable principles that could inform UK policy and wider systems that support children's health and wellbeing.

Methodology

Fellowship scope

This report draws on four weeks of travel across Iceland, Sweden, Norway, Finland and Denmark during August and September 2025, offering a snapshot of the policies, programmes and perspectives encountered.

Throughout the Fellowship, I shared reflections, insights and photographs through an accompanying blog. This report complements that material, by examining selected examples in greater depth and drawing out their potential implications for UK policy and practice.

Data collection

Given the novelty and breadth of the topics explored, and the importance of remaining flexible and responsive to emerging themes, I adopted an open-ended interview approach. This allowed emerging themes to shape subsequent discussion. I spoke with a wide range of stakeholders across each country, including policymakers, researchers, practitioners, municipality leads and public health professionals. This report combines insights from these discussions and site visits with relevant programme evaluations, policy documents and published research.

Analysis and interpretation

The evidence was reviewed comparatively to identify recurring themes, notable differences and examples with potential relevance to the UK. This report should therefore be read as a reflection of the perspectives encountered during the Fellowship, combined with personal observations and desk research. It is not intended as a comprehensive or representative synthesis of each national system, but rather a set of informed insights to support UK policy and practice.

Direct comparison is limited by differences in national contexts, terminology, datasets and survey methods. This is particularly important when comparing youth nicotine use, for which countries use different products, age groups and measures. Some of the policies and programmes considered were still being implemented or evaluated at the

time of writing, meaning that conclusions about their longer-term effectiveness cannot yet be drawn.

As much of this report is concerned with behaviour, the report draws on the COM-B model as a conceptual framework[46]. At the centre of the Behaviour Change Wheel, COM-B proposes that behaviour is shaped by three interacting factors: Capability (having the knowledge and skills to act), Opportunity (what their environment enables or restricts), and Motivation (what drives behaviour). Where relevant, the report considers Nordic policies and interventions through this lens.

Findings and Discussion

Part 1: Nicotine Policy and Proposals

Part 1 uses country case studies because the Nordic countries have made contrasting regulatory choices. The comparison highlights how timing, legal design, enforcement and market response shape outcomes and explores the lessons these experiences may offer as the UK implements the next phase of vaping and nicotine regulation.

The experiences described in this section can be viewed through the COM-B model (**Figure 2)** which provides a useful framework for understanding behaviour change and mapping how different policy interventions may influence youth nicotine use. The model proposes that behaviour is shaped by the interaction of three factors: Capability (knowledge and skills), Opportunity (environmental and social influences), and Motivation (beliefs, attitudes and drivers of behaviour). Many of the Nordic policies discussed in this report seek to influence one or more of these components.

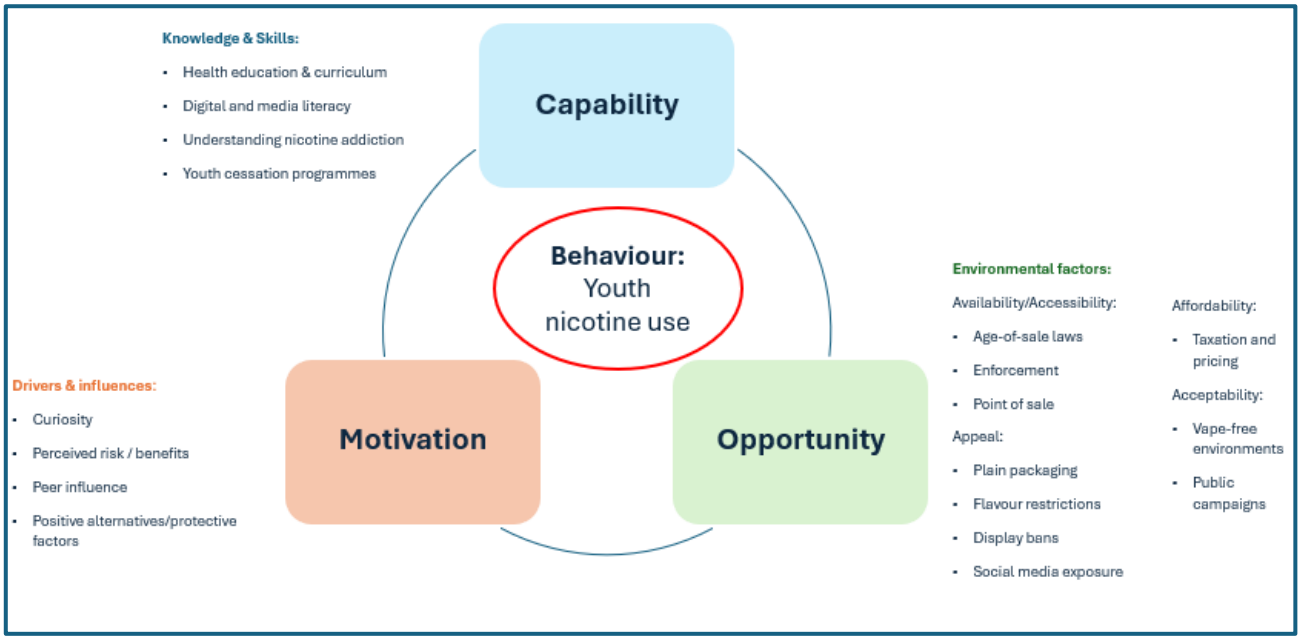


Figure 2. Application of the COM-B model to youth nicotine use. The diagram illustrates how nicotine use may be influenced by capability, opportunity and motivational factors. Adapted from *The Behaviour Change Wheel: A New Method for Characterising and Designing Behaviour Change Interventions* (Mitchie and others, 2011).

Regulatory Landscape: A Nordic Spectrum

Like the UK, the Nordic countries have implemented many measures recommended under the WHO Framework Convention on Tobacco Control and have often acted as policy innovators and early adopters[47]. Examples include Iceland's introduction of point-of-sale tobacco display bans, Sweden's expansion of smoke-free outdoor environments, Norway's introduction of plain packaging on tobacco products, Finland's early ban on characterising flavours in vaping products and Denmark's extension of plain packaging requirements to vaping products[48]. Viewed through the COM-B lens, many of these measures seek to influence the opportunities available for youth nicotine use by reducing product availability, accessibility, affordability or appeal.

Approaches to vaping and novel nicotine products nevertheless vary considerably across the region, creating a useful basis for comparison with the UK. **Table 2** summarises, at a high level, how the UK and Nordic countries currently regulate vapes and nicotine pouches, including age of sale, advertising, point-of-sale display restrictions, packaging requirements, flavour restrictions and smoke-free or nicotine-free places.

The resulting policy landscape reflects different 'endgame' ambitions. Finland has an explicit statutory goal to end the use of tobacco and other nicotine-products by 2030, while Norway has articulated ambitions consistent with a tobacco-free society[49] [50]. Sweden has pursued a smoke-free ambition, commonly defined as a daily smoking prevalence below 5% which it aimed to achieve by 2025, and Denmark's national control strategy seeks to create a smoke-free generation by 2030.

Comparing patterns of youth vaping and nicotine use across countries is challenging because national surveys use different methodologies. In Sweden and Norway, snus[i] has a longstanding role in nicotine consumption and remains an established component of youth nicotine use. This is distinct from tobacco-free nicotine pouches, which have expanded rapidly across Nordic markets in recent years[51].

[i] Snus is a form of oral tobacco that is prohibited for sale in the UK and the EU, with Sweden retaining an exemption from the EU-wide prohibition on the sale of oral tobacco.

While youth nicotine use in the UK remains primarily associated with vaping, awareness and use of nicotine pouches[ii] has increased in recent years. Since they entered the market in 2019, the UK has experienced a growing presence of nicotine pouch advertising (**Annex A**) with marketing often positioning these products as a modern, convenient, and lower-risk alternative to smoking[52] [53]. This marketing strategy has drawn comparisons with techniques historically used to promote tobacco products, including the use of lifestyle branding, attractive packaging and associations with independence, freedom and social identity[54].

Although vaping and nicotine pouches are likely to expose users to far fewer harmful substances than combustible tobacco products, concerns remain around nicotine dependence, youth uptake and long-term health effects, prompting increasing regulatory attention[55] [56].

The UK has begun to strengthen its regulatory response to novel nicotine products. However, Nordic countries have acted at different speeds and adopted different approaches. These differences create a natural policy landscape for examining whether the timing, design and implementation of interventions may influence youth nicotine use.

The following case studies illustrate a range of policy responses adopted across the Nordic region and consider the lessons they may offer the UK.

[ii] Nicotine pouches are tobacco-free oral nicotine products. Data from the Smoking Toolkit Study found that, among 16–24-year-olds in Great Britain, nicotine pouch use increased from 0.7% in January 2022 to 4% in March 2025. The ASH YouGov Youth 2026 Survey reported about 1.1% of 11-17-year-olds in Great Britain currently use nicotine pouches and almost half (48%) are aware of them.

Table 2. Illustrative comparison of regulatory approaches to vaping and nicotine products in the UK and Nordic countries

Country	Product	Minimum age of sale	Advertising restrictions	Display restrictions	Plain packaging	Flavour restrictions	Vape-free places
Sweden	Vapes	18y ✓	~	~	✗	✗	✓
	Pouches	18y ✓	~	~	✗	✗	
Norway	Vapes[1]	18y ✓	✓	~	~	✓	✓
Denmark	Vapes	18y ✓	✓	~	✓	✓	✓
	Pouches	18y ✓	✓	~	✓	✓	
Finland	Vapes	18y ✓	✓	~	✓	✓	✓
	Pouches	18y ✓	✓	~	✓	✓	
Iceland	Vapes	18y ✓	✓	~	✗	✗	~
	Pouches	18y ✓	✓	~	✗	✗	
UK	Vapes	18y ✓	✓†	✗	✗	✗	✗
	Pouches	✓†[2]	✓†	✗	✗	✗	

Note. *Adapted from the Nordic Welfare Centre 'Use of nicotine products among youth in the Nordic and Baltic countries (2025) (Table 2, p.25) and Tobacco Control Laws. The table is intended to provide a high-level illustration of regulatory approaches. Regulatory frameworks differ in scope, implementation and enforcement, and some measures apply differently across product categories.* ***Key*** *✓ implemented; ~ partial; ✗ no specific restriction.* [1] Nicotine-containing vapes are not currently permitted for ordinary sale in Norway. [2] † reflects requirements introduced by the UK Tobacco and Vapes Act but not yet in force at the time of writing.

Sweden

Legislative context

In Sweden, nicotine products are regulated under the Law on Tobacco and Similar Products[57]. Vape packaging must carry health warnings, but plain packaging is not required, and there are currently no flavour restrictions. Advertising is restricted, yet non-intrusive point-of-sale display remains permitted[58].

Snus is sold legally under a longstanding exemption from the EU ban on the sale of oral tobacco products[iii]. It is consumed by placing a pouch of powdered tobacco leaves under the lip, allowing nicotine to be absorbed through the oral mucosa. It is often confused with 'nicotine pouches', which are tobacco-free products and, under Swedish law, are regulated under a broadly similar framework to vaping products.

Regulatory and evidence gaps

A recurring theme in discussions was that nicotine pouches expanded rapidly in an environment where regulation lagged behind product innovation. Nicotine pouches were introduced in Sweden in the mid-2010s but were not brought under a dedicated regulatory framework until 2022. During this period, the market expanded rapidly, using appealing flavours, branding and design features that broadened their appeal to women and young people.

Since 2022, Sweden has introduced a regulatory framework for tobacco-free nicotine products, including a minimum age of 18. However, regulation of nicotine pouches remains relatively permissive, compared with other Nordic countries. For example, there is currently no maximum limit on nicotine strength, while partial advertising restrictions[iv] remain relatively limited.

Concerns have emerged that the expansion of these products may be shifting nicotine use towards new groups who historically had relatively low rates of tobacco or snus use,

[iii] Snus is a traditional Swedish oral tobacco product, with origins dating back to the sixteenth century. It remains widely used in Sweden, where approximately 14% of adults reported daily snus use in 2024. Snus use includes at least 28 carcinogens and is associated with a range of health risks (IARC, 2018).
[iv] Sweden allows a partial exemption for commercial advertising directed exclusively at adults aged 25 and older.

such as CYP and women. For example, the Swedish Council for Information on Alcohol and Other Drug's (CAN) national school survey reported that, in 2024, approximately 25% of Year Nine pupils and 40% of students in the second year of upper secondary school reported trying pouches[59].

The international evidence base for nicotine pouches remains limited, particularly long-term evidence on their health effects. Recent reviews conclude that nicotine pouches are likely to expose users to fewer harmful constituents than cigarettes and some traditional smokeless tobacco products, suggesting potential for harm reduction among people who switch completely from smoking[60,61]. However, both reviews emphasise that long-term epidemiological evidence is lacking and that the overall public health impact remains uncertain. Concerns regarding youth initiation and whether nicotine pouches may attract people who would otherwise not have used nicotine or tobacco products at all persist.

Most concerns relate to nicotine dependence, particularly because some nicotine pouch products contain nicotine concentrations substantially higher than those found in many cigarettes or vaping products[62]. Emerging evidence has also raised concerns about oral health effects, including gum irritation and mucosal lesions, and some studies have identified potentially harmful chemical constituents, although exposure levels and long-term clinical significance remain uncertain[63 64 65].

Importantly, a large share of published evidence on nicotine pouches has received funding from, or involved authors affiliated with, the tobacco and nicotine industry[66]. Independent research remains comparatively scarce, limiting confidence in current estimates of long-term health effects and smoking cessation effectiveness. Researchers at the University of Gothenburg and elsewhere have called for high-quality, independent longitudinal studies to clarify patterns of use, health impacts and the potential role of nicotine pouches in smoking cessation[67].

“The Swedish experience”



Sweden is frequently presented as an international public-health success story: while oral nicotine use is widespread, it has one of Europe's lowest rates of daily cigarette smoking[68]. This combination has contributed to the development of what is commonly described as the "Swedish experience", “Swedish example” or "Swedish model" – the proposition that widespread availability and use of lower-risk oral nicotine products can contribute to reductions in cigarette smoking and therefore represents an effective tobacco harm-reduction approach[69]. This narrative has been actively promoted by tobacco and nicotine industry actors and subsequently used in campaigns and advocacy internationally.

However, discussions throughout the Fellowship reinforced that the Swedish experience should not be interpreted as evidence that the availability or use of a single nicotine product alone explains Sweden’s low smoking prevalence. In fact, public health authorities and researchers offer a broader interpretation, emphasising that the decline in smoking has occurred alongside broad and sustained tobacco-control measures over several decades, including smoke-free environments, taxation, advertising restrictions, age restrictions and other prevention measures[70 71 72 73]. The Public Health Agency of Sweden also highlights evidence that use of snus and vapes is associated with an increased risk of later cigarette smoking. It therefore notes that tobacco prevention needs to encompass nicotine prevention, and that more consistent regulation of nicotine products, more aligned with the regulation of cigarettes, would strengthen protection for young people.

The Swedish experience therefore provides a more complex lesson than the simple proposition that oral nicotine products have driven Sweden's low smoking rates. Sweden demonstrates that very low cigarette smoking can coexist with widespread oral nicotine use, but this has occurred within the context of decades of comprehensive tobacco control. At the same time, the rapid growth of nicotine pouches and vapes among young people raises questions about whether the expansion of newer nicotine

products is reducing cigarette use, shifting nicotine use between products, encouraging dual or multiple-product use, or bringing nicotine use into groups who might otherwise not have used nicotine at all.

Key learnings

- **Sweden's low smoking prevalence should not be attributed to a single product.** Sweden's low smoking prevalence reflects sustained, system-wide tobacco control rather than simply the availability of snus or nicotine pouches alone. This illustrates the importance of critically evaluating policy narratives, particularly those promoted by organisations with commercial interests.
- **The risks of regulatory delay.** The rapid growth of nicotine pouches shows the risk of allowing a new market to become established before regulation catches up.
- **A significant evidence gap.** Despite growing use, independent evidence on the health effects of nicotine pouches remains limited. Robust conclusions cannot yet be drawn regarding their long-term safety or their potential effectiveness as a smoking cessation aid.

Case Study 1a: The Swedish Experience

KEY LESSON

Sweden's experience highlights the importance of regulating emerging nicotine products early and comprehensively.

WHAT HAPPENED

- Sweden has a long-standing cultural association with snus and is frequently cited internationally as an example of tobacco harm reduction.
- Nicotine pouches entered the Swedish market in the mid-2010s and expanded rapidly.

CHALLENGES IDENTIFIED

- Rapid market expansion through flavours, attractive packaging & extensive marketing.
- Emerging evidence suggests risk of nicotine addiction and potential oral health effects, but independent, long-term data remains limited.

POLICY IMPLICATIONS

- Interpret evidence cautiously and consider broader tobacco control context when assessing claims about the Swedish experience.
- Use Tobacco and Vapes Act powers proactively to introduce nicotine strength limits and reduce product appeal before pouches become entrenched among new youth cohorts.
- Invest in independent research and surveillance on pouches, including long-term health outcomes and patterns of use among young people, and transition between pouches and other nicotine products.

Finland

Legislative context

In 2016, Finland introduced one of the world's earliest and most comprehensive regulatory frameworks for vaping products, through reforms to its Tobacco Act (549/2016). These reforms were designed both to prevent youth uptake of vapes and to support Finland's goal of ending the use of tobacco and other nicotine products by 2030[74] .

Key measures included:

- a ban on all characterising flavours in vape liquids (except for tobacco);
- retail licensing requirements;
- a ban on distance sales;
- taxation;
- advertising and display bans, and
- inclusion of vapes in smoke-free environments.

More recently, Finland extended regulation to nicotine pouches through amendments to the Tobacco Act. These introduced restrictions on flavours, a maximum nicotine limit of 16.6 mg/g, product notification requirements, retail controls, and packaging and labelling requirements[75] [76].

Precautionary regulation and implementation challenges



Finland's approach reflects a precautionary regulatory stance. With the objective of becoming nicotine-free, policymakers acted early to introduce stricter controls on vapes. The flavour restrictions are particularly significant: characterising flavours in liquids intended for vaporisation are prohibited, meaning vape liquids are effectively limited to tobacco flavour[77].

Early monitoring suggested that daily youth vaping declined between 2015 and 2021, while smoking continued to fall[78]. However, from 2021 onwards, increasingly appealing disposable vapes, and new product designs

circumvented the regulatory controls, and youth vaping subsequently rose among both girls and boys.

Implementation of the flavour ban has also raised enforcement challenges. Following the introduction of flavour restrictions, the market adapted through practices such as selling flavour concentrates separately for 'do-it-yourself' mixing and marketing nicotine free flavoured products as food-grade flavourings. This created uncertainty about whether some products fell within the scope of the legislation and prompted legal challenges from retailers, leading to a series of appeals to regional administrative courts[79].

Key learnings

- **Early action can prevent emerging trends from becoming established.** Finland's approach reflects a precautionary regulatory stance, with policymakers acting early to reform legislation and reduce the appeal of vaping products to young people. This was enabled both by a clear national objective to become nicotine-free and by a legislative framework that allowed vaping products to be incorporated within a wider tobacco control framework.
- **Regulations should anticipate industry adaptation.** Finland's experience demonstrates the practical challenges of implementation and the need for legislation to be designed with future product innovation in mind. For example, the repurposing of food flavour concentrates to create DIY e-liquids at home illustrates the capacity of industry to identify and exploit regulatory loopholes, reinforcing the need for clear legal definitions, and active market surveillance.
- **The long-term effects of flavour restrictions require continued evaluation.** While flavour restrictions may reduce product appeal and youth uptake, robust international evaluations are needed to understand the longer-term effects on youth vaping, adult smoking cessation, product substitution and illicit markets.

Case Study 1b: The Finnish Flavour Ban

KEY LESSON

Finland's experience highlights the importance of designing regulations that anticipate industry adaptation and emerging product innovation

WHAT HAPPENED

- Finland adopted one of Europe's most restrictive approaches to vaping products, including a ban on characterising flavours.
- The primary aim was to reduce the appeal of vaping products to children and young people.
- Initial monitoring suggested that youth vaping remained low whilst smoking continued to decline, supporting the rationale for early action.

CHALLENGES IDENTIFIED

- Industry adaptation, including the repurposing of food flavour concentrates and nicotine free liquids, created enforcement complexity.
- Disposable vapes and new product designs emerged that were not fully captured by existing definitions, leading to renewed increases in youth vaping.

POLICY IMPLICATIONS

- Anticipate industry responses when designing new controls. Policymakers should expect attempts to circumvent restrictions through product redesign, marketing and classification.
- Extend protections across product categories and keep regulatory frameworks under review, updating them as markets evolve.
- Strengthen evaluation of flavour restrictions to understand impacts of youth uptake, adult smokers, product substitution and illicit markets.

Denmark

Legislative context

In Denmark, nicotine products are regulated across several laws, including the *Law on Tobacco Products*, *Law on Electronic Cigarettes*, and age-of-sale legislation[80]. Since 2019, regulation has been strengthened significantly through targeted youth prevention policies and a national prevention plan focused on reducing youth nicotine uptake.

Key measures include:

- plain packaging with health warnings,
- flavours restricted to tobacco and menthol only,
- a ban on the advertising, sponsorship, and distribution, and,
- a requirement that products are not visible at the point-of-sale.

Nicotine pouches are regulated as 'tobacco surrogates'. From 1 July 2025, new Danish requirements introduced a maximum nicotine content of 9 mg per pouch, a restriction limiting flavours to tobacco and menthol only and introduced plain packaging requirements.

Youth nicotine cessation



The international evidence base on nicotine and vaping cessation for young people remains limited, predominantly US-centric, and lacks robust longitudinal data[81]. While regulatory measures may reduce youth uptake, dedicated cessation support is needed for young people who are already dependent on nicotine products. This remains an important evidence gap for policymakers.

Denmark's U-Niko programme (*Unge uden nikotin* or *Youth without nicotine*) is one of the most substantial efforts to address this gap[82]. It is a two-arm cluster randomised controlled trial involving young people aged 16–25 across 55 Danish municipalities who use at least one tobacco or nicotine product and wish to quit. Twenty-seven municipalities were allocated to the U-Niko intervention group and 28 to

the control group, which continues with usual tobacco and nicotine cessation recruitment and counselling.

The nationwide field trial is designed to test whether a structured, youth-oriented cessation approach can improve municipal nicotine cessation support. The intervention targets three areas:

- Training of counsellors who support young people to stop using nicotine products.
- Improving recruitment pathways into tobacco and nicotine cessation services.
- Delivering structured cessation programmes for young people.

Its primary outcomes will assess three areas: (i) counsellors' self-efficacy in providing youth cessation counselling, (ii) the number of young people recruited into cessation counselling, and (iii) self-reported 14-day point prevalence abstinence at six months. Secondary outcomes include short-term self-reported abstinence, continuous self-reported abstinence and validated 14-day point prevalence abstinence at six months.

This makes U-Niko a particularly significant case study for the UK to continue to monitor because it evaluates cessation support in real-world municipal settings. It also recognises that young people may use a range of nicotine products, including cigarettes, vapes, nicotine pouches, and smokeless tobacco, and that cessation support needs to respond to patterns of use beyond smoking alone.

Key learnings

- **Regulation should be accompanied by a youth-appropriate support service for nicotine dependence.** The UK should closely monitor U-Niko's findings and test a structured youth cessation model. A possible UK adaptation could include dedicated training for youth cessation practitioners, a proactive recruitment strategy using schools, colleges, sports clubs and youth services, and a structured multi-session cessation course, tested across a small number of local authorities.

- **Support should be youth-centred and holistic, addressing all nicotine products.** Emerging UK practice, including pilots such as the Alder Hey vaping clinic, suggests that nicotine use may cluster with wider vulnerabilities, including mental health challenges and the use of other nicotine, tobacco or other substances. Services should therefore create opportunities to identify and address broader health and wellbeing needs.
- **Youth cessation can sit alongside adult smoking cessation.** Denmark's approach suggests that youth cessation support and adult stop-smoking services can operate as complementary parts of the same prevention system by ensuring emerging patterns of youth nicotine use are addressed early, while maintaining support for adult smokers.

Case Study 1c: Denmark's U-Niko Youth Nicotine Cessation Programme

KEY LESSON

Denmark's U-Niko programme highlights the importance of investing in and evaluating dedicated youth nicotine cessation interventions.

WHAT HAPPENED

- Denmark has strengthened regulation of vaping and nicotine products as part of a broader strategy to reduce youth nicotine use.
- Alongside regulatory measures, Denmark is testing dedicated youth nicotine cessation support.
- U-Niko is a large-scale RCT trial involving 16–25-year-olds across 55 municipalities.
- It evaluates not only CYP outcomes, but also counsellors' confidence and capability in delivering nicotine cessation support.

CHALLENGES IDENTIFIED

- There is limited evidence on effective youth nicotine cessation interventions.
- Young people use a range of nicotine products, requiring services that go beyond smoking cessation alone.
- Services need to reach young people in settings where young people can easily access support.

POLICY IMPLICATIONS

- Monitor U-Niko outcomes closely to inform future UK youth nicotine cessation policy.
- Test dedicated youth interventions rather than relying on adult stop-smoking services.
- Design services around nicotine dependence across products, including vapes, pouches, cigarettes and emerging nicotine products.
- Deliver support through youth-facing settings to improve access and engagement.

Norway



Legislative context

In Norway, nicotine products are regulated under the Tobacco Control Act. A ban on new tobacco and nicotine products, introduced in 1989, was replaced in 2021 with an approval system, requiring all novel products to be authorised by the Norwegian Directorate of Health. In practice, this means nicotine-containing vapes, refill containers and tobacco-free nicotine pouches are not currently permitted for ordinary sale in Norway[83]. The Directorate of Health has rejected applications for tobacco-free nicotine pouches, citing concerns including their potential appeal to children.

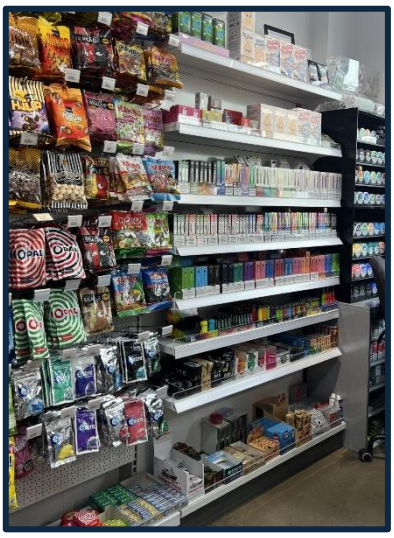
By contrast, snus remains legal because Norway, like Sweden, is exempt from the European prohibition on oral tobacco products. This creates an unusual regulatory distinction: tobacco-free nicotine pouches cannot legally be sold, while "white snus" is permitted because it contains small amounts of tobacco and is therefore regulated as snus rather than as a tobacco-free nicotine product[84]. Norway has also tightened wider controls in recent years, including a flavour ban for nicotine-free vapes and restrictions on cross-border sales.

Key learnings

- **The importance of monitoring cross-border, online and other informal supply channels when domestic restrictions are stringent.** Despite these restrictions, Norwegian data shows substantial youth use of vaping, snus and nicotine pouches[85].
- **Restrictive regulation involves policy trade-offs.** The Norwegian Directorate of Health explicitly considers the potential appeal of new products to young people when assessing applications. Discussions during the Fellowship highlighted the ongoing debate about how to balance the prevention of nicotine initiation among CYP and ensuring that adult smokers have access to alternative, less harmful nicotine products.

Iceland

Legislative context



In Iceland, nicotine products are regulated under the Act *on Nicotine products, E cigarettes, and Refills*. Both vapes and nicotine pouches must carry health warnings, and advertising is prohibited and point-of-sale display is restricted, except in specialist stores. Vaping is prohibited in schools and other settings where CYP are present. Iceland does not currently prohibit flavours, although legislation provides enabling powers for future restrictions. Nicotine pouches are subject to a 20 mg/g maximum nicotine content, aligned with the limit of vapes[86].

Iceland has a strong history of tobacco control, however, discussions highlighted concerns that the infrastructure developed to reduce smoking has not been transferred fully to newer nicotine products. The shift in product use is particularly evident among young adults, with comparative data indicating high levels[v] of nicotine use among young people compared with other Nordic countries and prompting concerns about youth uptake and attractiveness of newer nicotine products[87].

Against this backdrop, Iceland introduced a tiered taxation system on nicotine pouches from 1 January 2025, with rates increasing according to nicotine concentration, alongside a ban on products exceeding 20 mg/g. The Directorate of Health reported an initial decline in nicotine pouch use during the first quarter of 2025 following the introduction of the revised tax measures[88]. While it is too early to determine whether this reflects a sustained trend, the finding provides an early indication that pricing may influence youth consumption.

Key learnings

- **Taxation can be designed around nicotine content**. Iceland provides an early example of combining a nicotine strength cap with nicotine content taxation,

[v] In 2023, 33% of Icelanders aged 18-24 reported daily or occasional use of oral nicotine products.

increasing the financial cost of higher-strength products. While early monitoring suggests a decline in nicotine pouch use, longer-term evaluation is needed to distinguish effects on use from substitution or illicit purchasing.

- **Regulation must be supported by prevention and cessation infrastructure.** Iceland's experience suggests that success in reducing smoking does not automatically translate into control of newer nicotine products. Regulation should be accompanied by accessible cessation provision covering all forms of nicotine use.

Key learnings from Part 1: Nicotine policy

1. **Act early before products become entrenched.** Finland demonstrates a precautionary approach, while Sweden illustrates the challenges of regulating products once they have become entrenched. Delays can allow rapid market expansion and increase the likelihood of products becoming normalised in CYP.
2. **Design regulation with industry adaptation in mind.** Finland and Norway show how manufacturers and retailers can respond to restrictions through product reformulation and product designs. Regulations should therefore be supported by clear, future-proof legal definitions, active market surveillance and regular review as products and markets evolve.
3. **Strengthen the independent evidence base.** Given the novelty of many nicotine products, important evidence gaps remain, particularly around long-term health effects, patterns of use, product transitions and the toxicology of flavourings. Strengthening the international evidence base would support both measures to reduce youth appeal and improve understanding of product safety, while helping to clarify the potential role of novel products in smoking cessation.
4. **Continue investment in enforcement and market surveillance.** Legislation is only effective if supported by adequate enforcement capacity. A consistent challenge across the Nordic countries was online sales, social media promotion and cross-border purchasing. Discussions highlighted concerns that products marketed and sold through social media channels can be more difficult to monitor and enforce than products sold through traditional retail settings.
5. **Develop dedicated support for youth nicotine dependence**. Denmark's U-Niko trial provides a valuable example of structured, youth-oriented cessation support being tested in real-world settings. The UK should consider how cessation services can evolve to support all forms of nicotine dependence while maintaining a strong focus on adult smoking cessation. Consideration should also be given to strengthening workforce capability so that professionals working with young people are equipped to address nicotine dependence.

Part 2: Wider Preventative Care and Youth Systems

Part 2 explores examples of upstream prevention, organised by setting and system features. It examines how schools, municipalities, families and community services can reduce risks, build protective factors and respond earlier.

The final section examines the wider system features that appeared repeatedly throughout the Fellowship, including data, youth participation, resilience, trust and Health in All Policies.



Schools as Health Promotion and Prevention Hubs

Across the Nordics visited during the Fellowship, schools emerged as important settings for prevention. As universal services, schools provide a unique opportunity to reach almost all CYP, regardless of background, making them a powerful platform for improving health and wellbeing at population level.

- The holistic role of school nurses and school doctors (Finland)
- The KiVa anti-bullying programme (Finland)
- Health and Life Skills education (Norway)
- Embedding physical activity throughout the school day (Denmark)

Finland: Redefining the role of a school nurse

Finland provides a strong example of a whole-school approach to health and wellbeing[89]. Wellbeing is embedded within both the national curriculum and school culture, and young people have a legal right to pupil welfare services as part of their education[90]. Schools are required to provide access to multi-professional pupil welfare services, including school nurses, doctors, psychologists and social workers.

As a result, early intervention and health promotion are integrated into school life, with services designed to support all pupils, not only those already experiencing difficulties School nurses play a particularly important role, taking a holistic view of pupils' physical, emotional and social wellbeing[91]. Regular health and wellbeing reviews provide opportunities to discuss a broad range of issues, such as sleep, physical activity, screen time, digital wellbeing, relationships and nicotine use. These interactions provide opportunities to identify emerging concerns and connect pupils with wider support services[92].Although Finland faces workforce pressures, resource constraints and growing demand for support[93], the model demonstrates the value of maintaining a visible and universal health service within schools.

Key learning:

- **Embed health promotion within universal school services.** Finland demonstrates the value of school nurses as more than providers of clinical care. As visible members of multidisciplinary teams, they support children's physical, mental and social wellbeing, identify emerging concerns and connect pupils with wider support. This provides an accessible route to prevention and early intervention without requiring children to identify themselves as needing help.

What this means for the UK:

- The Finnish model makes the case for strengthening the role of UK school-based health services as visible, universal prevention settings. It highlights the need for more consistent access across local areas, better utilisation of existing services through closer integration with GPs and wider children's services and more structured opportunities to engage families.

Case Study 2a: Finland – Redefining the Role of the School Nurse

KEY LESSON

Finland's embedded, multidisciplinary school health model highlights the value of providing accessible support within schools and identifying concerns before they escalate.

WHAT HAPPENED

- Finland provides universal, legally mandated school health services in every school.
- Services are delivered through multidisciplinary teams, including school nurses, psychologists and social workers.
- Support is embedded within the school environment and available to all children and young people.

CHALLENGES IDENTIFIED

- Workforce requirements. Maintaining universal access requires sustained investment in specialist staff.
- Coordination across services. Effective delivery depends on strong integration between education, health and social care.
- Rising demand. Increasing needs relating to mental health and wellbeing place additional pressure on school-based services.

POLICY IMPLICATIONS

- Normalise help-seeking. Embedding support within schools may reduce stigma and barriers to accessing help.
- Prioritise early intervention. Accessible services can enable concerns to be identified and addressed before they escalate.
- Take a whole-school approach. Multidisciplinary teams can support children's physical, mental and social wellbeing in a coordinated way.
- Consider the role of school-based health professionals. School nurses and wider wellbeing teams may provide an accessible route into health and support services for children and young people.

Finland: KiVA antibullying programme

KiVa (from *Kiusaamista Vastaan*, meaning 'against bullying') was developed by researchers at the University of Turku following a Finnish government initiative to strengthen national approaches to bullying in 2006. Rather than focusing solely on the perpetrator and the victim, KiVa targets the wider peer group, particularly bystanders, recognising that bullying is often reinforced by how classmates respond. The programme combines universal lessons and activities designed to build empathy and encourage pupils to defend victims, with a structured school response when individual cases of bullying are identified.

KiVa has an unusually strong evidence base for a school-based prevention programme. A nationwide rollout evaluation involving 888 schools and around 150,000 pupils found reductions in both bullying and victimisation within the first nine months of implementation, equivalent to an estimated 12,500 fewer victims and 7,500 fewer bullies nationally[94]. The programme has also been associated with improvements in school engagement, academic motivation and attainment[95].

Evidence outside Finland is also encouraging. A large-scale Dutch study found greater reductions in bullying and victimisation in KiVa schools than in control schools, with effects increasing after two years, while a UK trial found KiVa was effective at reducing bullying victimisation[96] [97].

Key learning:

- **Address the social environment in which behaviour occurs, not just individual behaviour.** KiVa demonstrates the value of interventions that seek to change the peer environment in which behaviour occurs, rather than relying solely on individual education or behaviour change. By mobilising bystanders and changing classroom norms, the programme seeks to reduce the social rewards that sustain bullying

What this means for the UK:

- There is a useful parallel with ASSIST (A Stop Smoking in Schools Trial), a Welsh-developed peer-led smoking prevention intervention that identifies influential pupils and trains them to promote non-smoking norms through informal conversations within their friendship networks[98]. Although KiVa and ASSIST address different outcomes, both use a similar prevention logic: harnessing peer influence to shift social norms and behaviour.
- The comparison suggests a wider opportunity for UK prevention and nicotine policy: rather than relying primarily on adult-led health education, schools could make greater use of peer networks, influential pupils and positive social norms to address behaviours such as vaping, nicotine use and other risk behaviours. This may be particularly valuable during adolescence, when peer influence becomes increasingly important.

Case Study 2b: Finland – KiVa anti-bullying programme

KEY LESSON

KiVa demonstrates how a whole-school programme can reduce bullying by changing peer norms and bystander behaviour, rather than relying solely on individual education.

WHAT HAPPENED

- KiVa was developed in Finland to prevent bullying by targeting the wider peer group, not only the child bullying or the child being bullied.
- The programme combines universal lessons for all pupils with indicated actions when specific bullying cases are identified.
- A UK multicentre cluster randomised trial found reductions in self-reported bullying victimisation and favourable ongoing costs after the first year.

CHALLENGES IDENTIFIED

- Effects depend on consistent implementation, requiring training, time and leadership.
- The programme is not a standalone solution; wider school culture and the quality of implementation are important to sustaining impact.

POLICY IMPLICATIONS

- Consider designing nicotine and wider youth prevention interventions to address peer networks, social norms and the wider school environment, rather than relying primarily on individual knowledge or adult-led health education.

Norway: Health and Life Skills in Education

In 2020, Norway introduced Public Health and Life Skills *(Folkehelse og livsmestring)* as one of three mandatory interdisciplinary themes within the national core curriculum[99]. The reform aims to promote physical and mental health by helping young people develop the knowledge, skills and attitudes needed for "mastering one's own life".

The reform was introduced in response to concerns about increasing mental health symptoms and declining emotional wellbeing among Norwegian CYP, alongside rising academic pressure, stress and the influence of social media. The curriculum covers physical and mental health, healthy lifestyle behaviours, sexuality and gender, substance use, media and digital consumption, personal finance, relationships, emotional regulation, values and meaning in life[100]. Rather than treating health as a discrete subject, these themes are intended to be embedded across the curriculum and reinforced through everyday school experiences.

However, implementation has not been without challenges. Delivery varies between schools, partly reflecting differences in teacher confidence, interpretation and available guidance. While teachers broadly support the aims of Public Health and Life Skills, research suggests some remain uncertain about how the themes should translate into classroom practice[101]. The ongoing Health, Learning and Life Skills (HeaLS) research programme will provide important evidence on how different approaches to implementation affect pupils' mental health and quality of life[102].

Key learning

- **Embed prevention across the school experience.** Norway demonstrates the potential of moving beyond discrete health-education lessons towards a broader curriculum and school culture that develops young people's resilience and critical judgement and life skills. Rather than treating health as a standalone subject, health and wellbeing are reinforced across the curriculum and through everyday school experiences.

- **Treat resilience and life skills as a core educational outcome.** Coping, relationships, mental health, critical judgement and everyday decision-making are framed as core educational outcomes and reinforced across subjects and school culture. While England's RSHE curriculum addresses similar topics, the Norwegian approach raises the question on whether resilience, critical judgement and life skills could be more consistently embedded across the wider curriculum. The findings of the *HeaLS* research programme will be particularly relevant to this question.

What this means for the UK:

- The Norwegian approach highlights the potential value of reinforcing health and wellbeing across multiple subjects and everyday school experiences, rather than relying solely on dedicated health lessons. The UK could consider how existing health and relationships education can be better connected across the curriculum and reinforced through the wider school environment.

Case Study 2c: Norway's Public Health and Life Skills

KEY LESSON

Norway's approach highlights the potential of embedding health and wellbeing as a core educational outcome, but its long-term impact on young people's health is under evaluation.

WHAT HAPPENED

- In 2020, Norway introduced Public Health and Life Skills as a cross-cutting theme within the national curriculum in response to concerns about worsening mental health.
- The curriculum covers physical and mental health, healthy lifestyle behaviours, sexuality and relationships, substance use, digital consumption, personal finance, emotional regulation, and meaning and purpose in life.
- These themes are embedded across multiple subjects and incorporated into wider school culture.

CHALLENGES IDENTIFIED

- Implementation variation: Schools may interpret and deliver the curriculum differently, creating variation in pupils' experiences.
- Workforce capability: Effective delivery requires teachers to feel confident discussing health, wellbeing and life skills topics.
- Measuring impact. It can be challenging to isolate the impact of curriculum changes on mental health and wellbeing outcomes.

POLICY IMPLICATIONS

- Monitor findings closely. The Health, Learning and Life Skills (HeaLS) research programme may provide valuable evidence on whether curriculum-based approaches improve mental health, wellbeing and quality of life.
- Consider whole-school approaches. Embedding health and wellbeing across multiple subjects may provide an alternative to standalone health education.
- Strengthen prevention. Integrating life skills into everyday learning may help support resilience, emotional wellbeing and healthy decision-making.
- Learn from implementation. Future policy should consider both the content of the curriculum and the practical factors that enable successful delivery in schools.

Denmark: Promoting physical activity

In 2013, Denmark introduced a legislative requirement through the *Folkeskole* (Education) Act that pupils should receive an average of 45 minutes of physical activity during each school day. However, implementation has been inconsistent with schools reporting challenges including limited resources, time pressures and variation in how the requirement is delivered.

Two school-based physical activity approaches explored during the Fellowship illustrate how this ambition can be implemented in practice:

- **11 for Health**: An 11-week football-based health education programme for 10–13-year-olds combining football activities with structured lessons on nutrition, hygiene, bullying and emotional wellbeing. Each session links sporting activities with wider health and social themes. Evaluations of 11 for Health have shown improvements in health knowledge and physical fitness with strongest wellbeing effects seen among children not already active in organised sports.

- **FIT FIRST:** A structured programme providing three weekly sessions of organised physical activity using 26 different sports. It aims to introduce pupils to a range of activities, increase enjoyment of movement and create pathways into community sport[103]. Evaluations of FIT FIRST involving more than 5,500 children aged 7–15 found improvements in physical fitness, body composition and overall health profile, while also increasing enjoyment of movement.

Together, these examples illustrate how physical activity can be integrated into the school environment and how structured approaches can help schools provide consistent opportunities for physical activity while reducing the burden on individual teachers.

Key learning:

- **Support implementation.** Setting expectations for physical activity is not sufficient on its own. Schools need practical resources, lesson plans, training and leadership support to translate policy into consistent delivery. FIT FIRST

provides a useful example of a structured programme with ready-made activities and a wide range of sports, reducing the burden on individual teachers.

- **Integrate health education with physical activity.** Programmes such as 11 for Health demonstrate how physical activity can provide a vehicle for reinforcing wider messages around healthy lifestyles, relationships and wellbeing.

What this means for the UK:

- Denmark's experience suggests that increasing physical activity requires more than setting targets for schools. The UK could consider how existing curriculum time and school facilities can be used more flexibly to incorporate shorter, varied and enjoyable forms of activity throughout the school day, rather than relying primarily on traditional PE.
- Programmes such as 11 for Health demonstrate the potential to combine movement with health education and create links between schools and community sport. Strengthening these connections could help reach children who are less likely to participate in organised sport and support longer-term engagement with physical activity.

Case Study 2d: Denmark's School-Day Physical Activity

KEY LESSON

Denmark's experience demonstrates that setting physical activity requirements is not sufficient on its own, highlighting the importance of providing schools with practical, evidence-based delivery models to support implementation of physical activity requirements.

WHAT HAPPENED

- Denmark introduced a legislative requirement for pupils to undertake an average of 45 minutes of physical activity each school day.
- In response to schools reporting challenges meeting this requirement, programmes such as 11 for Health and FIT FIRST were developed to provide structured approaches and ready-made resources for teachers.
- 11 for Health combines football-based activities with health education, while FIT FIRST provides structured lesson plans and activities designed to increase physical activity throughout the school day.

CHALLENGES IDENTIFIED

- Implementation burden. Schools and teachers reported challenges translating policy requirements into day-to-day practice.
- Sustaining engagement. Activities must be enjoyable and varied to maintain participation.
- Balancing priorities. Physical activity initiatives must fit within existing curriculum and timetable pressures.

POLICY IMPLICATIONS

- Support implementation. Schools may need practical resources, lesson plans and training to translate policy into practice.
- Integrate health education with physical activity. Programmes such as 11 for Health demonstrate how physical activity can be used to reinforce wider health messages.
- Evaluate delivery models. FIT FIRST provides an example of a structured, scalable model designed to reduce the burden on teachers.

Community and Municipal Prevention Approaches

A recurring theme across the Nordics was the emphasis placed on local integration and community-based prevention. In Denmark, Norway, and Finland, municipalities typically hold responsibility for a range of services affecting children and families, such as family support, early childhood education, school health and mental health services. This can support more coordinated approaches to prevention, although decentralised systems can also create variation between municipalities and difficulties in maintaining consistency in delivery.

- Family Centres (Finland)
- Tingbjerg Changing Diabetes (Denmark)
- FRAMM oral health programme (Sweden)
- Icelandic Prevention Model (Iceland)

Finland: Family Centres (Kallio, Helsinki)

Helsinki organises its social and healthcare services into three integrated centre types:

- Family Centres (ages 0–18),
- Health and Wellbeing Centres (working-age adults) and,
- Senior Centres

Family Centres act as low-threshold points of access, bringing together services that would otherwise be spread across different parts of the health, social care and education systems.

Helsinki has seven Family Centre districts, comprising four full centres and three networked satellite centres. Each brings together maternity and child health clinics, preventative oral health services, psychologist and speech therapy services, physical and occupational therapy, and a full range of social work and family support functions. Services are organised around a tiered model: families with less complex needs can access early support through multidisciplinary teams, while families with multiple or complex needs receive a combined needs assessment and a named case worker to coordinate subsequent support.

Helsinki has also invested heavily in shared digital infrastructure, including the Apotti system, which integrates health and social care records, and the Maisa portal, through which families can access services and information. Other tools, including the Sotebotti Hester AI chatbot and the Lapsiperheiden Helsinki information platform, are intended to make information and signposting easier for families and professionals.

What this means for the UK

- The UK's Best Start Family Hubs provide a close parallel, bringing maternity, health, parenting and family support together locally[104]. The Finnish model provides an example of how this infrastructure could be developed further, for example piloting a single multidisciplinary assessment and named coordinator within established Family Hubs for families requiring support from multiple services, to reduce the burden on families.

Case Study 2e: Finland's Family Centres

KEY LESSON

Finland's Family Centres demonstrate how integrating health, social care and family support around a single access point can reduce fragmentation and make early intervention easier to access.

WHAT HAPPENED

- Helsinki established a network of Family Centres bringing together maternity and child health services, oral health, therapy services, social work and family support.
- Services are organised around a tiered model, with multidisciplinary support for families with emerging needs and more intensive coordination for families requiring support from multiple services.
- Families can access services through shared digital infrastructure, including integrated records and online service portals.

CHALLENGES IDENTIFIED

- Coordination across services. Effective integration requires strong collaboration across health, social care and education systems.
- Workforce and resource requirements. Multidisciplinary models require sustained investment, staffing and digital infrastructure.
- Maintaining consistency. Integrated services must balance local flexibility with consistent access and standards across different areas.

POLICY IMPLICATIONS

- Reduce fragmentation. Consider piloting a single multidisciplinary assessment and named coordinator for families requiring support from multiple services.
- Build on existing Family Hubs. The UK's Best Start Family Hubs provide a strong foundation that could be developed further through deeper service integration.
- Invest in shared infrastructure. Integrated records, digital platforms and coordinated referral pathways can improve access and continuity of support.

Denmark: Tingbjerg Changing Diabetes (Copenhagen)

A useful example is Tingbjerg Changing Diabetes (TCD) in Copenhagen, a long-term 'supersetting' initiative in a diverse neighbourhood of Copenhagen with high rates of type 2 diabetes and other chronic diseases.

TCD uses a "supersetting" approach, working simultaneously across multiple settings including schools, housing, community centres, local businesses and healthcare. Rather than focusing solely on individual behaviour change alone, interventions are designed to reinforce healthier choices across the environments in which residents live and spend their time. The programme combines community kitchens, active play spaces, local walking groups, school activities, capacity-building and social initiatives, developed with residents and local partners. Importantly it is designed as a long-term initiative rather than a time-limited pilot.

Early descriptive and qualitative evidence suggest increased community engagement, stronger social connections and encouraging changes in some health-related behaviours. However, because TCD comprises multiple interconnected interventions delivered over a long period, it is difficult to attribute observed changes to individual components or establish longer-term effects on population health.

What this means for the UK

- England already has a strong foundation through place-based initiatives such as Healthy New Towns and Neighbourhood Health. Tingbjerg offers a complementary example of how these approaches could be strengthened through a "supersetting" model, with greater coordination across settings, meaningful community involvement and sustained local action.

Case Study 2f: Tingbjerg Changing Diabetes

KEY LESSON

The Tingbjerg Changing Diabetes initiative (TCD) demonstrates the value of a long-term, place-based and community-led approach in supporting healthier behaviours and strengthening community engagement.

WHAT HAPPENED

- Long-term "supersetting" programme in a diverse Copenhagen neighbourhood.
- Coordinated action across schools, community organisations, housing and healthcare services.
- Activities include community kitchens, walking groups, active play spaces and school-based programmes, co-designed with residents.
- Early evaluations report stronger social networks, greater community participation and encouraging trends in type 2 diabetes outcomes.

CHALLENGES IDENTIFIED

- Long-term investment required. Meaningful reductions in chronic disease risk may take many years to emerge requiring sustained funding and support
- Coordinating multiple stakeholders with differing priorities and organisational cultures.
- Evaluating impact. Because TCD consists of many interconnected activities delivered over a long period, it is difficult to isolate which elements are responsible for observed changes.

POLICY IMPLICATIONS

- **Adopt a whole-system approach. Sustained, locally tailored approaches to help address the underlying social and environmental drivers of chronic disease.**
- **Co-produce interventions with communities. Involving residents and local organisations in design to improve participation and sustainability.**
- **Think beyond short-term pilots:** Prevention may require sustained investment before meaningful changes in population health become visible.

Sweden: FRAMM Oral Health Programme

Sweden's FRAMM programme (*Fluoride, Advice, Arena, Motivation and Diet*) implemented across the Västra Götaland region in 2008, demonstrates how oral health prevention can be delivered through a life-course approach. It aims to improve adolescent oral health and reduce inequalities in dental cavities through population-level prevention rather than relying on individual dental attendance.

A core element is twice-yearly, school-based fluoride varnish for all children aged 12-15 years, delivered alongside oral health education, dietary and toothbrushing advice, supervised flossing and tobacco prevention messages. Prevention also begins during pregnancy, with parents receiving oral health information and toothbrushes at key developmental stages. The intervention is adapted according to need, with more intensive support in areas with higher levels of dental disease and tailored approaches for children requiring additional support.

Evidence suggests that applying fluoride varnish in schools can help prevent tooth decay and that FRAMM is cost-effective by reducing the need for treatment later in life [105] [106].

What this means for the UK:

- The UK has a strong rationale for earlier, population-level dental care prevention. Tooth decay is the leading cause of hospital admission for 5–9-year-olds with substantial inequalities by deprivation, costing the NHS £40.7 million[107]. FRAMM demonstrates how existing school toothbrushing programmes could be extended across the life course and additional support where need is greatest.

Case Study 2g: Sweden FRAMM life-course dental prevention

KEY LESSON

A life-course approach combining universal school-based prevention with ongoing support from early childhood can improve oral health outcomes.

WHAT HAPPENED

- FRAMM (Fluoride, Advice, Arena, Motivation and Diet) was introduced in Västra Götaland in 2008 to improve adolescent oral health and reduce inequalities in dental decay.
- Oral health support begins before birth through parental information and toothbrush packages throughout childhood.
- The programme provides twice yearly fluoride varnish applications for all children aged 12-15 years during the school day. Interventions are supported by oral health education, advice on diet, supervised flossing and tobacco-prevention messages.
- Evaluation points to long-term cost-effectiveness.

CHALLENGES IDENTIFIED

- Requires sustained investment and coordination between schools and dental services.
- Public concerns and misinformation about fluoride can affect acceptance and uptake.

POLICY IMPLICATIONS

- Combine clinical prevention with health education and behaviour change support.
- Use schools as effective settings for delivering population-level interventions.
- Accompany preventive programmes with clear public communications to address misinformation and build trust in evidence-based interventions.

Icelandic Prevention Model ('IPM')

One of the most extensively studied Nordic youth prevention models is the Icelandic Prevention Model (IPM). Developed during the 1990s in response to high levels of adolescent substance use, it brought together policymakers, government officials and social scientists to redesign prevention around the environments in which young people live and develop new approaches to preventing substance use[108].

The IPM is a population-level intervention that seeks to strengthen protective factors and mitigate risk factors across four domains: family, peer groups, schools and leisure time.

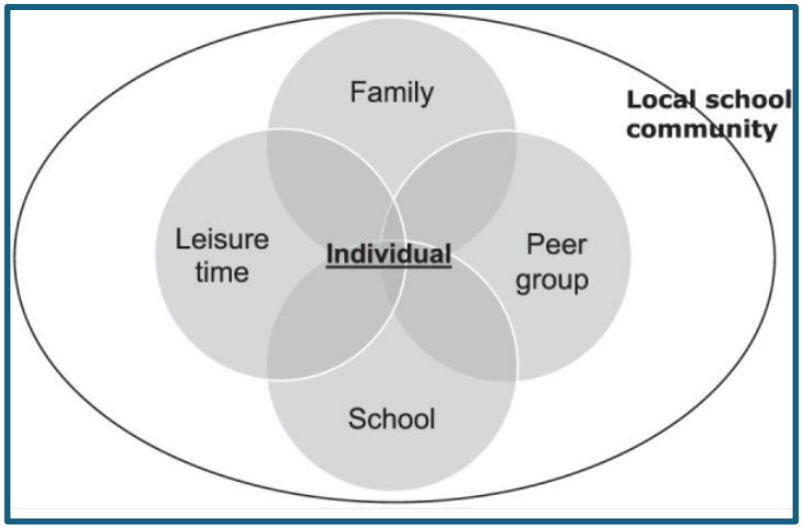


Figure 2. Domains of Community Risk and Protective Factors in the Icelandic Prevention Model (Kristjansson and others, 2019)

The model is underpinned by five guiding principles:

1. Applying a primary prevention approach that strengthens the social environment,
2. Using schools as the natural hub for community action.
3. Empowering communities to make practical decisions using local, high-quality, accessible data.
4. Integrating researchers, policymakers, practitioners, and communities into a unified team.
5. Matching the scale of intervention to the scale of the problem through long-term investment.

Several measures illustrate how the IPM translates these principles into practical community action. These include policies and initiatives designed to strengthen parental involvement, increase structured leisure opportunities and reduce exposure to risky environments. Examples include:

- **Outdoor-hours policies:** restrictions on when children and young teenagers can be outside without adult supervision, with earlier limits applying to younger children.
- **Leisure cards:** municipalities provide financial support for children to participate in organised sports and other extracurricular activities, helping to reduce cost as a barrier to structured leisure.
- **Parental night walks:** organised groups of parents patrol local areas in the evening, increasing adult presence and encouraging teenagers to return home.
- **Public campaigns:** initiatives such as *Stay Smart* reinforce prevention messages and mobilise parents and communities around shared expectations for young people's behaviour.

Since the model was developed, Iceland has experienced one of Europe's largest declines in adolescent substance use. By 2015, Iceland had some of Europe's lowest rates of youth smoking, alcohol consumption and cannabis use[109]. The IPM has since been adapted and implemented in more than 19 countries, from Ireland to South Africa. Today, the model operates globally through the Planet Youth platform.

What this means for the UK:

- The IPM (Planet Youth) illustrates that individual interventions are more meaningful when they form part of a wider local system - interventions need to connect with other services, opportunities and community assets. However, UK experience highlights the importance of sustained funding, collecting local data, strategic buy-in and local infrastructure; short-term funding and fragmented implementation can limit the effectiveness of place-based prevention.

Key learnings from Part 2: School and Communities

1. **Tackle the school environment and embed prevention within the school day.** School-based prevention appears most effective when it works with the social environment of the school rather than relying solely on classroom teaching. The wider lesson is that schools can be particularly powerful prevention settings when interventions work through relationships, belonging and peer networks. This highlights the importance of evaluating initiatives such as the HEALS study and considering whether the UK could go further in building resilience, critical judgement and life skills as central educational aims.

2. **Provide holistic, visible health support within schools and communities.** Finnish school nurses illustrate the value of embedding holistic health support within schools. Universal provision can normalise support, reduce stigma and create opportunities for early identification. Finnish Family Centres similarly show how integrating health, social care and family support can reduce fragmentation and make early support easier to access.

3. **Reshape environments and invest in protective factors.** Nordic examples go beyond individual behaviour change to shape the settings that influence behaviour. The IPM, Tingbjerg and FRAMM strengthen protective factors through families, schools, communities and access to positive activities. Access to sport, arts, social connections, supportive families and accessible services can help reduce risk and promote healthier behaviours, but require sustained local investment rather than short-term projects.

4. **Build on existing UK approaches.** Family Hubs, school-based oral health programmes and place-based prevention provide a foundation in the UK. Nordic examples offer ideas for strengthening these approaches, but successful implementation requires long-term funding, local ownership, responsive use of data and adaptation to the UK context.

System Features Behind Nordic Prevention

Across the case studies explored throughout this Fellowship, five enabling features recur: actionable data, meaningful youth participation, a balance of risk reduction and resilience, institutional trust and Health in All Policies. While each country applied them differently, these features may explain why individual programmes can operate as part of a prevention system rather than isolated projects.

- Data as Infrastructure and Local Action
- Risk and Resilience
- Youth Voice and Co-creation
- Health in All Policies
- Trust: The Nordic Gold



Data as infrastructure and local action

Why it matters

Data is often viewed as a tool for monitoring outcomes. The Nordic experience suggests it can also function as active infrastructure for prevention itself. Rather than being collected centrally and reported retrospectively, data is returned rapidly to the schools, municipalities, and local services, where it can be interpreted and acted upon.

What I observed

Examples observed during the Fellowship, such as Planet Youth and Ungdata, demonstrate how data can function as a tool for action, rather than a retrospective measurement. The value of these models lies in their ability to connect data collection, local interpretation and community action through a structured and recurring process. Planet Youth illustrates this clearly: survey findings are used to identify emerging trends, adapt local priorities and guide collective action on the wider environment.

Norway's Ungdata model provides a particularly clear example. Established in 2010, it is a national survey system delivered locally. Pupils complete a web-based survey during school hours, covering topics such as mental and physical health, wellbeing, substance use, relationships, leisure activities and school life[110]. By 2025, almost 900,000 young people had participated, covering students from nearly all Norwegian municipalities.

Importantly, Ungdata is designed first and foremost as a local planning tool. Municipalities receive their own reports and data outputs, designed to be accessible to local leaders and practitioners, with findings discussed locally to support shared interpretation and responses tailored to community needs. Local datasets are then combined into a national database, supporting wider monitoring and research while retaining a strong focus on local action.

What emerged repeatedly during discussions was that the strength of these systems lies less in the survey itself and more in what happens afterwards. Data is returned rapidly, discussed locally and used to create shared understanding across schools, services, parents and policymakers. This creates a continuous cycle of collecting,

interpreting, sharing and acting on evidence, allowing priorities and interventions to evolve in response to changing local circumstances

What this means for the UK

The UK already has strong and valuable sources of youth health data, including Office for National Statistics and NHS digital surveys, alongside administrative datasets, such as the National Pupil Database. The key lesson from the Nordic approach is that data systems are most effective when they support a continuous cycle of collecting, interpreting, sharing and acting on evidence.

In Nordic countries, municipal and school-based surveys help identify emerging issues and adapt responses more quickly. National registers and linked data sets also support evaluation of major reforms, such as Norway's Health and Life Skills curriculum changes, at a population level.

The RCPCH's State of Child Health 2026 identifies a related national gap, recommending a single overarching measure of children's health and wellbeing and a universal child identifier, using the NHS number, to improve data-sharing across datasets[111]. The Nordic experience suggests an additional opportunity: rapid, locally returned survey infrastructure that supports decision-making within the same academic term in which evidence is collected.

A UK pilot could test an Ungdata-style survey-to-action model within a small number of local authorities, using existing validated survey questions. Findings would be returned locally within the same academic term and discussed within a named local forum, such as the Health and Wellbeing Board, creating a clear link between evidence, discussion and action.

Youth voice and co-creation

Why it matters

Youth participation can improve the quality, legitimacy and effectiveness of decisions by ensuring policies reflect the lived experiences of those they are intended to support. Its value, however, extends beyond better policymaking. Meaningful participation can strengthen democratic confidence, build trust in institutions and help young people develop the knowledge, skills and confidence to engage in democracy. Youth councils and other participatory structures provide opportunities for young people to influence decisions that affect them, while helping policymakers better understand local needs and priorities.

Participation is also closely linked to trust and prevention. When young people can influence decisions and see how their views have shaped outcomes, they are more likely to engage with services, programmes and wider public institutions.

What I observed

A consistent lesson running across the Fellowship was that Nordic countries treat young people as social actors whose experience should shape policy and services, not simply as targets for behaviour change. This appeared in different forms, including youth councils, co-designed national programmes and local interpretation of survey findings. Underpinning these approaches was a broader cultural assumption that CYP should be listened to in matters that affect them.

In Sweden, Iceland and Denmark, youth councils are optional. Whereas, in Finland and Norway youth councils are mandatory on local and regional levels. Finland demonstrates what statutory backing can achieve in practice. Youth councils became a legal requirement under the 2015 Municipal Act and are now embedded across almost all municipalities. 75% felt they had influence in their municipality and 90% felt they had influence in county-level decision-making[112]. By contrast, Denmark's youth councils remain voluntary and coverage is less consistent, demonstrating how participation can depend on local priorities.

The Planet Youth model also illustrates the value of co-creation. Rather than asking young people to endorse pre-determined solutions, it involves them in shaping research questions, interpreting findings and informing local responses.

Discussions with colleagues at Sweden's National Board of Health and Welfare (Socialstyrelsen) described an extensive consultation and co-creation process involving CYP from all ages to inform new national guidance. This reflected a wider principle observed throughout the Fellowship: CYP were not simply consulted on policy but increasingly involved in its design.

What this means for the UK

The UK has many examples of good practice, but youth participation remains variable and can often relies on one-off consultation rather than routine involvement.

A large-scale consultation of children in England conducted between September 2023 and January 2024 reported that only one in five children believed their views are important to adults who run the country, while only 10% of teenagers believe they have the power to influence the issues they care about[113].

Similarly, evidence suggests almost 75% of CYP aged 11-25 would like to learn more about politics and democracy in school[114]. While most hear about politics from TV or social media, many also express concerns about whether those sources can be trusted. Together, these findings suggest both an appetite for greater participation and an opportunity to create more meaningful routes for CYP to shape decisions that affect their lives.

The Nordic experience suggests that youth voice is most effective when it is built into the design of systems from the outset rather than added at the end of a process. For the UK, this means moving towards a more structured, consistent involvement of CYP in shaping policy, interpreting evidence and evaluating whether services meet their needs. Doing so would not only improve the quality of decisions but also strengthen the legitimacy and trust on which effective prevention depends.

Trust: the 'Nordic gold'

Why it matters

Trust[vi] is often described as the 'Nordic Gold' of the welfare model. It is the expectation that others will act in ways that are beneficial, or at least not harmful to us.

One of the clearest lessons from the Nordics is that trust is not simply a cultural trait. It is actively strengthened or weakened by how systems behave, whether systems feel fair, whether people feel able to influence decisions, and whether public services are reliable, accessible and visible in everyday life. Evidence suggests that higher levels of trust are associated with greater engagement with public services, better adherence to public health advice and improved health outcomes[115]. Trust therefore functions as an enabling condition for prevention.

What I observed

Trust emerged as a consistent theme throughout the Fellowship. At the Nordic Welfare conference, speakers linked trust to perceptions of fairness, transparency, equal treatment, social mobility and institutional competence, while also warning that trust declines when inequality grows, people feel unheard or decisions appear captured by private interests[116].

Several speakers also highlighted that trust operates at multiple levels: between individuals, between communities and within institutions. Schools in particular were repeatedly described as trusted local institutions, with some arguing that co-locating health, family and community services around them can improve both access and a sense of belonging, particularly in disadvantaged areas. This echoed wider observations from the Fellowship, where school health services, family centres and community-based support were intentionally designed as visible, accessible and low-threshold points of contact.

[vi] The literature distinguishes between interpersonal trust (trust in one another) and institutional trust (trust in governments and public services), both of which are fundamental to public health.

An additional insight was that several Nordic countries have actively explored "trust reforms" within public services. These reforms seek to reduce unnecessary bureaucracy, provide greater autonomy to frontline professionals and strengthen relationships between citizens and institutions. The underlying principle is that trust is not simply inherited but can be strengthened through the way services are organised and delivered.

What this means for the UK

Nordic prevention policies operate within systems where trust has been built over decades through reliable, transparent public services and relatively low levels of inequality. This helps explain why interventions, such as school wellbeing surveys, health programmes, and local prevention initiatives often achieve high levels of participation - they are delivered by institutions that people generally believe are acting in their interest.

This is particularly relevant for the UK. In 2025, 33% of people in the UK reported high or moderately high trust in the national government, compared to the OECD average of 40%[117].

The Nordic experience suggests that trust should be viewed as a form of prevention infrastructure. Building trust depends on creating institutions that young people experience as fair, responsive and reliable, providing meaningful opportunities for participation, giving clear feedback on how views have influenced decisions and consistently delivering on commitments.

Risk and resilience

Why it matters

Resilience[vii] is often defined as the ability to adapt positively to adversity, challenge or change. While frequently discussed as an individual characteristic, resilience also exists at community and systems level. Families, schools, communities and public services can all either strengthen or weaken a young person's ability to cope with challenges.

What I observed

Across the Fellowship, a recurring distinction emerged between approaches focused primarily on controlling risk and those aimed at building resilience. Discussions often framed risk not as something that should be eliminated entirely, but as something that young people can learn to navigate safely within supportive environments.

This could be seen both in physical and digital environments. Examples ranged from playgrounds designed to encourage exploration and managed risk, to digital wellbeing approaches that focused less on complete restriction and more on helping CYP to develop the skills to critically evaluate information, recognise misinformation and manage online risks.

Resilience also emerged as a broader systems concept. The Icelandic Prevention Model, for example, focuses on strengthening protective factors such as organised activities, family connection, community belonging and positive peer relationships. A practical example of this is Iceland's leisure card scheme, which provides financial support for CYP to participate in organised extracurricular activities.

What it means for the UK

The Nordic perspective challenges a false choice between regulation and resilience. The strongest examples combined structural protections, such as restrictions,

[vii] Resilience operates at several levels: individual resilience (a young person's capacity to cope with adversity), community resilience (the degree to which families, schools, and local services buffer children against adverse exposures), and systems resilience (the capacity of public institutions to sustain prevention efforts over time).

guidance and service access, with investment in the capabilities, confidence and relationships that help young people manage risk.

This is particularly relevant to digital policy. In June 2026, the UK Government announced plans to ban social media access for children under-16, with implementation expected in spring 2027. The Nordic experience suggests that any regulatory measures should be accompanied by an equally strong resilience approach, ensuring CYP have the skills, confidence and critical thinking needed to participate safely in digital environments.

There are already examples of resilience-building approaches in the UK. Free to Play UK, a five-year programme supporting outdoor, child-led and adventurous play, provides a practical example of investing in opportunities as well as reducing risks. School-based social prescribing, arts-based wellbeing programmes, Family Hubs and wider pastoral support models also illustrate how trusted settings can support wellbeing and resilience and help young people develop greater independence. The Nordic lesson is not necessarily to create new services, but to embed resilience-building within existing trusted settings, particularly schools, families and communities.

Health in All Policies

Why it matters

Health in All Policies (HiAP) is an approach to policymaking that seeks to systematically consider the health implications of decisions across sectors to improve population health and health equity[118]. For example, policies to reduce road congestion could simultaneously promote active transport, improve air quality and encourage physical activity, delivering wider health benefits alongside transport objectives[119].

The relevance for CYP is particularly clear. Much of what determines health occurs outside the healthcare system itself, such as decisions about school environments, active travel, green space, housing quality, family support and digital environments.

HiAP therefore provides a framework for tackling the wider determinants of health and ensuring that improving population health is viewed as a shared responsibility across government and society, rather than solely the responsibility of health services.

What I observed

HiAP emerged throughout the Fellowship, despite it was rarely described explicitly in those terms. Across the Nordics, there was recognition that improving health and wellbeing requires coordination action across multiple actors and sectors. Many of the examples explored, including Family Centres and school-based services, reflected a practical understanding that child health is influenced simultaneously by multiple policy areas.

Finland first championed the approach internationally during its Presidency of the European Union in 2006, building on the success of its public health campaigns in the 1970s which improved public health through changes to national diets[120]. Norway's Public Health Act 2012 similarly established health as a shared responsibility across sectors and levels of government.

An important lesson from the literature and discussions during the Fellowship was that legislation alone is insufficient[121]. Successful implementation depends on leadership, accountability, capacity and culture. Countries may adopt HiAP frameworks, but

without mechanisms to influence decision-making and align priorities across sectors, implementation can remain inconsistent.

What this means for the UK

The Nordic experience suggests that the greatest opportunity is not necessarily creating new structures but strengthening alignment across existing ones. A clearer and more consistent focus on child health across government could help ensure that decisions on education, housing, transport, planning and the digital environment are considered not only for their primary objectives, but also for their impact on children's health and wellbeing.

Elements of a HiAP approach already exist within the UK. Wales's Well-being of Future Generations Act (2015), for example, provides a statutory framework for embedding wellbeing considerations across public policy[122]. Some local authorities in England have also adopted HiAP approaches[123]. There is an opportunity to bring this practice together into a clearer national framework that places child health at the centre of decision-making across government. This could include greater use of health impact assessments and stronger cross-government accountability for child health outcomes helping to create a culture in which improving the health and wellbeing of CYP is recognised as a shared responsibility.

Conclusion

This Fellowship began with a focus on youth vaping and nicotine use, but its central lesson is broader: regulation cannot be separated from the systems that shape children's health. Across the Nordic countries, stronger prevention is supported by timely local data, accessible universal services, meaningful youth participation, protective environments, institutional trust and attention to health across government.

What the UK could integrate now

The UK can act through existing structures. It can use the Tobacco and Vapes Act powers proactively, develop youth nicotine surveillance and cessation support, pilot rapid survey-to-action feedback, strengthen schools as universal prevention settings and align neighbourhood health centres and local partnerships around shared child-health outcomes.

Longer-term reform

Other lessons require deeper change, for example, a stronger statutory foundation for youth participation, sustained cross-government accountability for child health, greater local capacity and more secure investment in preventive services. Universal provision must be accompanied by proportionately greater support in communities facing poverty, exclusion and poorer health.

A UK opportunity

There are strong examples of UK public-health initiatives, such as Sure Start, vaccination programmes, National Child Measurement Programme (NCMP) and Family Hubs that demonstrate that prevention can work in a UK context when it is sustained and connected. The Tobacco and Vapes Act is also an ambitious public health reform that places the UK ahead of several Nordic comparators in tobacco control. In pushing the boundaries of what is both politically and practically possible, the UK is helping to set a new international direction of travel.

The opportunity now is to match that regulatory ambition with equally strong prevention infrastructure. Delivered together, bold regulation and adaptive prevention offer a credible route towards the Government's ambition to create the healthiest and happiest generation of children in Britain's history.

Financial perspective

In a constrained fiscal context, Nordic approaches require realism about affordability, delivery capacity and competing demands. Immediate pressures on health services and local government can make longer-term prevention investment difficult to sustain, particularly where costs fall to one part of the system while benefits emerge later or elsewhere.

This report has not estimated the cost implications of its recommendations. However, evidence illustrates the potential value of investing earlier in children's health and wellbeing. For example, in the UK KiVa trial, bullying victimisation was lower than under usual practice at an additional education-sector cost of £20.78 per pupil in the first year and £1.65 in subsequent years, and the Swedish economic modelling of FRAMM projected better dental outcomes and lower long-term costs.

Not every recommendation in this report requires a new service. Some involve using existing structures differently, applying a stronger prevention lens, making better use of local data, involving CYP in design and strengthening resilience through opportunities such as outdoor and creative play. Others, including dedicated youth nicotine cessation support and stronger survey-to-action infrastructure, are more likely to require additional workforce, training and service capacity.

There may also be value in making local investment in CYP more visible. Drawing on Reykjavík's Recreation Card, local areas could explore a clearly identified contribution toward sport, arts and creative activities, complementing the Government's investment in Young Futures Hubs. This could give young people greater choice while directing investment towards youth clubs, grassroots organisations and other local providers.

Funding certainty also matters. While Nordic approaches tend to embed prevention within ongoing municipal responsibilities and longer-term planning, funding in England has historically been shorter term. The 2026-29 Public Health Grant, the first three-year public health settlement in a decade, is a welcome move towards greater certainty for authorities to plan prevention services.

Future areas for learning

The Fellowship identified priorities for future exchange and research:

- Youth nicotine cessation and long-term evaluation of product regulation.
- Scaling survey-to-action models in the UK.
- Protecting young people from digital harms.
- Ethical public–private partnerships.
- Digital infrastructure and public-sector capability for prevention.

Appendices

Annex A: Examples of nicotine pouch advertisement, London









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